LEEDS BECKETT UNIVERSITY

Evaluation of Age UK Eatwell and Livewell Programme

Final Report

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Dr Louise Warwick-Booth, Susan Coan and Dr Anne-Marie Bagnall

Executive Summary including summary of evaluation findings

1. Introduction

The Eatwell and Livewell Programme was set up in 2014 to provide support in the malnutrition pathway for older people within two Yorkshire areas. This report presents the findings from an evaluation of the programme conducted by the Centre for Health Promotion Research, Leeds Beckett University. It presents evidence about the project's background, its progress in relation to target outputs, the outcomes for service users, and learning from both delivery sites.

2. Project Background

Age UK Yorkshire and Humber successfully secured funding from the Department of Health's Innovation, Excellence and Strategic Development Fund to implement a 3-year project called 'Eatwell and Livewell', 2014-2017. The project involved two local Age UK charities in Yorkshire – Doncaster and Calderdale/Kirklees. The project aimed to benefit older people and their carers, by reducing the effects of being underweight, and clinicians in secondary and primary care, including community dieticians, by offering a referral route to a growing population of older people at risk of malnutrition.

3. Evaluation aims and objectives

The specific objectives of the evaluation were to:

1. Explore the effectiveness of the project in terms of improving the health-related and general quality of life of older people via changes in their diet and nutrition;

2. Ascertain the impact of the project in relation to the more effective use of health resources;

3. Explore the effectiveness of the project in terms of improving the quality of life for carers whilst establishing what outcomes are important for them;

4. Ascertain the impact of the project for volunteers in relation to measures such as improved employability; empowerment and improvement in community resilience;

5. Highlight any potential social return on investment indicators within the short scope of the evaluation timeframe.

Evidence for the evaluation derived primarily from interviews with stakeholders (4 in total), referrers (2), volunteers (3) and service users (3), carers (2) as well as analysis of routinely collected monitoring data.

4. Overview of evaluation findings

- Service users interviewed by the evaluation team reported many positive perceptions and outcomes as a result of their involvement with Eatwell and Livewell. These included weight gain, increased motivation and diversity of diet, improved hydration, changes in their approach to food preparation and cooking, increased confidence, improved strength and less social isolation.

- Stakeholders and referrers who had been involved with Eatwell also reported several positive outcomes that resulted from the intervention. For example, Eatwell added value to existing provision by reducing demand on other services and offering a holistic approach.

- Volunteers working within Eatwell reported positive experiences including being well-trained, receiving good support from their local Age UK and benefitting personally in terms of increased confidence, knowledge and skills.

- Both delivery partners (Doncaster, as well as Calderdale/Kirklees) did not meet the project targets set by the regional office.

- Quantification of the project's impacts is not possible based upon the in-house monitoring data collected at both sites. Tools measuring improvements in weight and nutrition (MUST) and quality of life were not used in the vast majority of cases, leaving data sets in both of these areas incomplete.

- Learning reported by the delivery partners included the need for a different approach with revised targets (reduced numbers), the importance of linking into other existing projects to ensure successful delivery, closer monitoring from a regional perspective and the development of alternative mechanisms to ensure linkages with clinicians such as GPs and dieticians.

5. Lessons from Eatwell and Livewell

- The need for promotion of the service as an on-going aspect of the project delivery was identified.

- Strategies to ensure broader clinician engagement (GPs and community dieticians) needed to be embedded within both delivery partner approaches.

- Improved communication strategies between all of those involved within Eatwell under the Age UK umbrella was needed. However, it is recognised that limitations on staff time were a barrier to more effective communication in these areas.

- Revised support mechanisms from a regional to local level within the Age UK structure should be considered for any future project.

- Mechanisms should be put into place to ensure that learning from project delivery can be used within the remaining life-time of any interventions.

6. Issues for consideration

- Future delivery of services such as this should ensure that broader measurement of service user outcomes is on-going and embedded within the monitoring approach, to encompass quality of life changes in a robust and sensitive manner. Evaluation partners could be drawn upon to advise of appropriate tools.

- Access to health service usage data in future Age UK projects is advisable to ensure more robust measures of impact. For example, access to health data such as GP appointments and Accident and Emergency attendances for all service users participating would allow fuller conclusions to be drawn in relation to effectiveness.

- The early adoption of a test and learn approach working with evaluation partners is worth considering in the delivery of future interventions to refine and improve practice during the life-time of any given project.

1. Introduction

Project Background

Age UK Yorkshire and Humber successfully secured funding from the Department of Health (specifically the Innovation, Excellence and Strategic Development Fund) to implement a 3-year project called 'Eatwell and Livewell', 2014-2017. The project involved two local Age UK charities in Yorkshire – Doncaster and Calderdale/Kirklees.

The project aimed to demonstrate the role of the voluntary sector and volunteers in the malnutrition pathway for older people. The two local age UK sites named above aimed to work with older people identified as having nutritional issues following a MUST (Malnutrition Universal Screening Tool) assessment either in hospital or primary care. The MUST score combines data on BMI, unplanned weight loss in the past 3-6 months, and acute disease, to produce an overall risk of malnutrition score which ranges from 0 (low risk) to 2 or more (high risk), with associated treatment guidelines http://www.bapen.org.uk/pdfs/must/must_full.pdf. Using an outcomes tool, workers supported older people and their carers in addressing any issues impacting upon their diet for example, isolation, access to groceries and financial issues. The project aimed to benefit

- older people and their carers by reducing the effects of being underweight
- clinicians in secondary and primary care and community dieticians by offering a referral route to a growing population of older people at risk of malnutrition.

The project also aimed to improve the health related quality of life for older people and to establish a place for the voluntary and community sector in the care pathway for older people with nutritional issues.

At the outset of the project, it was envisaged that volunteers would be used in order to support the older person and their carer (if they had one) with food diaries; education programmes on food choices; simple cook and eat sessions; on-line shopping as well as access to groceries. Ultimately this support aimed to not only improve nutrition, but to also improve the older person's wellbeing and therefore reduce their reliance and use of health resources.

Project outputs

Over the three years of the project, the planned outputs were:

- 480 older people per Age UK supported with issues of nutrition
- At least 38 volunteers per Age UK recruited
- Project evaluated and lessons learned disseminated
- Regional and national partners aware of the project
- Sustainability agreements made with local health and social care commissioners for 2016-17 onward.

Project outcomes

The measurable outcomes of the project were:

1. To improve the health-related quality of life of older people by improving their diet and nutrition;

2. To improve the quality of life of the older person (not just heath related);

3. To establish a more effective use of health resources, freeing resources to be used elsewhere;

4. To improve the quality of life for carers by enabling them to help their partner or family member in a positive way, working with carers to establish what outcomes are important for them;

5. To assess the impact upon volunteers such as improved employability; empowerment or improvement in community resilience.

2. Findings

2.1 Project Outputs (in-house monitoring data)

Table 2.1.1 – Summary of Project Outputs

Doncaster	Calderdale/ Kirklees	Target
Numbers referred: 98	Numbers referred: 19	480
Volunteers recruited: 3	Volunteers recruited: 9	38

Calderdale/ Kirklees Site

Of the 19 people referred, 9 either did not get accepted onto the service or did not want to have an assessment. Two more people did receive interventions but were discharged (one moved into a nursing home, one is now under the care of a dietician). One person had an assessment but no interventions.

9 people received interventions. Total time spent on the interventions ranged from 6 to 45 hours, with a mean of 19.2 hours per person.

Of the people not taken on by the service, one person received an intervention (healthy recipes), 4 were referred to other Age UK services and 2 were referred to dieticians.

Table 2.1.2 – Referrals into Eatwell

Referrals into the Eatwell service in Calderdale/Kirklees came from a variety of sources as illustrated within Table 2.1.1, with no dominant referral partner being identifiable.

Referral route	Frequency
Age UK Volunteer	1
Carer	2
Community Group	1
Day Centre	1
Eatwell Presentation	3
Friend	1
Home from Hospital	3
Neighbour	1
Physio	2
Sector Support Calderdale/Calderdale/Kirklees	1
Self	2
Son	1
Total	19

At the point of referral 15 MUST scores were recorded, ranging from 0 to 4, with an average score of 1.07. 9 were noted at the 3-month follow-up after referral, ranging from 0 to 2, with an average score of 0.78, and then 2 more (scores of 0) at the 6-month point. It is not possible to draw any quantifiable conclusions about the impact of the project upon MUST scores using these figures, as the sample size is too small.

Table 2.1.3 – Interventions provided to Eatwell Clients

Service users were provided with support in a number of different ways upon referral as illustrated within table 2.1.3, with work around the Eatwell plate being the most common.

Interventions	**Number of people**
Healthy Eating Advice	2
Matched to E/L Volunteer	4
Work with Carer	4
Work with Eatwell plate	6
Sharing Recipes	2 (1 not accepted)
Food Diary	5

Table 2.1.4 Referral patterns (within Age UK)

Services users were provided with a range of support within Age UK's existing provision.

Other Age UK services referred into	**Number of people (Total)**	People accepted on EWLW	People declined
Falls exercise class	1	1	0
Benefits Check	1	1	0
Safe and Warm	3	3	0
Befriending	4	2	2
Falls Group	2	1	1
Domestic Services	2	1	1

Table 2.1.5 – Referral Patterns into other services (external to Age UK)

Service users were also referred into other services, where appropriate.

Other agencies referred to	**Number**
Continence Service	1
Careline Alarm Service	1
School Community Lunch Club	1
Dietician	2 (Neither accepted to EWLW)

Table 2.1.6 – Reason for discharge

Service users were discharged from Eatwell for a range of reasons, illustrated in table 2.1.6, with no common pattern evident.

Reason for discharge (e.g. declined assessment; refusal of service; death; successful completion)	Number
Long stay in hospital. Now under Community Dietician.	1
Moved to a Nursing Home	1
Declined assessment	3
Not accepted	6

Table 2.1.7– Postcodes of Calderdale/Kirklees

Service users came from a range of postal code areas, the most from HX7 however, the geographical spread was relatively even across the district.

