



**Project part financed
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[Evaluation of CAWT Health Inequalities Project]

Final Report

The health profile could be used to study the nature of health inequality within the CAWT region and to develop action to address these

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CONTENTS

Executive summary	3
Background/Context	4-5
Evaluation Methodology	5
Process Adopted	6
Evaluation Findings	6-11
Conclusions	11-12
Recommendations	12-14

EXECUTIVE SUMMARY

This health inequalities project was established in 2006 to address the recommendations arising out of a one day conference a year earlier. The main focus of the project was engagement of key stakeholders to raise awareness and create action to address the problem of inequality in health and to produce a second health profile for the CAWT region. The project was supported with funding from the European Union INTERREG IIIA programme.

The project was project managed using PRINCE methodology with direct input from most of the health authorities in the region at Project Board level. A number of changes in key personnel during the life of the project have contributed to some slippage in the delivery of the project objectives against the planned timetable.

This evaluation included a review of all documents developed as a result of the project and discussions with key individuals involved in the delivery of the project.

A few of the objectives set for the project, were ambitious and beyond the control of the Project Board. This resulted in a modification of the desired outcomes. There was significant commitment and enthusiasm given by the Project Team. They did have a communication structure in place and engaged with key stakeholders throughout the process. A second health profile has been compiled which is a central product to a successful completion of the project, with its launch planned for late September 2008.

While the project did encounter significant challenges including gaining commitment from all the geographical areas involved, collecting the required data and dealing with differences in the data available in the two jurisdictions, they have produced a second health profile that identifies unique health differences effecting the border communities. This profile which will need updating in the future could prove to be valuable to service planners across a range of agencies in planning to deal with their responsibilities to address health inequalities.

REPORT ON THE EVALUATION OF THE CAWT HEALTH INEQUALITIES PROJECT

1.0 Background/Context

1.1 This project was established in 2006 to address the recommendations arising out of a one day conference held during March 2005 on health inequalities in the region covered by Cooperation and Working Together (CAWT). The report arising from that conference contained four recommendations. These were:

- A strategy for tackling health inequality in the CAWT region should be developed
- CAWT should consider setting up a multi-sectoral, multi-agency group to specifically address the issue of health inequality in the region. This should in no way detract from the fact that tackling health inequality is the responsibility of many individuals and groups
- A second population health profile for the CAWT region should be developed to provide a five year update on the health status of the region
- The lessons learnt from models in use in the CAWT region such as Investing for Health Partnerships Health Action Zones (HAZ) and County Development Boards should be considered.

1.2 There has been much interest at strategic and policy levels in the issue of health inequality for some time. The Black report on Inequality in Health and the Independent Inquiry into Inequalities in Health chaired by Sir Donald Acheson, 1998 examined the determinants of inequality in health, making recommendations for future policy development aimed at reducing inequality in health. The report of the later inquiry recommended that there was a need for a review of data to improve the capacity to monitor inequalities in health and the need to establish mechanisms to monitor inequalities in health and to evaluate the effectiveness of measures taken to reduce them.

At a European level the “Closing the Gap” Strategies for Action to tackle Health Inequalities, states that reducing socio-economic health inequalities is one of the main challenges within the public health sector in Europe and sets out the need for a knowledge base and infrastructure in order to implement and strengthen strategies and actions aimed at reducing these inequalities. Within the Irish context both jurisdictions have developed policy frameworks for tackling inequalities through the National Action Plan for Social Inclusion 2007-2016 in the Republic of Ireland and Lifetime Opportunities and the Regional Strategy for Public Health, Investing for Health in Northern Ireland.

1.3 This project was stimulated by the outcome of the Cooperation and Working Together (CAWT) European Union sponsored conference in 2005. After some initial consideration the project aim was refined to; “The overarching aim of this project is to collate and supplement identified key information on health inequalities in the CAWT region, raise awareness about health inequalities, identify key areas for future development and make recommendations for a coordinated approach to reduce the impact of health inequalities within the CAWT region for the mutual gain of its resident population”. This aim appears to be in keeping with the policy requirements set out in both jurisdictions and is consistent with CAWT’s objectives of identifying opportunities for cooperating in planning, supporting public sector bodies in joint initiatives and addressing special development problems arising from their relative isolation. The project has six specific objectives and desired outcomes or products which will be the subject of review through this evaluation.

