



EVALUATION OF THE SECOND PHASE OF THE SKILLED FOR HEALTH PROGRAMME



Final evaluation report April 2009

CONTENTS

EXECUTIVE SUMMARY	i
1. Introduction.....	1
2. Key Features of Skilled for Health in Phase 2	7
3. The Activities planned by sites	11
4. Implementing Skilled for Health	19
5. Outcomes at individual level	33
6. Sustainability	47
7. Conclusions: Main messages from the National Evaluation	51
8. Key learning Points	55
9. Recommendations	57
10. Future Research Questions and how these could be addressed.....	61
APPENDICES.....	65
1. Reflections on the evaluation approach and methods	67
2. Evaluation questions.....	69
3. Case Studies	71
4. Short description of Skilled for Health projects considered in-depth by the national evaluation	83



EXECUTIVE SUMMARY

Skilled for Health is a national programme jointly funded by the Department of Health (DH) and Department for Innovation, Universities and Skills (DIUS) and managed by the community learning charity ContinYou in a strategic partnership with the two departments. It aims to engage people with skills for life needs in learning in order to improve their health literacy and their language, literacy and numeracy. Skilled for Health supports the cross cutting objective of reducing health inequalities as well as improving Skills for Life in the adult population of England. But it allows considerable flexibility in individual project design to reflect differing organisational and/or local objectives and diverse target groups of participants. The National Evaluation team (The Tavistock Institute and Shared Intelligence) used a 'Theory of Change' framework to evaluate the Skilled for Health at programme, project and individual level. The main findings are set out below.

THE ACTIVITIES PLANNED BY SITES: "A USEFUL ENGAGEMENT TOOL"

Motivations for sites

- A high proportion of phase two Skilled for Health sites were motivated to join the programme in order to address a 'lack of knowledge on health issues' amongst their local population. Sites also believed it could be a useful 'health focused' engagement tool to meet broader aims of addressing deprivation, low aspiration and tackling specific health problems (like smoking or mental health).
- The perceived benefits to the organisations involved were - the potential for creative (and sometimes new) partnership working between health and education, a way of enhancing existing training offers with new materials and being selected as site for trialling a health literacy course amongst target groups.
- Strong organisational support has also been identified as an important factor in the successful establishment of local sites, and this is often complemented via senior management support or a local 'champion'.

Staffing

- All sites used sessional or part-time staff to run the Skilled for Health courses. The roles required to

deliver the programme varied by site, the majority of staff had an educational background (either in adult teaching or Skills for Life), others had a health background (as a health specialist or a health visitor) or employed trainers or facilitators for specific topics.

- Different delivery staff also had different training needs. Some (light touch) training is appreciated in particular by Skills for Life tutors to increase their confidence in delivering health materials and, possibly, to improve basic teaching skills.

Financing delivery

- It was difficult to identify the cost of a 'typical' Skilled for Health scheme or course, as costs can be affected by a number of different factors, such as the number and length of courses run, the number of participants recruited. However, actual costs per course varied widely from one site in which this was just over £2000 to another in which it was nearly £16,000. The average cost was £6200 per course. However, it was also clear that costs per course reduced as sites ran more courses: several sites ran more courses than they had originally planned, and the cost per course reflected this.

IMPLEMENTING SKILLED FOR HEALTH: “NO ONE BEST MODEL”

There was no ‘one best model’ of delivering Skilled for Health courses and activities. The actual form that Skilled for Health projects took was determined, in part, by the needs of participants as well as the capacity of the organisation to deliver activities at different times or in different types of setting.

Sites often crafted an ‘offer’ that would appeal to participants and encourage them to join courses or workshops. The actual ‘offer’ could vary along a number of different dimensions: how Skilled for Health was delivered, length, adaptation of materials and the kind of staff that were employed to deliver the materials.

Recruitment & Draw for participants

- Successful recruitment of participants is the key to successful projects. Some sites had difficulties in recruiting the numbers originally anticipated, and most sites had to explore a range of different methods in order to recruit from the target groups that they originally planned to involve.
- The key element was finding a recruitment method that was suitable for their particular target population. This might include referrals from other agencies, or from existing courses, but the most successful routes were often informal ones – word of mouth and self referral, supported by a range of informal meetings with other organisations, or organising informal introductory events. Health related topics were generally seen as a most effective ‘draw’, although some sites did use improving language skills as one approach to recruiting participants particularly from ethnic minority groups.
- The ‘draw’ for learners in the Skilled for Health programme varied from site to site. Common factors were an interest in health (healthy eating), the desire to ‘do a course’, the availability of a crèche, the chance to socialise, meet new people and the visibility of the course in familiar and

informal locations such as libraries, community centres, workplaces etc. What an organisation was able to provide as a ‘draw’ for participants also varied according to what resources or facilities they could access (i.e. a gym).

- The majority of participants recruited were women, but workforce and sector sites were unusually successful (for health related activities of this kind) in recruiting men. Community organisations were particularly successful in recruiting from younger age groups (although this was primarily because of their targeting of these groups).
- Some target groups, often the hardest to reach, required a wide range of recruitment approaches, which also required the investment of considerable resources.

Delivery

- The format for Skilled for Health courses is shaped by the organisational context and learner needs. The materials could be delivered through one day workshops, short or longer courses to learner groups, one to one learner support, or using e-learning methods.
- Course lengths varied between sites. Where Skilled for Health courses lead to accreditation courses had to comply with required teaching hours for (entry) level exams.
- The learning could be self led, delivered by tutors with qualifications in health, community development, Skills for Life or ESOL training. Experts could be brought in for specific topics, or discussion of the topics could be facilitated by non experts or via IT/e-learning.

Materials

- The Skilled for Health materials were well received by the tutors delivering courses. The greatest use was made of healthy drink and food, mental health

and physical activity related topics, but topics related to using the NHS and communicating with health professionals were also popular.

- The majority of tutors adapted the Skilled for Health materials, although in most cases they were changed ‘only slightly’. GP and local primary care services and The NHS and other support were sections that required least adaptation, whereas First aid and Substances were most extensively changed. The main reasons for adapting the

materials were to respond to learners’ specific interests, or to bring the materials at the right level for the audience.

- The development of sexual health materials also highlighted the need to keep learning practical and lively by allowing tutors to have enough time and training in sexual health to be able to simplify technical information in STIs and HIV to the specific learner group and be able to answer questions from them.

OUTCOMES AT INDIVIDUAL LEVEL: “PROGRESSING LEARNERS”

Health outcomes

- Learners showed a substantial increase in knowledge on health after having participated in a Skilled for Health course, particularly in the areas of healthy eating, exercising, smoking and drinking or looking after their mental health. Indeed, Skilled for Health courses seem to have produced wider changes in learner behaviour by helping them to take up healthier options in terms of fruit and vegetable consumption and more frequent exercise.
- Changes to smoking and drinking behaviour are far less pronounced. In both cases, around three quarters of phase two learners reported they had not changed their behaviour in this respect. The most significant outcome here is that learners understand the negative consequences of these habits even though they are not always able to change them.
- Mental health is another agreed area of outcome for individuals in a number of projects. Learners reported some ‘better than usual’ responses to concentration, enjoying day to day activities and feeling reasonably happy. The social side of the courses may also be an outcome that contributes to these changes.

- The skills and knowledge in healthy eating developed during courses can also be said to have secondary outcomes, with learners making improvements to family health and cascading their new knowledge back into the community.

Learning outcomes

The programme opens up two kinds of progression routes - improvement in skills levels and a high motivation to continue learning together with some learners realising these plans through increased confidence to enter educational spaces (i.e. classrooms). Around 80 % of Skilled for Health learners were interested in further study, with a quarter finding or registering on another course.

There are important external conditions that need to be present to support this movement. These are: advice and guidance by tutors, integration of Skilled for Health with other learning provision locally and free spaces on courses.

Six sites progressed learners along literacy, language and numeracy (Skills for Life) levels, even though this was not the intention of the programme. Some accreditation resulted directly from a project aiming to support learners to gain an Skills for Life qualification or delivery via a further education institution.

IMPACTS: "SUSTAINABILITY IS AN ISSUE"

Sustainability at project level

All sites plan to continue their Skilled for Health projects/activity, but some have been more successful in finding ways of sustaining Skilled for Health. Two sites have confirmed funding to sustain activities. These include MLA London, where three of its libraries have been successful in gaining funding locally to deliver Skilled for Health courses and another is in discussions with its PCT and RDA; and Pentonville Prison, which has secured resources from within the prison and from Islington PCT to continue its Skilled for Health project.

Concerns about the availability of funding/ support from mainstream sources persist, especially where delivery models are not geared towards accreditation.

Some key factors appear to contribute to making a project sustainable: (1) Resources available from the host organisation and partners; (2) Having senior management commitment and leadership; (3) links to strategic partners; (4) strength of project evidence of success; (5) making explicit links to local, regional and national policy priorities; (6) variance between 'sector' and 'community' in terms of dual intervention and match funding.

Sustainability at programme level

The programme level infrastructure of Skilled for Health has clearly been important in providing support for the sites and giving the programme an identity within Government and other stakeholders. On the whole, sites have generally been quite positive about this relationship with the programme as a whole and have valued the contact and support they have had from the national team.

To enable Skilled for Health to be a sustainable approach in a range of settings, future national programme level support would need to include:

- support with organisational negotiations on potential projects;
- information about the programme and clarity about likely resource requirements for delivery and evaluation;
- coordination of a network of sites to share learning and good practice;
- establishing a clear identity for the programme; and
- support for sustainability through information and guidance on funding options.

Sufficient resources are required centrally for the above tasks to occur and thought needs to be given to the way sites can be best supported around the issue of sustainability in future phases. Championing and maintaining national commitment to the programme in the face of organisational, ministerial and policy change are also considered to be vital.

CONCLUSIONS

The second phase of Skilled for Health has focused on introducing the programme into a range of 'employer', 'sector' and 'community' sites and testing it out in these different settings. Overall 1600 participants in 18 sites have been engaged in the programme, primarily through an interest in health issues. This initial 'draw' has, however, led to learning outcomes as well as positive changes in health literacy, awareness and behaviours. Individual outcomes have also included an increase in confidence and an interest in further learning.

The national evaluation has found that one of the distinctive aspects of Skilled for Health is its flexibility in responding to a range of learners' needs and circumstances, through user-led approaches that

have attracted 'hard to reach' groups who would have been unlikely to access mainstream learning or health promotion provision.

The backing of the national programme has been important to the sites, in terms of financial resources, the Skilled for Health materials and support from the management team and ContinYou staff in setting up and managing the projects. The evaluation has identified some key factors in sites that help making projects sustainable but has concluded that programme level support will also continue to be required in the future to champion, co-ordinate and maintain the innovative approach that Skilled for Health represents.

RECOMMENDATIONS

There is an urgent need to agree on the vision for the future of Skilled for Health in terms of its purpose and scope.

Whatever form a further phase takes, sufficient resources are required centrally, for five key tasks: negotiation and contracting with new sites; supporting sites in the set up process; supporting networking and learning across sites; support for sustainability planning; and maintaining the overall strategic direction of the programme (which is likely to also

require ongoing negotiation with key stakeholders at a national level).

Skilled for Health is a very diverse programme and sites will be looking to tap into different – and often local or regional - funding streams in order to achieve sustainability. The national programme should keep up-to-date with progress around this to prepare for any future work and opportunities.



INTRODUCTION

Skilled for Health – which was jointly funded, during its second phase, by the Department of Health (DH) and Department for Innovation, Universities and Skills (DIUS) and managed by the community learning charity ContinYou in a strategic partnership with the two departments – is a national programme that aims to engage low skilled people in learning in order to improve their health and skills for life. It has done this through piloting and testing out new approaches through a range of diverse and innovative projects in employer, other institutional and community sites.

1.1. ABOUT THE SKILLED FOR HEALTH PROGRAMME

The second phase of the Skilled for Health programme therefore had two specific objectives:

- To contribute to reducing health inequalities (premature mortality/morbidity) by improving health among those communities that demonstrate the worst health outcomes, and to enhance the ability of individuals within those communities to make informed decisions about health and well-being in a variety of different settings; and
- To use health improvement topics, which embed skills for life learning, as an incentive to engage and recruit individuals who do not traditionally

participate in adult learning initiatives, with a view to supporting them to progressing into other learning opportunities – including where appropriate a Skills for Life qualification based outcome.

A distinctive characteristic of the second phase of Skilled for Health has thus been the combination of a high level, cross cutting objective of reducing health inequalities, with considerable flexibility in individual project design to reflect differing organisational and/or local objectives and diverse target groups of participants.

1.2. THE NATIONAL EVALUATION

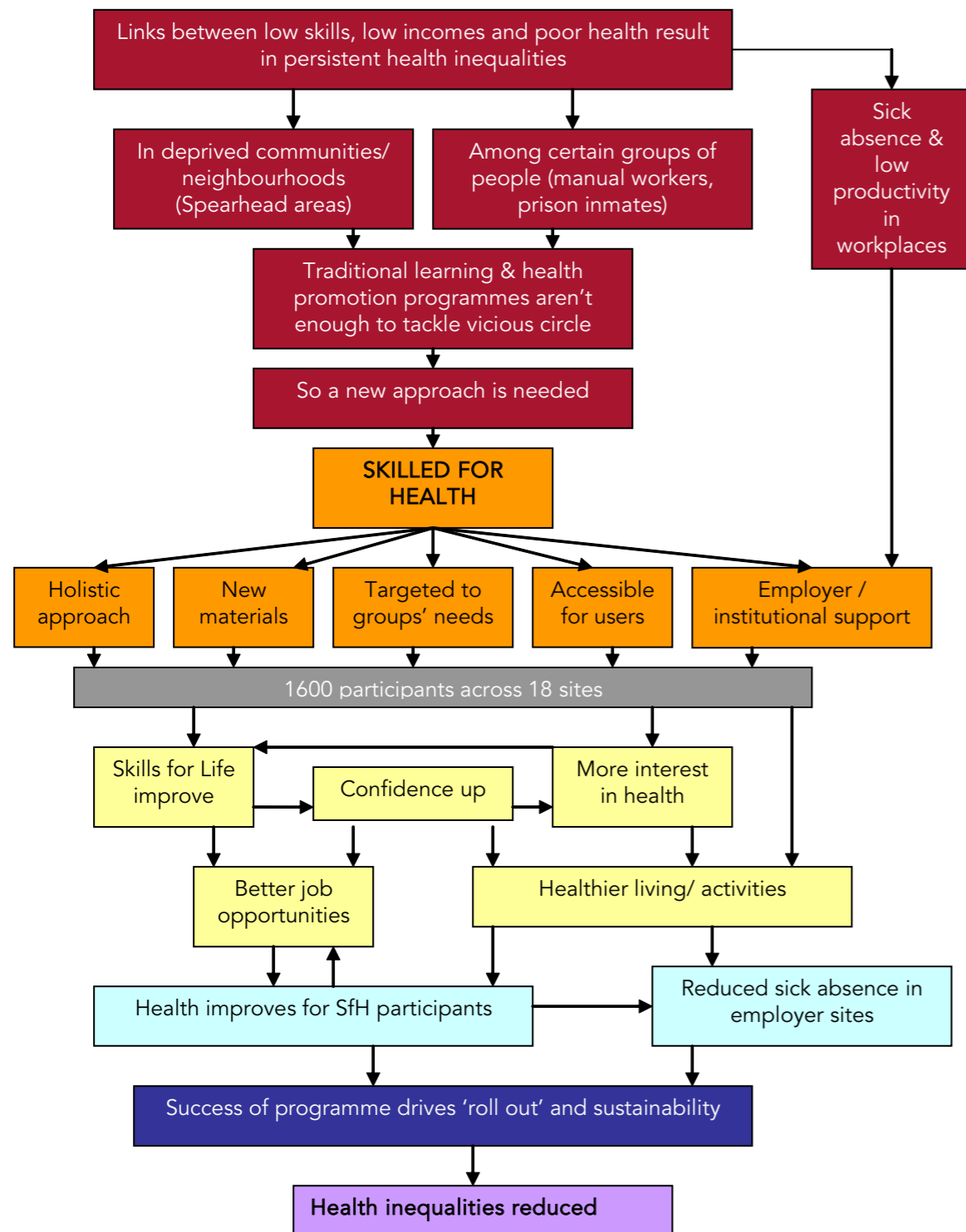
1.2.1. A theory of change approach

Our evaluation uses a '**theory of change**' framework to describe the rationale by which the activities in the different sites of the programme are expected to lead to outcomes for individuals as well as project and programme objectives. This is shown in Figure 1 below.

Going through the theory of change from top to bottom, we see that:

- The **rationale** for the programme is that there are known links between poor health and low skills that result in persistent health inequalities: These affect people in deprived neighbourhoods and communities more than others, but these are the very groups that traditional, mainstream provision (for both Skills for Life and Health promotion) find it hardest to reach. So a new approach is needed.

Figure 1: The Skilled for Health theory of change



- **The new approach is Skilled for Health.** One of the early tasks of the evaluation was to clarify what were the defining features of the programme. The objectives had been agreed, but ‘what was *Skilled for Health*’? The theory of change diagram shows the key features that emerged from our scoping work that, taken together, make the programme what it is. These include the holistic approach and the materials that reflect and enable this. Another feature that emerged early on (and has been a key theme to test and develop throughout the evaluation) is Skilled for Health’s user-led approach and the flexibility and accessibility to support this ethos. This enables the programme to target ‘hard to reach’ groups in a variety of settings and contrasts with much of more standardised mainstream provision. Lastly, a key feature of Skilled for Health in this second phase is the employer and other institutional support at the ‘sector sites’ (the first phase was only piloted in community sites).
- The flexibility of Skilled for Health to address different user needs in a range of settings means that the **activities** – at project level – have developed and evolved as sites have joined the programme. For the programme-level theory of change, the variety and adaptability of interventions helps ensure that individuals from key, and often ‘hard to reach’ populations are recruited to join these activities – a key element if health inequalities are to be addressed. (The projects have been encouraged to develop their own theories of change which surface the rationale for choosing specific activities to meet local objectives).
- The project activities can be expected to bring about a range of **outputs and outcomes for**

participants. Some of these will be tangible and direct (e.g. weight reduction due to healthier eating and physical activities), others will be indirect and more difficult to measure (e.g. increased confidence coming from a combination of developing new skills, participating in groups and feeling healthier). Our theory of change also shows some of the ways these outcomes may be related (e.g. interest in health acting as a motivator for increasing language skills which lead to improved health literacy as well as an interest in further learning). These are just possible linkages and the purpose of the evaluation was to explore these individual outcomes and the way they interrelate in practice.

- Individual outcomes are then shown as potentially contributing to **project and community outcomes** (in terms of improved health and Skills for Life of participants) and **organisational outcomes** (such as reduced sickness absence for employers or take up and effectiveness of existing learning programmes).
- In turn, if individual projects and the programme as a whole can be shown to be successful in achieving the desired outcomes, this should provide evidence for a **sustaining and ‘rolling out’ the Skilled for Health approach** which would be necessary to see a **reduction in health inequalities – the key objective.**

The theory of change has thus helped us clarify the objectives and rationale of Skilled for Health and how the design and activities of the programme were expected to deliver the outcomes. The evaluation was to test this out, so the theory of change was very helpful in generating some of the important questions the evaluation needs to address to do this. These are the questions that we explore in this report¹.

1.2.2. Focus and methods

The national evaluation has been carried out by a joint team from the Tavistock Institute and Shared Intelligence. The overall approach to the evaluation was developmental and collaborative, working with second phase sites in the design and development of the evaluation, and supporting them to carry out their own project level evaluations.

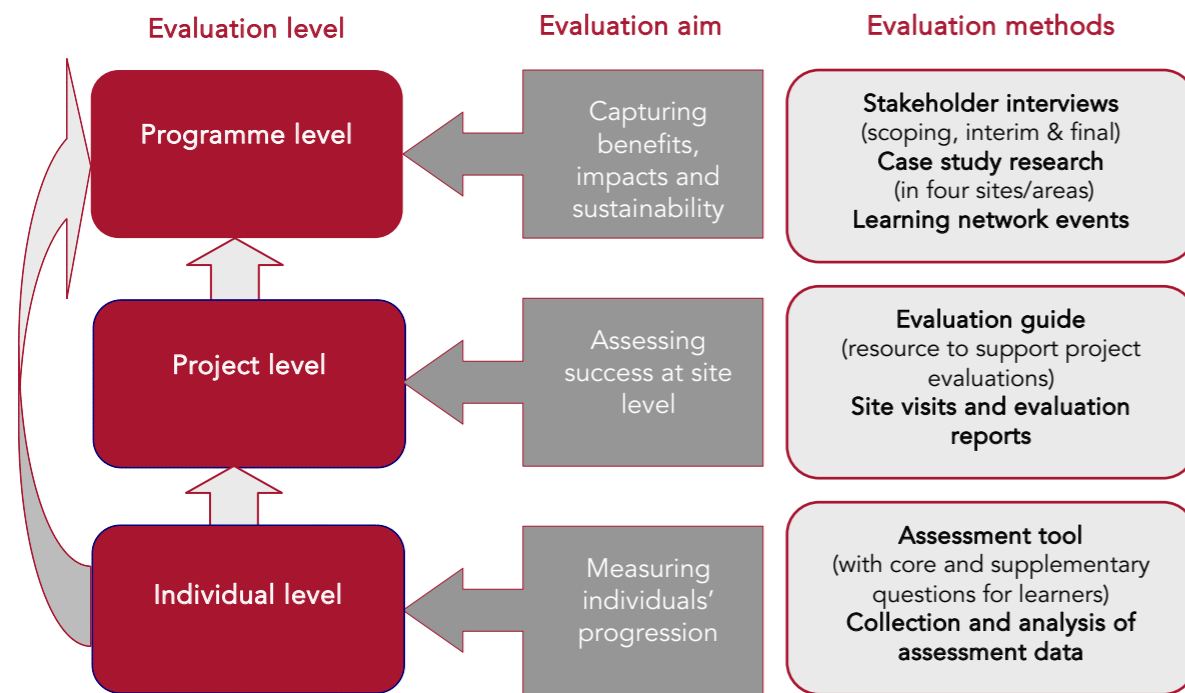
As such, the evaluation was carried out at three levels as shown in the diagram below which sets out the three levels and the main methods used within them.

The national evaluation team was primarily responsible for the programme level evaluation, which included drawing together findings and messages for the programme as a whole.

The national team supported sites that were responsible for their own project evaluations and for assessment of individuals' outcomes and distance travelled.

Reflections on this approach from the national evaluation team can be found in Appendix 1.

Figure 2: The national evaluation of Phase 2 of Skilled for Health



1.3. Structure of the report

The report presents the findings from the national evaluation. It is structured as follows.

Chapter 2 sets the scene for this evaluation report by introducing the phase two sites as well as their main contractual task and explaining the national-level support that was available to them during their work.

Chapter 3 looks at the main features of Skilled for Health sites by analysing the activities they were planning on carrying out as part of their participation in the programme. The chapter analyses the reasons for taking part, the way sites used the materials to deliver their Skilled for Health courses and the support that was available to them and the anticipated costs of their projects.

Following this description of the initial set-up of phase two, **Chapter 4** then presents an analysis of Skilled for Health 'in practice'. It analyses the learners that were actually reached by Skilled for Health courses, looks at the main delivery models and how the materials were

used (which sections were most popular and to what extent they were adapted).

Chapter 5 analyses the main outcomes for learners from participating in Skilled for Health, both in terms of health and in terms of Skills for Life. This discussion is followed by Chapter 6 which explores the potential impact of the Skilled for Health programme through the lens of project and programme sustainability.

Chapter 7 presents the key lessons emerging from phase two of the Skilled for Health programme. This is followed by the main conclusions (**Chapter 8**) from the evaluation, the recommendations (**Chapter 9**) and future research questions (**Chapter 10**). A number of **appendices** offer supplementary information on the evaluation and phase two sites included in the bulk of the work.

¹A full list of evaluation questions can be found in Appendix 2.



2 KEY FEATURES OF SKILLED FOR HEALTH IN PHASE TWO

There have been 18 sites in phase two of the Skilled for Health programme. In three of these sites, a large organisation has delivered Skilled for Health to their own staff or client group. We generally refer to these as 'workplace' or 'employer' sites. In other sites, large organisations (prisons, the army primary care service, libraries) incorporated Skilled for Health into their services for client or user groups. We generally refer to these as 'sector sites'. In 12 sites, community-based organisations led delivery to provide training to a local, usually deprived, community. We refer to these as 'community sites'.

2.1. THE PHASE TWO SITES

The sites that were examined in detail by the National Evaluation can be clustered into three main groups:

Table 1: List of phase two sites considered in-depth by the national evaluation

TYPE OF SITE	NAME OF ORGANISATION OR PROJECT	TARGET POPULATION
Employer/ workplace	Royal Mail	All employees in three mail centres – from managers to floor staff, cleaners, catering staff.
	Gateshead Health NHS Foundation Trust	Staff in work requiring manual skills (carers, cleaners)
	Nottingham City Council	Street scene, adult services social care and waste management staff
Sectors	Museums Libraries and Archives (MLA) London	BME groups, mainly ESOL learners
	Prisons (Pentonville and Holloway)	Prison population with low levels of literacy, language and numeracy skills
	Army Primary Health Care service	Army families
Community	County Durham	Prison population, people with mental health problems, young people
	Northumberland	Parents using children's centres and extended school settings with limited Skills for Life
	North Liverpool Partnership	Various deprived sections of community – young mothers, older people, travellers, problem drinkers
	Bolton Partnership	Various disadvantaged groups, including people with disabilities, young mothers, BME groups, families on low incomes
	Salford partnership	Local residents who face barriers to traditional learning – people with mental health problems, young parents etc.