Postcode	Frequency	Percent	IMD ranking
HD3	1	5%	30% least deprived
HD4	1	5%	50% least deprived
HX1	2	11%	10% most deprived
HX2	3	16%	50% least deprived
HX3	3	16%	50% most deprived
HX4	3	16%	40% least deprived
HX5	1	5%	40% most deprived
HX7	4	21%	40% least deprived
OL1	1	5%	n/a
Total	19	100%	

Gender of Calderdale/Kirklees

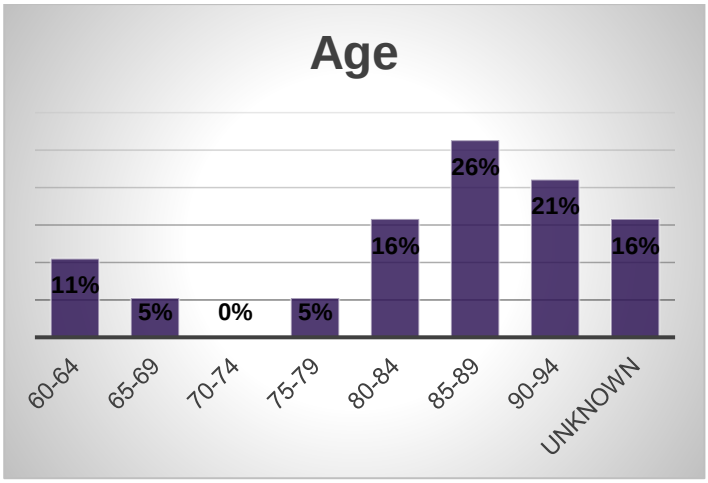
The majority of the service users were female (74%), with only 5 men (26%) supported within the Calderdale/Kirklees area.

Ethnicity of Calderdale/Kirklees

All 19 of the Calderdale/Kirklees were White British.

Figure 2.1.1 – Age of Calderdale/Kirklees

The majority of the clients supported within the Calderdale/Kirklees area were in the age groups 85-89 (26%), and 90-94 (21%), as table 2.1.8 illustrates.



Referral patterns (Calderdale/ Kirklees)

Case studies from the Calderdale/Kirklees site show that referral onto other services was an important component of the project delivery.

Table 2.1.8 – Case Studies of referrals on from Eatwell and their impact

Case Study	**Referral Made**
Mrs L	Following referral into Eatwell, Mrs L's condition quickly deteriorated and she was admitted to hospital before meeting the allocated volunteer. Her weight plummeted and she had a MUST score of 2+. Mrs L's case became beyond the remit of the Eatwell project and she was referred to the Community Dietician.
Mrs P	Mrs P was having difficulties cooking warm meals, so she was referred to Time to Care hot meals delivery service. One month after the referral Mrs P said that she was enjoying the meals and that they were just the right portion size.
Mr C	Mr C was unable to walk to his local supermarket, but liked to choose his own food. He was referred to the Access Bus which now takes him there each week. At follow-up a month later, he reported being pleased with the service and he appreciated being able to keep his independence.

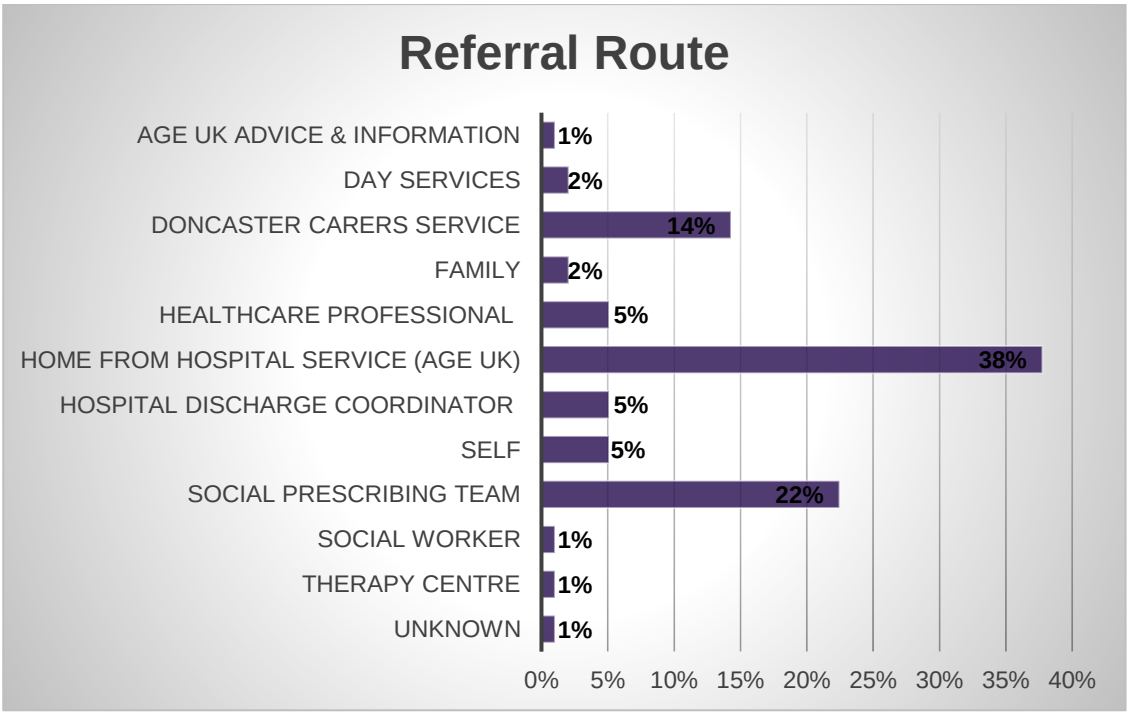
Mr M	Mr M hadn't been interested in cooking meals for himself since his wife died, but when Wiltshire Farm foods were suggested he said he would try them. In the follow-up a month later, he said that the microwave meals were easy to cook and that he was enjoying them very much.
Mrs A	Mrs A was unable to make her own meals after a recent illness, but she didn't want a care provider to come in and cook them for her. A referral was made to Time to Care for the daily hot meals delivery service. She reported enjoying the hot meals and the daily contact with the nice man who delivers them for her.
Mrs H	Mrs H was referred to Time to Care hot meal delivery service but found it inconvenient to have to wait in every day, so an additional referral was made to Wiltshire Farm Foods. She reported finding the combination of both meal services, a much better arrangement for her and is having a more varied diet.

Doncaster site

Referrals into Eatwell

98 people were referred into the Eatwell project at the Doncaster site.

Most referrals into the Doncaster project came from the 'home from hospital' service (38%), as well as the social prescribing team (22%). Figure 2.1.2 illustrates the referral patterns.



At the point of referral MUST scores were taken in some instances. There are 47 initial scores, ranging from 0 to 2, with an average score of 0.76, but no follow up scores. There were 8 follow up weights, 5 second follow up weights, 4 third follow up weights. This limited data set does not offer any opportunity for analysis and comment.

Table 2.1.9 – Interventions provided to Eatwell Clients

Service users were provided with support in a number of different ways upon referral as illustrated within table 2.1.9, with work around providing fortifying food and healthy eating information being the most common.

Intervention	Number of people
Advice on shopping	6
Advice to family	3
Advice Variety in Meals	2
Carers to provide meals	1
Checked home provisions	2
Day services	2
Diary sheets	3
Eatwell Plate	13
Enriching foods information	4
Fortifying foods information	30
Healthy eating information	18
Info about exercise and the need to eat more	1
Info on healthy eating and food patterns	3

Information about adaptations	3
Information about increasing weight and muscle gain	3
Information about MIND charity	2
Information about social groups	4
Information on diets for health conditions	9
Information on eating and dementia	2
Information on Hydration	11
Meal Delivery Services	11
Meal planning	2
Offer of volunteer	2
One to one cooking session	2
Portion Sizes	1
Recipe Adapting	10
Recipes	14
Snack advice	5
Volunteer to visit/contact	9
Ways to Boost Calorie Intake	14
Weekly contact to keep motivation up	3
Weight Tracking Chart/Weighing	6
Total	295

Referrals into other agencies

Service users were also referred into other services, where appropriate as table 2.1.10 demonstrates.

Table 2.1.10 – Referrals into other agencies

Referrals to Other Agencies	Frequency	Percent
Adult Contact Team	1	1%
Alcohol Services	1	1%
Contacted referrer to check out finances/ hsg and shopping.	1	1%
District nurses	1	1%
Hamilton's meals	2	2%
N/A	92	94%
Total	98	100%

Referrals were also made into other Age UK Services including,

- Active in later life
- Active in later life and Gardening Services
- Admiral service
- Benefits check
- Day Services
- Doncaster Carers Service

Day services had the most internal referrals (n=5), followed by Doncaster Carers Service (n=3).

Figure 2.1.3 – Reason for discharge

Service users were discharged from Doncaster Eatwell for a range of reasons, illustrated in Figure 2.1.3. The most common reasons recorded were individuals no longer needing the service (20%) and people completing the service (16%). 16% of referrals did not respond to contact, therefore it was not possible for delivery partners to engage all of those referred in.