2.0 Evaluation Methodology

2.1 The specification for this assignment set out the inputs, processes, outputs and outcomes of the Project that were to be assessed through the evaluation. The methodology put forward as part of the tender for the evaluation was considered appropriate following initial discussions with the Project Chair and the Project Manager.

2.2 All documents relating to the establishment and management of the project have been reviewed. These included the Project Initiation Document, Stage Plans, Risk Logs, End Stage Reports,

minutes of Board and Sub-Group meetings, the products arising out of the work of the Communication Sub-Group and all relevant correspondence.

2.3 A range of discussions were held with key individuals involved in the management of the Project and the delivery of the products arising from its work. These discussions involved the Project Chair, Project Manager, Project Board members, the CAWT link to the Project and a member of the Quality Assurance Group.

2.4 An assessment of the products/outputs of the Project against the proposed outputs as set out in the project plan.

3.0 Process Adopted

3.1 The stimulus for this project was generated by a range of health professionals working in the field of Public Health Medicine or Investing for Health, and arose out of a European Union INTERREG IIIA funded one day conference on health inequalities in the CAWT region held in March 2005. A Project Board was established and the first meeting was held on 5 October 2006 to commence the work on this project through a coordinated approach in tackling health inequalities with partnership working between the health services in both jurisdictions, Health Action Zones (HAZ) and the County Development Boards. The membership of the Project Board included representatives of most of the interested parties including the Institute of Public Health. At that stage EU INTERREG IIIA funding had been secured to support the project for a 21 month period until June 2008.

3.2 The objectives set out for the project in the funding application were reviewed at the initial Project Board meeting, resulting in the development of revised aims and objectives which were communicated to the Chief Officer CAWT in a letter of 27 October 2006 by the Project Board Chair. The main difference set out was that the project stopped short of producing a strategy for tackling health inequalities in the CAWT region, based on the view that there was insufficient time to deliver such a strategy within the timeframe.

3.3 This project has been formally project managed with all relevant documentation produced in keeping with the PRINCE methodology. A Project Manager was appointed and the majority of the work was undertaken by three Sub-Groups that worked specifically on a 2nd Health Profile, Communications and a Database.

3.4 The work of the project has been supported by the Information Departments of the relevant health authorities and a Quality Assurance Group. One element of work on engaging other public authorities was commissioned through the use of an external organisation, the Holywell Trust.

4.0 Evaluation Findings

4.1 This project developed aims and objectives arising out of the recommendations from the one day conference on health inequalities in the CAWT region held during March 2005. The review of documents available reveals that these were modified at the 1st Project Board meeting held on 5th October 2006. This meeting was attended by the CAWT Executive Officer. Following the meeting the Chair of the Project Board wrote to the Chief Officer, CAWT advising of the proposed changes to the project, offering an explanation and seeking confirmation that CAWT was satisfied with the revised aims and objectives. There are a number of communications on file between CAWT and the Dept of Health, Social Services and Public Safety for N. Ireland Nov. 2007 – Feb. 2008 in relation to these modifications. Formal confirmation of acceptance of the revised Project Objectives and Desired Outcomes was not received until 28 May 2008.

4.2 The revised aims, objectives and desired outcomes for this project stopped short of the original intent to produce a strategy for tackling health inequalities within the CAWT area, but the Chairman of the Project Board in his correspondence communicating these revisions set out the Board's anticipation that the strategy development would follow on naturally as a result of the activities associated with the project. This anticipated outcome could prove to be optimistic given the changing structures within the health systems, unless the products arising out of the project are embraced by organisations such as the proposed new Regional Agency for

Public Health and Social Well-being, which will have a responsibility for health improvement and inequality and the Institute for Public Health as well as the Health Services Executive in the Republic of Ireland.

4.3 Some of the objectives and desired outcomes are defined in terms which do not aid the Project Board in assessing their success in achieving the same. It could also be contended that the achievement of some of the objectives and desired outcomes are beyond the direct control or influence of the Project Board. Such an example would be their ability to liaise and share information at a European level unless they get abstracts accepted for presenting at conferences or forums at that level. Finally the revised objectives and desired outcomes may have proven beyond the capacity to deliver from within the Project Board and Team given the range of substantive roles and responsibilities of the individuals concerned.