Some sites were organised across a number of different locations, often with quite different schemes in different places, depending on their characteristics of their target population. This is in particular the case for the prisons and County Durham sites. In some of the analysis undertaken, we have therefore split these up, so that the information is entered into the correct 'cluster'.

2.2. DELIVERY OF THE MATERIALS AS CORE TASK

Sites were given significant freedom in the way they wanted to design their courses and what kind of learners they were to work with (as long as these belonged to the target group for the programme). The key requirement that all phase two sites had to adhere to, however, was to use the Skilled for Health materials³.

The materials were one of the key outputs from the first phase of the Skilled for Health programme, and their usefulness in different settings was to be tested in phase two. In two files, they cover 10 topics:

- **File 1:** healthy food and drink, physical activity and fitness, substances, mental well-being, keeping safe, first aid,

- **File 2:** the NHS and other support, GP and local primary care services, finding out about health concerns, self-care.

The materials, and the flexibility with which they can be used and tailored to fit an organisation's and learners' needs, was seen by sites as one of the key advantages of the Skilled for Health programme. They allowed sites to reach out people who are often forgotten by 'conventional' learning and health care provision and experience barriers in accessing such services. It also enabled organisations to provide courses in non-traditional settings, which were acceptable to people who might find more formal learning environments off-putting. A more in-depth analysis of the materials is undertaken in Chapter 4.

2.3. PROGRAMME SUPPORT FOR SITES

All sites had access to support from the national Skilled for Health team, based at ContinYou under the leadership of the programme Director. ContinYou had a number of roles, including managing the overall programme on behalf of the two sponsoring Government departments (DH and DIUS) and liaising with these departments as well as other bodies (e.g. Government Offices in the Regions, Business in the Community) to attract and establish sites for local/sector projects and support to sites.

Part of ContinYou's programme management role involved providing support to phase two sites, initially through a 'buddy system' which paired members of the

Technical Support Group (TSG) with sites, and later by a project manager. This support involved, for instance, help with setting up the project, monitoring progress and drawing out key lessons learned when sites were winding up. Support has also been provided for seeking funding for longer term sustainability in some sites. Sites have generally been positive about this relationship and have valued the contact and support they have had from the national team. In particular, appointing a Project Manager with a specific remit to build relationships with sites was very effective and has taken pressure off other members of the team.

FOOTNOTES: SECTION 2

² A number of these community sites came into the programme too late to be considered in-depth. Whilst their learner assessment data was considered for the analysis of individual-level outcomes, their experience of delivery has not informed the national evaluation to the same extent as the earlier sites

³ More information on the Skilled for Health materials can be found here:
www.continyou.org.uk/what_we_do/healthy_active_learning_communities/skilled_health



3 THE ACTIVITIES PLANNED BY SITES

This section provides an overview of Skilled for Health projects as they were set up and intended to carry out their work. The key finding of this analysis is that one of the core features of Skilled for Health is its flexibility. Skilled for Health learning activities can be employed in different types of settings (be this employers or community organisations) and sectors and benefit learners and organisations in all of these. It can be delivered by tutors with different backgrounds, be this health, education or another background, though some additional training can be beneficial.

3.1. REASONS FOR PARTICIPATING IN SKILLED FOR HEALTH

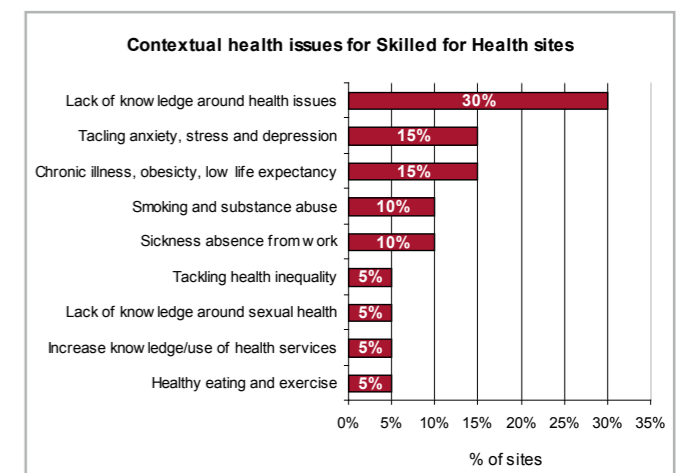
As sites had significant creative freedom on how to shape their Skilled for Health intervention, a range of motivations underpinned their interest in participating in the programme. Nevertheless, motivations can be grouped into two broad categories: the anticipated health and literacy benefits to the target groups; the benefits for the delivering organisations.

3.1.1. Addressing health and literacy needs in the target populations

All sites could see how Skilled for Health could help them improve the lives of their target groups, both in terms of their health needs and in terms of their literacy needs. Cutting across these two areas, however, were the broader aims of addressing deprivation and the low aspirations of sites' target groups.

Most sites anticipated that Skilled for Health would bring health benefits, both improving peoples' health generally and reducing health inequalities specifically. The chart below specifies the main health related benefits sites were looking to address through the Skilled for Health programme.

The chart above shows that poor health among the target population was an important motivation for all sites, with 10 per cent citing smoking, drinking and alcohol behaviour and 15 per cent citing chronic illness, obesity and low life expectancy as issues to address. Another 15 per cent was looking to tackle mental health issues such as anxiety, stress and depression.

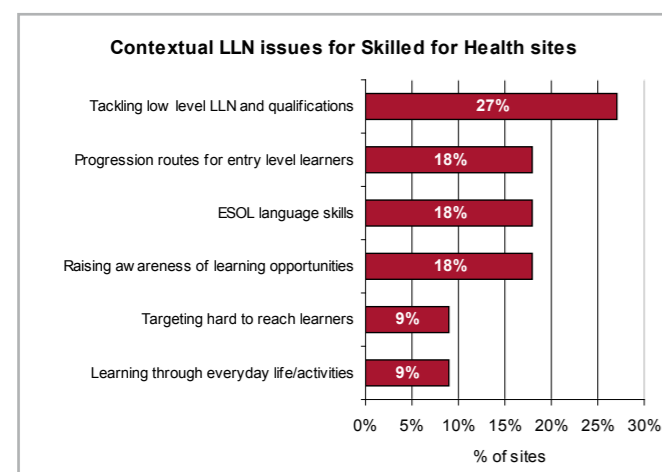


Interestingly, 30 per cent – by far the highest share of sites – were looking to address the lack of knowledge amongst their target groups on health issues. Many sites indicated that giving people information was one way of addressing health inequalities: this would give learners the knowledge they need to make more informed decisions. This would also bring subsequent changes in health behaviour. Some sites also felt that groups of informed learners could act as champions of 'good health' and pass on their knowledge to inmates, families and friends. Several sites were interested in enabling participants to find their way more effectively around the health service and communicate better with health services staff.

Perhaps unsurprisingly considering the focus of the Skilled for Health programme, specific reference was frequently made to addressing health inequalities, with

some references to using Skilled for Health to address some of the specific local targets around health inequalities at the PCT, Local Area Agreement and RDA objectives. References to health inequalities tend to reflect the integrated nature of the programme. For example, the MLA puts the case for its work in three boroughs as follows: "(...) the three boroughs with the lowest ranking in both health and skills are Barking & Dagenham, Tower Hamlets and Newham (...). These will be part of the pilot group".

Indeed, offering learning opportunities and skills improvements was the second set of reasons why sites engaged in Skilled for Health.



As the figure above indicates, most sites referred to the challenges of their target populations of entering more formal learning opportunities or accessing other forms of health education. This is often seen as much as a result of learners' low aspiration as of more tangible barriers to access. For example, the Salford community site explained that Skilled for Health helps tackle the 'Salford disease': "People think that they are not good enough – there are no aspirations. Getting involved in Skilled for Health raises people's confidence."

In terms of **Skills for Life**, several sites indicated that there was a strong need for Entry Level courses for their target population, and saw Skilled for Health fitting into existing structures to enable people to

move forward onto more advanced courses. For example, Nottingham City Council felt that there needed to be more progression routes for learners who were already on Skills for Life embedded courses in Waste recycling.

Whilst data from the sites indicate a range of motivations for participating in Skilled for Health, there are differences in emphasis according to whether the sites were workforce, sector or community based:

- The **workforce sites** tended to see Skilled for Health as providing reduced levels of sickness and absence, which would have both benefits for their employees and for the organisation itself. One employer site saw the programme as helping to "Decrease in sickness absence due to better ability of members of the workforce to manage health issues". Another saw Skilled for Health activities as being useful to boost morale, and complement existing Professional development activities.
- **Sector sites**, like the workplace sites, also saw Skilled for Health activities as complementing existing learning or health related activities, and also as achieving greater participation of 'non-traditional' learners. The Army site, for instance, attempted "to reach learners (army families) who have never been reached before". Pertinent to both the prisons and army sites was an interest in mental health. In the Army site it was felt that mental health problems were exacerbated/arose when "army wives are isolated for long periods of time when their husbands are away". Similarly offenders were considered to have long periods of isolation and be more prone to disruptive/depressive behaviour. Both sites felt there was a need to provide a more basic level of mental health care to individuals which involved group activities. The sector sites also saw themselves as organisations which can provide more accessible learning environments which suit the everyday activities of its users.
- **Community organisations** saw Skilled for Health as an opportunity to diversify their activities and enhance the service they provided to existing user groups, or extend their work into new groups.

3.1.2. Benefits for organisations and organisational support

Sites often also identified benefits that running these projects could bring to their own organisation. Again, motivations seemed to vary slightly depending on the type of site⁴:

- For **workforce sites**, the welfare and health of their workforce was a key motivator, but most also anticipated that this would have additional benefits on improving morale, reducing sickness absence and improving productivity. For example, one workforce site put forward a key aim as being: "To create a healthier workforce: a reduction in sickness absence and absenteeism and increasing productivity - there has been a move to preventative initiatives."
- **Sector sites** had a range of motives, with Skilled for Health seen as complementing existing learning and health opportunities, with the additional benefit of having access to a bounded population to which the courses could be delivered. In the prison sites, Skilled for Health was seen as having potential benefits in creating a calmer environment and reducing disruption, while in the army, the scheme was seen as complementing learning opportunities provided to service personnel.

- **Community sites** often saw Skilled for Health as providing opportunities for increased partnership working, the diversification of provision and profile building. For example, one site aimed to "Use materials to build up an organisation's skills, and also getting the organisation's name out to the community. It is helping us to permeate the community". Increasing Skills for Life and Health education activities through Skilled for Health was also seen as providing important continuation funding for existing activities.

There are two organisational motivations that apply to all types of sites. The potential for **creative partnership working** was noted by nearly all sites, particularly where the partnerships were spanning, for the first time, learning and health sectors. Skilled for Health was also often seen as a way of **enhancing existing training offers** with new materials: one workforce site was approached particularly because it already had a strong educational programme in place for its employees. An additional benefit was being selected as a site for trialling a health literacy course: this was an important motivation for the prisons and the MLA, and at least one of the community sites.

In addition to recognising that Skilled for Health can meet certain organisational needs, almost all sites in phase two were also able to draw on strong

Table 2: Summary of anticipated organisational benefits for different kinds of site

OUTCOMES FOR THE HOST ORGANISATION	WORKPLACE SITES	COMMUNITY SITES	SECTOR SITES
Sites	✓		
Increase Productivity	✓		
Improve staff morale, level of professional development	✓		
Engaging with hard to reach members of the community		✓	✓
Building organisational profile		✓	✓
Funding to provide activities that follow on existing activities	✓	✓	
Partnership development	✓	✓	✓
Diversified provision	✓	✓	
Embed the course into existing provision	✓	✓	✓

organisational backing for their projects. This included senior management support or a local champion – sometimes the manager and in one instance one of the tutors. One of the workplace sites specifically recruited union officials as ‘champions’ to spread the work amongst employees.

Several of the sites involved partnerships between one or more organisations, and most sites were receiving support from either a local health, or local Skills for Life organisation. Only one site indicated that it had had support from neither side, and was also lacking management support - this site appears to have had some difficulties, particularly in recruiting

participants. Although these partnerships were generally productive, a few did note that it had initially been difficult coming to a common agreement and understanding about the projects and its aims. One site said that the ‘making the case’ document put out at the start of the programme was said to have been helpful in working towards resolving these problems.

There is therefore evidence that learning from Phase one on success factors has been used to good effect in phase two: strong organisational support for Skilled for Health had been identified as an important factor in the success of local sites by the Phase one evaluation.

3.2. DELIVERING SKILLED FOR HEALTH

Two sets of tasks were involved in delivering Skilled for Health in the phase two sites: managing the project and / or co-ordinating activities on the one hand, and teaching the course on the other.

3.2.1. What roles were required to deliver the programme in phase two?

Project management and / or co-ordination was mostly fitted into an already existing role within a delivery organisation. Only three phase two sites specifically recruited full-time staff to support the delivery of the Skilled for Health project. Where full-time staff was recruited, this was done to coordinate the programme or to provide relief from the normal duties to project managers rather than to teach the courses.

All sites used **sessional or part-time staff** to run the Skilled for Health courses. In many cases, the tutors came from local colleges (e.g. Nottingham City Council, Prisons, Northumberland, Gateshead Health NHS Foundation Trust), or were already existing staff (e.g. Bolton, Salford, North Liverpool sites). The ease with which tutors could be recruited onto the programme depended on at least two factors. Where an organisation had a pre-existing relationship with

a tutor, their engagement in the Skilled for Health programme was comparatively straightforward, both in terms of engaging them in the design of courses and their delivery. Where no such relationship existed, and specific skills were required (e.g. ESOL), this proved more difficult. Where delivery locations were geographically removed from one another, engaging a tutor proved more difficult due to the extra travel time involved in getting to the courses.

Most tutors came from one of two kinds of educational backgrounds:

- Around two thirds of tutors who delivered Skilled for Health courses had an **educational background**: either in adult teaching or Skills for Life.
- Around a third had a health background – either a health specialist or a health visitor.

In a few cases the materials were delivered by trainers/facilitators specialising in other fields.

Where the materials were delivered by an adult education specialist, a health professional was used in most cases to deliver or assist in some parts of the course. This was done to:

- Cover specific topics, that tutors felt needed specialist input. Examples included: a nurse to talk about NHS Direct or contraception, an oral hygiene specialist, a nutritionist;
- To complement the materials and make delivery more interesting;
- To provide a safe environment for learners to meet health professionals.

Where the materials were delivered by someone with a health background, guest speakers were used less frequently. Some tutors felt that bringing in a health professional was not appropriate for their group:

Two groups I worked with made it clear that they valued the fact I was not a health professional as that meant I wasn't telling them what to do. The third group – adults with mental health problems – already had a lot of contact with health professionals and I didn't feel it would be appropriate.

In many cases, other professionals were brought in to help deliver the courses, e.g. personal safety specialists in Nottingham City Council or interpreters helping with ESOL learners in Bolton.

3.2.2. What development needs did tutors have?

Overall, tutors felt very comfortable with the materials. However, delivery in phase two highlighted that different deliverers can have different training needs.

Skills for Life tutors can have concerns about their ability to cover the health aspects of the materials as competently as the Skills for Life elements. Often, therefore, they spent a considerable amount of their own time reading up on the health topics they were covering.

Few sites organised specific training for the Skills for Life tutors delivering the materials, and these tutors felt that they would have benefited from extra training to increase their confidence on health topics. Training needs seem to be greatest the lower the Skills for Life level of learners in a Skilled for Health course as tutors will then need to know how to teach Skills for Life.

One site where tutor training was offered is Northumberland site where a workshop was organised which introduced tutors to the health improvement service, gave information on health trainers and offered a chance to meet health staff. Since then training opportunities have been signposted, including a level 2 course for tutors at The Royal Institute of Public Health.

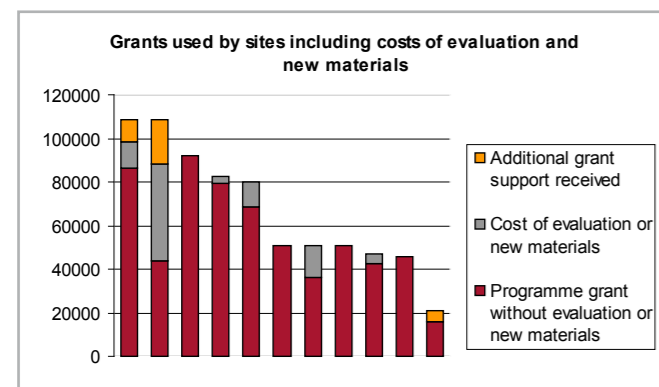
Elsewhere, those involved in Skilled for Health without a Skills for Life qualification were offered tutoring training. For instance, in the MLA site library staff were given one day's facilitation training.

More generally, some phase two sites have found that there is demand in their organisation to know about Skilled for Health generally, and what is involved in delivering it. This was addressed in phase two by sites offering designated short training sessions on Skilled for Health only (e.g. Royal Mail, Bolton).

3.3. FINANCING THE DELIVERY OF SKILLED FOR HEALTH

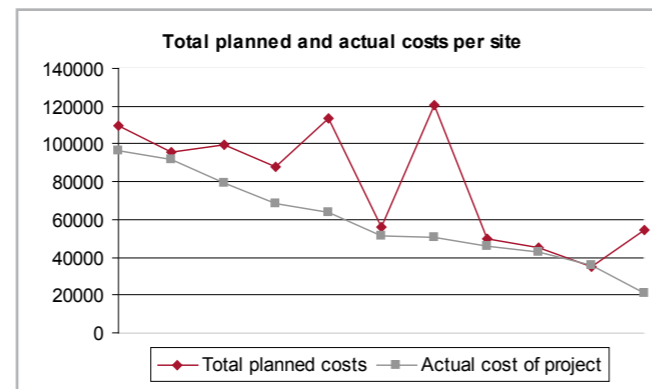
The costs of providing Skilled for Health activities are likely to be one important consideration for organisations considering taking on such activities. In phase two, all sites received grants of varying sizes. A number of sites have also obtained additional funding to supplement this (often from local sources) and support in kind from their organisation or partners, e.g. in the form of staff time, premises and use of facilities, or administrative support. The availability of support in kind for most sites makes the assessment of the real costs of schemes difficult: there is no easy way of attributing a specific value to this kind of support.

The level of financial support received by sites was very varied – the lowest amount was £21,000 (more is planned, but the scheme is ongoing) and the highest was £109,000 (mean level of financial support £72,000). Some of the sites were using their grants to develop new activities or pay for evaluation activities, in addition to running courses or workshops. If the costs of these are taken away from the overall amount received, the highest level of financial support received was £92,000, with a mean level of financial support being £55,000).

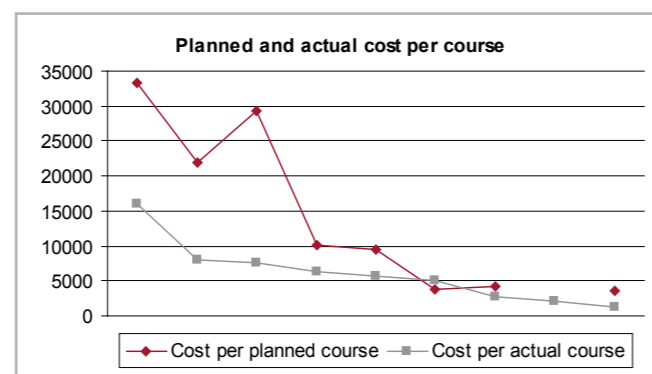


Not all sites had completed their activities at the time these final costs were calculated, and some had not yet claimed their complete grant. Partly because of this, planned costs were often higher than actual costs.

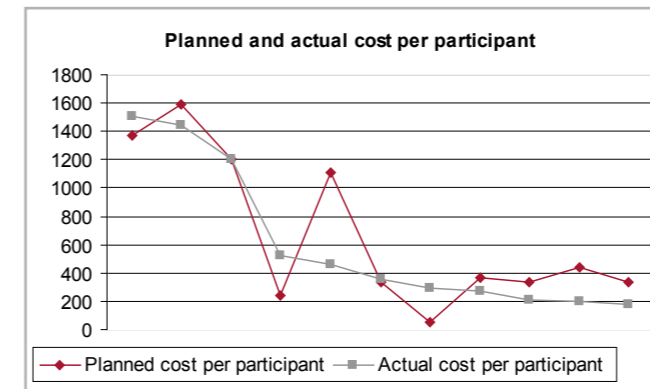
It would be difficult to identify the cost of a 'typical' Skilled for Health scheme or course, as costs can be



affected by a number of different factors, such as the number and length of courses run, and the number of participants recruited (see next sections). Actual costs per course varied widely from one site in which this was just over £2000 to another in which it was nearly £16,000. The average (mean) cost was £6100 per course. However, it was also clear that costs per course reduced as sites ran more courses: several sites ran more courses than they had originally planned, and the cost per course reflected this.



The variations in project and course costs also reflected wide variations in costs per participant. In one site this was as low as £197 per participant, while in another it was over £1500. The average (mean) cost per participant recruited was just over £600. Costs per participant were often higher than anticipated because sites had been unable to recruit as many participants as they hoped.



All these figures have to be treated with caution, particularly because final figures were not yet available for some sites, and because it was not always possible to explain why the costs in some sites were higher than others. It is likely that the challenge of recruiting their target populations and the level of resources required to support them, is one factor. In particular, it is important to note that while some sites were bringing new materials to existing groups of learners, others were seeking out new learners, as well as developing courses to meet the needs of these learners.

3.4. SECTION SUMMARY

Sites' motivations for getting involved in Skilled for Health mirrored the dual programme objectives: addressing the health needs of learners (both lack of knowledge and behaviour) as well as improving Skills for Life. Underlying this, however, were different expectations of the end-result depending on the type of site: workforce sites hoped to gain reduced sickness and absence levels; sector sites hoped to achieve greater participation of no-traditional learners; community sites hoped to diversify and enhance existing services. Looking ahead, these different motivations for taking up Skilled for Health are likely to have implications for marketing the programme in future: different 'hooks' might appeal to different types of organisation.

In all phase two sites, delivery of Skilled for Health activities required a project manager to manage and co-ordinate delivery (normally added to an already

existing role within the delivery organisation) and a tutor (mostly from an educational background, but health backgrounds could also be found) to teach Skilled for Health. Combining the expertise of different tutors was not uncommon and seemed to work well for filling skills gaps and making delivery more interesting to learners. Nevertheless, Skills for Life tutors in particular appreciated some (light touch) training to increase their confidence in delivering health materials and, possibly, to improve Skills for Life teaching skills. In addition, almost all sites could draw on strong organisational backing for the programme which supported implementation and, towards the end, efforts to secure sustainability of activities. This is evidence that learning from phase one of the programme on criteria for success has been taken on board in phase two.

FOOTNOTES: SECTION 3

⁴ However, it is important to note here that these were the motivations of organisations that were also offered funding to run their Skilled for Health activities. How far the same motivation would apply if there were no funding available to set up and run schemes has yet to be tested.

4

IMPLEMENTING SKILLED FOR HEALTH

This section moves from exploring the delivery of Skilled for Health courses as planned to analysing what sites actually delivered in phase two. The evaluation has found that there were a number of distinct delivery models, but a key finding is that there was no 'one best method' of delivering Skilled for Health courses and activities. Rather, the actual shape that Skilled for Health projects took was therefore determined, in part by the **needs of participants** as well as the **capacity of the organisation** to deliver activities at different times, or in different types of setting. Of key importance was crafting an 'offer' that would appeal to participants and encourage them to join courses or workshops offered. The actual 'offer' could vary along a number of different dimensions: how Skilled for Health was delivered (in courses, workshops, one to one training), how much time was involved, the way the materials themselves were adapted and the kind of staff that were employed to deliver the materials. Flexibility, therefore, once more emerges as one of the key benefits of Skilled for Health in phase two.

4.1. PROGRAMME LEVEL SUPPORT FOR DELIVERY

All phase two sites were given support by ContinYou's national Skilled for Health team at all stages of their work. Coordinating the programme created some challenges, though some of these were addressed as the programme progressed. Challenges included:

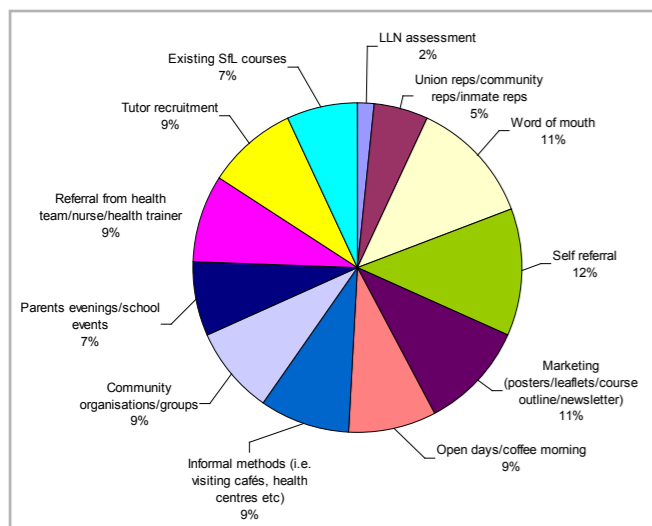
- **Negotiations at contracting stage:** this has been particularly lengthy in work-based and institutional settings where in several cases this has been rather more protracted than in the community sector. The selection process for community sites seems to have been more straightforward, with more clarity about the criteria and selection procedure.
- **More information about the programme and clarity about requirements** at the contracting phase for funded sites/projects. Some sites have felt that there should have been more information about the programme and their role within it, particularly in terms of what they were required to deliver and how they were contributing to the wider programme. This feedback was taken on board by ContinYou who produced a welcome pack. While this has helped, it is generally felt that more information on the programme would be beneficial.
- **Coordination of a network of sites:** this has been challenging because of the rolling nature of the programme. The evaluation's learning events have been useful for bringing sites together, but there was still a sense of some sites having to 'reinvent the wheel' rather than being able to draw on the experience of other sites about what does, and does not, work. Also, for many, the learning events have been the only opportunity to really find out about what other sites have been doing.
- **Establishing a clear identity for the programme:** there has not always been a clear understanding of the concept of Skilled for Health, and sites have felt that it lacks a clear identity. There has not been a strong feeling among sites that they are part of a national programme. Especially in the early stages the flexibility the programme allowed created a degree of uncertainty among some sites about what the programme was aiming to achieve and what was required of them. However, the subsequent development of the welcome pack by the national team helped, and the support offered by role of the project manager (and previously TSG buddies) was widely appreciated by sites.