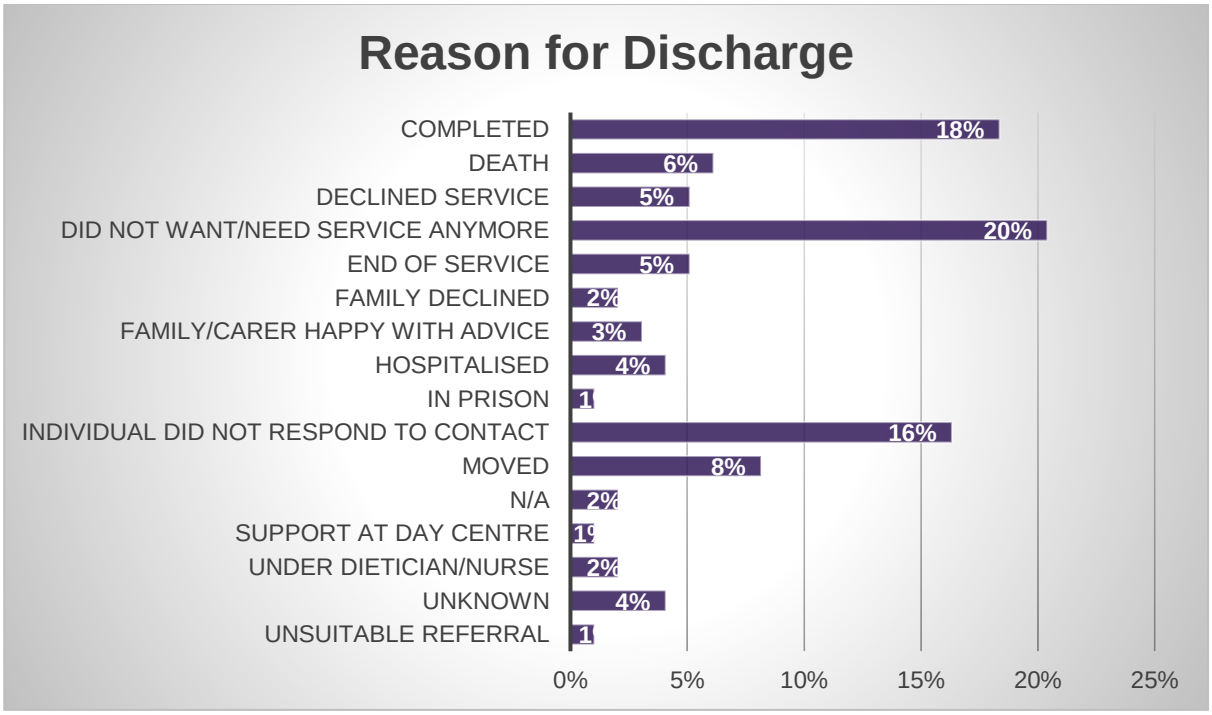
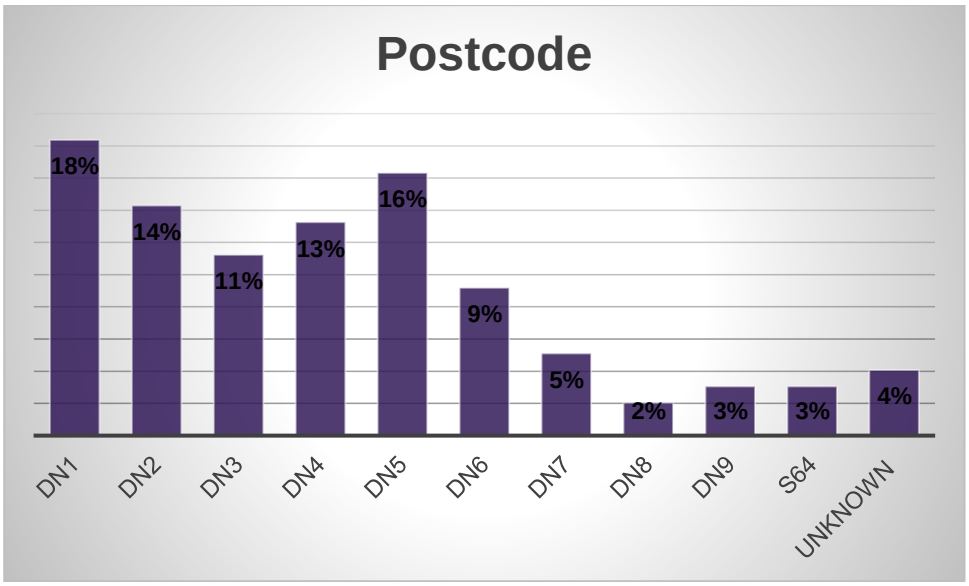


Figure 2.1.4 – Postcodes of Doncaster clients

Service users came from a range of postal code areas, the most from DN1 (18%), followed by DN5 (16%) and DN2 (14%). Figure 2.1.4 provides a full overview of the areas from which clients were drawn.



Index of multiple deprivation scores for the above postcodes are as follows:
DN1 and DN2 = 20% most deprived;
DN3 = 30% least deprived;
DN4 = 50% most deprived;
DN5 = 50% least deprived;
DN6 = 30% most deprived;
DN7 = 50% least deprived;
DN9 = 20% least deprived.

The service uses from Doncaster were located in the 20% most deprived areas (32% were from DN1 and DN2 postal codes).

Gender of Doncaster Clients

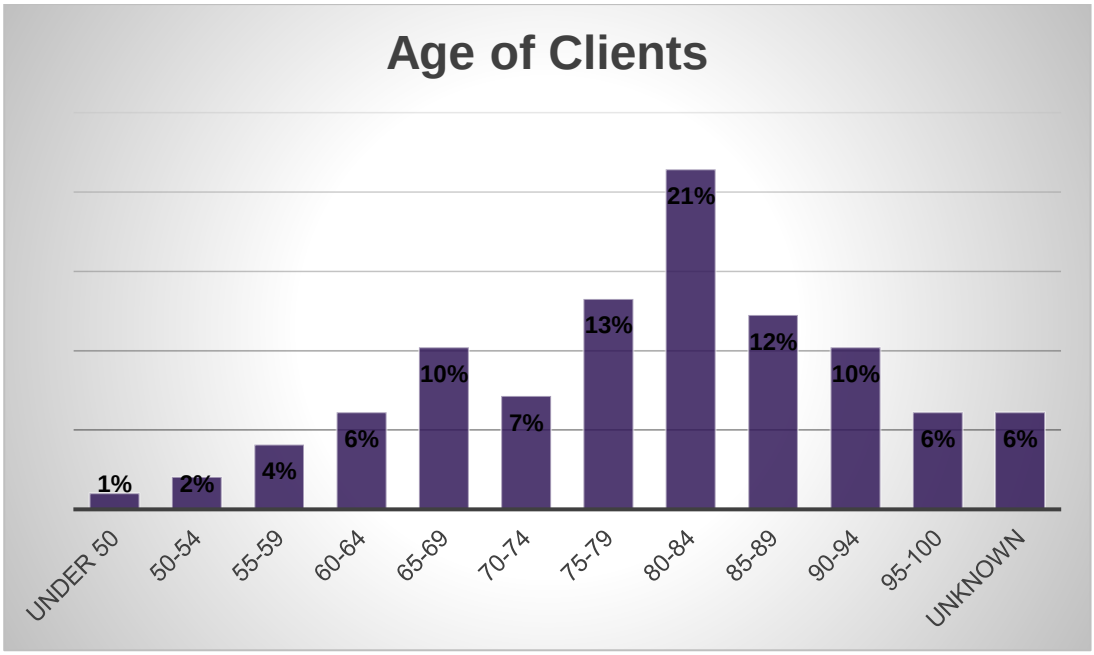
There was a more even gender spilt in the Doncaster area, with 58% of clients recorded as female and 42% as male.

Ethnicity of Doncaster Clients

81% of the Doncaster clients were White British, 2% were recorded as 'white other' and 1% as Black Caribbean. For 16% of clients' ethnicity was unknown.

Figure 2.1.5 – Age of Doncaster Clients

The majority of the clients supported within the Doncaster area were in the age groups 80-84 (21%), followed by 75-79 (13%), and 85-89 (12%) as Figure 2.1.5 illustrates.



Referral patterns (Doncaster)

Whilst the project was seen as an addition to existing service provision by those involved with it, there was discussion about the strategies that had been used to raise awareness of the service which was necessary to facilitate referrals. Established existing relationships had been used as a starting point to gain referrals:

> "So we already have very good relationships with the community dieticians here, so we were able to build on that and were able to get other contacts from them to give some guidance about who else we need to talk to." *Stakeholder*

Workers had also invested time in promoting the Eatwell service locally to ensure that they were raising awareness and securing referrals as a consequence:

> "It's just about keep banging on the door with all the other professionals really, so I've delivered talks to community dieticians, to all the discharge nurses from each ward (in one local hospital) and also one of the other hospitals, so I've delivered talks to all the occupational therapists, discharge nurses and dieticians around there, community nurses, physiotherapists, and just let them know what the project is all about and if they have anybody that they feel would benefit from a little bit of low-level support really, and to come to us and literally how to refer in to our service…taken it out to all the GP practices, so one of the hardest things to crack has been the GP surgeries and the practices." *Stakeholder*

It was also suggested that the project needed more promotion to ensure increased awareness of its existence, however, this was difficult with limited staff numbers:

> "The only thing I think is with the project's coverage, it just needs to be increased. I think it needs to reach more people. I think it's really good at what it does, but I think there's not probably enough resources being put into it in order for it to reach more people so I

> think, I don't know, it's quite hard for one person to run the whole project and I think if more money was put into it then it wold be able to cover more people and yeah I think that would be really beneficial." *Volunteer*

> "I've done a lot of promotional work with the discharge nurses and that initially did stimulate quite a few referrals directly from the wards… but it's like all these things really we've got to keep banging on all the time, staff change, different priorities come along, so they've got a lot of other things to think about. I think it will be good to go and revisit some of those places again." *Stakeholder*

Referrals were seen to be coming from just a small number of organisations and had been slow to begin which caused concern for those involved in delivery:

> "It does tend to be mainly with charities and council, so the social prescribing service. I wouldn't say that the contact with the other health professionals has been as strong as it has been with the charities or with the third sector. Some more referrals and that would make my day if I could just get some more referrals from a broader, lots of different areas and have a lot of people feeding into us and really raise people's knowledge of what we're here for." *Stakeholder*

> "But I think if I was, of one concern I think the take-up, I know projects take a long time to… to get to a critical mass almost really." *Stakeholder*

The project did use some referral criteria as a mechanism to try to make it clear what the service was about:

> "Since I've been in post I've made a short nine-point referral criteria which makes it easier for people referring in, to tick each one on the referral form it says do they, yes or no do they meet all the criteria, if it's no then it's just an ok well we'll write down what one they don't need and then I can follow that up with any individual." *Stakeholder*

Social media was also used as a mechanism to promote awareness and to try to increase referral numbers and sources. Referrals were also done into other services when this was felt to be necessary:

> "We've noticed that the reason that her eating is not very good is because of the depression so you've got to, we've giving her advice on the food, but you've got to deal with this primary cause so advising her on what Mind does and they can help her and we've actually been able to get her a befriending meeting." *Stakeholder*

> "We can refer to them and they would help with the stability and have more of a social element to it as well as they do exercises for about 45 minutes, then it's a cup of tea and a biscuit or a piece of cake and a bit of a social chat as well, so it's a dual element for that individual there so it's about connecting people with other social groups." *Stakeholder*

2.2 *Quality of Life*

Limited data were collected for this measure at baseline, with a very small number of participants having follow-up data. The measure used was the Life Satisfaction Scale, which is a measure of individual wellbeing, rather than quality of life. There seems to have been some data collected at baseline using the holistic LEAF (Life Essentials Assessment Framework) tool, which again does not measure health related quality of life.