4.4 There were a number of significant changes in personnel involved in the project during its life which may have contributed to the need to revise the timetable for achieving the products of the project on a number of occasions. These changes included the clinician who initially led on the work relating to the second health profile, the Project Manager and the Executive Officer, CAWT.

4.5 This project involved the four geographical health and social care areas within the CAWT region. Much of the drive and commitment for the delivery of the project outcomes was given by key members who work in substantive posts within HSE North West with no representation at Project Board level from within HSE North East. Documents to hand identify that a representative from HSE North East did participate in at least one meeting related to the project and the Project Chair kept the representative briefed on progress on a regular basis. This limited commitment to this project from HSE North East has been attributed to a lack of staffing capacity which has restricted their ability to contribute to a greater extent.

4.6 The project was supported by a Quality Assurance Group made up of three individuals each of whom brought specific and different expertise to support the project. While at times there was a perceived lack of clarity in relation to the expected role for the Quality Assurance Group, their contribution was considered to have

been important and helpful to the Project Board and Project Manager.

4.7 Project Board members and staff involved in this project have demonstrated enthusiasm and commitment to work to a successful outcome of this project and in particular the delivery of a second health profile for the CAWT area. Perhaps there were opportunities to recruit the replacement Project Manager and the clerical support post earlier, and to have engaged them to a greater extent in the development of the products. This may have reduced the burden of demand placed on Project Board members and assisted in the earlier delivery of the products.

4.8 There has been significant slippage in the timescale for the delivery of some products arising out of this project. This is most noted in the development of the health profile. The original target was to be at final draft stage by December 2007. It is anticipated that the final product will now be with the printer by the beginning of September 2008, with a launch event thereafter. A number of factors influenced the need to revise the timetable for the delivery of the health profile. These included the departure of the initial lead person, who was working on the second health profile, the departure of the Project Manager and the challenge and time commitment involved in collecting and collating the required information. This second profile is in greater detail and focuses on inequalities within the geographical area.

4.9 Those engaged in compiling the second health profile did encounter significant challenges in the collection and analysis of the data required. These challenges included those relating to the differences in the availability of baseline demographic information within the two jurisdictions, the structures for collecting information and problems with compatibility of information in areas such as the use of timeframes, definition of social classes and the timing of censuses.

4.10 The second health profile is near completion at the time of this project evaluation and plans were in hand for its launch on 24 September 2008. The profile which has eight main chapters will also contain conclusions and recommendations, some of which are

aimed at aiding the achievement of some of the other desired outcomes for the project. Given the nature of the profile which covers the CAWT areas in both jurisdictions of Ireland, the authors did encounter a number of challenges particularly in relation to establishing common definitions for the information required to establish the profile. This has resulted in restricting the contents relating to some elements of current service provision. However this second profile will contain more information on some elements such as children's health, will contain recommendations on tracking inequality and on the issue of consistency of data. The profile has identified evidence of inequality in the border regions which should be helpful in service planning.

4.11 The capacity to influence the potential for producing a mechanism to create a regular CAWT health profile is probably beyond the control of the current Project Board members given the proposed change in the health structures in N. Ireland. In the proposed new structure the Regional Agency for Health and Social-wellbeing will carry the responsibility for health inequality and there is no certainty that they will adopt a sub-regional approach to deal with this responsibility which will equate to the CAWT region. The Project Board take the view that ideally the profile would be updated every 4-5 years. Such a frequency of updating would allow a tracking of the impact service changes had on existing inequalities.

4.12 The project has achieved the establishment of an electronic database of projects and initiatives in the CAWT region that address health inequalities. The contents of the current database were collected as a result of a trawl of projects in 2007. There are currently 51 projects profiled on this database with the intention of tracking good practice in dealing with health inequalities. A review of the frequency of searches of the database until 21 April 2008 reveals that there have been 191 searches of its contents. This database has a number of limitations and is presenting a difficulty in its sustainability beyond the life of the project. While the profile of each project contains the same data fields there are inconsistencies in the data available between projects such as the presence or absence of the life span of the projects. There have not been arrangements put in place to quality assure the contents of the database or to keep it updated. While the contents of such

databases can be a useful reference source for examples of good practice that could be replicated in other areas with reduced duplication of effort, the current contents of this database is not considered to contain all projects that aim to address health inequalities within the geographical area. The availability of the database and its link into the Institute of Public Health electronic library does create the potential for sharing initiatives aimed at addressing health inequalities within the CAWT area nationally and at a European level. The database is currently hosted on the CAWT website. The Project Board are currently exploring the continuation of running the database with the Centre for Cross Border Studies beyond the life of the project.