- **Developing project buddies** from within the membership of the TSG. This was a helpful idea for project support, but there were difficulties in terms of the skills of the buddies and the specific needs of the sites. This approach was therefore dropped in favour of more input from the Project Manager, alongside support from members of the national team.
- **Support for sustainability:** as picked up in Chapter 8 of this report, sites have not received

4.2. RECRUITING LEARNERS

4.2.1. A range of recruitment methods

Phase two sites used a wide range of different recruitment methods to recruit the participants to their Skilled for Health courses, as shown in the chart below.



Self-referral and word of mouth both make up two of the largest groups, as they were reported as a key method of recruitment in all sites.

The effort that needed to be put into recruitment varied across types of site, mainly because their access to potential participants was different:

- Most **workforce sites** already provided Skills for Life courses to their staff and took a more targeted approach to recruitment. For example the

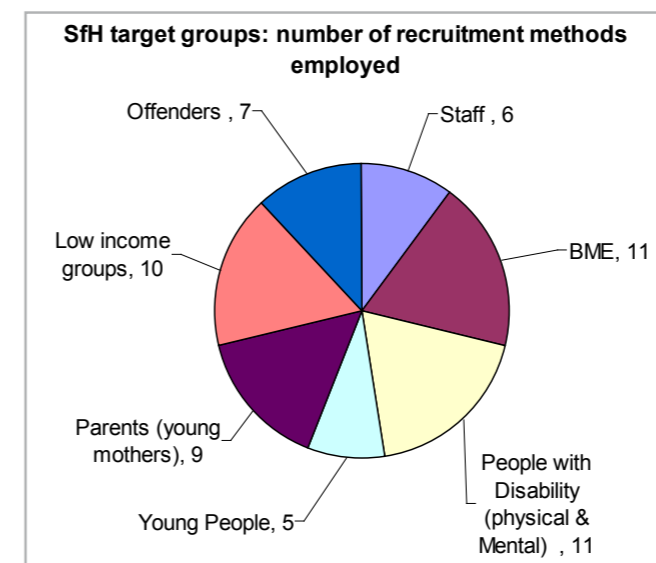
much support for sustainability from the national team and discussions around this and the future of the national programme have led to some confusion among sites about future funding.

- **Maintaining national commitment to the programme** in the face of organisational, ministerial and policy change has also been demanding.

Nottingham site ensured that the target workforce underwent an assessment of Skills for Life at the beginning of existing courses and used this as a basis to recruit learners onto Skilled for Health. Union Learning Reps also encouraged learners by helping with assessments. Similarly personal contact with staff, marketing and open days that worked around shift patterns recruited learners. In Gateshead Health, self-referral from a lunchtime weigh-in class was used as the recruitment method for the nutrition courses Run as part of Skilled for Health.

- **Sector sites** were more varied. Some, like the prisons, had very direct access to learners. Others, such as the MLA and Army sites had to do more by way of outreach and use a wider variety of recruitment methods, such as coffee mornings, open days, marketing, referrals from health visitors/nurses and written course descriptions. The prison sites used 'inmate reps' who actively invited offenders on the wings to attend classes and see what the course was about.
- **Community sites** also had to use a range of methods, not least because some of these were targeting some of the hardest to reach groups. They generally relied heavily on informal methods (conversation, open days, parents' evenings) or work via existing groups and organisations, or a community network organisation such as the CVS.

Some target groups also required more effort to engage, and therefore wider range of recruitment methods, than others. As can be seen in the chart below, offenders, people with disabilities and people on low incomes required a greater range of recruitment approaches than others.



4.2.2. The main 'draw' for participants

The interest - or 'hook' - in the Skilled for Health programme at an individual level varied from site to site. However, the table below points towards the importance of health and health-related issues (such as gym membership) as a hook to get learners engaged. This also emerges from of learners' answers to the question in the assessment tool of what taking part in Skilled for Health meant to them. Few, if any, learners mentioned improved reading or writing and there is only one mention of better communication. By contrast, there is much reference to knowing more about health and healthy eating. A further point of triangulation is the fact that healthy eating topics did feature strongly in the programme (see use of learning materials in the section below), considering that the user-led approach to Skilled for Health meant that many sites designed their programmes around learner interests.

In addition to health, other common factors include the desire to 'do a course', the chance to socialise and meet new people. The visibility of the course in familiar and informal locations such as libraries, community centres or workplaces as well as the availability of a crèche were also important 'pull factors'.

Table 3: Draw for participants by type of Skilled for Health site

OUTCOMES FOR THE HOST ORGANISATION	WORKPLACE SITES	COMMUNITY SITES	SECTOR SITES
Use/membership of gym	✓		✓
Use of leisure centre facilities	✓		
Fit for purpose courses	✓	✓	✓
Staying in an existing learning group/network	✓	✓	
Crèche facilities		✓	✓
Health education	✓	✓	✓
Language skills		✓	✓
Use of IT	✓	✓	
Skilled for Health as marketed locally		✓	
Sold as a project rather than a formal education course		✓	
Exercise		✓	✓
Socialising		✓	✓

What an organisation was able to provide as a 'draw' for participants varied according to what resources or facilities they could access. Several workforce sites, and the prison site, used gym membership and use of leisure facilities as a key draw. In the case of Nottingham City Council, for instance, this was facilitated by the fact that the gym facility was Council-owned. Community sites more often used social aspects, often tapping into existing networks. The Northumberland site explained that Skilled for Health was a draw because it was marketed as a project and not a course, so learners would not be scared off by formal education. The army site said that without

crèche facilities the course could not go ahead and this had been a useful method of drawing women out of isolation.

Effective recruitment to a Skilled for Health course therefore requires a careful consideration of the needs and interests of their target groups, and their ability, or inability, to engage in more formal activities. For some of the harder to reach groups, an informal approach may be needed, and it may require a number of different 'channels' of recruitment in order to fill courses.

4.3. PARTICIPANTS RECRUITED

4.3.1. Type of learners reached

The target populations that sites identified and recruited were quite varied in term of socio-economic characteristics or the specific issues that they faced. Many of the sites appear to have had difficulty in recruiting participants onto their courses in the numbers originally planned, although in some cases this might have been because their original plans were overambitious. Success also depended on the groups targeted.

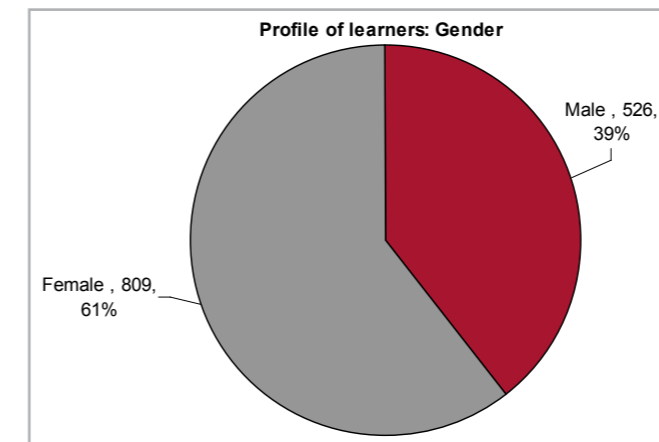
Some groups were clearly harder to recruit than others. These were generally the same groups that required the investment of greater resources and different methods to engage. It is therefore vital for organisations taking on Skilled for Health to be aware of the resource and effort that will be required to recruit participants onto their activities, particularly in the early stages. Without careful consideration of this issue, many will find their courses undersubscribed. They may also be in danger of 'creaming off' those who are most 'ready' to be involved in activities of this kind, while others, who might benefit more, are overlooked.

Table 4: Sites by main target group and success in recruiting numbers planned.

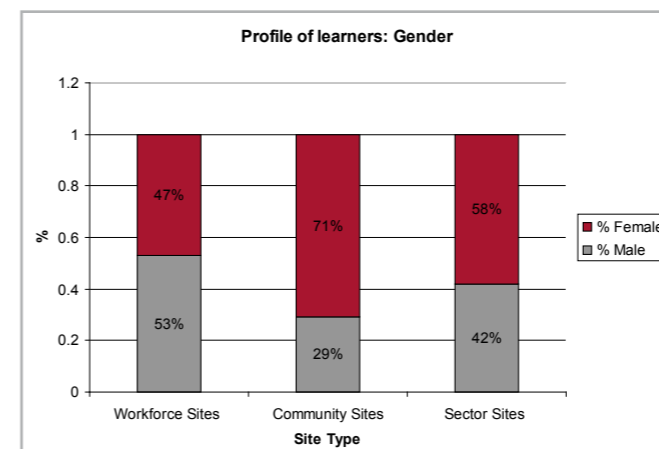
PARTICIPANTS/TARGET GROUPS	PLANNED	% REACHED
BME groups	500	36.4
Offenders	672	60.3
People with mental health problems	52	32.7
Young people	52	75.0
Parents	150	52.0
Hospital manual staff	75	70.7
Street cleaners and care workers	90	164.4
Employees (men)	60	88.3
Deprived communities	450	119.1
	2101	72%

4.3.2. Demographic profile of participants

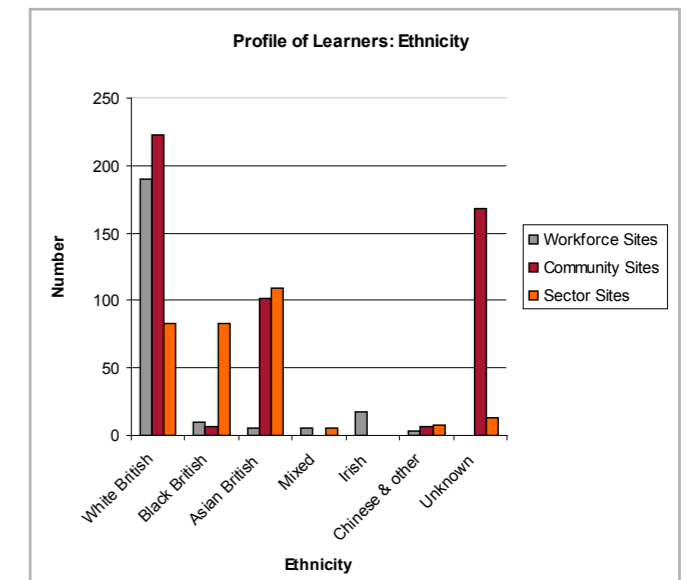
More women have been recruited onto Skilled for Health activities than men, reflecting a general pattern for courses and activities of this kind.



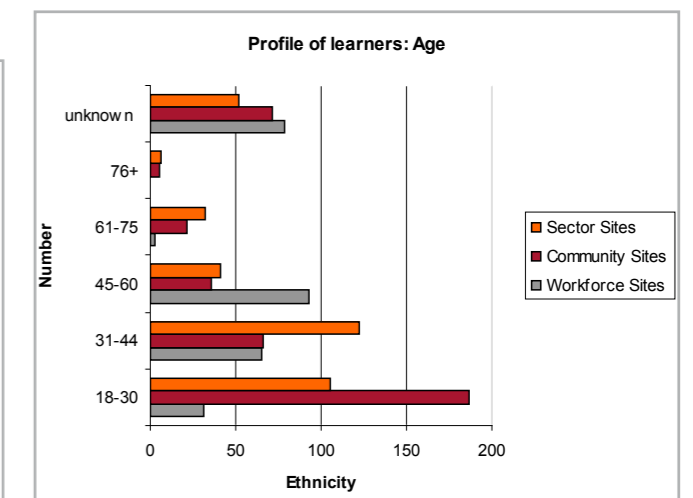
What is noteworthy is the success that some sites, and particularly some of the workforce and sector sites, had in recruiting men, who are generally hard to involve in activities of this kind. This generally was the result of a specific intention of working with men, or with professions that are typically male (e.g. street cleaners). The success in engaging men, however, was also the direct result of choosing appropriate recruitment methods. Exercise in particular proved a very effective engagement tool for sites wanting to work with men.



Sector sites appear to have been particularly successful in recruiting from ethnic minority groups. These figures are likely to be explained to a large extent by the targeting by the MLA of these groups through the provision of their embedded ESOL courses, and also by the relatively high population of BME groups in the prisons site⁵.



Community sites, on the other hand, were particularly successful in recruiting participants from younger age groups⁶.



4.4. METHODS OF DELIVERING SKILLED FOR HEALTH

The majority of phase two sites have delivered Skilled for Health as a course. A few have experimented with other methods, delivering through one-day workshops, via one-to-one or even self-directed teaching (through e-learning materials).

Overall, four broad models of delivering Skilled for Health can be identified:

- **Self-delivery/self-led through e-learning.** This approach was only practiced by Royal Mail and involves individual eLearning over a six-week period to achieve objectives set in an individual learning plan at the beginning of the course. Royal Mail is one of the case study sites for the national evaluation and this approach is explored in the case study annexed to this report.
- **Training or tutoring by 'experts'** with qualifications in community development, health and/or Skills for Life or ESOL. This happens in particular for Skills for Life tutors who tend to be given health training.
- **Bringing in experts to support Skills for Life tutors** in the delivery of specialist areas of the Skilled for Health courses. For instance, the nutrition course in Gateshead Health Foundation NHS Trust is delivered by qualified nutritionists as well as a Skills for Life tutor. Tutors in Northumberland are supported by health improvement practitioners and parent support partners.
- **Facilitation** around the topics by non-experts (the

Bolton partnership).

Group settings, chosen by all but one site, tended to be appreciated by learners and seem to somewhat support the delivery of Skilled for Health. Across sites that used group teaching learners commented on how much they enjoyed learning with and from people: for social reasons (meeting new people), because of the discussions that could be had and the sharing of knowledge that ensued. For one learner Skilled for Health, and the group setting in particular, meant realising that "there are other people as unaware as I was".

"I enjoyed meeting people and having discussions, this helped with my agoraphobia."

"I gained general knowledge and found out that other people have things they don't know as well. It was good hearing what other people think."

Learners from Northumberland

"Discussing health problems with a group and learning from people's experiences."

A learner from Durham

"Sharing knowledge with others in the group"

A learner from the Gateshead Health site

4.5. LENGTH AND NUMBER OF 'COURSES'

The length of Skilled for Health teaching also varied. phase two sites have experimented with a number of different formats:

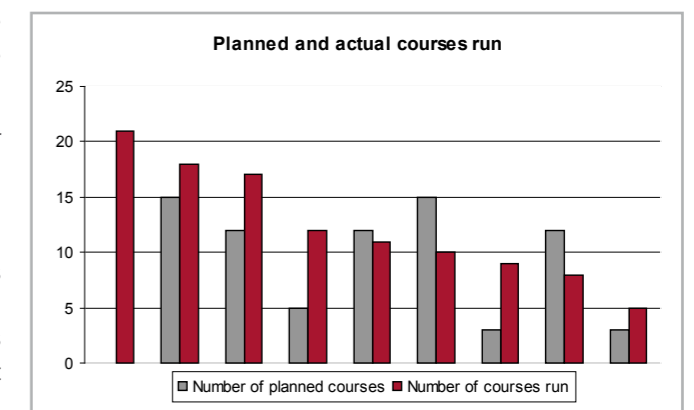
- **Workshops and one-day sessions.** These were used in a number of the community sites (e.g. Bolton, Liverpool and Salford), as well as by the MLA and Nottingham City Council. The army site ran discussions around Skilled for Health topics.
- **Courses.** This is a frequent delivery model for Skilled for Health courses and has been used by sites such as the MLA, Gateshead Health Foundation NHS Trust Foundation NHS Trust, Northumberland Care Trust and others. Courses may last four weeks (Bolton), six weeks (e.g. MLA, Army, Bolton, Royal Mail), ten weeks (e.g. Gateshead Health Foundation NHS Trust Foundation NHS Trust Foundation NHS Trust, Nottingham City Council, Northumberland Care Trust, Bolton), twelve weeks (Salford Partnership) or fourteen weeks (MLA).

In addition, one site (the Army) offered progression courses to Skilled for Health learners and elsewhere (Northumberland) tutorial support was offered after Skilled for Health courses to discuss progression.

The format of Skilled for Health courses is shaped by the organisational context and learner needs. However, an additional factor influences course formats. Where Skilled for Health courses lead to accreditation, the requirements in terms of teaching hours of the (entry) level exams must be complied with. This was, for instance, a key factor shaping the design of the 'return to learn' programme run by Gateshead Health Foundation NHS Foundation Trust and the planning around the "Benefits of Exercise" course.

In terms of the number of hours that these courses and workshops ran, these varied from around 7 hours to courses of up to 60 hours in length, delivered over a period of weeks. Clearly this has implications for the level of change that individuals taking part in courses or workshops might be expected to achieve. The mean length of a course was 23 hours. This is relevant

particularly in terms of the level of Skills for Life change achieved, in particular where pre-entry Level students are concerned; many Skills for Life courses work with such students for around 300 hours in order to achieve a level change.



Some sites ran a small number of courses or workshops for relatively large numbers of participants (up to 30) while others ran a number of smaller courses. The smallest number planned was 10 participants, but some sites had difficulties recruiting so courses were often smaller than this. Many sites ran more courses than was originally planned - sometimes because the courses were successful with demand growing over time, and sometimes because numbers were lower than expected, so more courses needed to be run in order to reach the anticipated numbers.

Generally, a responsiveness to learners characterised Skilled for Health courses. This meant that course contents were designed around their interests. There was a continuum in terms of how much participants shape the programme (from a highly personalised programme as offered by Royal Mail, over the shaping of Skilled for Health courses by learner interests in the case of the MLA London to a tailoring of course structure and delivery to support accreditation in the case of some of the courses run in the Gateshead Health NHS Trust Foundation Trust site). Often, the first session is used to determine learners' needs or interests and hence the shape of the following programme.

4.6. USE OF THE MATERIALS

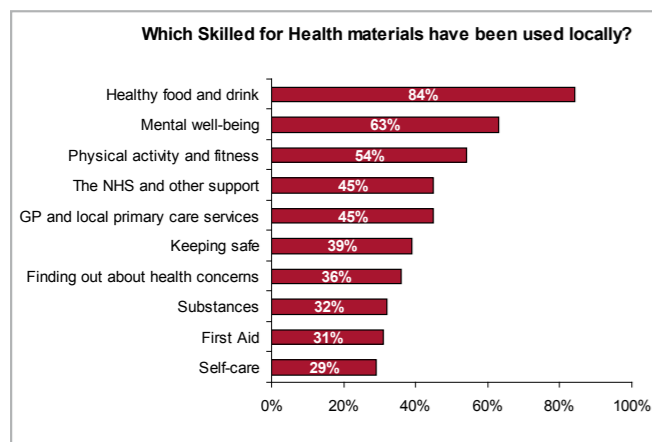
Using the Skilled for Health materials was one of the key requirements of phase two sites, and indeed all deployed them in their teaching. In addition, a set of sexual health materials was developed and tested by HMP Holloway as part of its phase two contract. The following sections report on tutors' experiences with these resources.

4.6.1. Tutors' feedback on the 'core' materials

In addition to the qualitative research carried out on the site level, **tutors' feedback** on the Skilled for Health materials was collected directly through an online survey. The majority of respondents were tutors delivering Skilled for Health courses; seven responses were from project managers in charge of designing local projects. In total 59, people responded to the survey from 16 phase two Skilled for Health sites.

All sites have used centrally created Skilled for Health materials, but sections within the materials have been used to varying extents:

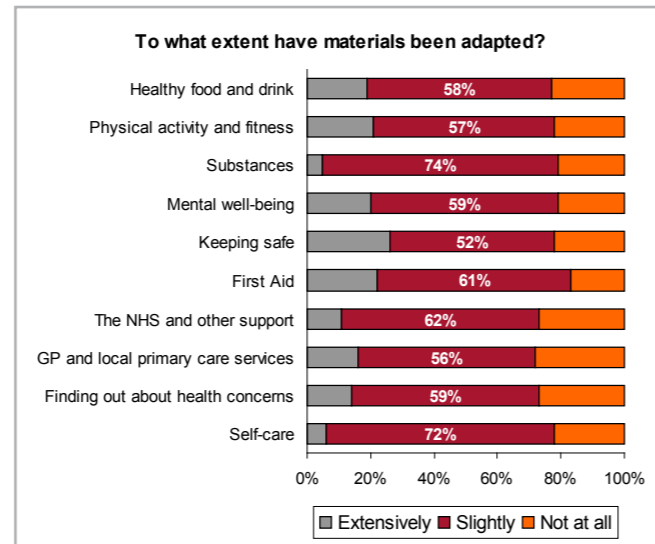
- *Healthy food and drink* section was used most often – 84% of tutors used the section; 63% used Mental well-being section and 54% *Physical activity and fitness*;



- The least frequently used sections were *First Aid*, *Substances and Self-care* - delivered by just under a third of tutors.

On average a course contained **five sections** from the materials, but this varied from using all of the sections (the Army Families, Northumberland Care Trust) to adapting just one or two – particularly when a section was embedded into another course (e.g. in Bolton and North Liverpool).

The majority of tutors **adapted** the Skilled for Health materials, although in most cases the materials were changed only slightly. GP and local primary care services and The NHS and other support were sections that required least adaptation, whereas First aid and Substances were most extensively changed.



The main reasons for adapting the materials were to respond to learners' specific interests, or to bring the materials at the right level for the audience. This was done by:

- Bringing in additional resources, introducing local information (mostly additional up-to-date statistics or materials found at a local health resource centre);
- Using alternative methods to cover the same contents if this was thought to deliver the same

information more successfully, often where these materials had been used in previous courses, or where a guest speaker introduced their own materials;

- Introducing interactive elements, e.g. by adding practical demonstrations (cooking sessions), physical activity, extra discussion sessions; and
- Changing the wording of the contents to meet learners' level of skills – both 'upwards' where materials were too basic for the learners (e.g. budgeting for parents), or more basic, where learners language skills were thought to be low (e.g. ESOL).

Around half of the phase two sites **introduced extra topics** to the Skilled for Health courses. Depending on the focus of the course, this was to enhance the literacy/numeracy or the health element:

- Tutors felt that the Skilled for Health materials on their own would not do a 'complete job' to improve Skills for Life. Where the focus of the Skilled for Health course was on Skills for Life, in all cases additional materials were introduced to cover this element more methodically (e.g. Nottingham City Council, Bolton)
- Extra topics introduced to health element, covered topics that were relevant to particular target groups, e.g. to enhance physical activities session (Prisons, Army families); introduce emotional well-being (Royal Mail), etc.

Many tutors introduced **practical activities** or tasting sessions to make learning more interactive. Some examples are provided in the following box.

Overall, the majority of tutors found the materials very useful – 54% of the tutors said that the materials overall were 'very' useful and 39% thought these were 'fairly' useful. In total then 92% found the materials useful. Just 3% (2 tutors) were 'not sure' and 3% thought the materials were 'not very useful'.

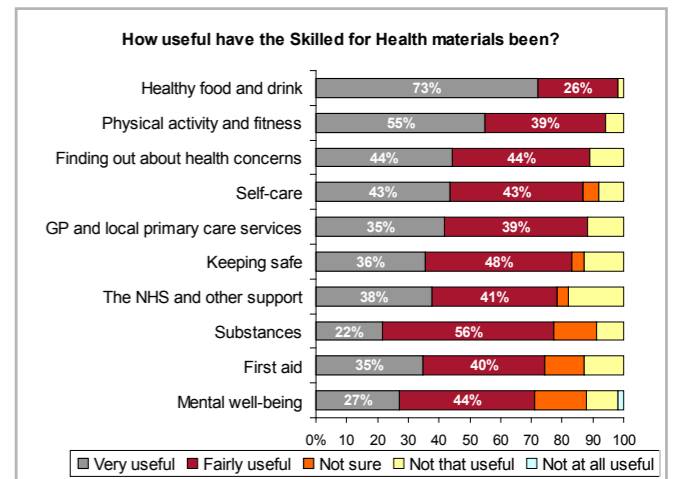
The tutors were most satisfied with the *Healthy food and drink* section – 99% said that the section was very

Within the physical activity section we provided our students with pedometers to count their daily, weekly and fortnightly steps. We then used this data to calculate conversions between the length of an average step to miles and kilometres.

The students were all interested in healthy recipes and cooking, so I included examples of recipes with pictures during the sessions.

I measured out an amount of drink into a glass and then using a bar measuring cup related this to how many units that glass had. We then worked out units in a drink – the learners enjoyed working out how much is in their favourite tipples.

For the sessions on physical activity I used various aids representing different physical activities, and got the learners to guess what the activity was. This led on to a discussion about what sort of physical activity they enjoyed and what they might consider doing in the future.



or fairly useful - and least sure about the *Mental well-being* section, although even then 71% found this very or fairly useful.