Calderdale/Kirklees

Baseline scores for 3 clients were taken and follow up at T1 for 2 of those clients, were reported. It is not possible to draw any meaningful conclusions about the impact of the project upon quality of life based upon these figures.

Doncaster

Quality of Life data – initial scores were collected for 32 individuals; 7 first follow up scores were collected; and 4 second follow up scores were recorded. There is not sufficient data to analyse and draw any conclusions on the impact the interventions had on the clients' quality of life. One stakeholder did comment upon the improvements that they had seen;

> "Quite a few improvements in the quality of life indicator, the score, starting off at maybe two individual just wasn't happy and I know that five might not be, not seem like you are overly happy but it's an improvement." *Stakeholder*

2.3 Project delivery

Type of service delivered

The Eatwell and Livewell approach used in Doncaster involved offering dietary advice in the form of supportive conversations, information via leaflets and suggested recipes as well as providing on-going support for example, via telephone. The workers offered a one to one visit after the referral in the location of the service-users' choice. Visits were open to family members and/or carers:

> "I would then make an appointment to go out and see them on a one-to-one basis, lots of initial meetings I've had with other family members there as well, so that's quite useful because we can actually support carers as well to the project, it's not just the individuals but we can also give advice and support to carers which has been quite useful as well. So it might be that I go out and make that initial contact with them over the telephone and go out and visit them in their own homes. I also have made a point that if somebody's in hospital and they would prefer us to see them in that environment beforehand so that they can see us in a safe environment." *Stakeholder*

The service adopted a holistic approach to assessing people's needs:

> "That's to look at it holistically according to where the client is at and an assessment of what can be put in place to help their nutritional needs over time. Eatwell is a rounded service and it's for the long-term, and also it's about affordability for a lot of people. A high proportion of the people we see can't shop for example, so, and a lot of them can't lift pans and so Eatwell would be able to work around smaller pan, microwave, desktop freezer, all that kind of stuff…" *Referrer*

> "I've thought of somebody else who they supported very well, a gentleman with mouth cancer and they were really good with him, what they did was give them information of places where they could get pureed meals and things like that so there's a whole range of things that they do." *Referrer*

This holistic, tailored approach was recognised as necessary by workers because individual service user's needs were different upon referral:

> "The lady I saw she was depressed so she'd lost a lot of interest in food so I think cases are very different depending on their age as well as each person, someone maybe very old, elderly people and some are a lot younger they may be in their 60s and still, quite young yeah, so I think it differs on each person" *Volunteer*

> "It's not a simple treatment or cure because when they reach a specific weight then what do you do? So I think that we tackle or try to tackle a wider range of issues that might be affecting it, their malnutrition." *Stakeholder*

> "They are still currently supporting is a lady that's suffering quite badly with depression and struggling to eat and she's starting to panic at meal times and struggling to go out and buy food 'cos she's getting into a panic and they have been really, really good, they placed a volunteer with her who'd been going at meal times and perhaps having something to eat with her or importantly they're planning and thinking about meals she can prepare and then going shopping with her to support her in the shops because I think the lady prior to that was just going and panicking and they supported her through that." *Referrer*

> "I think there is a real need for the project like this. I think it's good the fact that it's very tailored to the individual and that people know they've got the support and that the service is there if they need it. In regards to referrals, I like the fact that it's tailored to individuals I think some people need that extra one to one support so I think that's very good, and also I think Age UK really go out of their way to support the individual." *Volunteer*

There was recognition amongst the stakeholders and volunteers that social isolation and a range of other issues were related to nutrition:

> "There's another one of my service users, I did get the impression that she was quite lonely, she did have a carer that came to her three of four times a day so I think for her just having someone there to chat to, she enjoyed the visits and fish and chips and stuff like that, I took them round for her a few times, so yeah it made you feel like you were impacting someone's life in a positive way."
> *Volunteer*

> "I think she has really benefited from the support and from having me go around. I think with her case it's more the depression, it's a mental health problem" *Volunteer*

> "I mean eating is such a social event that when you're doing it on your own you're very unlikely to want to cook a large meal just for yourself. I would say that loneliness is still quite a problem and that something that's quite difficult to tackle," *Stakeholder*

> "That's probably a main thing that affects under-nutrition is loneliness and social isolation." *Volunteer*

Given the range of need and variety of issues being experienced by service users, there was a personal approach taken by those delivering Eatwell and Livewell. This was highlighted as important from both a service user, stakeholder and referrer perspective:

> "She's very friendly, she's very polite and I really did like her, I liked her attitude." *Service User*

> "She's casual and just explains how just these little alterations can make a big difference. The fact that somebody is helping you, and you're seeing a different face, somebody to speak to and somebody that can help you at the same time." *Service User*

> "It befriends in a way and helps somebody through something that they're struggling with and it improves people's wellbeing because people do worry about nutrition." *Referrer*

> "I tend to try to find out about the individual themselves to make them feel like it is quite personalised so what did they use to do, what was their job, lots of mining communities around here so a lot of struggles in terms of unemployment and loss of jobs in people's youth so that can be quite a worry for people in terms of money. It's probably just looking at the individual as a whole rather than looking at them as, what do you eat, what are you doing wrong." *Stakeholder*

This personal approach involved the provision of social support as well as nutritional advice:

> "They just need a little bit of reassurance, a little bit of encouragement, somebody to talk to and they can progress in the right way, whereas if we weren't around they would've gone really downhill and, getting a lot more health implications." *Volunteer*

> "It's really nice to be able to just have a genuine relationship – they're happy that you're calling them, and you're happy that they're part of the service and enjoying the time and effort you're putting in to hopefully make them feel better." *Stakeholder*

> "She certainly felt the benefits of it and I think the very fact that she felt as though somebody as taking an interest in her, it's that I'm not just here on my own, there are people that can help me, yeah so she was really grateful. Yeah, I think generally the impact has been good, everybody seems to appreciate our intervention." *Stakeholder*

The personalised approach was also used with regards to the amount of time allocated to each service user, this is decided upon a case by case basis:

> "I think that you can't just say, well four weeks and that's enough because every individual is completely different and so making those changes is gonna be a lot slower for some people than it is for others." *Stakeholder*

One of the referrers commented that the service has an impact because of its focus upon food and nutrition which is essential for everyone:

> "I think it's just a really valuable service that's had a big impact on, being able to eat is one of the things that we all need in life and it's taking the stress away from that with the clients I guess." *Referrer*

The written information provided also enabled service users to revisit and check their approach to nutrition:

> "I've got letters and details and I have a look at them every now and again to see if there's anything else on them." *Service User*

Service users were also offered a revolving door back into Eatwell if they felt that they needed support at a future time once the support that they had received was coming to an end, this was recognised by stakeholders and volunteers as being an important part of the provision:

> "Then obviously she could come back if she needed anymore support, so it's very much there, they're in control of it" *Volunteer*

Experiences of the service

Experiences of the service were reported as being positive by all of the service users interviewed:

> "I was delighted with what the service gave me because the lady kept coming, and she was very patient, and she came on a regular basis." *Service User*

On-going support in the form of either visits, telephone calls or a mixture of both were positively viewed by service users:

> "She'll phone me and see how I'm doing, which is nice, and she's a nice person, I suppose you've met her, yeah she's a lovely girl." *Service user*

> "It shows somebody does care. In my opinion it gives you more encouragement." *Service User*

> "Her advice was excellent." *Carer*

The opportunity for service users to speak to someone if they needed further advice was cited as being positive by all of the service users interviewed:

> "She gave me a phone number and said if I had any problems or difficulties that I shouldn't think twice about phoning her, I phoned her straight away and she came through and helped me, which was very nice to know." *Service User*

> "It's nice to know there's somebody you can get in touch with, I mean that's another nice thing to have someone you can speak to." *Service User*

> "There's always somebody you've got you can phone up when you need help, you can phone up for advice." *Carer*

2.4 Effectiveness of the project

Weight gain

One positive outcome was that individuals had been able to gain weight following the support that they had received from Eatwell and Livewell:

> "I'd not been eating very well and I wasn't quite sure what correct foods to eat, I was hoping to gain a bit of weight which I did at the end of the course, I gained three pound and I was delighted with the service." *Service User*

> "I found improving changes in weight, in one individual two pounds every week which I was so pleased about." *Stakeholder*

> "She told me which foods to eat, she kept leaving me leaflets and documents and things like that, with the correct foods to eat, she told me to change from semi-skimmed to full creamed milk, she said that will eventually start to make you gain weight, which I did do." *Service User*

A case study from the Calderdale/Kirklees site also illustrated weight gain as an outcome;

Case Study of Mrs B (23/2/2015)

When Mrs B was referred to the project, she was underweight with a MUST score of '1' and was in danger of losing more weight. She was suffering from early onset Dementia, wasn't interested in food and often just didn't bother to eat. Following conversations and support from the project Coordinator, Mrs B was matched with a trained volunteer within a month.

They focused on making their weekly meal together a pleasurable experience, cooking and eating at Mrs B's home, as well as occasionally dining out. Our volunteer also engaged Mrs B's family in getting involved and monitoring the situation.

When reviewed in August, Mrs B's weight has increased by five pounds, giving a MUST score of 0. Most importantly; her mind set has changed and now even if she doesn't really feel like eating, she ensures that she has something.