4.13 The project has been successful in engaging with others at local and national levels in sharing information and expertise in relation to health inequality. This engagement included the external contributions to the working of the project through inputs from the members of the Quality Assurance Group and the participation at Project Board level from the institute of Public Health in Ireland. Plans are at an advanced stage for the launch of the Health Profile. Invitations to this event had included representatives from the governments in both jurisdictions and from a wide range of local and national organisations who have an interest in the subject of health inequalities or who have a part to play in addressing this issue. In addition to the launch the Project Board plans to distribute the profile and the second Newsletter to a wide range of organisations for their information and use. While liaising and sharing the information at European level is probably beyond the control of those developing this project it is their intention to submit abstracts for consideration of conference organisers which could result in a wider sharing of the work and information.

4.14 This project engaged with key stakeholders on a number of occasions during the course of their work. This engagement included linking with the relevant health and social care agencies within the CAWT region during the collection of data required for the completion of the health profile. The Holywell Consultancy was engaged to undertake a survey of a wide range of representatives from across the area on health inequalities using a questionnaire developed as part of the project. In total 151 people were contacted with a 44.4% return rate contributing to a report being

compiled of the findings in December 2007. While the completion of this survey probably contributed to raising awareness of the work involved and in the issue of health inequalities it is unclear how the results have contributed to the delivery of the project objectives and desired outcomes.

4.15 The Project Board and Project Manager held three workshops during May 2008 in Armagh, Enniskillen and Letterkenny. These events were aimed at engaging a wide range of statutory and voluntary agencies, raising their awareness of this issue, establishing what was happening locally to address the issue and sharing some of the preliminary analysis arising out of the health profile work. A final evaluation report on these workshops was produced and distributed.

4.16 The travel restrictions placed on non clinical journeys for staff working in the HSE which were introduced towards the end of this project have resulted in the Project Board Chair deciding to cancel the planned event to launch the health profile. To communicate the publication of the health profile it was decided to issue a press release and a summary of the key statistics to both national and local media. A distribution list was developed and the health profile issued to a wide range of stakeholders.

4.17 It is beyond the control of this project and those involved in delivering its products to develop an infrastructure to enable a sustained Multi-sectoral approach to reducing inequalities over time in the CAWT region. This outcome should have been refined or eliminated at the commencement of the project. However the other products of the project especially the health profile could be used by relevant agencies to study the nature of such inequalities and develop action to address these.

4.18 This project has a projected under spend of approximately 10% of the agreed budget. While there are some areas of over spends especially with costs incurred to conduct workshops and the meetings, the main contributions to the final project financial outturn is related to savings on staff recruitment and salaries.

5.0 Conclusions

- 5.1 The project objectives and desired outcomes needed better refinement and perhaps some of them eliminated at the outset given the makeup of the Project Board and their limitations to influence the development or introduction of a multi-sectoral strategy for addressing health inequalities.
- 5.2 The project did experience some issues in relation to gaining full commitment from all the stakeholders. They also experienced capacity problems which contributed to delays in the delivery of the planned outcomes against the timetable set. These difficulties were compounded by changes in personnel during the life of the project and the delay in having the revised objectives accepted.
- 5.3 The Project Board worked well as a group and brought considerable enthusiasm to the delivery of the products that were possible to achieve, especially the second health profile. The Project Board and sub-groups held a workshop to examine progress and consider the way forward which was considered to have been helpful in increasing awareness of the total project by sub-group members.
- 5.4 Engagement did take place with key stakeholders and they will be engaged again with the launch of the health profile. The travel restrictions introduced for HSE staff for all non clinical travel has the potential to limit further engagement on this agenda at this time.
- 5.5 The work undertaken in this project has resulted in the delivery of a number of products including the health profile, the database of projects and the sharing of information through the workshops and newsletters.
- 5.6. An arrangement has been put in place in which the database will be maintained by the Centre for Cross Border Studies.
- 5.7 There is no certainty that the work undertaken will be sustainable beyond the end of the project in September 2008. Changes to the health structures could have a negative impact on the use or further development of the other products.