Most tutors were very positive about the materials – some comments are included below:

They are very well presented and attractive. The range of activities is excellent and really engaged the learners.

They are good quality and full of ideas that can be adapted to local use. Very well presented and very useful.

Very thoroughly prepared file with good explanations of how to use the activities and resources. Some excellent resources, e.g. NHS Immunisation Programmes.

4.7. TUTORS' RECOMMENDATIONS FOR IMPROVING THE MATERIALS

The survey asked tutors to give feedback on how to improve the materials. The most common suggestions for improvements from tutors were that the materials should include more interactive elements and **practical 'hands-on' sessions**, e.g. by introducing extra activities, videos clips, or internet sessions.

Tutors delivering to **ESOL learners** thought that including simpler and more practical sessions, and having a stronger reference to the core curriculum would make it easier for them to use the materials.

Diversifying the materials to cater for a diverse range of learners was another suggestion. Some comments are included in the following box.

Some simpler activities for ESOL learners would make it easier to use – simpler reading and writing activities and including speaking and listening to cover the whole of the curriculum.

Activities should be at a range of levels – I had learners with a wide range of abilities so it was important not to insult them with activities that were too simple whilst still catering for those with poor Skills for Life.

In addition, tutors felt that materials should give them **more specific guidance** or additional materials that would help them deliver courses more effectively, for example.

It needs to be made much clearer which individual sections are appropriate for ESOL or those with greater learning needs. There were a couple of sections that I had intended to use but when I studied them closely I realised that they were at a too basic level for my groups.

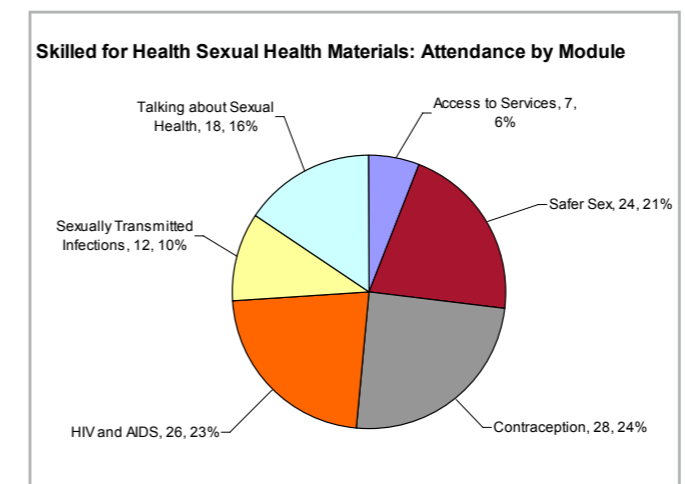
I spent hours and hours printing, laminating, guillotining and sorting the resources. It would be much more efficient if these resources were produced centrally and were available as a pack for each section that could be purchased by the organisations running the courses.

4.8. SEXUAL HEALTH MATERIALS

As part of the Skilled for Health contract in the Prisons site, HMP Holloway agreed to develop and deliver a new set of learning materials on Sexual health for its female offenders. The Head of Learning and Skills commissioned and worked with the centre for HIV and sexual health at Sheffield University to produce six stand alone modules⁷ aimed at Entry level 3 to level 1 (at a planned cost of around £32,000). The project was called 'Sexual Health Awareness Programme' and evaluation of the materials was conducted by City and Islington College.

The materials were delivered by three tutors in the Prison to 73 learners in three courses⁸. Learners were primarily aged 18-30 (76%) and from diverse ethnic backgrounds with round 42% were British white and 17% British Black. Women from Asian and Black ethnic backgrounds were under represented on the sexual awareness programme in comparison to the general population of learners in the education department. This may mean that materials need to be tailored to those specific groups.

The following chart shows that the *HIV and AIDS* (23%) and *Contraception* (24%) modules were the most popular with learners. Access to services was the least attended course at 6%.



Out of all the women who attended the courses 37.2 % felt they had improved their knowledge of sexual health. The tutors felt that this figure would have been much higher if more learners completed both the pre and post session parts of the questionnaire. Difficulties arose because of the Prison routine, inconsistency in attendance and personal circumstances. The most gains in knowledge however were said to be in *HIV and AIDS*, *Contraception* and *Safer Sex* which correlates with the level of interest in the topics.

Learner feedback on the modules was broadly as follows:

- The *Safer Sex* session was the most fun to do, easiest to follow, and the materials were judged as 'good' by providing new information.
- The session on *Sexually Transmitted Infections* had raised most awareness of sexual health and participants learnt the most information about the need to practice safe sex.
- The HIV session was felt to be less relevant and less fun.
- The relevance of learning about accessing sexual health services was also low.

This suggests that the materials were good but there was some diverse opinion amongst learners as to what was 'relevant' and 'fun to do'. The HIV session may have been less 'relevant' because tutor feedback suggests that the content of was too technical (*STIs*, *HIV/AIDS* & *Contraception*). A tutor needs to have enough knowledge to be able to simplify the information to the learner group and answer questions. Similarly the *Safer Sex* and *STI* course may have been more enjoyable because tutors said they supplemented the materials with additional resources such as photographs of *STIs*, 3D pelvic models and a contraception pack. There seems to be some benefit to keeping the learning practical and lively.

Tutors initially delivered materials as designed in order to evaluate them, but the professional expertise of a sexual health tutor was needed to deliver the key sexual health messages. All felt that the materials were set at the right level as most participants were at Skills for Life level 1.

Tutors also felt that *“the content should also include more themes that are directly relevant to the women lives. These are negotiation skills, self-esteem use and misuse of drugs and alcohol in relation to sexual health”*⁹. This could further be complemented by a

more ‘informal’ approach to the delivery of information by magazines, articles etc rather than fact sheets.

Above all the course was felt to work in the Prison context as a very good method of dispelling some of the *“myths and misconceptions”* offenders had about sexual health with factual information. Indeed a lot of the information was described by learners as ‘new’. Anecdotal information also shows that *“some women wanted the sessions to continue again, some even expressed that they were reviewing their sexual behaviour”*¹⁰.

4.9. SECTION SUMMARY

A range of recruitment methods is needed to attract learners to a Skilled for Health course. The less ‘direct’ an organisation’s access to learners is, and the more ‘hard to reach’ learners are, the more effort needs to be put into recruiting learners. Successful recruiting means, on the one hand, appealing to learners’ motivations for participating and on the other hand providing a ‘draw’ for them. Overall, health is a key draw for participants, and exercise / gym membership works particularly well for attracting men. This was also reflected in the use of the materials where the ‘healthy food and drink’ section was used most often.

Skilled for Health activities (both format and content) were highly responsive to learners’ interests,

organisational context and accreditation plans (though the mean number of hours taught was too little to help learners move up a level). This often also meant adapting the materials with extra activities, topics or resources to support learning objectives. In future, therefore, ongoing central support will be required to support the quality control over the delivery of the materials and the development of schemes if the concept of Skilled for Health is to maintain some integrity. Independent of delivery style, however, group settings tend to work better, not only for learner retention but also support peer learning, reducing isolation among target groups and provide enjoyment of Skilled for Health classes.

FOOTNOTES: SECTION 4

⁵ Data was not consistent as many learners preferred not to say their background.

⁶ Some data not provided across sites

⁷ Talking about sexual health, Sexually Transmitted Infections, HIV and AIDS, Contraception, Safer Sex, Access to Services

⁸ Although it must be noted that there was some cross over in attendance as 22 learners actually attended all 6 modules within the course.

⁹ Taken from the Sexual health awareness evaluation report HMP Holloway 2008

¹⁰ Taken from the Sexual health awareness evaluation report HMP Holloway 2008

5

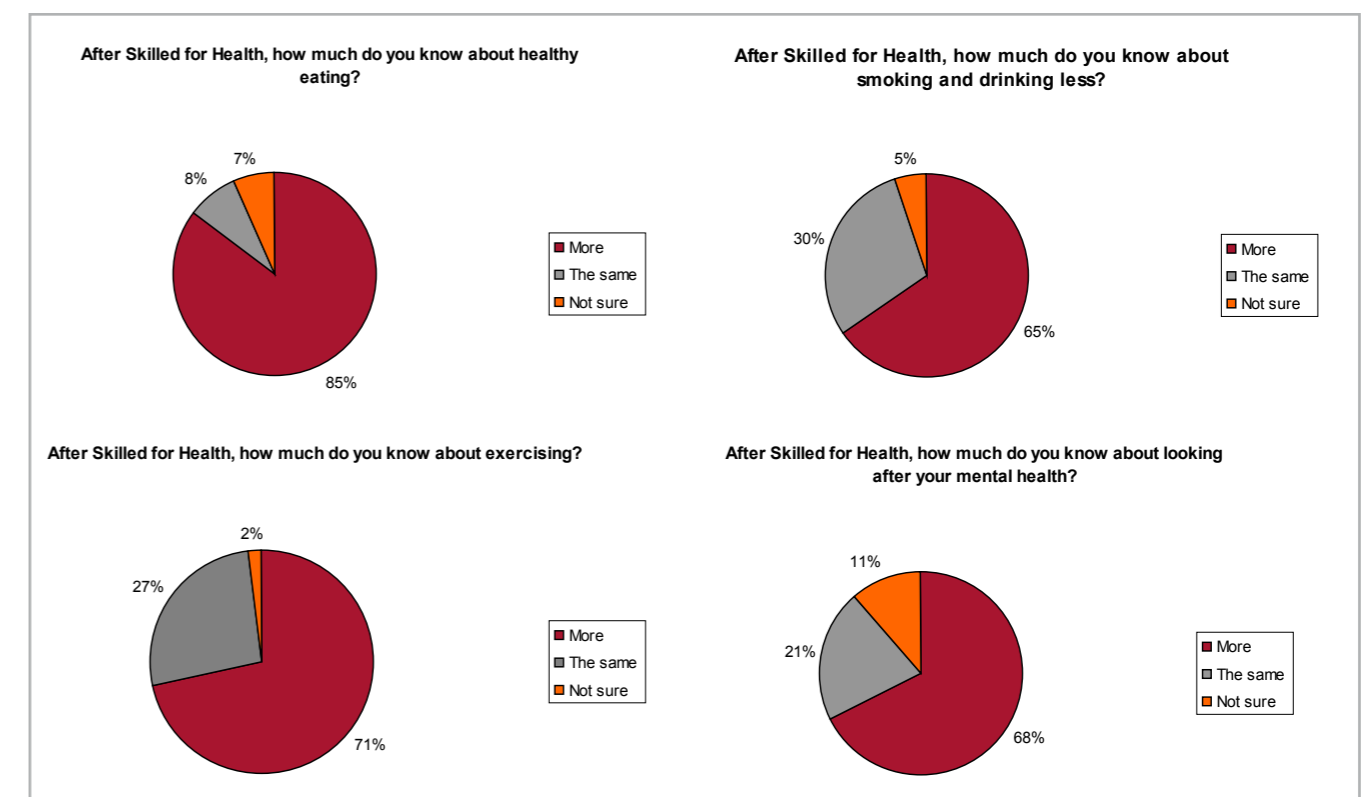
OUTCOMES AT INDIVIDUAL LEVEL

This section analyses the outcomes achieved by Skilled for Health interventions at the individual learner level. It explores both the health and the literacy gains achieved by learners and identifies some of the key variables that have contributed to achieving these gains¹¹. Key findings from the analysis of learner data include the strong knowledge gains on health that learners experience as a result of their participation in Skilled for Health, as well as significant behaviour changes in particular on healthy eating and drinking. On the learning side, key findings are some increases in Skills for Life but most noticeably the high proportion of learners interested in further learning and making plans to doing so.

5.1. HEALTH GAINS: ENHANCING THE ABILITY OF INDIVIDUALS TO MAKE INFORMED DECISIONS ABOUT HEALTH

5.1.1. Improved knowledge about health

Learners show a substantial increase in knowledge on health after having participated in a Skilled for health course, be this healthy eating, exercising, smoking and drinking or looking after their mental health.



The charts above show the figures for seven sites and six projects¹². They show that knowledge increase on healthy eating and drinking has been pronounced among phase two learners. This perhaps reflects the overall strong focus of Skilled for Health courses on healthy eating and drinking, as also evidenced by the strong use of these sections of the materials. Variations between sites, though they exist, are fairly small.

Learners' comments on what their Skilled for Health courses meant to them further substantiate these outcomes. Here, many learners report specifically on what they have learnt about a healthy diet.

"I have learnt how to cut down on fatty foods."

Learner from Salford

"I know more about alternatives e.g. alternatives to eggs or sugar."

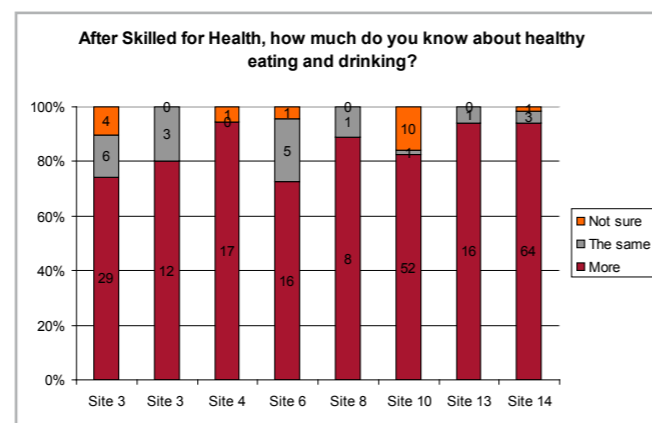
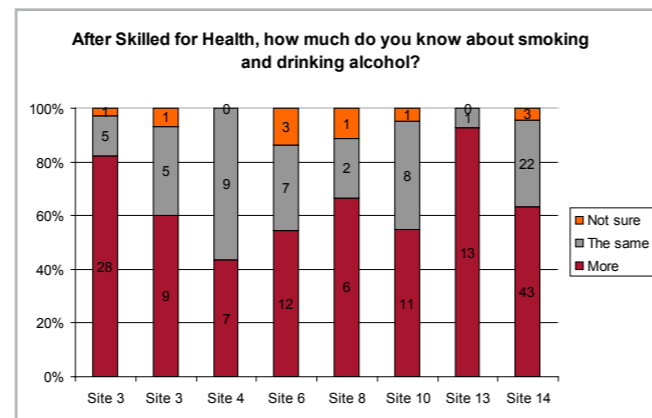
"I have learnt a lot about healthy food and how to put this info into healthy eating."

Learners from West Sussex

"It has opened my eyes to healthy eating and understanding about carbohydrates."

A learner from the Army site

Learners felt least confident claiming they now knew more about smoking and drinking alcohol, though 65 % still say they knew more about smoking and drinking after their Skilled for Health course than before. One explanation for this might lie in the coverage of this issue in the Skilled for Health curricula of phase two sites. In the figure below, for instance, we can see that



more than 50 % of learners in site four felt there was no change in their knowledge of smoking and drinking. These were learners from a course that concentrated on nutrition rather than smoking and drinking. In Royal Mail, where the *Substances* subsection was optional for learners, only those who chose this option responded to the question – which contributes to the higher rate of awareness among Royal Mail learners.

5.1.2. Changes in health awareness and behaviour

In particular in the area of healthy eating and drinking, Skilled for Health courses also seemed to have produced changes not only in awareness but also in behaviour. Changes in awareness are best illustrated using learner quotes:

"I think more about what I cook."

"I think about how much oil I use."

"More thinking about what I eat."

Learners from West Sussex

"It has opened my eyes to a lot of things shops put on food labels that make you think its good for you, when really it isn't."

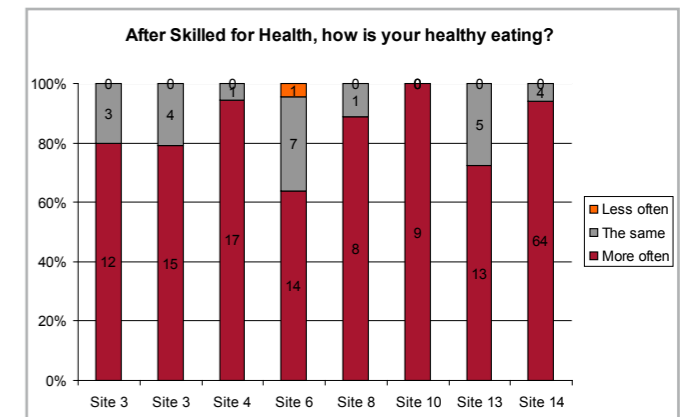
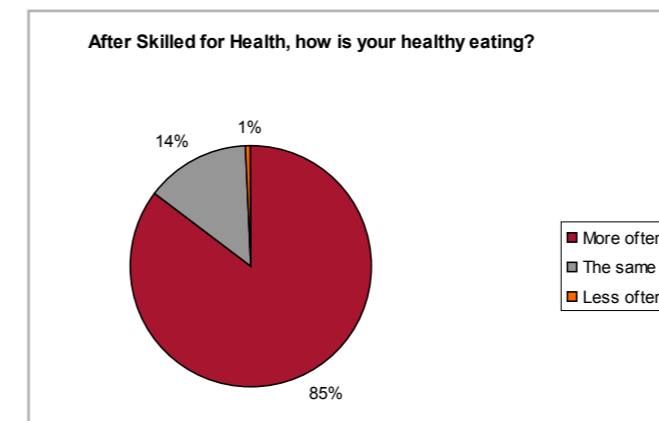
A learner from Durham

"It has made me more aware of ingredients. More aware that the older I get the more I have to take care of my health."

A learner from Gateshead Health Foundation NHS Trust

Healthy eating and drinking

Especially in the area of healthy eating we are also able to observe a change in behaviour. Learners are making positive choices away from unhealthy foods and towards healthier options.

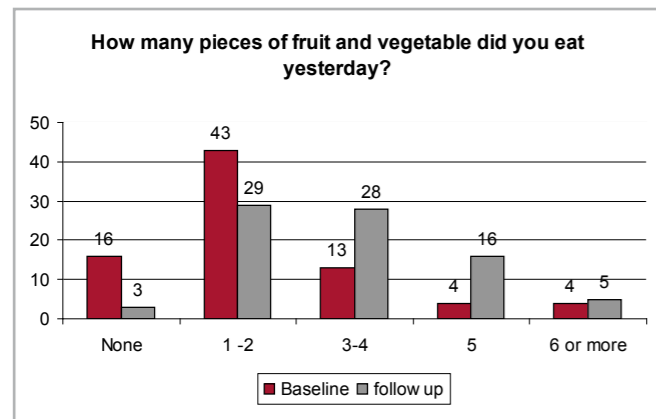


Overall, 85 % of learners claim to be eating more healthily. This result is particularly strong among learners participating in courses with a strong focus on nutrition and where there was a pre-existing interest in nutrition (e.g. the Gateshead Health site).

The assessment tool provides before and after data specifically on the consumption of fruit and vegetables which offer some degree of triangulation of this self-assessment. It is, however, important to bear in mind that healthy eating involves more than the consumption of fruit and vegetables, as the quotes above illustrate, so a smaller degree of change can be expected from this data.

Nevertheless, looking at before and after data on fruit and vegetable consumption, which covers learners from five sites, the trend towards healthier eating indicated by the self-assessed questions seems to be confirmed. The figure below indicates a noticeable decline of people who had not eaten any fruit and vegetable after completing the Skilled for Health course, a trend that is accompanied by a noteworthy increase in learners who said they were eating three to four and five pieces of fruit and vegetable the previous day.

In addition, some learners of the classes run at the MLA site agreed to eat one portion of fruit per day and learners were more able to make healthy choices in food. There were changes to dietary habits, cooking, the amount of oil in food etc.



In addition, some learners of the classes run at the MLA site agreed to eat one portion of fruit per day and learners were more able to make healthy choices in food. There were changes to dietary habits, cooking, the amount of oil in food etc.

"[Skilled for Health] meant a lot to me as my diet as changed as I'm pregnant. I'm now getting more energy and having my 5 a day portions of fruit and veg and less fat but I am having a balanced diet now."

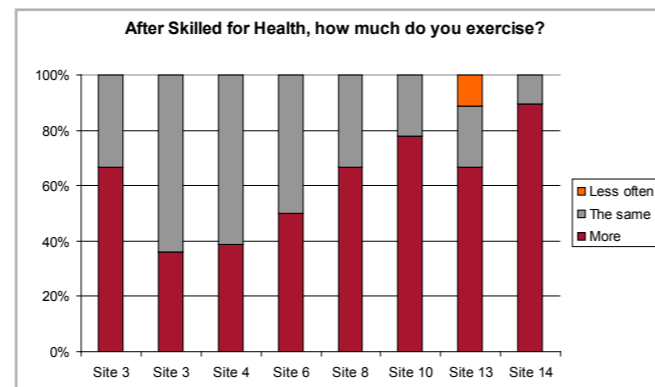
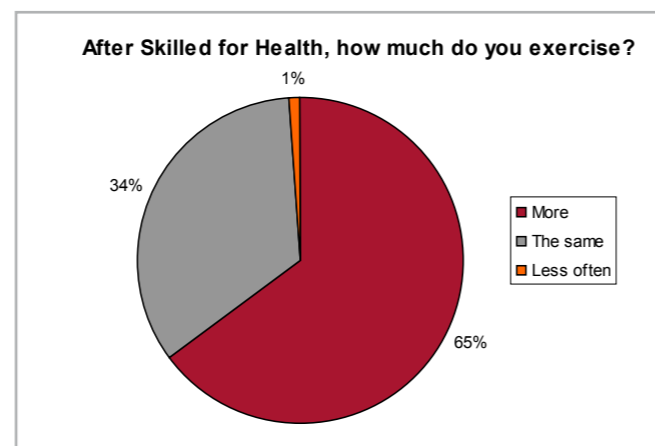
Learner from West Sussex

Changes in exercise behaviour

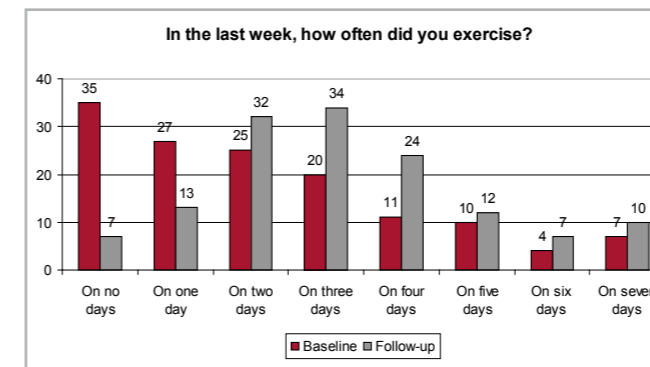
Learners are also reporting to exercise more after their Skilled for Health course. Compared to healthy eating and drinking, there were fewer people claiming to exercise more, though the number still came to 65 per cent.

One of the sites where self-reported increase in exercise was highest was in Royal Mail. Here, learners had access to a subsidised gym and were asked to keep an exercise diary. These two components of the Skilled for Health course will not only have contributed to increased awareness of learners' exercise routine, but also encouraged more exercise. That this was

indeed taken is evidenced further by the fact that many learners experienced weight loss during the programme. By contrast, one of the sites with the lower degree of change was Gateshead Health where exercise was not part of the learning curriculum. The exercise data therefore also show a connection between the course content and learner outcome.

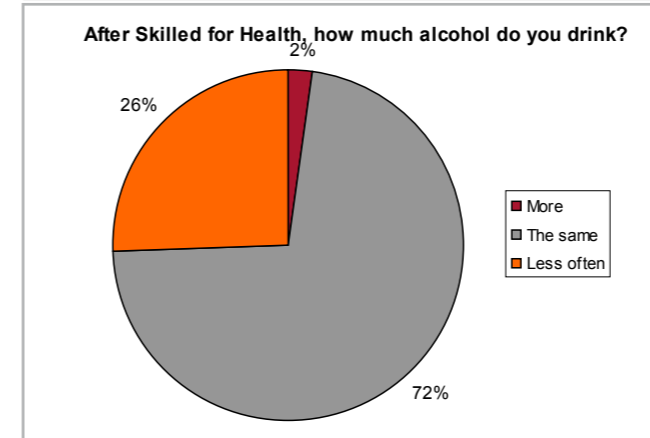
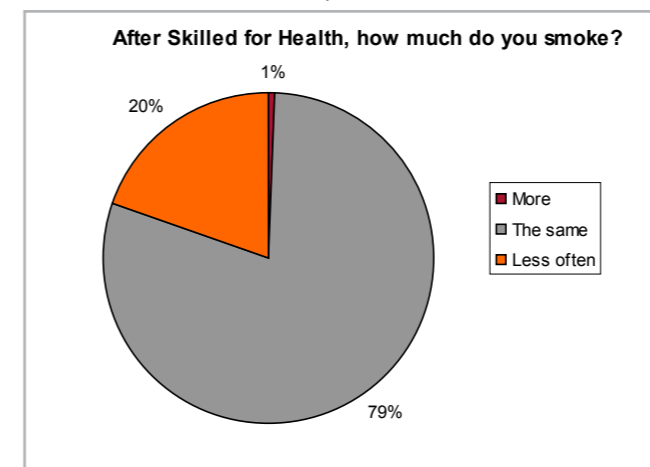


The before and after data on exercise included in the assessment tool also indicate a change of behaviour across the sites that answered this question (5). We can observe a noticeable drop in the number of learners who had not exercised the previous week after their Skilled for Health course and an increase in learners who said they exercised on two, three and four days in the week.



Changes in smoking and drinking

Changes to smoking and drinking behaviour are far less pronounced. In both cases, around three quarters of phase two learners reported they had not changed their behaviour in this respect¹³.



The most significant outcome here is that learners understand the negative consequences of these habits even though they are not always able to change them. The quotes below illustrate this.