Whilst weight gain is important, other positive outcomes need to be recognised;

> "Not just weight gain, because if we focus on that solely then you'd get so caught up in it you'd never see the benefits of it in any other part of people's lives, I think looking at the little things is much better than looking at the huge overall picture." *Stakeholder*

Another case study from Calderdale/Kirklees also illustrates that positive improvements can be made, but that these do not necessarily result in weight gain;

Case Study – Mrs E (12/6/2015)

Mrs E self-referred to Age UK as she was struggling to cope. She had had a low body weight for many years and accepted that as normal. She had been eating meals, but was still losing weight and showed a MUST score of 2. Since being introduced to a trained volunteer, she has enjoyed the social aspect of the scheme and benefited from discussions and ideas around increasing the nutritious value of her food and adding simple ingredients to increase the calorific value. She was reviewed in October and although her weight has not increased, it has remained stable. Mrs E says that she feels much better for the one to one support of her volunteer and ensures that she has at least one warm and nutritious meal each day.

Supporting people through the provision of Eatwell and Livewell may also mean the prevention of further weight loss therefore the avoidance of any further deterioration;

Case Study – Mrs M (27/7/2015)

After coming out of hospital Mrs M, already a petite lady, had very little appetite and was at risk of becoming malnourished. She had a few issues and her mood was low. Her outlook and health improved within a short time of being linked with a supportive Eatwell volunteer.

When reassessed in October Mrs M said that she was feeling much more positive and her appetite had increased. With the volunteer's support, she had improved her diet and hadn't lost any more weight.

Motivation and diversity of diet

Others discussed how the advice that they had received had encouraged and motivated them to diversify their diet, eat more and enrich their usual food choices:

"I've tried omelettes and different salads, sprouts and new potatoes and carrots and things like that, things that I just couldn't even be bothered to even try." *Service User*

"She gave me lists of different things that was available, and she said what about a diet and that's how I come to get here but all these little adds and changes to me diet which have helped. I'll have cheese and biscuits half-way through the morning, even if you only have one biscuit and a piece of cheese, you've got something going all the time and if I have fruit, tinned fruit or anything I always have double cream on it and things like that. And cream in my porridge. It was all just adding these little extra things that I wouldn't have thought of them giving me a bit of strength." *Service User*

"I say their motivation as well and having me come in, if someone said I just don't wanna cook, I just can't be bothered, and what's the point really, so I went and visited this lady and just discussed with her, you obviously have a lot of knowledge and she was telling me about how she used to bake, but she just didn't really want to, she wasn't motivated to, and I rang her up the following, two weeks after she said I don't know what's happened to me, since you came I've just, I'm back to being myself." *Stakeholder*

Attending a presentation was useful for some clients in terms of encouraging them to change their diet as the following case study illustrates;

Case study – Mrs G (15/10/2015) Mrs G attended an Eatwell presentation at her local community room and requested an assessment to see if she was a healthy weight. Her MUST score was 0 and deemed not to be at risk, but she was given some recipe ideas. 6 weeks later at follow-up, she reported cooking a more varied and nutritious diet.

Hydration

Some clients were encouraged to drink more fluids following listening to a presentation provided by the Eatwell Co-ordinator in Calderdale/Kirklees;

Case Study	**Changed approach**
Mrs S	Mrs S attended an Eatwell presentation at her local church hall and learned that she wasn't drinking enough liquids (8-10 drinks a day). When followed up a month later, Mrs S said that she was trying to make

	sure she is drinking a little and often throughout the day now.
Mrs B	Mrs B who attended the same presentation said that she realised she didn't always drink enough fluids throughout the day and did feel a little lightheaded sometimes. With the sheltered housing scheme where she lives always being very warm, it was even more important to drink regularly. She was supplied with a hydration chart for recording her fluid intake and upon follow-up reported finding the chart useful as a reminder and that she was drinking more fluids.

Changed approach to food preparation and cooking

Support from the Eatwell and Livewell service had enabled some service users to change their approach to food preparation and cooking:

> "One referral I made was an elderly gentleman who was struggling to cook and they helped him get a slow cooker and gave him recipes so he was able then to cook for him and his wife that's got dementia so he was quite chuffed that he had some recipes and he could prepare some healthy meals, so he felt as though the project had really supported him and helped him very simply." *Referrer*

> "I've been with her, her main reason that she's lost interest in food, she finds shopping very difficult and stressful. She's finding that food doesn't taste the same and really struggles and has to force herself to eat, so in her case I've been thinking about different recipe ideas with her and what food she did enjoy, and speak about why she doesn't enjoy them anymore." *Volunteer*

Case studies from Calderdale/Kirklees also illustrate how individuals changed their eating patterns as a result of the project:

Case Study	**Changed approach**
Mr K	Mr K is housebound and relies on his carers to provide his meals. The Eatwell Coordinator responded to concerns about Mr K's recent increased weight loss, by looking at how his meals were prepared, then by advising his carers on how more nourishing ingredients could be used to

	supplement his meals. Mr K has also started to take Fortsip (125mg daily).
Mrs L	Mrs L attended the presentation (at the church hall) and decided to try adding some more ingredients to her microwave meals (cheese and extra vegetables). When followed up she noted finding her meals more appetising and not as bland. So much so that she told her neighbour who is now doing the same.
Mrs J	Mrs J who was also at the church hall Eatwell presentation decided to take home one of the recipe books to try some new meals. After a month, Mrs J reported trying the winter stew, ratatouille pasta and fish pie recipes and enjoying the meals so much that a friend had joined her to share her winter stew. Living on her own she was not always cooking like she knew she should do, but she reported making more effort.

Increased confidence

Service users also reported increased confidence and self-esteem as a result of being involved:

> "It's made me feel more confident in myself, by making me feel good about myself because I was very withdrawn and I wasn't eating very well so that makes a difference in how you feel, especially about yourself, and what you feel like doing doesn't it? Yes, I think I feel a lot different about myself, I feel more outgoing." *Service User*

Less social isolation

The project support resulted in some service users feeling less socially isolated following the intervention of Eatwell and Livewell staff:

> "I didn't go anywhere at all, but now I've gone out, only visiting and things like that. I've been going out, I've been shopping and to my auntie's, whereas as before I was just quite content to sit in the house all day, but I think that's had a lot to do with it because I feel as though I've got more energy." *Service User*

> "The lady I was just speaking about again looked forward to the volunteer going round, she's getting better at, trying to think about things to eat and it's calming her down so again positive feedback." *Referrer*

Social isolation was also tackled through linking clients into provision such as lunch clubs:

Case Study – Mr H (20/10/15)

Mr H was discharged from hospital and unable to do his own shopping. He was referred to Eatwell, who discussed his preferences with him and also suggested some alternative meals. On following up with Mr H at the end of November, he was having a more nutritious diet but also attending a local lunch club every Wednesday.

Increased energy levels

Gradual changes in relation to individuals showing increased energy levels were recognised by service users and a stakeholder:

> "I'm gradually feeling stronger." *Service User*

> "The changes aren't always very obvious but feeling stronger on their feet being able to stand and moving around a lot more, and when I walk in and I've met the individual and they've been sat in the chair and they've been quite tired and not very interactive but then the next time I go they're really chatty and they're having a great day and they're actually eating in front of me." *Stakeholder*

Improved relationships

One stakeholder also recognised that personal relationships were benefitting as a result of improvements associated with the Eatwell intervention:

> "I've also seen relationship changes with another individual who is, when I first went round I was chatting with the gentleman and his wife, it seemed quite tense, there was quite a lot of tension and things that he was saying she didn't agree with in terms of his eating and when I went round there and he put on some weight and he was obviously doing more things around the house, I noticed that they were having quite a laugh and it was really quite nice to see that." *Stakeholder*

Adding value to existing provision

Referrers noted that the Eatwell and Livewell approach is able to work with older people for longer periods of time and that this is important because whilst other services exist they do not work in this way over longer time-frames:

> "That doesn't resolve the long-term issues that people might have once we've left." *Referrer*

Both of the referrers spoken to noted that the Eatwell and Livewell service was a form of provision unlike any other within the locality in which they were operating:

> "I wouldn't know who else to refer to, I mean sometimes we've spoken to the dieticians at the hospital but usually what they send us is a leaflet and, I don't do it no because we've got Eatwell so I can ask Eatwell, but in the past, I mean they do their best and they've got their own criteria, but it is this kind of service, it isn't this intense as far as I understand it, it's not this one-to-one holistic look at this particular group of people." *Referrer*

> "There's nothing else out there that makes it different because they have volunteers working for them and supporting clients as well. It can be a bit more long-term that they can offer the support and I think because they do take a wide range of clients as well and it's very accessible" *Referrer*

Similarly, one volunteer outlined a potential negative impact for one service user when discussing what would have happened without Eatwell being available*:*

> "The other gentleman he would have just continued to go downhill, he'd have sat and picked at his cereal every day and his self-esteem would have gone downhill, his weight, his whole health everything would've deteriorated, but because we've stepped in and had a chat with him, advised him about a few things and let him take control of his own diet, I mean it's all about them really, we've just sat there to support them, to take control of their own diet, give them a little bit of support, they've got a bit of enthusiasm for life, for food and he feels better about himself, so yeah, I generally think that he would be a very, very ill man, but he's a lot better now." *Volunteer*

The friendly approach to service delivery has already been documented from a service user perspective, but this was highlighted as being important in adding value to existing provision by one referrer who voiced the view that older people perceive the service more positively because of its location within the voluntary sector:

> "I mean it's quite a friendly service as well and I think that's quite important. I suppose if you get statutory service going in, older people think you're looking to take me into care aren't you, and I know you're dressing this up in plenty of other ways, but I know that's what you're at… Whereas if you have a voluntary service you're less likely to have that kind of perception." *Referrer*

A volunteer commented upon the focus of the service as important because it is a form of prevention:

> "It is easily accessible…whereas it would probably take them to be re-admitted to hospital again, really malnourished before somebody actually took action, whereas what they're saying at the minute is come out of hospital, a little bit low on weight, don't struggle with putting it back on again there's somebody here who can help you, make a phone call and somebody's there, whereas if not there might have been a waiting list, so I think, yeah, obviously there is somebody there to help them but it would be at a much later stage when it would be

> more of serious issue, so we are stepping in there and say hang on, come on, let's pick you up now…" Volunteer

Stakeholders and referrers also made note of the potential impact of Eatwell in relation to reducing demand upon other services:

> "Eatwell will support them in the longer term with nutrition so by inference that means people will stay in their own homes longer and that reduces the public purse for 24-hour care for example. It certainly reduces the public purse in terms of admissions to A and E, if that was tackled." *Referrer*

> "They're perhaps not going to their GPs as much because somebody's there advising them what to eat, supporting them to go shopping perhaps, fixing them a meal, so that can all have an impact on them not attending their GPs as regularly, they might not need to go as much, or access dieticians etc." *Referrer*

> "Care professionals that can support them in the community to prevent that then I think that's always gonna be a good thing. I think it's a good thing I think there are certain people that are going to use it because they feel a little bit isolated, a little lonely, but generally on the whole if those people are malnourished anyway that's why they've been referred, so feeling better about themselves is gonna make them progress, they are gonna eat more… they're less likely to be admitted to hospital which is what it's about." *Volunteer*

> "It's looking at the problem and helping the problem before it gets too bad, like under-nutrition if someone is undernourished that can enhance their illness so that's another thing, so I think if that's targeted and someone's visiting them and assisting with that that may keep them out of hospital or keep them fitter and healthier for longer." *Volunteer*

> "From the individuals who receive it (EWLW) in terms of being discharged from hospital, they'd probably be readmitted for… it may not be for malnutrition it may be something else and while they're in hospital they might put on some weight but as soon as they come out that support stops, they're left to their own devices and the same thing happens again, it's just a vicious circle." *Stakeholder*

It was also suggested that Eatwell acts as a mechanism to mop up because of the existing demands currently being placed upon hospital provision:

> "Well I think one of the big things really is that it's still lacking is that people that go into hospital, they have a MUST assessment when they first go in and should have ongoing assessments but it is a bit hit and miss and that's also not followed through with perhaps a letter to their GP to say this person's health or diet needs to be looked at." *Stakeholder*

Eatwell staff were able to support other professionals thereby adding value to existing services, as the following case studies (from Calderdale/Kirklees) illustrate:

Case Study	Changed approach
Mrs C	Mrs C was referred to the scheme by colleagues at an Age UK Day Centre, which she attends three times per week. Although a hot meal is provided at the Centre, Mrs C doesn't seem to be interested in eating and was found to have a MUST score of 1. Staff working at the Centre were given a few ideas by the Scheme Coordinator and then tried to encourage Mrs C to eat and enjoy the experience.
Mrs S	Mrs S suffers from Alzheimer's and had lost quite a lot of weight in a short period of time at the point of her referral into Eatwell. She had a MUST score of 1 and the main reason for her weight loss was found to be that she was simply forgetting to eat. Mrs S had four daily visits from Carers, who only had sufficient time to put the food on the table in front of Mrs S. The Eatwell Coordinator discussed the situation with Mrs S's family, then a review of her care was requested. More time was subsequently allocated to the carers, who were then able to prompt and encourage Mrs S to eat the food that had been prepared for her.

2.5 Impact of the project from a carers perspective

The evaluation team interviewed one carer who reported positive experiences of the project in terms of being informed about how to make diet-related improvements which has resulted in improved eating;

> "She sent me a diet thing, puddings and rice pudding, a diet plan, and she said try and eat in-between a little bit or a couple of biscuits with a cup of tea and things like that which he did, and he has picked up a little bit. He's eating a little better, he's having a cooked breakfast now or porridge in a morning, he never used to eat that at one time you couldn't get him to eat anything hardly." *Carer*

Having advice and support were identified as important from the carers perspective;

> "Her advice was excellent." *Carer*

> "There's always somebody you've got you can phone up when you need help, you can phone up for advice." *Carer*

Case Study – Mr H (10/11/2015)

Mr H attended an Eatwell presentation and requested more information regarding healthy eating for people who need to be cared for. He was supplied with some of the Fit as a Fiddle recipe books and Eating Enough in Later Life Advice for Carers Publication. A month later at follow-up on 08/12/2015, Mr H had tried some of the recipes himself and with the family member he helps to care for. He felt that her diet was much improved.

2.6 Impact of the project from a volunteer perspective

The volunteer role involved supporting older service users in relation to their individual nutritional needs. This support involved being part of the initial assessment, doing home visits, delivering telephone call and providing advice, reassurance and motivation:

> "Being there to support them, I've only actually worked with two service users: one of the gentlemen was only one visit, but it was good because he was concerned he'd come out of hospital and concerned he wasn't eating enough and didn't have a lot of energy and it was kind of really just a reassurance. The other gentleman that I saw was on his own and he didn't feel like eating but he used to enjoy cooking so to kind of ignite that passion in him again and ring him up and say oh what have you eaten today, what do you think you might eat later, and get that passion going to cook something for himself and share the experience with you, so he'll do more for himself." *Volunteer*

Another volunteer confirmed the importance of motivating service users in relation to their eating patterns and choices:

> "We got talking to him and he was talking that he liked to cook and liked to do and he liked to share the information so he would then cook and I'd phone him up and say how are you doing today what have you done today and he'd say oh I've done this and tomorrow I'm gonna to the shop and gonna get this, and because he had somebody to share it with his motivation to do more and eat healthier as well it was just, it kind of clicked again, there was a bit of a spark." *Volunteer*

The 3 volunteers interviewed reported positive experiences of their involvement with the project. The training they had received was seen as good and useful:

> "We had some really good training, intensive training, there were two public health dieticians, they delivered the key nutritional messages, I think it was a three-day course, really, really beneficial and then we did another

> day or two for the specifics around the older person and how it differs, so that was the starting point for me." *Volunteer*

> "I think in regards to training and things like safeguarding issues and training and support it's been really good." *Volunteer*

One volunteer also reported receiving good support from Age UK:

> "We used to have regular meetings with (Age UK worker) and I think that worked quite well so obviously we were all separate and had different service users but then we'd come together like once a month and have a meeting and chat about where the project's at and what we were doing, and I thought that was really important to do that." *Volunteer*

One volunteer felt that her experience with Eatwell was positive because she could see the small improvements that the service user she was supporting was making:

> "I think it's a very positive experience 'cos they are welcoming a volunteer into their home and they're happy to take your input on board. I saw (service user) for a couple of months and by the end of it we did see some positive changes like, she was more active, when I first went round to see her she was very much in a chair, she didn't really get up and do things for herself like making cups of tea and cleaning, it was very much her husband, but by the end of me visiting her, she was doing that herself, she was walking around the kitchen so seeing that difference was really rewarding." *Volunteer*

Volunteers commented that they had increased knowledge and awareness around nutritional issues, and more confidence in their own skills as a result of their involvement with Eatwell and because of the training that they had received:

> "For me just the general understanding of nutrition and knowing the advice that I could give someone could help them in the future." *Volunteer*

> "Knowledge and skills definitely, confidence." *Volunteer*

> "So the training delivered the knowledge and that gives you the confidence to then sit with people and say this is what we've got, this is what you need to be working towards and why and helping them." *Volunteer*

Another volunteer mentioned a number of positive benefits associated with volunteering for different people:

> "I think it's always good to volunteer, it's good for your morale and you give a little bit back and you're helping others and you are using your skills to help another individual so I think that's good and obviously it would be good for students as well and people in the college who are maybe looking into going into social work or anything like that, so I think it would benefit the local community." *Volunteer*

A stakeholder also noted the importance of volunteers in supporting clients;

> "Some of the people ended up with a volunteer that ended up more like a befriender. That has actually helped from another angle because if you've got a reason to go… if somebody goes and sees you and checks on you and talks to you about other things, you know, encourages you to eat. I think that is the other thing. I think from the volunteer's point of view, some of the volunteers have sort of said I've taken a meal round and had things. The volunteers have benefits from it as well." *Stakeholder follow-up interview*

2.7 – Lessons learned from project delivery

The importance of impact

One stakeholder commented upon the importance of recording the service user experience in addition to the more quantitative recording requirements;

> "From the interim report, I think there was some quite telling quotes and sort of soft data that said people appreciated it and that they did feel more confident about what they were doing, more connected and were just more interested in the food that they were eating." *Stakeholder follow-up interview*

The project enabled delivery staff to work with other professional services in a broader capacity, educating others in relation to eating and therefore had an impact in a way that had not been envisaged;

> "We also worked with West Yorkshire Fire Service because we were working with them on Fire Safety and we introduced to them don't just look out for fire safety, look out for people that aren't eating or drinking properly. We did get some referrals through them as well. *Stakeholder follow-up interview*

Gaps in some service provision were also noted, which meant that clients were supported in a more holistic sense;

> "We highlighted things like people that haven't got dentists or haven't got access to a dentist because they couldn't get out easily and all those sorts of issues. It was recognised that they are having trouble eating so they have made arrangements to help them eat or they've made arrangements so that they go and get their dentures sorted. That makes a difference." *Stakeholder follow-up interview*

Learning from delivery; implementation lessons

Learning did result from the intervention within the Age UK team as well as in broader staff areas:

> "I think the positives were right towards the end when we did, this last member of staff got very involved with some dieticians. They did some free health-day training for a number of the staff and volunteers that were interested and so actually our direct delivery staff in day care and Home From Hospital and some in domestic services have actually got a far

> better understanding now of what malnutrition, in its broadest sense, means and what to look out for and how to help." *Stakeholder follow-up interview*

Staff involved in delivery reported a number of areas where the project needed to be implemented differently, including less ambitious targets,

> "I think some of the targets were too high in reality." *Stakeholder follow-up interview*

The Doncaster site had a staff member with nutritional knowledge, whereas this was perceived as a gap within Calderdale/Kirklees;

> "We needed a member of staff dedicated to it that had a real interest in nutrition. I think that would have really helped." *Stakeholder follow-up interview*