5.8 The project was project managed with all relevant documentation available for the evaluation team. The contribution of the second Project Manager was considered crucial to the successful completion of the outcomes achieved.

5.9 The health profile does identify that there are some unique health inequalities which affect the residents of the border regions which would warrant further exploration and monitoring. More specific recommendations are contained within the Health profile publication.

6.0 Recommendations

6.1 The CAWT Development Centre needs to be clear about their role and responsibilities in relation to advising and monitoring projects and how these are fulfilled. At the initial planning phase the CAWT Programme Manager needs to engage in a more robust examination of the objects set for projects and the capacity of Project Boards to deliver these given the range of responsibilities Board members carry in their substantive jobs and the sphere of influence they can assert in order to achieve some outcomes.

6.2 All projects sponsored through CAWT need to be owned by the relevant CAWT partnership organisations. These partnership organisations need to appoint suitable personnel to Project Boards, who will be allocated time and support to manage the delivery of these projects in keeping with the Project Initiation document and Letter of Offer.

6.3 Project Board members need to be clear about their responsibilities in relation to delivering projects. The CAWT Development Centre needs to provide clear and consistent guidance to Project Boards and Project Managers in relation to their responsibilities for defining, managing and monitoring the project within the defined budget and agreed timeframe.

6.4 There was a significant delay in receipt of an outcome in respect of the proposed changes to the scope of this project. The key link person for projects from the CAWT Development Centre needs to be of sufficient seniority and have delegated authority to make decisions relating to changes in projects or have these made at a

relevant level, quickly, so as not to lead to undue delays in projects. This may involve the development or refinement of procedures with the funding bodies which govern the decision making process within agreed time limits.

6.5A number of projects supported by CAWT partnership have included the development of databases. These CAWT partnership organisations should give consideration to how such databases could be sustained in the longer term so that relevant updated information is available for common use.

6.6 Consideration needs to be given to the level of project support required to deliver projects. This consideration should include the necessary level of experience and knowledge of the subject area required for Project Managers. Historically the project assistance for CAWT projects has tended to have been recruited to be based at an area of their choice and at a salary linked to the health service salary bands of the successful applicant's jurisdiction base. They also are managed by the service provider responsible for that base. While this arrangement appears to have worked well in the case of the current Project Manager for this project, it does raise a number of issues which warrant careful consideration for future projects. There are often significant differences in the salary structures between the jurisdictions which may attract or deter a good field of applicants for such posts. Consideration should be given to evaluating the posts for salary purposes on the basis of the complexity of the job and the skills required to deliver and paying a single salary band irrespective of the base of the successful candidate. Consideration should also be given to having the post holder/s reporting to the Chair of the Project Board.

6.7 Project Boards should contain representatives from all key stake holders. These should be established at the application stage for funding of projects with part of the assessment of projects being a review of capacity to deliver the proposed outcomes.

6.8 Project management is an important discipline required to monitor progress and risks throughout the life of the project. The detail within the project documentation should be commensurate with the size and complexity of the project involved.

- 6.9 This project identifies that there are unique health inequality issues that affect residents in the border region of Ireland. Government agencies need to accept responsibility for developing analysis of the reasons and developing programmes within the limits of their resources to address such inequality. There is a need to have the profile updated, probably every five years to track progress on addressing inequality within the CAWT region.
- 6.10 The theme of cross department and multi-agency working is common to the strategies of the governments of both jurisdictions. Departments need to utilise the Health Profile as part of their intelligence when planning services. The health authorities in both jurisdictions should accept responsibility for coordinating the development of a multi-sectoral approach to addressing health inequality in the region.
- 6.11 Work should continue beyond this project in relation to agreeing common currencies for information relating to health detriments and service provision across the jurisdictions. Perhaps the Institute of Public Health for Ireland could play a key role in such work.