"I tried to quit the fags but back on them"

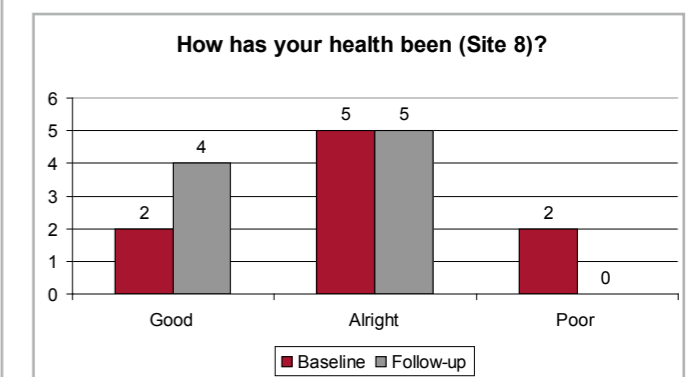
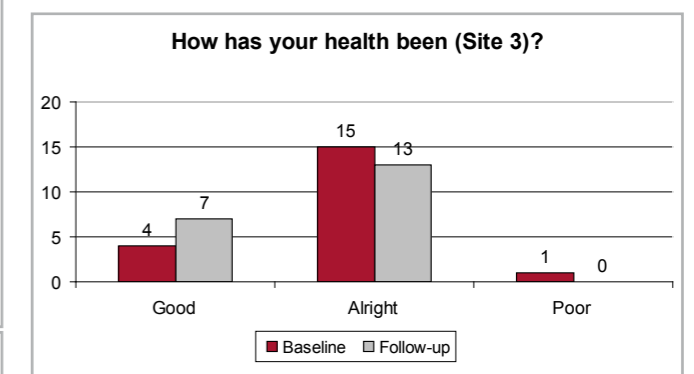
A learner from Durham

"Alcohol awareness was an eye opener and I have taken this on board."

A learner from Northumberland

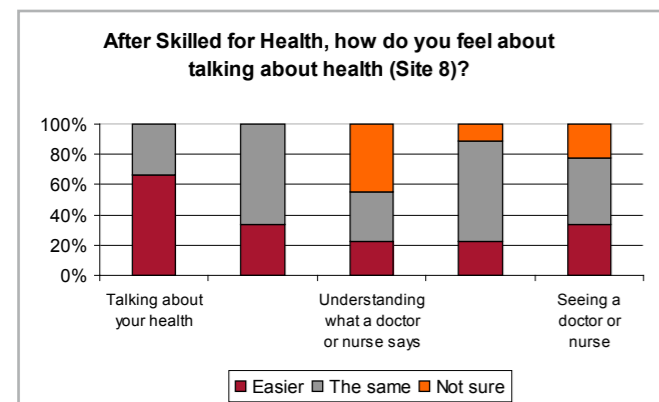
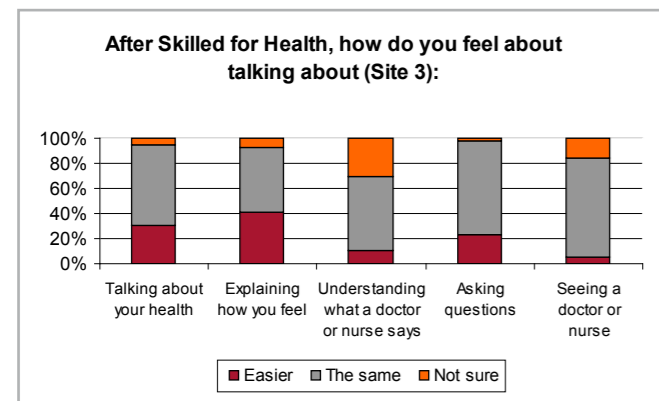
5.1.3. Health generally

The assessment tool gave sites the option to ask learners generally how they felt their health has been in the last four weeks. Two sites chose to use this question. In both cases, learners report slight improvements in their general health after their Skilled for Health course.



5.1.4. Ability to talk about health

Data from two sites further point towards some modest changes in learners' ability to speak about their health. The figures below indicate that some learners improve in particular their ability to talk about their health and explain how they feel.



In the MLA, the finding was that learners gained confidence, mainly with regard to literacy skills but also in making doctors appointments and asking professionals for help.

5.1.5. Taking learning into the family and the community

The skills and knowledge in healthy eating developed during courses can also be said to have secondary outcomes with learners making improvements to family health and cascading their new knowledge back into the community. Indeed, without being prompted a small number of learners in many sites has referred to the benefits of the Skilled for Health

"I love this course. You learn so much about how to care for yourself and your kids."

A learner from Holloway Prison (Prison site)

"I discuss everything I've learnt with my sons and husband"

A learner from the West Sussex site

"Learn something new for me and my whole family. It was very educational. Enjoyed every bit of it."

A learner, Army site

"Using the skills we learned will be good for me and my family also enabling me to use these skills on a daily basis i.e. getting myself healthier, more aware of how to make my family safer in the house and know more about first aid."

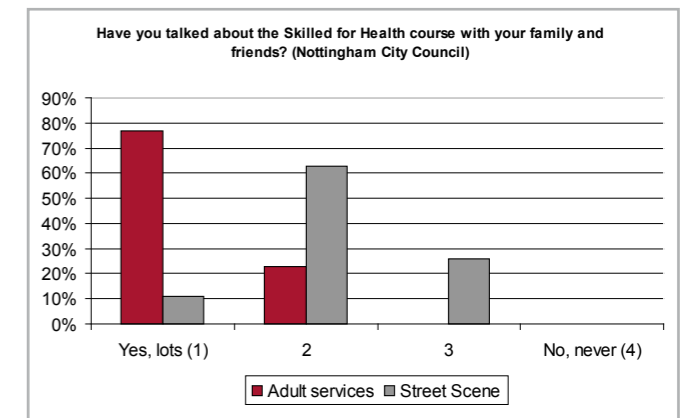
A learner from the Northumberland site

"I think more now on what I cook. I also try to use less oil. I tell my family about healthy eating so that they know how important it is for them."

A learner from the MLA

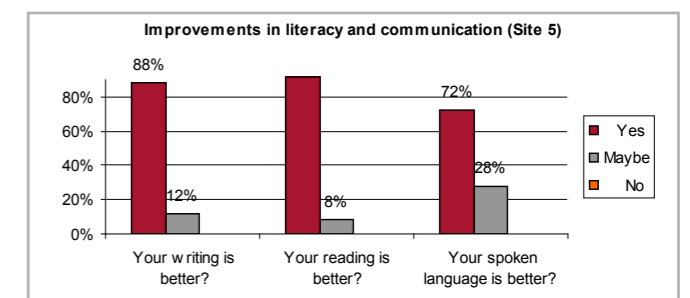
course to their families. Unsurprisingly, this number is largest in the Northumberland site where there was a particular focus on family learning. However, as the quotes below show, elsewhere learners also discussed, implemented or planned to otherwise take their new knowledge into their family or community.

Nottingham City Council asked their learners specifically whether they were talking about the course with their family. The chart below illustrates the response. In both courses, learners tended to talk to their family and friends about the course, or talk to them about it a lot.



5.2. PROGRESSION ROUTES INTO FURTHER LEARNING

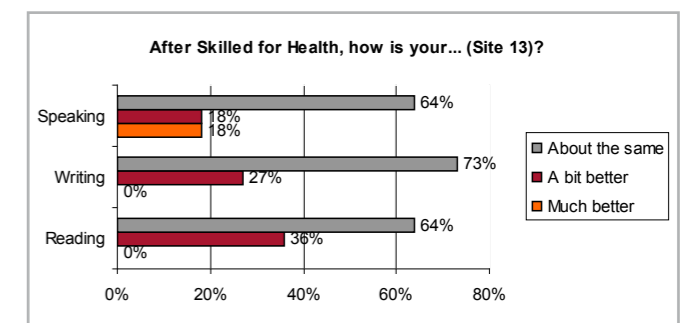
Learner assessment data show that Skilled for Health opens up two kinds of progression routes into further learning among course participants. On the one hand, improvement in skills levels can be observed which opens up new opportunities to continue learning with a view towards gaining qualifications. On the other hand, a high motivation to continue learning together with some learners realising these plans can be observed. Importantly, learner data show that Skilled for Health lays an important precondition for further learning: increased confidence.



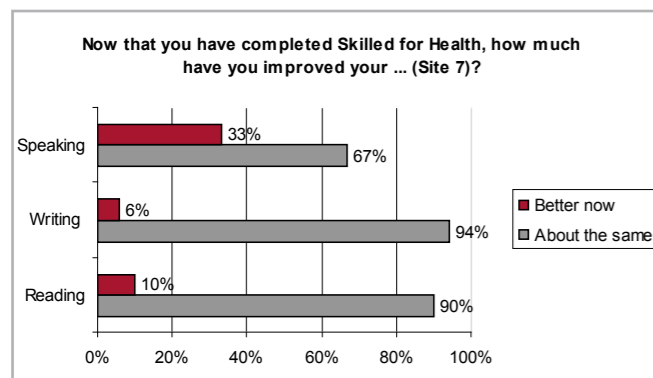
5.2.1. Self reported learning outcomes: reading, writing, speaking

Three phase two sites assessed their learners' progression by asking them to rate their reading, writing and speaking skills after they had completed their Skilled for Health course¹⁴. This data shows that learners improved these skills, but that the degree of improvement that is achievable with a Skilled for Health course can vary significantly between sites.

The figures above show a significant difference in self-reported outcomes between Site 5 and the other two sites. Improvement levels in Site 5 were extremely high, with 88 % of learners reporting positive changes



in writing skills, 92 % in reading and 72 % in speaking. These strong improvements are in some contrast to the more modest changes recorded by Site 13 and Site 7. In both of these sites, the dominant trend is learners reporting experiencing no change in their speaking, writing and reading skills. Nevertheless, change is reported by some learners: in Site 13, improvements were greatest in writing and reading



skills; in Site 7, most learners felt that their speaking skills had improved.

These different results can only be understood in context, ie by looking at how Skilled for Health was delivered in these sites. This analysis highlights that two main factors¹⁵ will affect the degree of change that a Skilled for Health course can achieve:

- The **learning needs** of Skilled for Health participants and the skills level with which they join the course. Site 5, for instance, attracted mostly ESOL learners who started from a very low level of literacy. The courses were delivered by qualified ESOL teachers using health topics with embedded ESOL. Structurally, this created positive preconditions for change. In Site 7, by contrast, learners' needs were less coherent as the groups were more mixed (e.g. learners included graduates as well as individuals with low literacy skills).
- The **content, focus and delivery style** of the programme. In site 7, for instance, the focus of Skilled for Health was on mental health outcomes with a specific slant on addressing confidence and "working with feelings", encouraging participants in the programme "to be assertive rather than aggressive, and to have more confidence to express how they are feeling." This focus, together with the group setting, can explain the fact that improvements were greatest on speaking skills. The group setting is also an important explanation for the learner progression in Site 5 where the talk and conversation in classes helped ESOL students

to practice their speech. In Site 13, exercise was an important aspect of the Skilled for Health project, it was further delivered with the help of an eLearning methodology and learners were asked to keep diaries during the programme. These two elements can explain the relatively stronger increases in self-reporting writing and reading skills among learners than for speaking.

The varied learning outcomes achieved by sites therefore cannot, and should not be, interpreted as a 'failure' (of the programme or sites' work). Rather, what the data teaches us is that learning outcomes are a function of what the project set out to achieve in the first place and hence how the delivery of the project was designed.

5.2.2. Changes in Skills for Life levels

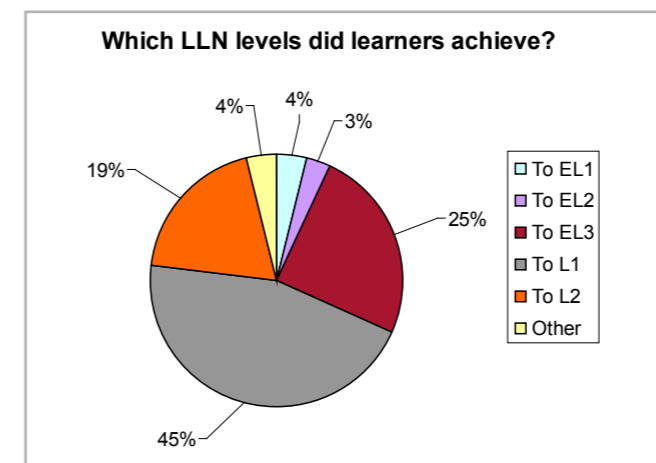
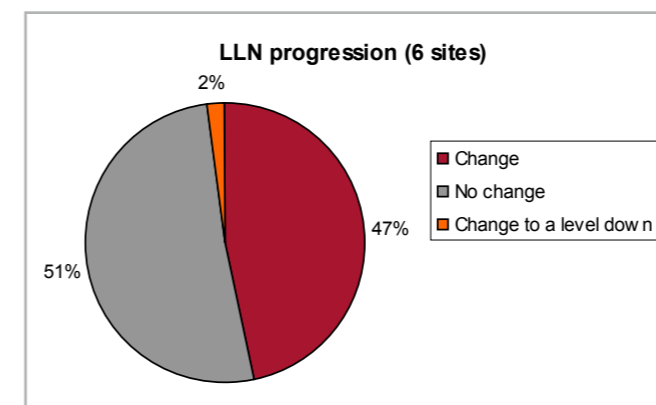
It was not the intention of phase two of Skilled for Health to progress learners along Skills for Life levels. Nevertheless, six sites (7 projects) carried out some form of Skills for Life assessment for all or some of their learner cohorts: Durham (Darlington College and Bridge projects), Northumberland, West Sussex (2 projects), Nottingham City Council, Royal Mail and Gateshead Health NHS Foundation Trust.

Some of the motivations for accreditation resulted directly from a project aim to support learners to gain a Skills for Life qualification (Nottingham City Council). Others appear to be a result of the delivery arrangement: Darlington College (part of the Durham site), for instance, integrated Skilled for Health courses into existing – accredited – provision. In Gateshead Health Foundation NHS Trust, accreditation of the nutrition courses was due to a mix of reasons, including giving learners a sense of achievement and accessing LSC funding for the delivery of the courses.

Progression

Almost half of the learners assessed in these sites (47 %) were assessed at one level up after completing their Skilled for Health course. For 51 % of learners there

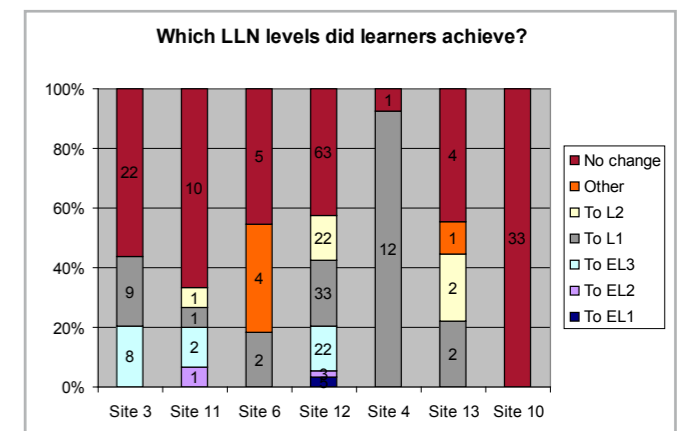
was no change. Of those learners that progressed by one Skills for Life level, the vast majority were assessed at Entry Level 3 (24 %), Level 1 (43 %) or at Level 2 (19 %) after their Skilled for Health course. There was no progression to Level 3 and little movement in the lower entry levels.



Differences by site

However, Skills for Life progression varied greatly between the sites, as the following chart shows.

In Site 10, learners did not progress. At least part of an explanation for this lies in the composition of the two courses where accreditation took place (and where this was captured by the assessment tool). At the beginning of the course, a majority of learners were

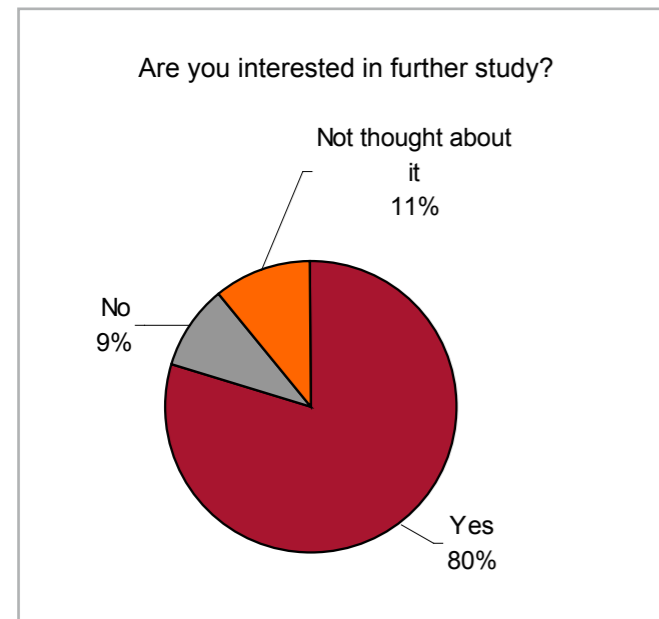


assessed to be at Entry Level 1, 2 or 3 and were also mostly ESOL speakers. Learners at these Levels are assumed to take at least 300 hours of tuition to gain a whole level¹⁶. Such extensive tuition could not be achieved as part of phase two of Skilled for Health: at this site, the longest course lasted 10 weeks.

By comparison, all but one learner in site 4 achieved Level 1 at the end of their course. Other than Site 10, they started from a comparatively high level. Though learners had been identified by the organisation as disengaged from learning, they counted as their qualifications GCSEs, A-levels, NVQs as well as some professional qualifications. Moreover, the course was designed with a view to accrediting learners at the end, and the tutor designed the course and worked with learners specifically towards an accreditation objective. Finally, learners also had not been assessed at the beginning of the course so a direct 'before and after' comparison cannot be made. In Site 12, too, accreditation was an explicit objective of the course. Here, course length is also likely to have contributed to the fact that more than 50 % of learners moved up one Skills for Life level: a large number of courses ran over either 30 or 60 hours. This is a long timescale compared to most other Skilled for Health sites / projects which increases learning and hence opportunities to progress.

The progression figures also point to the fact that measuring progression by Skills for Life level is a rather

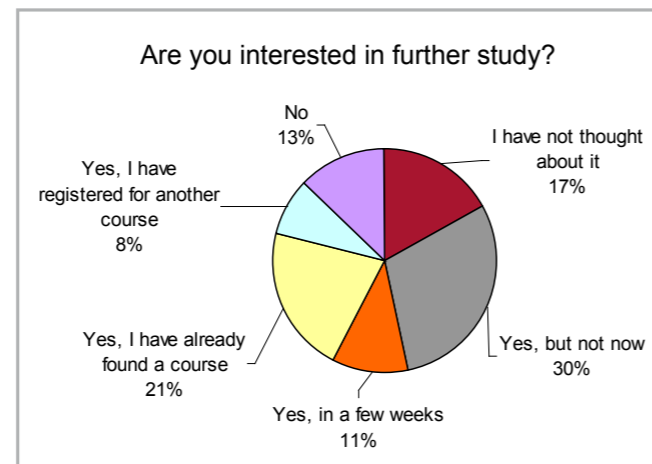
crude instrument in the context of Skilled for Health. In two of the sites, a very small number of learners showed a lower Skills for Life level after the Skilled for Health course than before (the 'Other' category in the figures above). One interpretation offered was that this could be down to a change in the perception of the tutors. Where there was no formal assessment, tutors may have changed their initial assessment when they got to know learners better and reviewed it.



5.2.3. Progression into further learning opportunities

Considering the aims of phase two of Skilled for Health, perhaps more important than Skills for Life level progression is the interest learners gain in continuing to learn. In this regard, phase two of Skilled for Health has been extremely successful. 80 % of learners who were asked this question¹⁷ stated that they were interested in further study. Only 9 % categorically said they were not, and 11 % said they had not thought about it.

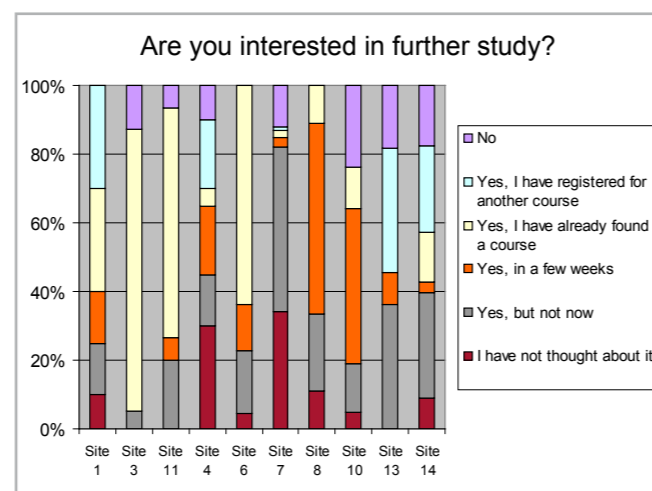
A more differentiated picture is delivered by the assessment tool which asked learners whether they



were interested in further study and, drawing on the model of behaviour change, attempted to elucidate from learners how concretely their plans are for engaging in further study¹⁸.

This data shows that interest in further study amongst Skilled for Health learners is strong. More than a quarter of learners who had been asked this question (29 %) had already translated this interest into concrete action by the end of their Skilled for Health course, either by registering for another course (8 %), or by having identified another course (21 %)¹⁹.

However, as can be expected, learners' plans for further study vary between the phase two sites (see the chart below).



In this figure, two trends are particularly noteworthy. The variation between sites / projects in finding another course and registering for one varies particularly between sites 1, 3, 6 and 13 on the one hand (where positive answers are particularly strong) and sites 7, 8 and 10 (where concrete action towards progression is weaker).

Looking at these sites more closely, we can conclude that there are important external conditions that need to be present to support learners moving from an intention to further learning to identifying a course and even registration.

Advice and guidance by tutors appears to be an important factor supporting learners in finding and registering for another course. In Royal Mail, for instance, where a comparatively high number of learners who completed the course registered for another, follow-up interviews were held which included further recommendations on the courses available and scoping learners' interest in continuing with the gym. The possible learning routes were, for example, NVQ courses offered on site by the college involved in the programme (team leading, warehousing, business studies), or Skills for Life courses working towards national tests. The army site not only offered a continuation course after Skilled for Health but, importantly, covered opportunities for other courses for those who wanted to go on to learn more in the last session of this continuation course. In Northumberland, too, all learners are offered information, advice and guidance appointments near to the end of their Skilled for Health course which helps progression into further learning.

"The exit route is almost as important as the course itself – once they've made their first step in learning, it is important to help them consider what to do next. On their own I don't think the materials can do a complete job [of improving literacy/ numeracy] but as a motivator and an introduction I think they are very successful."

College tutor

An integration of Skilled for Health with other learning provision locally further aids progression. For instance, both the Army site and Royal Mail offered progression courses to learners which explains the high levels of learners who were able to identify and register onto another course. In Northumberland, learning providers are all keen to recruit new learners onto their courses - Skilled for Health learners expressing an interest can mean that a course becomes viable. This is somewhat in contrast to the situation in Site 7 where this integration was not achieved (and learners had made less concrete plans to attend further courses).

However, to allow registration, a key variable is, of course, free spaces. For instance, whilst many learners at the MLA site were interested in further study, and in particular in taking English classes, their ability to progress was restricted by the shortage of ESOL courses in their Boroughs.

5.2.4. Other gains: confidence and enjoyment of learning

Regardless of differences between sites, however, for many learners participating in Skilled for Health has laid an important foundation for a continuing engagement in the learning process. Assessment data show subtle, yet noteworthy, improvements in learners' confidence generally, their confidence in learning in particular as well as their enjoyment in learning. These changes are likely to support learners seeking out, and engaging in, learning in the future.

Increased confidence

Phase two of Skilled for Health has produced some evidence that participating in a Skilled for Health course can increase learners' confidence in general.

Nottingham City Council, for instance, asked learners to rate their confidence in everyday situations before and after the Skilled for Health course. The answers given reveal a subtle shift towards more confidence among learners, with fewer or no learners rating their confidence in everyday situations low (-5 %) or very low (-2 %), and more learners feeling their confidence was

high (+4 %) or very high (+ 15 %). The vast majority of learners attributed this change to the Skilled for Health course.

There is also anecdotal evidence from other sites to support the conclusion that Skilled for Health can increase confidence. MLA learners' increased confidence manifested itself, among others, by the fact that they attended the closing event, asked questions and took an active part in the film. In addition, learners appeared to feel like they 'could' achieve more (learning, work, skills) –visible from the film shown. When asked what participating in Skilled for Health had meant to them a few learners said they now felt more confident.

*It has given me confidence to do new things.
It has brought me out of myself and made me a little more confident.*

Two learners from the Army site

In addition, participating in a Skilled for Health course can increase confidence in learning more specifically. At the MLA site, for instance, 91 % of learners stated that they felt more confident in learning generally after their Skilled for Health course. Clearly this is part of the explanation for the high interest learners at this site showed in continuing to learn. Learners taking the Ashington course at the Northumberland site offered similar feedback. Here, it is reported that several learners said that as a result of taking part in this course they were now much more confident about tackling other courses²⁰.

The quote below offers feedback from one learner at the Gateshead Health Foundation NHS Trust site.

'It has given me a boost to do more learning and gain more qualifications.'

A learner from the 'Return to Learn' course in Gateshead Health Foundation NHS Trust

Enjoyment in learning and confidence in the classroom

Further, there is some evidence that Skilled for Health courses can increase learners' enjoyment in learning and confidence of being in a class room.