The focus of the project upon malnutrition was noted as being limited, a more holistic approach was perceived as an area of need;

> "I think actually to have had the project that it was both extremes, that it was people that were overeating and people that were undereating would have made it an all-round project where you could have included everybody. I know the member of staff that did a lot of work in the beginning went out and talked to communities, older women's clubs, women's institutes, those sorts of settings and people talked to him with interest but most of them said well, actually the thing that I am worried about is I don't drink enough or I've got that problem rather than not eating enough or actually I could do to lose a bit of weight because I know I eat the wrong things. The whole project if it had been scoped around more holistic sort of avenue of eating and exercise and things, you would have found the people that were at one end and you would have found the people at the other end." *Stakeholder follow-up interview*

Similar interventions were not in existence hence the perceived need of this approach was seen as important, but the delivery mechanisms needed refinement to ensure that this was a more workable approach in practice. For example, by linking into other existing provision rather than having a stand-alone project such as Eatwell;

> "The only one that comes to mind at the moment is a thing called the Casserole Club that is around in some areas where you are encouraging neighbours to cook a meal and take it round to a lonely, isolated person that might not be bothered to cook for themselves. But they've been trying to get that up and running in Kirklees for the past three years and seem to be hitting all sorts of different hurdles. That is the principal, if you take a meal round to somebody else, sit and have a meal with somebody then they are more likely to eat it and enjoy it aren't they. And that is part of the thing. I think there are some schemes within hospitals to encourage people to eat, to help people to eat and maybe that is where some of this needs to sit although we don't really want people [volunteers] in hospitals if we can help them. I think it needs to become part of something else rather than something in its own right so that you look at the person all-round and why are they not eating. Let's establish that rather than say you are not eating so let's work on the not eating. There is more to it than the not eating isn't there." *Stakeholder follow-up interview*

Furthermore, the need to be more targeted with volunteer recruiting was also commented upon;

> "I think it was purely volunteering in our case and that was maybe another trick that we missed out on. Maybe we should have approached nutritional students or something to have come on as volunteers because then they would have seen a benefit because they could have used it in project work. So, hindsight, yeah, we should have actually gone into the students at the university and said would you like to come on board with this as part of your degree course." *Stakeholder follow-up interview*

Despite the issues associated with both delivery sites not achieving the targets set, learning again was reflected upon in relation for closer monitoring at regional level and clearer mechanisms for communication and feedback on the work being done;

> "I have to say it is not a project that I am particularly proud of in that I think we failed dismally to make it work but on the other hand I do think, from our point of view as an organisation, we've learnt a huge amount of lessons from it and I think the regional company have recognised a huge lot of lessons from it in that the way that they manage a project that has two independent organisations sitting under a regional umbrella. If that regional umbrella isn't, for want of a better word, controlling each of those partners and really keeping a close handle on what is going on it is no good just coming every three months and say what is the monitoring and then hitting us with a big stick if we haven't achieved it." *Stakeholder follow-up interview*

> "It came as a complete shock. It was the numbers haven't come through, stop it immediately. That was it, stop it immediately. It was very difficult." *Stakeholder follow-up interview*

The need for the project

Stakeholders were asked about the need for the project and reflected upon the evidence used within the application made by the regional office;

> "We know from other research, when the project was first set up, all the data that was produced by the regional office, that there are older people that go under the radar, that are missing meals for whatever reason, becoming undernourished, becoming weaker, prone to more infections and more trips to the GP and trips to the hospital. That was identified at the early stages of the project. And it was, as I say, to provide that low level of intervention to hopefully build people up and get them more interested in eating, give them some knowledge about the food that they eat and to reduce the number of hospital admissions and trips to the GP." *Stakeholder follow-up interview*

Those involved with managing the delivery of Eatwell discussed the need for a project such as this but again linked success to an alternative

implementation model with better connections to GPs and other clinicians;

> "It needs to be very, very closely aligned with clinicians to actually sort of… a lot of people in the older generation if the doctor says do it then they will do it. I don't think we got the sort of… I don't think we worked at it but I don't think we got the GP buy into this." *Stakeholder follow-up interview*

> "I thought there would have been more referrals from GPs because they see people that are perhaps presenting with confusion, falls, losing weight perhaps if they are having an annual check-up and it would have been an easy referral for them to make for us to be able to have some contact with them anyway. Whether there was a huge change or not at least it would have alleviated them of some of the perhaps more medical and clinical interventions it may have led to, especially if someone falls and breaks their hip or something." *Stakeholder follow-up interview*

Issues reported by clients who had been supported by Eatwell were related to nutrition but were broader in scope than initially envisaged in the regional office design;

> "But I think there is a role for this because what we were finding was it wasn't necessarily… we weren't just picking up on people not eating properly we were finding a lot of older people not drinking enough and then that was causing further problems. We actually picked up on a lot of other things rather than just the fact that they've gone off food or they are not interested in food. And also, people that are getting early dementia were picked up on… they forget that they haven't eaten." *Stakeholder follow-up interview*

Summary of findings

- Service users interviewed by the evaluation team reported many positive perceptions and outcomes as a result of their involvement with Eatwell and Livewell. These included weight gain, increased motivation and diversity of diet, improved hydration, changes in their approach to food preparation and cooking, increased confidence, improved strength and less social isolation.

- Stakeholders and referrers who had been involved with Eatwell also reported several positive outcomes that resulted from the intervention. For example, Eatwell added value to existing provision by reducing demand on other services and offering a holistic approach.

- Volunteers working within Eatwell reported positive experiences including being well-trained, receiving good support from their local Age UK and benefitting personally in terms of increased confidence, knowledge and skills.

- Both delivery partners (Doncaster, as well as Calderdale/Calderdale/Kirklees) did not meet the project targets set by the regional office.

- Quantification of the project's impacts is not possible based upon the in-house monitoring data collected at both sites. Tools measuring improvements in weight and nutrition (MUST) and quality of life were not comprehensively used, leaving data sets in both of these areas incomplete.

- Learning reported by the delivery partners included the need for a different approach with revised targets (reduced numbers), the importance of linking into other existing projects to ensure successful delivery, closer monitoring from a regional perspective and the development of alternative mechanisms to ensure linkages with clinicians such as GPs and dieticians.

3. Discussion

The need for a project such as Eatwell and Livewell

There are several published studies that highlight the problem of malnutrition amongst the elderly, which is widely discussed within the literature. Hence, the case for a project such as Eatwell can clearly be made irrespective of the delivery sites not meeting targets.

- Malnutrition is more common within elderly populations (when compared to younger adults). This is associated with worse prognosis for those malnourished. Malnourishment is also a risk factor for morbidity and mortality (Pirlich and Lochs 2001). Newer evidence illustrates that the prevalence of malnutrition is well understood, and clearly documented amongst elderly populations. The costs associated with malnutrition are significant in terms of treatment (health and social care costs), resource implications as well as personal, health and social costs. Furthermore, malnutrition is preventable and treatable therefore more preventative approaches are needed. Further research is also required in relation to the implications and associated costs of dehydration (Wilson 2013).

- Malnutrition amongst the elderly is one of the main risk factors for the onset of frailty. Therefore, there is a need for screening and early diagnosis of malnutrition amongst elderly populations to prevent disabilities, with effective treatment focusing upon correcting nutrient deficiencies and physical exercise (Artaza-Artabe et al 2016).

- Malnutrition within elderly populations is caused by physical, psychological and social problems with much of its associated cost being avoidable if it is treated within the community (Dinsdale 2006). Therefore, the holistic community-based approach used within Eatwell is based upon existing evidence.

- Older individuals who are malnourished or at risk within community settings have lower quality of life accompanied with greater loss of personal autonomy (Hernandez-Galiot and Goni Dra 2017). Therefore, improvements in nutritional status may also be paired with better quality of life as was one of the intended aims of the Eatwell approach.

- Evidence also suggests that improvements in nutritional care require joined up multi-disciplinary care pathways across community and acute settings (Brotherton et al 2010). Whilst this was an intended aim of the Eatwell approach, there were limitations in the extent to which Doncaster and Calderdale/Kirklees were able to effectively join up with other clinical services.

- Wilson (2010) also points out that a one size fits all approach to meeting the nutritional needs of older people is not effective, again offering evidence-based support for the use of a holistic service that can tailor to client need, as was envisaged within Eatwell.

Intervention design -including carers

There is moderate evidence to support the involvement of carers (domiciliary and family) in implementing nutritional screening and referral pathways. Emerging evidence suggests that carers may have a role in malnutrition interventions based in community settings, when supported by health professionals (Marshall et al 2017). Hence the design of Eatwell to include carers was a sound approach with potential to contribute to the evidence base.

The use of MUST (Malnutritional Universal Screening Tool)

The published evidence-base related to the use of screening tools for malnutrition amongst the elderly offers insight into a number of assessment approaches including MUST, which was included within the plan for Eatwell delivery. However, there is on-going debate about the effectiveness of all approaches with contradictory findings published. Thus, whilst practitioners and clinicians agree on the need for tools such as MUST, their efficacy remains unclear.

- Craven et al (2016) explored malnutrition screening practices used by community dieticians in Australia working with older people. Their study found that irrespective of the level of staff experience there was common agreement related to the need for routine screening. However, refusal of nutritional assessment was also reported as commonly occurring.

- Bokhorst-de van Schueren et al (2014) conducted a systematic review of screening tools for the hospital setting and found that MUST performed fair to good and was able to perform well in predicting outcomes in half of the studies they reviewed within the adult population but not within older patients. They concluded that no single screening tool or assessment is adequate. However, an earlier study by Poulia et al (2012) reviewed a range of tools used to screen for malnutrition amongst the elderly and found that MUST was the most valid in terms of assessing the risk of malnutrition within the elderly at the point of admission into hospital.

- Beck et al (2013) argue that nutritional risk screening is paramount within the nutritional treatment pathway for the elderly. They examined a range of tools within their validation which examined sixteen randomised control trials and found that the Eating Validation Scheme was the most capable of distinguishing those with a positive clinical outcome, compared to using body mass index, the mini-nutritional assessment (short form), MUST and the nutritional risk screening approach.