Three sites used the supplementary question from the assessment tool which asks learners how they feel about learning (Army, Gateshead Health Foundation NHS Trust, Prisons). Though in two of the sites (Army and Gateshead Health Foundation NHS Trust) the majority of learners felt the same about learning before and after their Skilled for Health course, important changes can be observed among some learners:

- Data from the Army site show, for instance, that there was about a 10 % increase in learners who, after completing their Skilled for Health course, stated they enjoyed learning, enjoyed helping others learn and believed they could learn new things. Around a quarter more learners said they felt confident learning in a classroom after their Skilled for Health course than before.
- A broadly similar trend resulted from the nutrition courses run by the Gateshead Health Foundation NHS Trust site. Here, more than a quarter of learners (28 %) gained enjoyment in learning after their Skilled for Health course, 17 % enjoyed helping others learn more and had gained belief that they can learn new things. More than a fifth of learners (22 %) felt more confident in a classroom.

For these learners clearly some important attitudinal preconditions were laid to allow them to engage in a wider range of learning opportunities after and beyond Skilled for Health.

It is interesting to note that the prison site has experienced much more significant changes on learners' enjoyment of, and confidence in, learning. Here, more than half of learners (55 %) said they enjoyed learning new things more after their Skilled for Health course and nearly half of all learners (48 %) said they enjoyed helping others learn more. 77 % of all learners said they now felt more confident in a class room.

5.3. SECTION SUMMARY

Skilled for Health courses are successful in achieving both health and literacy gains among participants. Health gains extend beyond an increase in knowledge and awareness to evidence of changed behaviour (in particular in the areas of healthy eating and drinking as well as exercise) with some learners achieving weight loss and lower cholesterol levels. The degree of change, however, is influenced by the content of the Skilled for Health activity. Literacy gains include improved reading, writing and speaking as well as a Skills for Life level improvements among nearly half of all learners assessed. Again, these changes vary

significantly across sites and are influenced by learners' starting points, course length and objectives. Perhaps more importantly, Skilled for Health succeeds in instilling an interest in further learning amongst almost all participants which can be successfully translated into further study where follow-on advice and / or progression courses are provided and where relevant courses locally have free spaces. Learners, finally, gain confidence from participating in Skilled for Health. This will support them in their future learning journey.

FOOTNOTES: SECTION 5

¹¹ Most of the data in this section was collected through the integrated assessment tool developed by the national evaluation team.

Feedback from sites and learning from implementation are presented in Appendix 1 Reflections on the methodology.

¹² The other sites used slightly different phrases or versions of this question and will therefore be discussed separately.

¹³ This is not untypical, and a similar result has been found by other evaluations of public health interventions

¹⁴ The assessment tool (core questions) offered Phase 2 sites to record changes in LLN levels experienced by their learners as well as record changes in reading, writing and communication measured through other methods. Other than the six sites that measured LLN progression (see next section), no site used the alternative core question or the supplementary question 12a as a way to capture learners' progress with reading, writing, speaking and maths. The discussion below, therefore, draws on three kinds of data: alternative questions sites asked their learners, learners' feedback and any evaluation reports available from sites.

¹⁵ Common sense dictates that the length of courses should also have an impact on the degree of change achieved by learners, but the data of the three sites do not appear to produce a strong correlation on this.

¹⁶ From MLA monitoring data.

¹⁷ 539 learners across 13 sites, either through the assessment tool or by the sites themselves.

¹⁸ This data is available for nine sites and a total of 316 learners.

¹⁹ This data does not take into account that in some instances the identification of other courses led subsequently to a registration. This was in particular the case in Northumberland where monitoring data shows that out of 51 learners who completed 6 Skilled for Health courses, 14 subsequently enrolled in other learning opportunities.

²⁰ Site's own course evaluation.

6

SUSTAINABILITY

6.1. EVIDENCE OF SUSTAINABILITY AT PROJECT LEVEL

Discussions around how to sustain Skilled for Health at the local level are ongoing, which means that plans are changing by the day. All sites plan to continue their Skilled for Health projects/activity, but some have been more successful in finding ways of sustaining or funding Skilled for Health in future than others.

There are two sites who have confirmed funding to sustain activities. These include MLA London, where three of its libraries have been successful in gaining funding locally to deliver Skilled for Health courses and another is in discussions with its PCT²¹; and Pentonville Prison, which has secured resources from within the prison and from Islington PCT²² to continue its Skilled for Health project.

Other sites have prepared funding bids to sustain their Skilled for Health locally, the MLA to the LDA and the County Durham site to County Durham and Darlington PCT to continue Skilled for Health but very much within the local and regional health inequalities agenda.

Other sites have taken a different approach to sustaining Skilled for Health and are working towards embedding the approach in their organisation or delivery of activities:

- Northumberland – the main focus for sustaining Skilled for Health here has been embedding the approach and materials into the teaching programme at the NHS Foundation Trust;
- Gateshead Health Foundation NHS Trust – this site has been working on embedding Skilled for Health into the learning activities of the Trust;
- North Liverpool – this site had embedded parts of the materials into most of their courses through the programme so this work will continue;
- Holloway – Skills for Life tutors at the prison will continue using the materials and delivering Skilled for Health courses;

- Nottingham – planned to continue with this approach in future;

For other sites, however, concerns about sustainability persist and it may be difficult for these sites to sustain their Skilled for Health work in its present form without new sources of external funding. As such, there are a few sites that are actively pursuing different funding options:

- The army site is fairly likely to get funding from the PCT, although this has not yet been confirmed;
- The Bolton Partnership is exploring a number of funding options through grant funding and commitment from partners;
- Royal Mail is looking at the possibility of linking into funding from Train2Gain;
- Broughton Database (the Salford Partnership) will continue its embedded work but is seeking funding from other sources (including local Learning Centres) for the stand-alone courses.

Overall, there seem to be some key factors that are likely to contribute to making a project sustainable. These include:

- Resources available from the host organisation and partners: it is easier to achieve sustainability for Skilled for Health if internal resources can be drawn on (be these financial, in kind or other) than if delivery of Skilled for Health relies entirely on outside funding.
- Having senior management commitment and leadership: this means not only the organisation backing the delivery of Skilled for Health, but also links to a more strategic political level locally and regionally and thereby opportunities to know about and access new funding streams.
- This, in turn, means that linking up with strategic partners both locally and regionally is important for the sustainability of a Skilled for Health project

which requires the involvement of individuals in Skilled for Health project who know about and are able to work at this level.

- Strength of the evidence projects are delivering on the difference Skilled for Health has made to learners, and whether the evidence collected matches up with evidence needs of funders.
- Linking it with current developments or policy priorities in the Skills for Life arena or elsewhere can help with sustainability, for instance by making an internal business case. For instance, Skilled for Health can contribute to curriculum enrichment and therefore make a contribution to the Every Child Matters agenda.
- Interviews with Skilled for Health stakeholders have suggested that the sustainability routes for 'sector' and 'community' sites may be quite

different. A "dual intervention" approach would mean sector sites would be developed as work (or institutional) based with progression routes and links into occupational health using employer/organisational funding and/or staff backfill. Community interventions would be more likely to pursue matching funding from PCTs, LSCs or LAAs etc. (possibly with lower, tapering Skilled for Health grants).

Whatever the options, there has been a need for the national Skilled for Health programme to instigate and support discussions and strategies on sustainability, to help address the issue at a local level. There has not been much focus on this in phase two, and discussions / planning for a next phase (initially talked about as "phase three") may have left sites with the impression that this could include an extension in grant funding.

sources persist, especially where delivery models are not geared towards accreditation. In these cases, there appear to be two options for achieving sustainability:

- Achieving strategic mainstreaming. Here, sustainability would be achieved if the Skilled for Health approach leads to organisation-wide learning so that existing service provision is changed to reflect this learning. Skilled for Health would therefore be totally embedded in the activities of the organisation and/or its core funding streams.

- Achieving project mainstreaming. This would be a more modest form of sustainability where the materials, or the 'pedagogic' approach, would be embedded in (and funded as part of) other courses delivered by the organisation.

Both approaches probably need some national funding as 'pump priming' or for leverage of local and/or regional funding. The combination of national support and access to some level of funding would, in turn, help sustain Skilled for Health as a national programme with a distinctive approach and clear identity.

6.2. PROGRAMME LEVEL SUSTAINABILITY

The programme level infrastructure of Skilled for Health has clearly been important in providing support for the sites and giving the programme an identity within Government and other stakeholders. On the whole, sites have generally been quite positive about this relationship with the programme as a whole and have valued the contact and support they have had from the national team. In particular, appointing a Project Manager with a specific remit to build relationships with sites was very effective and has taken pressure off other members of the team.

However, there have been some key challenges around coordination of the programme, some of which have been addressed as the programme has developed. These have been discussed in section 4.2.2. To enable Skilled for Health to be a sustainable approach in a range of settings, future national programme level support would need to include:

- Supporting potential employer sites with their internal negotiations about setting up a Skilled for Health project;

- Information about the programme and clarity about likely resource requirements for delivery and evaluation;
- Coordination of a network of sites to share learning and good practice;
- Establishing a clear identity for the programme;
- Support for sustainability through information and guidance on funding options;
- Championing and maintaining national commitment to the programme in the face of organisational, ministerial and policy change.

As discussed in the previous section, the sustainability of individual Skilled for Health projects appears greatest where delivery is linked to mainstream funding within organisations or to Skills for Life provision/LSC provision or has PCT support. For many projects, however, it may be difficult to sustain their Skilled for Health work in its present form without new sources of external funding. Concerns about the availability of funding/ support from mainstream

FOOTNOTES: SECTION 6

²¹ Enfield has core funding with match funding from a local college; Ealing has funding from the PCT for delivery of four courses; and Croydon put in a successful bid to the Personal and Community Development Learning/LSC. Islington is currently in talks with the PCT.

²² The Governor agreed to use credits offered by City and Islington College to pay for LLN support; the prison canteen provides fruit and refreshments from its own budget; the Head of Education has agreed to provide 'orderlies' to help with admin and recruiting; and Islington PCT agreed to hire a full time nurse to manage the programme.



7 CONCLUSIONS: MAIN MESSAGES FROM THE NATIONAL EVALUATION

The second phase of Skilled for Health has focused on introducing the programme into a range of 'employer', 'sector' and 'community' sites and testing it out in these different settings. Overall 1600 participants in 18 sites have been engaged in the programme, primarily through an interest in health issues. This initial 'draw' has, however, led to learning outcomes as well as positive changes in health literacy, awareness and behaviours. Individual outcomes have also included an increase in confidence and an interest in further learning.

The national evaluation has found that one of the distinctive aspects of Skilled for Health is its flexibility in responding to a range of learners' needs and circumstances, through user-led approaches that have attracted 'hard to reach' groups who would have been unlikely to access mainstream learning or health promotion provision.

The backing of the national programme has been important to the sites, in terms of financial resources, the Skilled for Health materials and support from the management team and ContinYou staff in setting up and managing the projects. The evaluation has identified some key factors in sites that help making projects sustainable but has concluded that programme level support will also continue to be required in the future to champion, co-ordinate and maintain the innovative approach that Skilled for Health represents.

The details of our conclusions are as follows:

There is no one best delivery model. All delivery models used by phase two sites deliver a combination of health and learning outcomes.

- Objectives, starting points, contexts and learners differ across sites. The selling point of Skilled for Health will therefore differ because objectives are different.
- Part of the delivery model is the balance between health and skills in a project. This is affected by the objectives of the project and the envisaged learning outcomes. Health may be used as the

engagement tool, but in terms of expected outcomes equal progress will mostly be expected. Partnerships (involving individuals or organisations from different backgrounds) help cover both elements and provide a richer and more interesting learning experience.

- An important learning from phase two is, however, that individualised learning as a model works less well than learning in a group setting where learners can learn with and from each other.

Health and language, rather than skills, are the main 'hooks' to get learners involved.

- Some learners require multiple methods of recruiting, others just a single one. The more 'distant' the target group from the organisation or the learning process, the more effort needs to be put into recruitment. Access to existing learners facilitates recruitment; reaching out to new learners makes it more difficult. This is linked to the resources available for Skilled for Health projects.
- It is very easy to cream off 'easy' learners and more difficult to engage the 'harder to reach' ones. This could be the main issue with running Skilled for Health not as a grant programme but through mainstream funding: harder to reach learners may be less likely to be attracted.
- Few sites used literacy as the main motivator to bring learners into Skilled for Health courses. This is due to the fact that the target group of the programme was 'disaffected' learners often with bad experiences of formal learning. Indeed, the

main draw was health or health related issues (e.g. exercise).

- Language skills are another draw, especially for ESOL learners. The advantage of using language as a hook is that people might learn about health and the health system as well as gaining literacy skills in English.

Skilled for Health is an effective engagement tool to help progress learners. It is a good mechanism to hook people into Skills for Life and other courses.

- Developing an interest in learning is a key outcome of phase two. The process of attracting learners through a health course did enable them to leave with an increased interest and commitment to another learning opportunity. This is important for the decision on whether to sell the programme as a learning tool or as a health tool.
- In most cases, courses are about motivating learners to learn, not about progressing them by a level. Courses were short enough to recruit hard to reach learners: engaging in a (relatively) short Skilled for Health course is less of a “big step” than enrolling in an accredited Skills for Life course which may be longer and more structured.
- Health outcomes are noteworthy in particular in the area of healthy eating and exercise. There is also evidence of learning on health being taken into families and the local community.
- This suggests that there should be two levels of ‘selling’ Skilled for Health: organisations and participants.
- To participants Skilled for Health needs to be sold on the health and language improvements.
- Organisational messages would need to differ for Health and the Skills organisations. For health organisations the selling point is that learners gain health skills; the programme is therefore an

important source of tackling health inequalities. For skills organisations, the selling point could be that Skilled for Health is beneficial for engaging learners onto Skills for Life courses who have genuinely low skills.

- Something on partnership here to reflect Jonathan’s suggestions.

Unless accreditation is handled flexibly and remains a learner choice it is likely to be detrimental to learner engagement and may affect the identity of the programme.

- Considering the target group the programme is looking to address (ie the most difficult to reach learners who have had bad experiences with the education system), accreditation might put learners off. It should therefore remain a choice, used in a way that is appropriate to the learners and the course length.

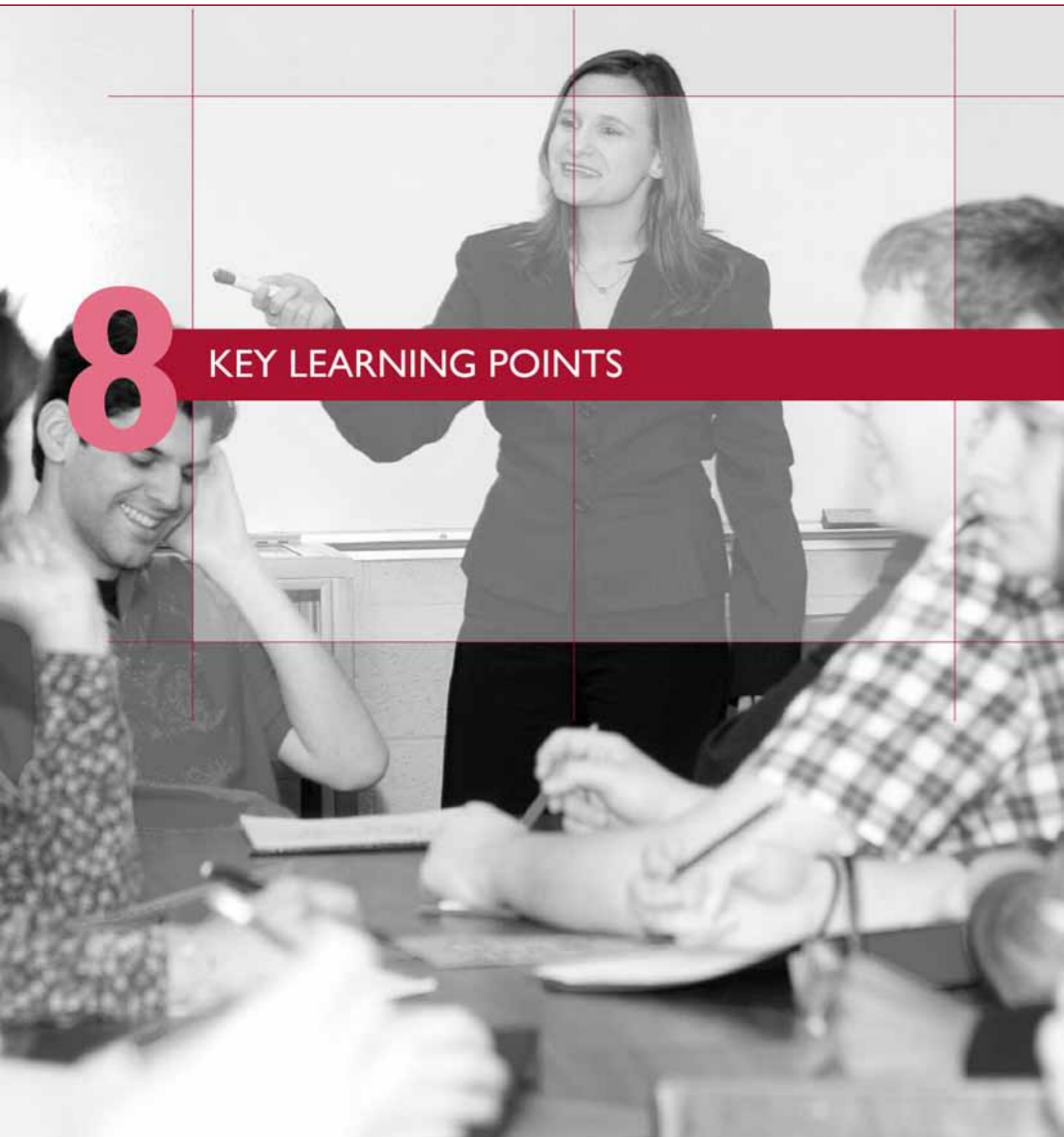
Programme level support will remain important to maintain the identity of Skilled for Health.

- Having an identity as a programme is important. Even in the next phase this is still an innovative way of working, and the Skilled for Health approach (e.g. on engaging projects and recruiting learners) will have to be enforced. The programme will therefore continue to need national level support.
- This support should include mixed resources: advice to new projects on issues such as monitoring, performance management, setting up a Skilled for Health project, the staff and other resources needed. There should also be an interactive element: building a community of practice, supporting peer learning or offering a wiki. Part of the support function will be to use previous evaluation findings to support this.

- This support should not come from a central government department but from an agency with a good understanding of support needs ‘on the ground’, including fundraising skills which could be offered to Skilled for Health sites.

Sustainability remains an issue.

- Some projects have made plans to achieve sustainability, and have had levels of success, e.g. prisons.
- Others have not made progress. Sites which may have believed that there may be funding as part of the next phase which could have affected their motivation to look for further funding. Sites may also have assumed that they become ‘seedbeds’ for the next phase (for instance the sector sites).
- Sustainability also links back to sites’ initial motivation for joining. If the Skilled for Health project is understood as a pilot rather than a grants scheme, a site is more likely to have an understanding of alternative funding sources.
- Nevertheless, funding routes are slowly being identified, including LDA, PCTs, LSC, JIF and other sources.
- Where new funding sources are being tapped into, sites are uncertain whether they can still call their activities Skilled for Health as in phase two funding was one of the key characteristics of Skilled for Health. Going forward, therefore, a centralised information structure is needed to create a programme identity.
- A condition for sustainability is the ongoing presence of the Skilled for Health champion or project manager. If they leave (as is already beginning to happen) continuity as well as sustainability of the project is under threat.



8 KEY LEARNING POINTS

- Recruiting learners can require a considerable investment of resources, especially where learners are not 'readily available' to organisations and are hard to reach. Projects need to factor this into their time and resource planning if they are to avoid 'creaming off' the easiest learners.
- What is used to 'draw' participants onto courses will vary from organisation to organisation, depending on what resources or facilities are available. Overall, however, health related topics are a greater 'draw' for learners than those relating to learning outcomes, except for those with an interest in acquiring language skills.
- There is not 'one best way' of delivering the materials. The flexibility of Skilled for Health materials to be delivered in a range of formats, supported by a range of different tutors remains its great strength, given the range of organisations and range of target groups for whom it can be beneficial.
- This means, however, that strong central programme support is likely to be important in the development of strong local sites, in order to help establish a strong identity for Skilled for Health schemes across the country, provide guidance to local projects in putting the conditions in place that will enable them to be successful, and to enable learning to be shared between sites.
- Within sites more specifically, management support is important not only for the delivery of a Skilled for Health project but also for championing the approach and increasing the probability that activities continue once external funding has run out.



9

RECOMMENDATIONS

9.1. PROGRAMME LEVEL ACTIVITIES TO SUPPORT LOCAL PROJECTS

- There is an urgent need to agree on the vision for the next phase, in terms of its purpose and scope. Some stakeholders see that phase as continuing the implementation and learning from the programme, albeit on a larger and more planned scale. Others see it as moving more quickly to embedding Skilled for Health in mainstream provision within learning, health and other policy areas.
- Sufficient resources are required centrally, for five key tasks: negotiation and contracting with new sites; supporting sites in the set up process; supporting networking and learning across sites; support for sustainability planning; and maintaining the overall strategic direction of the programme (which is likely to also require ongoing negotiation with key stakeholders at a national level).
- Interactive discussions with sites are needed in the early stages of project development/set up about what Skilled for Health is and what this will mean for them. These discussions should also focus on the importance of information, advice and guidance to support learners' progression into learning opportunities after Skilled for Health. While it is important that this is built into contractual discussions, it should go wider than this, including guidance on setting themselves up, how to draw on the experience of others etc.
- Developing an infrastructure for networking, peer support and information sharing would be essential for future phases – this might include a regular newsletter, website, online discussion forums and events – to share what is happening at the programme and project level.
- Advice from the programme level of implementation on appropriate training for people delivering Skilled for Health locally, and different options for this, would also be very helpful.

9.2. TUTORS

- One of the issues emerging from the exploration of delivery models so far is use of Skills for Life tutors to deliver Skilled for Health. Tutors can feel they lack health training to deliver all or some aspects of the material competently. Some projects have addressed this either by offering them training or by drawing on specialists for particular elements of the course. However, one consideration for the next phase might be whether the Health Trainer Programme can be drawn upon more systematically to support the delivery of Skilled for Health.
- Another area for exploration that has been raised by some stakeholders is the development of an accredited Skilled for Health tutors' programme that could also help bring together the different professionals involved in an integrated approach.

9.3. THE MATERIALS

The implications on the materials for the next phase, based on tutors' feedback, are:

- A need to ensure materials remain flexible, and adaptable to the local context. This is recognised by tutors as the key strength of the materials;
- A possibility for guidance/ ideas about how to enhance materials with supplementary materials and input from other sources and
- A need for adaptation of materials for more basic levels of Skills for Life. This seemed to be the main audience where tutors felt the materials needed extensive adaptation.

9.4. DELIVERING THE MATERIALS

- The possibility of national approach to training of trainers or at least sharing experience about suitable additional training resources to supplement trainers' main areas of expertise should be explored.
- It would be useful to explore links to other programmes, particularly the health trainer programme.

9.5. SUSTAINABILITY

- Skilled for Health is a very diverse programme and sites will be looking to tap into different funding streams in order to achieve sustainability. The national programme should keep up-to-date with progress around this to prepare for any future work and opportunities.
- Local Area Agreements should be looked to locally as a cross-cutting source of funding from both Government Programme monies (e.g. Working neighbourhoods Fund) and mainstream resources from PCTs and local authorities. To access these resources, It could also be beneficial for the programme to engage more with the learning and skills and adult education stakeholders, including LSCs, and local Learning Partnerships.
- Another possibility could be to investigate whether money given to Government Offices for the Regional Improvement and Efficiency Partnerships (RIEP) could be tapped into. This is mainstream funding which will continue for the foreseeable future and could therefore be an interesting source of funding for Skilled for Health.
- More thought should be given to how sites can be best supported around the issue of sustainability in future phases.

10

FUTURE RESEARCH QUESTIONS AND HOW THESE SHOULD BE ADDRESSED

10.1. FUTURE EVALUATION QUESTIONS

one, through providing grants and support to a small range of sites. It has demonstrated that there are real benefits for participants on completion of their involvement in activities, but not longer term impacts.

Future evaluation questions will therefore need to focus on two elements:

- What is required in order for Skilled for Health to become part of main stream provision for addressing health inequalities and improving Skills for Life; and
- What evidence is there that Skilled for Health has a continuing benefit of participants in terms of health benefits and learning progression

10.1.1. What is required in order for Skilled for Health to become part of main stream provision for addressing health inequalities and improving Skills for Life?

The evaluation has demonstrated that Skilled for Health can be a viable option, not only for community sites (who regularly depend on grant funding and initiatives of this kind) but also for employers and organizations that are providing a mainstream service within which health and/or learning are key objectives (prisons, PCTs and health trusts, libraries). However, for Skilled for Health to become part of mainstream provision, either the funding stream itself has to be considerably expanded (and changed in its focus and administration) or the activities will have to be funded as a regular part of health or learning provision. We have already indicated a number of areas in which we

believe central support will be required, if Skilled for Health is to maintain its identity and quality.

It will be extremely important for the robustness of any new financial and programme level support developed to be evaluated, in order to ensure that the essential qualities of Skilled for Health (flexibility, user focus, ability to recruit learners from 'hard to reach' groups) have been retained.

10.1.2. What evidence is there that Skilled for Health has a continuing benefit to participants in terms of improved health and learning progression?

The evaluation of phase two has provided considerable evidence that Skilled for Health can lead to an enhanced understanding of health issues, some changes in health related behaviour and some learner progression (including a move in Skills for Life level for some participants) on completion of a Skilled for Health course or activity. However, no follow up data has been collected concerning any longer term benefits from taking part in these activities and it would be unrealistic to have expected real health change, or even major changes in Skills for Life, within a relatively short term intervention. Further roll out of Skilled for Health to new sites, or the continuation of the scheme in existing sites would provide an excellent opportunity to recruit and follow up a 'panel' of participants over a longer period in order to investigate whether they did indeed progress into further learning opportunities, or whether their health actually improved.

10.2. A NOTE ON METHODOLOGY FOR FUTURE RESEARCH

The standard of evidence required in the fields of health and public health are generally high. While many organisational and service changes are introduced without a strong evidence base, before a clinical or prevention intervention is widely accepted, a 'robust' evidence base involving one or more experimental studies (preferably with participants randomly assigned to intervention and control groups) are usually required.

An experimental evaluation approach would have been unsuitable at this exploratory stage of Skilled for Health: interventions were very varied in nature and often subject to change during the life of individual projects. The recruitment of participants required considerable local investment, and the random assignment of those recruited to the 'control group' would not have been completely in feasible. It might be the case that, as a complex intervention, it will always be difficult to apply an experimental approach to Skilled for Health, but it might also be

useful to see phase two of the programme as similar to the developing/piloting stage of developing a new initiative as described in the Medical Research Council guidelines on developing and evaluating complex interventions (these guidelines²³ have recently been revised).

In this context, the qualitative and quantitative data gathered for the present evaluation, combined with the roll out of the programme to more sites potentially provides a sounder basis for considering some kind of experimental research design in the future. A key feature of an experimental design, however, is that considerable control has to be exerted by the researchers over both the allocation of participants to activities, the quality and consistency of the input they receive, and the collection of before and after data on the impact of the intervention. Such research is costly and intensive, and requires a very high level of cooperation from those delivering the intervention.

FOOTNOTES: SECTION 10

²³ Medical Research Council (2008) Managing and evaluating complex interventions: www.mrc.ac.uk/complexinterventionsguidance

APPENDICES

1. Reflections on the evaluation approach and methods	67
2. Evaluation questions	69
3. Case Studies	71
4. Short description of Skilled for Health projects considered in-depth by the national evaluation	83

APPENDIX 1 REFLECTIONS ON THE EVALUATION APPROACH AND METHODS

Although we have not specifically evaluated the approach, we feel it is useful to offer some reflections on how well the approach has worked, what the key challenges have been and what implications there might be for the future.

The rationale for the approach taken by the evaluation team was to work collaboratively with sites so that the evaluation was relevant and useful for them. As such, the collaborative nature of the approach was a way of gaining buy-in to the evaluation, while at the same time working to embed a more reflective way of working among the sites so that they could see the value of evaluation for delivery and continue to work in this way in future. To a certain extent, this approach has worked well and the team has had good relationships with sites as a result, but there have been some key challenges.

The rolling nature of the programme (which wasn't envisaged when the approach and methodology were being designed) has made this approach challenging. Rather than using initial visits early on in the evaluation to scope out appropriate support, resources and learning events, the team has had to provide support to sites in a very ad hoc way, at varying points of delivery. This has meant that some have received more in-depth support than others.

In addition to this, sites were asked to work with the national evaluation team when they signed up to the programme, but had not always been made aware of their specific responsibilities around evaluation at the contracting stage – in particular that they would be responsible for their own project level evaluations, which the national evaluation would be drawing on. As such, sites had not always set aside time and resources for evaluation, and although the evaluation team could encourage sites to collect data, there were no specific requirements on sites to do so and no guidance

about the capacity – skills and level of resources – that would be needed. Greater clarity around this at the contracting phase would have been helpful.

In order to provide some guidance and support to site, the national evaluation produced an evaluation guide. This was essentially a step-by-step guide, taking sites through why, what and how to evaluate their projects. The guide included exercises, examples and key tips.

To measure individual level outcomes, the national evaluation team also produced an integrated health and learning assessment tool to establish baseline and progression indicators for both health and educational measures. This assessment tool targets individual level outcomes by providing provide qualitative measures of progress made (often also described as 'soft outcomes' and 'distance travelled'). Considering that the programme works with traditionally disadvantaged communities and participants are likely to need to overcome a range of barriers to engage in learning, measuring 'soft outcomes' therefore allows for a wider range of facets of progress to be captured and provides a fuller picture of the progress made by individuals.

These resources were backed up by one-to-one support – either face-to-face through site visits or via email/telephone – but the evaluation team feels that, in hindsight, more in-depth and hands-on support would have been beneficial for sites – working with them individually to help them think through what they wanted to get out of their evaluations, what key things they wanted to measure and how they were going to go about it. This would have enabled greater buy-in

and commitment, and raises a key learning point that the written guidance and resources are not enough on their own to support self evaluation and help develop and embed an evaluative culture.

In addition to this, a key learning point has been that the 'core questions' included in the assessment tool (that all Skilled for Health sites were encouraged to collect data on) needed to be relatively few in number to make them usable for all learners, and they also needed to address both learning and health progression. An important learning point from the use of the tool in this phase is that there is a need to further tailor it to different learners. Especially for ESOL learners there are too many questions and the language needs to be simplified. Constructive feedback from some sites also indicated that even the core questions were fairly burdensome. This suggests that if the tool is to be used in the next phase, a slimming down of the core questions should be seriously considered. Finally, a suggestion was made that the assessment tool should have a greater focus on measuring changed awareness as a precondition for behaviour change.

The issue of hands-on support had been recognised by the team when the approach was designed and the learning network events were originally going to be used to support sites in developing their evaluations, but the rolling nature of the programme meant that many sites were not on board when some of the early events were held. The learning network events have, however, worked very well as a way of bringing sites together to share experiences and discuss key learning points.

Feedback from the events has been very positive. Sites clearly appreciated the opportunity to share experiences, network and learn from other sites. They valued hearing about what other sites were doing and meeting with other project managers and deliverers informally.

The really upbeat, enthusiastic and supportive atmosphere [was what I liked best], lots of useful ideas and reassurance that we are on the right lines were really useful.

Event participant

APPENDIX 2 EVALUATION QUESTIONS

Following the scoping phase we suggested an expansion of the original evaluation questions, in part to make these more specific, and therefore answerable. The original questions were also reframed slightly to ensure that lessons for the potential roll out of the programme elsewhere, to be captured. We also found it helpful to cluster the aims and questions into three groups, relating the evaluation tasks to be undertaken at programme, project and individual participant level. Suggested changes are in italics.

Programme level

Overarching evaluation aim: to demonstrate the benefits, impacts and sustainability of skilled for health projects on reducing the gap in health inequalities through both health improvement and skills for life Skills for Life programmes and projects

Evaluation questions to be addressed at a programme:

1. To what extent has the Skilled for Health programme *introduced activities in local projects which address Skills for Life and health inequalities targets?*
2. *In what way has the programme been influenced by, or contributed to, changing policy and practice in these areas?*
3. *What different service delivery models for Skilled for Health can be identified? What are the 'core elements' of these models (that are potentially replicable elsewhere) and which are the elements that are determined by the local context.*
4. *How sustainable are these models, and what are the key elements that enable these to be sustainable?*
5. *What programme level activities required to support the successful implementation of these models?*

Project level

Overarching evaluation aim: to develop a self evaluation framework for local sites to measure their own success against the project assumptions and indicators of success.

Evaluation questions to be addressed at project level:

1. *What are the characteristics of the delivery model that enabled Skilled for Health activities to be introduced at a local level? What are the key elements of the model that identified it as a Skilled for Health project? What elements have been added, or excluded, in order to adapt this to the local context?*
2. *To what extent have these projects met their own, the programme, and their host organisations' objectives?*
3. *What are the local conditions that enable a successful local Skilled for Health project delivered?*
4. *What central support was required to enable a successful local Skilled for Health project to be delivered?*
5. *To what extent was the local project successful in engaging people in improving their health and participation in learning and therefore reduce health inequalities? What are the characteristics*

of the people engaged, and to what extent are these characteristics similar to, or different from, other projects?

6. *Which learning materials have been most and least effective helping learners achieve improvements in their health status and literacy language and or numeracy? To what extent did the project use learning materials created centrally by Skilled for Health? Were any adaptations of these required to enable these to be used locally? Did the project develop additional materials of its own (and if so, why)?*
7. *What recruitment, engagement and teaching methods were used and what worked best, for whom and in what context and why? What were the features of the delivery model that supported these?*
8. *How was the project able to demonstrate learner recruitment, retention and progression?*
9. *To what extent will the model be sustainable without central funding and support?*
10. *What are the characteristics of the organisations and professionals/people delivered the materials, and what were their training and support requirements? How do these relate to other changes taking place, and new roles emerging more widely within the health service?*

Individual level

Overarching aim: to develop an integrated health and learning assessment tool that establishes baseline and progression indicators for both health and educational measures, as a result of participation in Skilled for Health programmes.

1. *What particular measure and proxy measures can be used to measure individual health improvements towards personal goals through behavioural change models?*
2. *What are the main features of the learning path of participants through local skilled for health projects? What level of input from project staff is required and over what time period to enable the individual to achieve measurable outcomes?*
3. *Is it possible to identify critical factors that ensure a positive impact for individual learners?*

APPENDIX 3 CASE STUDIES

1. HMP PENTONVILLE AND HMP HOLLOWAY

The prison site provides a unique insight into the implementation of the Skilled for Health (Skilled for Health) programme in a closed institutional setting. After a summary of the context this case study will focus on Pentonville Prison with references to alternative implementation through the example of Holloway.

Context of Skilled for Health

There is evidence to suggest that offenders experience significant health inequalities. Indeed around 80% of new entrants to the prison system have never registered with a doctor; have a history of drug and alcohol abuse, mental health problems or negative experiences of formal education. While the prison population have access to Skills for Life, ESOL and health education and GP services there has never been a formalised approach to health literacy. HMP Pentonville (for men) and HMP Holloway (for women) in London were selected to trial the Skilled for Health materials in the Prison Sector

The perceived aim was to improve the health and lifestyle outcomes of inmate-learners who may not have such knowledge due to low literacy, language and numeracy skills. It was also hoped that the programme as a whole could provide an impetus for learners to stay engaged in health education. The organisational aims were to embed the materials within existing structures and develop a strategy to sustain the programme beyond the end of the contract.

The delivery model for Skilled for Health therefore followed the prison routine, short courses were provided to groups of learners in an 'informal style' followed with some gym use at Pentonville prison. The site provided 5 courses (20 hours per week) at Pentonville and 6 courses (6 hours per week) at Holloway from May 2007 to October 2008.

Partners on the project became involved because of pre-existing relationships. City and Islington College

had responsibility for delivering the Skills for Life element of the programme in collaboration with the two prisons. The Offenders Learning and Skills Service (OLASS) were initially appointed to manage the budget on behalf of the two prisons and college and Islington PCT provided a Community Psychiatric Nurse to Pentonville.

Key features of implementation

One of the key features of Skilled for Health in the prison site has been the difference between implementation in Pentonville and Holloway. In Holloway prison the focus of participation in Skilled for Health was to evaluate the phase one learning materials with female offenders and to develop and trial learning materials on sexual health²⁴. The focus here was to embed the materials into the existing educational provision and was therefore the responsibility of the Education Department.

When Skilled for Health was conceived for Pentonville, an organisational strategy called "Pride in Pentonville" was in place which identified that it was the Head of Health Care's responsibility to "develop a safe, realistic and funded health management plan". Part of this plan was to introduce Skilled for Health as a 'programme' for male offenders which focused on mental health materials around stress, anxiety and depression. Skilled for Health in this location addressed confidence, encouraging participants on the programme to be assertive rather than aggressive, and express how they are feeling. Inmates were encouraged to keep emotional wellbeing diaries, eat healthily (were given fresh fruit) and take part in practical activities such as gym exercise²⁵. It was also anticipated that these aspects of the programme would reduce the high incidence of self-harming and disruptive behaviour amongst men within the prison who had 'low level' mental health issues. A Community Psychiatric Nurse (CPN) from Islington PCT was considered fundamental at this stage to the conception and initial management of the

programme. As a result, while funding was initially conceived as a 50:50 split between the two Prisons a higher percentage of monies went to Pentonville because of the greater level of implementation and project management.

A second key feature was that after the departure of the CPN at Pentonville, Skilled for Health across both Prisons was managed by an external contractor (a fitness company called Varsity fitness). This company took on all aspects of contract management, resources (i.e. fresh fruit) paying staff, budgets and invoicing. Courses were primarily delivered via a full time replacement CPN who delivered the physical/mental health topics, wellbeing and sexual health materials at Pentonville. Skills for Life tutors employed by City and Islington College delivered Literacy, Language and Numeracy elements (Skills for Life) at both Prisons. Finally, the head of Varsity fitness and a colleague (and Skilled for Health project manager) delivered tailored nutrition and lifestyle reports, fitness testing and providing yoga, gym circuit, body movement and transcendental meditation classes to music at Pentonville and Holloway. This worked because there was implicit support from the prisons via an assigned prison officer for classes, stationery and use of office space.

The flexible nature of Skilled for Health also meant that delivery could be adapted to fit the challenges of the Prison regime. At Pentonville and Holloway sessions relied heavily on the availability of prison officers to 'lock out' Skilled for Health students. Both Prisons also hold inmates on remand so stand alone sessions and courses of around 4 weeks worked best as it meant that an inmate on a short stay could still receive the course and cohorts were easier to manage. At Pentonville there were also differing constructs of 'mental health' between partners which meant there were some initial difficulties in deciding who would be most effective partner to deliver. 'Personalities' were seen as a big factor in the success of implementation, the determination and commitment from staff was felt

to drive the programme on at Pentonville by working "with the institutional system".

Learning outcomes

At the end of the first cohort of Skilled for Health at Pentonville it became clear that the 'mood' of inmates had improved. Some learners also reported losing weight and feeling positive – the course had a "wow" factor which included the participation of inmate reps in 'mentoring' other new inmates who sought admission onto the programme. Learners who completed Skilled for Health reported increased confidence, increased self-esteem, an ability to listen, an ability to cope with anger and stress, health knowledge, methods of addressing anxiety and tension, learning about yoga and looking after the body in a holistic way. More importantly, in this course the students perceived themselves to be respected by those involved in delivering the programme. It was as one inmate said – "important to be treated as a human being" and focusing on mental health was "as important as learning maths and english". Below are comments from two inmates who had been on the course at Pentonville.

M was a Skilled for Health student in his twenties. "A friend approached me about doing "Skills for Health" and with an open mind I agreed, first session was a surprise to me because I realised that I had issues with communicating the simplest bit of information to a group of strangers. By listening to others I identified things about myself and the solution was the same.

I have got a lot of helpful information telling me how to boost my confidence and maintain a healthy balanced lifestyle physically and mentally. A lot can be learned from this course because I feel comfortable and would be very proud of promoting Skills for Health to my friends on the wings.

G was a 44 year old man serving his first sentence. He had seen the Skilled for Health flier, and, although initially reluctant to consider a programme related to anxiety, which he considered to have been something he had experienced throughout his life, he decided to undertake the course.

In the 6 week course he felt that "it teaches you to deal with stress and anxieties you will suffer in prison life, getting a balance to carry you forward." In prison, he added, it is the little things that count, and as Skilled for Health representative he had been able to help those unable to read and write, and watch others "soften and develop".

Organisational outcomes & sustainability

The popularity of the programme at Pentonville amongst learners was felt at all levels of the institution. Prison officers were pleased because of the subsequent improvements in inmate behaviour. Indeed such was the interest that referrals for learners came from across the prison (drugs team, pharmacy and education). There was also interest in expanding the programme from the prison Pharmacy to teach prisoners to be responsible for their own medicines.

A Steering Committee was formed to address the issue of sustainability. It was decided that Skilled for Health should move from a perceived 'bolt on' initiative into an integrated programme within the Prison. This meant that only existing staff and resources should be used for delivery – there should be no additional costs to the prison in keeping the programme alive. Strategic support and leadership came from the Prison Governor and Head of Healthcare who championed the programme, the then integrated project lead (for Pentonville and Holloway) was also paid to stay on site and develop a sustainable Skilled for Health learning product. This included the development of a Skilled for Health delivery manual, staff training,

and the continued work of existing Skilled for Health tutors. This resulted in the successful handover of the management of the programme to the site CPN in November 2008 and subsequent reduction of delivery costs from £60,000 per year to £0.00 per year.

Key learning points

- The importance of being responsive and adapting the course to its environment as and when necessary. In a closed institution it is best to ask rather than expect support, try to work within the system and seek the support of senior staff (including the governor). It can also lead to the development of a strong team which has the ability to work under pressure.
- Health and fitness was considered to be the "hook" onto Skilled for Health for male and female offenders because many inmates have had bad experiences in formal education. An informal teaching style was also considered to retain learners by breaking myths of formal education.
- Recruitment was successful when using 'many methods' for example Inmate Representatives who had been on the course introduced colleagues to the class, word of mouth, flyers, "advertisements" on the Prison TV Infomercial Station "Channel 6" and referrals from health professionals, and prison officers.
- It is best to scope existing resources before implementing Skilled for Health using external staff, existing staff should be utilised and trained within the site to avoid duplication in delivery and achieve sustainability.
- It is important to address the issue of what happens after Skilled for Health? The course does not link inmates to any existing provision via the judicial system (probation service). The project needs to follow through to other sectors of an offender's life in order to work.

2. GATESHEAD NHS FOUNDATION TRUST

The context and motivation of running Skilled for Health

Gateshead NHS Foundation Trust is a major employer in the local area. Over 3,000 staff work for the organisation who represent the lifestyle and health issues found in the Gateshead District at large: 44 per cent of the population live in areas that are amongst the 20 per cent most deprived in England; lifestyle behaviours such as smoking, diet and consumption of alcohol are very poor compared to the rest of England.

Against this background, the Trust's participation in phase two of Skilled for Health was motivated by the opportunity the programme offered to improve both health and literacy skills of employees. Through its Skilled for Health activities, Gateshead Health NHS Foundation Trust intended not only to make an impact on its employees but also on its service users and the wider community in the Gateshead area. There was, finally, also an expectation that the organisation would benefit from better trained staff and less absenteeism.

The Skilled for Health project involved three kinds of courses, each delivered in a group setting with a length of 10 or 20 hours' of tuition: a Nutrition course (embedded numeracy), a "Return to Learn" course (focus on literacy) and a "Benefits of Exercise" course (embedded numeracy). A Skilled for Life tutor taught on all courses, supported by health specialists (e.g. a nutritionist) where needed.

The site, and others in the North East, was supported by a regional Skilled for Health Steering Committee which included the Government Office of the North East, the North East Workforce team, NIACE and the Strategic Health Authority. The Steering Committee was seen as a useful tool in providing accountability, helping sites share information, raise the programme's profile with key regional partners, monitor process and create links between Departments.

Key elements of programme implementation

Gateshead Health NHS Foundation Trust is an organisation which places much emphasis on staff learning and runs numerous training programmes both in the area of health improvement and on developing staff LLN skills and qualifications. Before starting Skilled for Health the Trust incorporated some questions about numeracy and literacy in the annual staff survey. Results from this were used to identify needs and target the training requirements; it was around those that the Skilled for Health activities were designed. Overall, there was a strong organisational match between existing activities in the Trust and Skilled for Health which extended and bridged existing health and learning activities through the use of the materials. The fact that Skilled for Health was a good 'fit' with the organisation seemed to facilitate the conceptualisation, implementation and possible sustainability of the project in the following respects.

First, from the beginning, Skilled for Health had support from the highest level in the Organisation: the project was developed jointly by the Director of Public Health (then on secondment to the Government Office North East), the Head of Modernisation (the role includes the remit as Head of OD&T) as well as the Work-based Learning Development Co-ordinator who also acted as project manager for Skilled for Health during implementation. The project further had the support of the Trust's Chief Executive. This awareness of, and support for, Skilled for Health meant that linkages could be made between Skilled for Health and other training programmes and activities run in the Trust. Internally, this benefited thinking on sustainability as it led to a commitment to embed the materials into 'standard' training activities. Externally, this meant that the strategic decision makers stayed informed about Skilled for Health which allowed them to promote the programme to partners in the Gateshead area and the North East region, working towards a use of the materials outside the Trust.

Second, there was a very good pre-existing working relationship between the Skilled for Health project manager and the delivery partner, Gateshead Adult Learning Service. This greatly facilitated the development of the course curricula as new relationships did not have to be built and there was a willingness to think flexibly around how Skilled for Health could be made to meet the needs of all organisations involved. One of these needs was funding the tutoring, and much energy and creativity was put into shaping the course contents so that it met Skilled for Health objectives on the one hand (in particular testing the materials) and funding needs on the other. For two of the courses run ('Return to Learn' and 'Benefits of Exercise') this meant designing the courses with a view towards accrediting learners at the end so that Learning and Skills Council (LSC) funding could be tapped into this would ensure that courses could be embedded within the organisation. There was a strong feeling that accreditation - as one signal of achievement - should be every learner's right and that Skills for Life tutors are well trained to work with learners to achieve this: there is "no one you will never reach by offering accredited courses." However, accreditation, as well as the focused content of Skilled for Health courses run at the Trust, presented challenges in the design of the courses: there was not sufficient content in each section of the Skilled for Health materials to cover relevant topics. This meant that elements from across the materials needed to be used and required supplementing Skilled for Health materials with other content (e.g. from Skills for Life teaching materials or from the organisation's own nutrition training "7 steps to healthy living").

Learner experience and outcomes

The 'Nutrition' and 'Benefits of Exercise'²⁶ courses used self-referral as main recruitment method, and learners were made aware of them through generally advertising in the organisation (e.g. in the form of leaflets on notice boards). Both classes ran out of

working hours: the nutrition course at lunchtime; the 'Benefits of Exercise' course in the evenings from 5:30 pm to 8pm. In both cases, 'extras' such as fruit bowl raffles (nutrition course) or salsa classes and 'tea' ('Benefits of Exercise') were offered. Only participants in the "Return to Learn" course were able to do their course during working hours as this had been requested as staff development.

The courses were well attended, though the timing of courses seemed to have an impact on attrition rates: these were slightly higher in the 'Nutrition' courses than in the 'Return to Learn' courses. This can be ascribed to the fact that participants' lunch time was 30 minutes; while they did not seem to find it difficult to get agreement from their managers to extend this to participate in the Skilled for Health course, issues such as inability to find cover for the additional half hour could affect attendance.

Learners particularly appreciated the group aspect of

"A fun way to spend your lunch"

Sue²⁷ saw the leaflet for the nutrition course one day on her way to lunch. She was interested in the course not because she wanted to lose weight, but because she "eats a lot of the wrong things" and wanted to learn how to eat more healthily. Having succeeded in securing release from her manager, Sue was able to attend the course which turned out to be a "fun way to spend your lunch" due to the friendly atmosphere. Learning about portions was the best part of the course: now, rather than having the equivalent of six portions of rice with one meal, Sue uses her new knowledge of portion sizes to control how much she is eating. She has also learned to always carry water with her to control her blood pressure and to read food labels to detect hidden sugars. Sue had not taken part in a learning activity before, but would now like to learn more about nutrition.

the courses as well as the participatory and interactive delivery. All learners in the 'Return to Learn' course achieved Level 1 accreditation. Learners participating in the Nutrition course seemed to experience a positive cycle where the additional knowledge gained on health and healthy eating helped them change their food intake (both in terms of quality and quantity). For instance, some learners felt better able to understand and measure portion sizes (a numeracy gain) and being able to understand and read food labels (again likely to be literacy and numeracy gain). Some learners also lost weight during the course, others exercised more.

Organisational outcomes

Skilled for Health delivery is still ongoing, and it is too early to make a sound assessment of the impact the programme has had at organisational level. It was felt, however, that through the 'Return to Learn' programme a more relaxed and supportive learning environment was created in the Trust where staff felt that learning was not just a part of their job: "we have created more of a learning culture" where staff think outside the box. Another important achievement was that the 'Return to Learn' course brought a cohort of staff, who had been very anxious about learning, back into education with some going on to do NVQs. In the medium to long term it was expected that impacts would be shown in the area of improving working lives and staff health and well being. This was accompanied by a recognition, however, that it might be difficult to fully evaluate the Skilled for Health impact on the organisation.

Key learning points

Design and implementation

- Before designing a Skilled for Health course it is important to see the materials. For instance, running very focuses courses (e.g. around nutrition or exercise) may mean not sufficient content is

included and will therefore require adding teaching resources from elsewhere.

- Having an organisational infrastructure for employee learning helps implement Skilled for Health, especially when it means these courses fit with existing provisions and good relationships with providers exist.
- Impact on the workload of staff need to be considered carefully. Monitoring and evaluation requirements of running an intensive programme of Skilled for Health activities may require recruitment of additional staff to support the project manager.
- A regional Steering Committee can be beneficial to learning from other projects, remain updated on programme developments and provide a check-back that requirements are met.

The materials

- Currently, running a Skilled for Health course with a view towards LLN accreditation requires supplementing the materials with Skilled for Life resources.
- In the organisational context, for some learners the materials are at too low a level and therefore need to be adapted as part of the lesson plan to remain engaging.

Sustainability

- As a connection can be made between Skilled for Health and Skills for Life, NHS organisations can obtain funding to run Skilled for Health through the Joint Investment Framework.
- Buy-in from the strategic level in the organisation can support sustainability beyond the organisation. It creates opportunities to link up with key organisations locally and regionally, provide and share information about Skilled for Health and through this promote the use of Skilled for Health materials in other settings.

3. ROYAL MAIL

The context and motivation of running Skilled for Health

Royal Mail developed their Skilled for Health project as part of a wider 'Feeling First Class' wellbeing strategy. This was a successful approach to reduce sickness absence and the company had begun introducing a proactive wellbeing strategy across the organisation to promote healthy lifestyles. A lot of work had also been happening on the learning and development strategy to widen access to learning and skills development opportunities; and Skilled for Health offered a universal topic that would attract new people into learning activities.

The Skilled for Health project aimed to help employees to understand and look after their physical health and emotional wellbeing. Raising awareness of emotional wellbeing was a key objective for the programme to enable people to better understand and cope with stress in their lives and at work. It was also hoped that people would progress into further learning after completing the Skilled for Health programme. The programmes were open to all employees, although the focus was on engaging the male colleagues, who make up the majority of the workforce and were known through previous work to be harder to engage in learning activities.

Key elements of programme implementation

This will be more of a drop-in and individual learning programme than a structured delivery. Our experience shows that people prefer a flexible delivery approach and if they are well engaged, they will give up their own time

Project stakeholder

The unique element of Skilled for Health in Royal Mail was that it was a self-led learning programme: each learner received a memory stick with Skilled for Health materials programmed specifically to focus on each learner's objectives. This model was chosen because of the high interest in the IT among the employees and because shift working patterns required a flexible delivery approach.

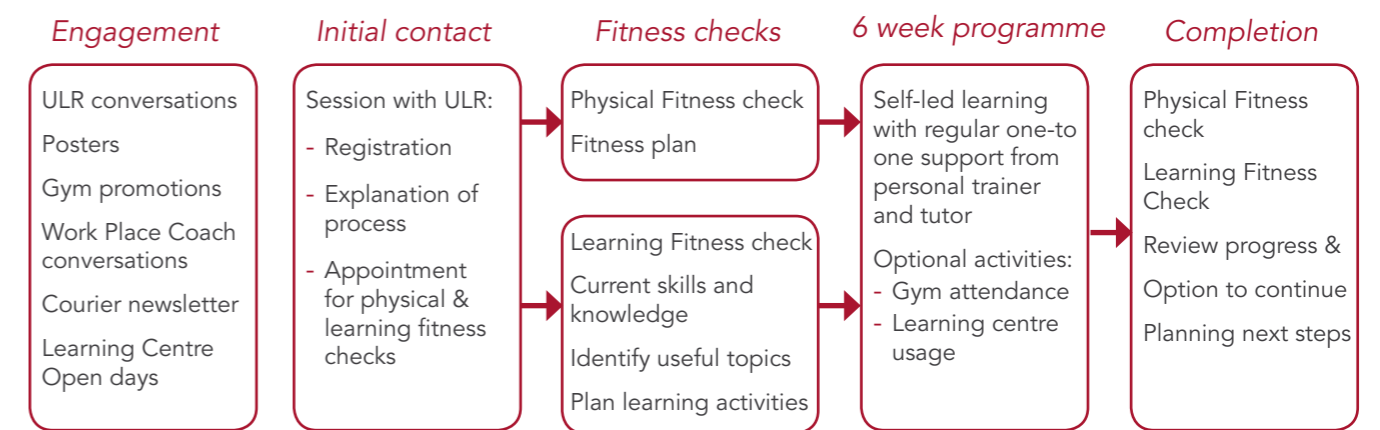
The Skilled for Health materials were adapted to a workplace context and the electronic self-led format. Additional elements were developed based on what the company was most interested in (including, for example body mass index and emotional wellbeing) and the materials were also supplemented with Skills for Life activities and information which were tutor-facilitated on a one to one basis..

Where facilities were available, the learners were given free access to a gym to complement learning activities.

Skilled for Health programmes were piloted in three Royal Mail Operations sites. The first pilot took place in the National Distribution Centre in Daventry, Northamptonshire and two further programmes took place in Wolverhampton and Mount Pleasant (London) mail centres. A team in each site included a Union Learning Representative (ULR) of the Communication Workers' Union; a local HR manager internally, and a personal trainer/fitness instructor and a basic skills tutor who were recruited externally.

Each learner went through a similar process: after recruitment and registration, the initial skills and health checks were carried out, which captured the 'baseline' levels of literacy, numeracy, learning motivation, health behaviours and physical health indicators. Then a tutor from a local college met with each learner to identify their interests and goals, and help to choose the most useful modules from the Skilled for Health materials.

Royal Mail Learner Path:



The most popular topics were diet, nutrition and exercise.

Whilst the rest of the programme was designed to be self-led, learners had access to the advice of the fitness instructor in the local gym, and of the Union Learning Representative (ULR) in the learning centre. At the end of the programme, final assessments were carried out, and a final meeting took place with the college tutor – this was an important element to identify progress and achievement and interest in routes for progression:

The exit route is almost as important as the programme itself – once they've made their first step in learning, it is important to help them consider what to do next

Project stakeholder

Learner outcomes

The tutors felt that the content of the materials was excellent and also attractive to learners. Nearly all learners (95%) said that they knew more about healthy eating as a result of the programme, and 84% felt they knew more about exercise. Some of this started to translate into healthier behaviour: 75% said that they ate more healthily as a result of the programme; and 58% felt fitter.

The materials were very good; people really liked them. This is very empowering for people who have never been taught to know how to manage their health and their diet.

Project stakeholder

In terms of improving literacy and numeracy, the tutors felt that the materials and the self-learning design worked as an engagement tool for progression,

rather than expecting learners to improve their skills considerably with the 6-week programme. As an engagement tool it worked well with a third registering for another programme straight after completion.

Because of the Skills for Life element, it's been quite easy to recruit learners onto Skills for Life programmes afterwards.

Project stakeholder

In Daventry the usage of the gym at a local Royal Mail site has been particularly popular. The number of employees using the local gym has increased from 322 before the programme to 509 at the end of the programme.

Self-led learning presumed a lot of motivation from the part of the learner and participant retention was therefore an issue. In Daventry around a half of starters completed the programme and project stakeholders felt that this could have been improved with more regular face-to-face support meetings between the learner(s) and the tutor to support and set expectations for the learners to progress.

Organisational outcomes

The evaluation of the programme is still underway but the initial results show that the programme has succeeded in attracting male employees to learn: around 50% of participants were men and stakeholders agree that this was a very good result that could be attributed to the fitness element.

The initial results on sickness absence on site level are encouraging too. In Daventry site there has been a considerable drop in sickness absence. Not all of this can be attributed to the Skilled for Health programme as this happened in the context of other learning and development opportunities. However, as a result of the Skilled for Health programme, the area management has introduced a 'match time' system for all employees to encourage learning and development activities. For example, for 10 hours spent on learning, the company gives 5 hours time off work.

Key learning points

Self-led learning model

- The self-led learning model fitted well with the company context of shift-working, participants' interest in IT, and preference for flexibility. It also fitted with the company principle of giving employees responsibility for their own learning, and 'not doing it for them'.
- There were some problems with retention, which would be improved if the self-led model included increased face-to-face support meetings throughout the programme. This would help to meet learner expectations and motivate them to complete.
- Where free usage of a gym was available, the fitness element (gym and health checks) was the main draw for employees to join. Retention was affected when there was no physical fitness or health specialist available to support learners (as was the case in London site initially).

Implementation

- Management support is crucial and aligning the project's aims with company objectives in Royal Mail was important in gaining this buy-in.
- Partnership with Communication Workers Union worked very well and the Union Learning Reps had a crucial role in managing the projects locally. They were well placed to promote the programme among employees, negotiate release time with the operational management teams and motivate the learners;
- Finding colleges to support the programme was time consuming but high progression rates indicate that it can be a successful engagement tool for the colleges to attract new learners to their mainstream provision.

4. NORTH WEST COMMUNITY SITES: SALFORD, NORTH LIVERPOOL AND BOLTON

The context and motivation for running Skilled for Health

Skilled for Health projects in the North West were delivered by community learning centres in Salford, Bolton and North Liverpool.

In Salford, Skilled for Health was delivered by Broughton Database (BD), a community learning centre that provides computer training from its base in Salford and from various community venues across the area. It has a strong focus on engaging with those who do not access the mainstream services. Getting involved in S4H was 'a natural step' for BD, as they had access to the 'Skilled for Health target group' - the most vulnerable learners within the community: *"Salford is a poor area with bad health. There is a need to raise health related knowledge."*

In North Liverpool the Skilled for Health project was led by Communiversity, a lifelong learning centre in the Croxteth area of Liverpool. The delivery was divided between Communiversity, Vauxhall Neighbourhood Council and Orrell Park Community Centre - both of the delivery partners were community learning centres in the nearby areas. Communiversity focuses on vocational courses, targeting the most deprived section within the community, who are not used to, or ready for, learning: *"People aren't ready to take on skills courses or enter education. There are literacy and numeracy problems but they don't realise these as problems. We're pushing people to come through the door and just use their different skills."*

In Bolton the Skilled for Health delivery was divided between BoltonWISE, a community learning centre that was leading the project, and Bolton CVS, a voluntary sector infrastructure organisation. BoltonWISE is an established training provider in the area, delivering NVQ's, ESOL and literacy and numeracy training. The organisation acknowledged that the area had pockets of high deprivation: *"In Bolton, those living in the most deprived areas, on lowest incomes and are disadvantaged by ethnicity or*

disability have a reduced health expectancy of up to 15 years compared to more affluent residents."

All three sites were already working with the target group that they aimed to reach with their Skilled for Health courses and the project added to the provision they were already delivering in their communities. Apart from Communiversity in Liverpool that had a team of community health workers, the organisations involved were also new to delivering health related activities.

All three community sites in the North West aimed to reach a wide range of groups within the community. For example, in Bolton, the aim was to target key estates that are known to experience deprivation and key groups (BME, new arrivals to the country, disabled people, young people, low income groups) who all have various health needs and barriers in accessing health professionals. North Liverpool also aimed to reach the most deprived groups, including travellers, single parents and problem drinkers. In Salford, the project targeted communities with the worst health outcomes.

Key elements of programme implementation

Easy access was an important characteristic of the Skilled for Health courses in the North West. In all three sites, the courses took place in accessible venues across the area. For example, in Salford a course was delivered from the local Sure Start centre; in Bolton, various community centres and churches were used.

In some cases, a Skilled for Health course was offered as a progression route to existing learners. For example, in Salford, a Skilled for Health course was offered after a group of learners had completed an IT course. All sites also made an effort to recruit new learners. In this case recruitment was more challenging and required a lot of effort.

A unique element of the Skilled for Health projects in the North West was embedding the Skilled for Health

materials in the existing courses. In North Liverpool and Salford this was the main delivery method. In addition, all sites were also delivering stand-alone Skilled for Health courses to existing or new groups. This was the main delivery method in Bolton.

All courses were tailored to the needs of learners and in all sites tutors were responsible for both the design and the delivery of the Skilled for Health courses. Each tutor decided which materials would be most relevant for their target group and designed a course based on this. For example, in Bolton a large proportion of courses were delivered within BME communities, where the courses aimed to help new arrivals to navigate the healthcare system. In Salford, one Skilled for Health course was targeting young parents and the course was based on healthy eating and exercise materials.

When embedding the Skilled for Health materials into existing courses, tutors also needed to adapt the materials. Tutors found embedding easy, when materials 'naturally' suited with the main topic (e.g. childcare, cooking), or where they were particularly relevant for the target group (e.g. budgeting for young mothers):

"Embedding was fairly straightforward – the materials were very good and relevant for the group, and budgeting was logical to include in the course. They really received it very well, interacted very well with it."

Where the link with between the main topic and the Skilled for Health materials was not as straightforward (e.g. hair and beauty), the tutors found it more challenging. In addition, there were elements within the Skilled for Health materials that tutors found 'universally useable':

"Topics around self-esteem and confidence are relevant to all of our learners. I wouldn't question using these in all courses."

Learner outcomes

In all three sites the tutors found that learners responded very well to the Skilled for Health materials. The outcomes depend on what sections of the materials were delivered. For example, a learner who had a session on healthy eating as part of a childcare course explains that: *"Since the course, I am more into healthy eating. I am eating more protein, fish and veg in every meal. I feel better in myself than I ever have done."*

For the BME learners the confidence to communicate with healthcare professionals was an important outcome: *"After the course, I can make appointments with the doctor more easily. I couldn't make an appointment with the GP before."* For the BME learners, improving English skills was an important draw for joining the course and there was some improvement of language skills.

The courses also aimed to increase confidence and for some learners this was the most important outcome. A group in Salford found that: *"We've got a lot more confident – we had no confidence at the beginning."*

Organisational outcomes

"We've been able to engage with groups we wouldn't have."

The Skilled for Health projects enabled the community sites to deliver more in their existing communities. In Salford and Bolton, it has also enabled the centres to test out delivering health courses. Both sites plan to continue health courses and have made links with local PCTs as a result of the Skilled for Health project.

Through embedding it has also enabled the sites to diversify existing courses: *"We were commended for the use of enrichment of materials by Ofsted inspection, and they wanted us to improve the enrichment of the materials further. If we had built Skilled for Health into every course – embedded it further, [we] would have seen even better results."*

Key learning points

Embedded learning model

- The embedded model worked well where the materials were more naturally suited – e.g. childcare; or where topics were relevant for the target group – e.g. ESOL communities learning about access to health services.
- The materials helped to enrich existing courses in a cost-effective way. As such, they are sustainable beyond the Skilled for Health funding and all North West sites plan to continue using the materials in the embedded model.

Delivering within communities

- The Skilled for Health reached a very diverse range of learners within communities. There is evidence that the courses reached the target group of learners with poor health outcomes in deprived areas.
- Recruitment was sometimes difficult and sites found that Skilled for Health was difficult to explain to learners. Health was used as a draw, but overall the recruitment was more successful where the course was delivered as a progression to existing courses.
- The materials worked well with ESOL learners, particularly around access to healthcare – learners were very positive about the courses and the opportunity to improve language skills; they were also easier to recruit as improving language skills was the draw.
- The tutors' role was crucial in the design and delivery of the courses. As a result, there were very flexible and diverse ways of delivering the materials.

Skilled for Health course in Liverpool

The learners participated in a stand-alone Skilled for Health course, which was delivered over a 10-week period for 2 hours a week at the local college. The course covered general health and how to keep healthy - different aspects were focused on each week. The learners said that they were made aware of fats, sugars and salts in food, drinking water and regular exercise, alcohol units. They also learned a lot from each other, from chatting and giving tips to each other.

The learners said that they found the course very enjoyable – it was fun and sociable. It also made them think about health. Most said that it had made them healthier - they ate better and tried to do more exercise, and tried not to eat processed foods

All of the learners said that the course had increased their confidence, to the point where they wanted to continue their learning. One of the participants had enrolled on basic skills courses in computers, English and maths (as when they were looking at food measures, she thought she could do with some basic skills). Another learner had started a positive thinking course.

APPENDIX 4

SHORT DESCRIPTION OF SKILLED FOR HEALTH PROJECTS CONSIDERED IN-DEPTH BY THE NATIONAL EVALUATION

Royal Mail – Workforce Site

Royal Mail developed their Skilled for Health project as part of a wider 'Feeling First Class' wellbeing strategy. There has been a coordinated approach within the organisation to reduce sickness absence and the company has begun introducing a proactive wellbeing strategy across the organisation to promote healthy lifestyles. A lot of work has also been happening on the learning and development strategy to widen access to learning and skills development opportunities; and Skilled for Health offered a universal topic that would attract new people into learning activities. The Skilled for Health project aimed to help employees to understand and look after their physical health and emotional wellbeing. It was also hoped that people would progress into further learning after completing the Skilled for Health programme. The unique element of Skilled for Health in Royal Mail was that it was a self-led learning programme: each learner received a memory stick with Skilled for Health materials programmed specifically to focus on each learner's objectives. This model was chosen because of the high interest in the IT among the employees and because shift working patterns required a flexible delivery approach.

Nottingham City Council – Workforce site

Nottingham City Council planned to engage around 90 staff for their Skilled for Health project. From within its workforce the council chose initially to work with its Street Scene employees (refuse collectors, street cleaners). The main reason for choosing this group was that staff were, in general, male, known to be difficult to engage in learning and in thinking about their health. Later on, as the project developed, the activities were extended to Adult Services Social Care staff. The main reason for rolling the programme out to this group was that they work directly with people with chronic health conditions and are often regular users of health services. The Skilled for Health courses

for Street Scene ran over 10 weeks at a local leisure centre with access to fitness facilities. The Council recognised that a group of learners who had been out of education for a long time and were used to a physically active working day, would not respond well to a long session of classroom activities. With this in mind the sessions were designed to allow for a balance of group learning and practical activities. Each Skilled for Health session contained an element on literacy/numeracy, a health topic from the Skilled for Health materials and physical or practical activities. From the Skilled for Health materials, the course mainly worked around the health and well-being file and found that most sections linked in and worked well with the groups. The Skilled for Health in Nottingham had a stronger focus on the literacy and numeracy than other sites: three hours of each six hour session were spent with a tutor working towards a national Skills for Life qualification – which most learners achieved by the end of the course.

Gateshead Health NHS foundation trust – Workforce Site

Gateshead Health NHS Trust employs approximately 3,400 people in a very deprived population with significantly higher mortality rates than the national average. The approach to Skilled for Health focused on staff but with the assumption that the benefits will trickle out to the wider community. The site concentrated on topics such as smoking cessation, drinking, health and well being, and sexual health. A key aim was to get participants onto Level 1 learning if they are not there already. The target groups were staff who undertook manual work, for example a group of health care assistants in the maternity department formed the first group and administrative support staff. The site also ran a series of courses on weight management and health eating, in conjunction with catering staff, 'return to learn' courses and a course focused on muscular-skeletal issues.

Prisons – Sector site

The prison site was divided between HMP Pentonville and HMP Holloway in London, the former being a prison for men the latter for females. The aim was to test the materials in a custodial setting. Partners in the site included City and Islington College, who had responsibility for delivering the Skills for Life element of the programme in collaboration with the two prisons. The Offenders Learning and Skills Service (OLASS) were also appointed to manage the contract on behalf of the two prisons and college. Pentonville Prison, focused on the mental well being section of the learning materials, with a particular focus on stress and anxiety at a primary level, after recognising that there is a deficit in primary care services. The 4-6 week course included a two hour classroom session followed by a walking exercise in the afternoon.

Holloway Prison took a more embedded approach to Skilled for Health and also agreed to develop materials on sexual health. The materials were not written specifically for offenders so they can be used in other sites and settings. In particular they include what sexual health means, safer sex, contraception, STDs, HIV and AIDS, and information on accessing services. The average length of stay at the prison is 28 days therefore the materials were designed as a set of six stand alone modules. The site began in May 2007 and ended in October 2008.

Army – Sector Site

The army sector Skilled for Health project was piloted on the wives of the army personnel in Tidworth and Bulford areas. Nothing had been delivered to this target group before by the army – all previous health promotion activities were targeted at the army personnel. The course provided an opportunity to widen the engagement to include families. Mental well-being was another key issue – with the army being away for long periods of time, the wives were known

to suffer from isolation and mental health issues. The Skilled for Health course therefore had a greater emphasis placed on improving learners' mental health, self confidence and self esteem than other sites. It was hoped that through the course the participants will make friends and get support from each other, which alleviates isolation. The courses were delivered from community centres where wives felt comfortable and were very flexible in terms of the topics covered - the contents of each course were decided with the participants at the start of the course. As the project developed, a progression course was designed for those interested in continuing to meet after the first six weeks.

MLA – Sector Site

The Museums, Libraries and Archives council delivered Skilled for Health materials in five London boroughs – Barking and Dagenham, Ealing, Newham, Islington and Haringey. Libraries were chosen as apposed to museums or archives because libraries were already being used for health information and staff were being trained in the continuation of such courses. Different groups were targeted in different boroughs. The project began in Ealing, with two groups of Tamil speaking mothers in a library next to their local primary school. Barking and Dagenham worked with a group of Asian elders recruited through Age Concern, and in Haringey with parents through the library's health consultant. Newham and Islington worked with homeless people, ex-offenders and a refugee group. Throughout, the focus was on ESOL learners.

County Durham – Community site

The County Durham site is managed and supported by County Durham and Darlington PCT. Skilled for health was seen to address wider local contexts around access to learning and health. Key objectives were to invite participation in Skilled for Health across a target group spectrum in County Durham – including

varying levels of education and background amongst learners. Consequently 4 projects delivered Skilled for Health materials across county Durham and targeted very different audiences:

- HMP Durham who delivered sessions to male offenders,
- Durham County Council who delivered Education in the community' to a variety of learners in deprived areas and those with ESOL needs.
- Bridge women's group, who targeted women who used the existing Bridge service (mental health and drug users were particularly targeted) and
- Darlington College who delivered materials to young people aged 16 to 18.

The site began in November 2007 and ended January 2009.

Northumberland Care Trust – Community Site

Northumberland Care Trust focused on delivery to parents with school age children, because there was already some good work going on in the schools getting children to understand health messages but this often fell down when children went home. The work has meant bringing together people who have never worked with each other before, since a range of people are part of the steering group. They are keen to start delivering before Christmas and have decided to use essential skills tutors (minimum level 4), co-facilitated by members of the health improvement team, fire and rescue etc – depending on what is being delivered. Parents are being recruited via parent support and the project will be delivered in children's centres where there are crèches. In terms of evaluation, colleagues working in Skills for Life will be measuring learning outcomes, and from health point of view, they will be looking at things like lifestyle changes, such as eating more fruit and vegetables. They are also looking at setting up storyboards to

illustrate the benefits, and are already trying to get a roll out with other groups; there is already someone who is interested in using this approach with people who are deaf.

Salford - Community Site

Skilled for Health in Salford was delivered by Broughton Database, a community learning centre that provides computer training from its base as well as from various community venues across the area. Broughton Database has a strong focus on those learners who do not access the mainstream services. Most of the trainers are local people who have progressed from being students to IT tutors and have a good understanding of their learners. Although health was a new area for Broughton Database, they felt that Skilled for Health was a natural step for them. Through an existing learner base they felt that they had access to the 'right' target group and Skilled for Health was an opportunity to offer something new to their learners. There were two ways of delivering Skilled for Health in Salford – the materials were embedded into the existing ICT courses, and Skilled for Health was offered as a stand-alone course to existing learners. There was a strong focus on health – particularly healthy eating, exercise and NHS services. The site has also developed a progression course for those interested in further learning of healthy living.

Bolton Partnership – Community Site

The Skilled for Health project in Bolton was delivered jointly by BoltonWISE, a community learning centre; and Bolton Community and Voluntary Services (CVS). This was a new partnership developed specifically for the Skilled for Health project. BoltonWISE saw the Skilled for Health funding as an opportunity for them to work with the most disadvantaged parts of the community – the groups that would be difficult to engage through mainstream funded projects that are 'geared towards numbers'. The project focussed

on a range of groups: BME communities, estates with high levels of deprivation, and economically inactive people, older carers and young people at risk of dropping out of education. The courses were designed to be 'learner-led' – instead of teaching a syllabus, a tutor facilitated learning based on the materials. The Skilled for Health materials were adapted for each target group focussing on the relevant needs – e.g. navigating the healthcare system for BME communities; budgeting for young mothers, substances for young people 'at risk'. There were two ways of delivering the materials – embedded to existing courses, or delivered as stand-alone courses, either to already existing groups as a progression course, or to new groups of learners. The project had a strong outreach focus, and most of the courses were delivered from various venues across Bolton.

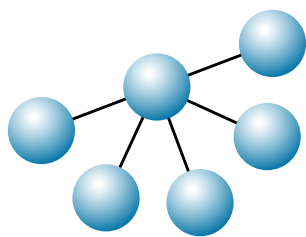
North Liverpool – Community Site

Skilled for Health partnership in North Liverpool was led by Communiversity, a lifelong learning centre in Croxteth area of Liverpool. The two partners - Vauxhall

Neighbourhood Council and Orrell Park Community Centre – were learning centres in nearby areas of Liverpool. Communiversity is an adult vocational learning centre with a very wide range of activities and courses – from fashion and beauty to theatre clubs. The centre targets the most deprived sections within the community, who are not used to, or ready for, learning. The centre already had an experience of community health work through a team of Community Health Ambassadors Team (CHATs) that were organising health fairs and raising health awareness in the community. The Skilled for Health was therefore a project that naturally suited to the centre's activities. The focus in Liverpool was testing the materials as embedded elements in a range of existing vocational courses, e.g. hairdressing, healthy cooking, art and design, childcare, etc. Some stand-alone courses were also planned. The materials were adapted by tutors to suit the main subjects of the courses. Apart from the courses, Skilled for Health materials were copied and widely used in other activities, e.g. by CHATs in health fairs.

FOOTNOTES: SECTION 10

- ²⁴ Seen as an identified gap in the SfH product and pertinent health issue for offenders
- ²⁵ Upon graduation from the programme, learners were awarded a City and Islington College Certificate of completion as well as a pineapple (motif of the course).
- ²⁶ At the time of completing this case study, this course was still in the planning phase.
- ²⁷ Name changed to preserve the anonymity of the learner.



SHARED INTELLIGENCE



Shared intelligence
1 Fitzroy Square
London W1T 5HE

t: . +44 (0)20 7756 7600
f: . +44 (0)20 7756 7601
e: . solutions@sharedintelligence.net
w: www.sharedintelligence.net

The Tavistock Institute
30 Tabernacle Street
London EC2A 4UE

t: . +44 (0)20 7417 0407
f: . +44 (0)20 7457 0566
e: . k.junge@tavinststitute.org
w: www.tavinststitute.org