4. Conclusions

This evaluation report shows that Eatwell and Livewell project did not meet its intended targets. The evaluation is unable to report upon any quantifiable improvements resulting from the project using standardized tools such as MUST and quality of life measures. However, there were positive service user reports about the intervention related to self-reported improvements in health for example, weight gain, increased confidence and less social isolation. Stakeholders interviewed also confirmed service-user benefits and reported that Eatwell had been able to add value to existing provision by reducing demand on other services and offering a more holistic approach. Volunteers also reported positive experiences and personal benefits resulting from their involvement including increases in confidence, knowledge and skills. Finally, the evaluation team captured learning from the delivery partners after the intervention was no longer funded. This learning suggested the need for a different approach with revised targets (reduced numbers), the importance of linking into other existing projects to ensure successful delivery, closer monitoring from a regional perspective and the development of alternative mechanisms to ensure linkages with clinicians such as GPs and dieticians for future interventions in this area.

4.1 Learning from project delivery

- The need for promotion of the service as an on-going aspect of the project delivery to ensure the continuation of referrals as well as increased understanding of the purpose of the project amongst professionals who are likely to refer in.

- Strategies to ensure broader clinician engagement needed to be embedded within both sites, for example to ensure that GPs and dieticians were more involved within Eatwell as a mechanism to increase referrals and ensure success with establishing a place for the voluntary and community sector in the care pathway for older people with nutritional issues.

- Improved communication strategies between all of those involved within Eatwell under the Age UK umbrella was needed. The regional office needed to update the delivery sites more frequently about progress including issues with not meeting the targets as well as conversations with funders. Additionally, some collaboration between sites (Doncaster and Calderdale/Kirklees) may have facilitated lessons for practice and delivery. However, it is recognised that limitations on staff time were a barrier to more effective communication across all of these areas.

- Revised support mechanisms from a regional to local level within the Age UK structure should be considered for any future project. For example, delivery sites may need advice related to monthly reports, project measures (such as Quality of Life tools), as well as specific assistance in achieving targets. Where targets are not being met, clear conversations need to be held with delivery partners as well as funders. For example, discussions to explore the importance of outcomes for service users and the implication of different models of delivery for meeting the targets would have been useful in this instance.

- Mechanisms should be put into place to ensure that learning from project delivery can be used within the remaining life-time of any interventions. A test and learn approach (with support from external partners including the evaluation team) would have been useful to identify delivery issues at an earlier point and to refine delivery (if necessary). For example, the intervention if broader in scope (focusing upon overweight and dehydration as well as underweight) could have had broader impact given the transferable nature of both advice and interventions being used within both Doncaster and Calderdale/Kirklees.

4.2 Issues for consideration

- Future delivery of services such as this should ensure that broader measurement of service user outcomes is on-going and embedded within the monitoring approach, to encompass quality of life changes in a robust and sensitive manner. Evaluation partners could be drawn upon to advise of appropriate tools.

- Access to health service usage data in future Age UK projects is advisable to ensure more robust measures of impact. For example, access to health data such as GP appointments and Accident and Emergency attendances for all service users participating would allow fuller conclusions to be drawn in relation to effectiveness.

- The early adoption of a test and learn approach working with evaluation partners is worth considering in the delivery of future interventions to refine and improve practice during the life-time of any given project.

5. How we did the evaluation

The evaluation was conducted by researchers from the Centre for Health Promotion Research, with data collection starting in January 2016. The evaluation used a mixed method approach including gathering qualitative data from interviews with stakeholders, referrers, carers and volunteers as well as desk-based analysis of existing monitoring data. The evaluation data collection has sought the views and experiences of staff, referrers, carers and volunteers in order to ascertain the extent to which the project had met its outcomes and to map current care pathways. The overarching aim of the evaluation was to ascertain the extent to which the Eatwell and Livewell project's aims and objectives had been met. The specific objectives of the evaluation were to:

1. Explore the effectiveness of the project in terms of improving the health-related and general quality of life of older people via changes in their diet and nutrition;

2. Ascertain the impact of the project in relation to the more effective use of health resources;

3. Explore the effectiveness of the project in terms of improving the quality of life for carers whilst establishing what outcomes are important for them;

4. Ascertain the impact of the project for volunteers in relation to measures such as improved employability; empowerment and improvement in community resilience;

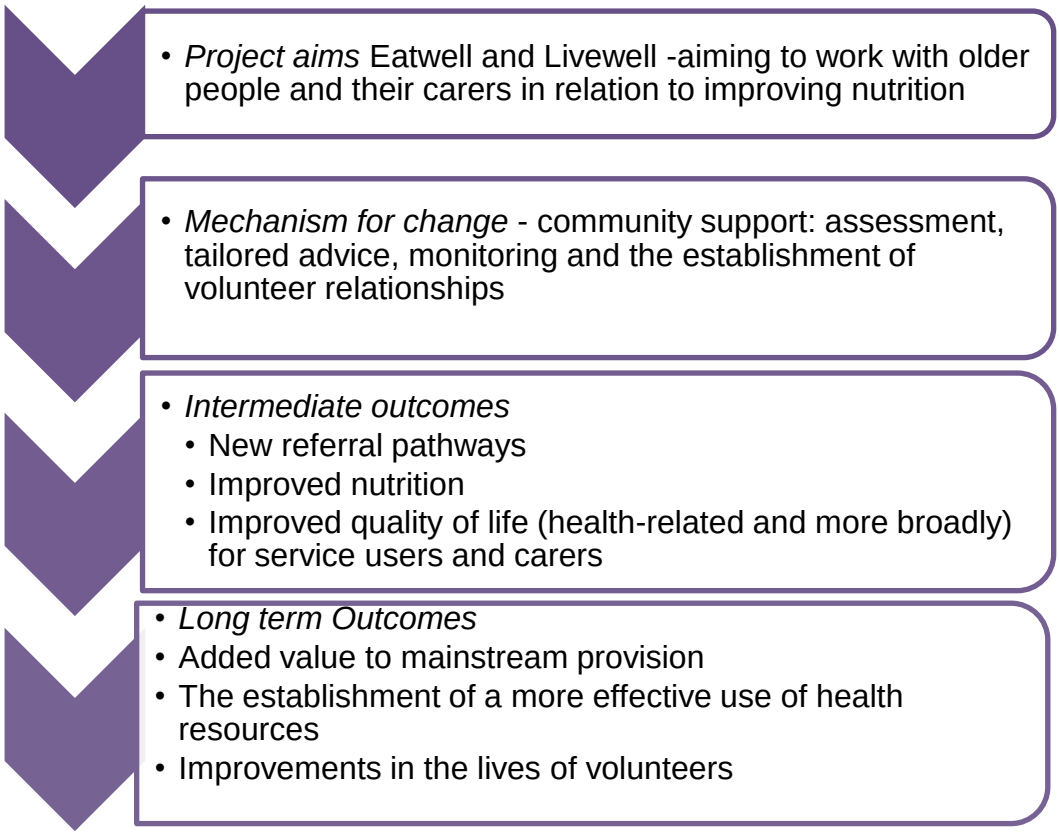
5. Highlight any potential social return on investment indicators within the short scope of the evaluation timeframe.

These evaluation objectives provided a framework for the evaluation that link to the Eatwell and Livewell Project's aims and objectives.

5.1 Theory of change

The evaluation also tested the programme's 'Theory of Change' (Judge and Bauld 2001). This makes explicit the links between programme goals and the different contexts and ways in which the project works. It provides a framework for mapping subsequent outcomes and outlining how these fit with the overall objectives of the Eatwell and Livewell project.

Figure 5.1 – Theory of Change for Eatwell and Livewell



Approach to gathering evidence

Evidence for the evaluation derived primarily from interviews with stakeholders (4 in total), referrers (2), volunteers (3), service users (3) and carers (2) as well as analysis of routinely collected monitoring data.

Qualitative data collection

***Stakeholders*:** 4 semi-structured interviews were conducted with key stakeholders at two different points in time (March 2016 and then December 2016) to capture their views and experiences of involvement. An interview schedule was developed in line with the objectives for the evaluation and broadly covered the following key areas: the project background, the approach adopted, the changes that had taken place as a result of the project, the impact of the project on service users, and any aspects of learning during the project delivery (see appendix 7.1 for the interview schedule).

Service Users/Carer*:* 3 interviews were conducted with service users and 2 interviews were conducted with a carer. The delivery partner advised the research team of suitable participants to invite. Service users and their carers were given the opportunity to self-select to participate within the evaluation by the

project worker. The semi-structured interview schedule was designed in line with the objectives of the evaluation (see appendix 7.2 for the schedule).

Volunteers: 3 volunteers were interviewed from the Doncaster site in March 2016 to capture their experiences of the project and its impact upon them. The schedule was once again designed in line with the objectives of the evaluation (see appendix 7.3).

Data analysis

The verbatim transcripts from all of the interviews, along with the accompanying notes, were analysed using Framework Analysis. Framework Analysis develops a hierarchical thematic framework to classify and organise data according to key themes, concepts and emergent categories. The framework is the analytic tool that identifies key themes as a matrix where patterns and connections emerge across the data (Ritchie et al., 2003). The matrix was constructed using the aims of the evaluation. Themes were agreed by members of the research team. The monitoring data was analysed using descriptive statistics and is presented in charts to illustrate key points.

Desk-based data

The aim of the desk-based analysis was to provide a rigorous synthesis of monitoring data collected by the delivery partners. The primary data sources were demographic data collected from participants at both delivery sites, quality of life data from the Doncaster site and 20 case studies from the Calderdale/Kirklees site. There were only 19 clients, but the case studies included the perspective of a carer. The desk-based analysis was also intended to ascertain if there had been any changes in health service usage in terms of reduced uptake of services and therefore decreased demand and associated costs. This was not possible as access to health service user data was not provided.

Research ethics

The evaluation was given ethical approval through Leeds Beckett University ethics procedures. The following practices were adhered to ensure ethical rigour:

- Informed consent – written or verbal consent was obtained from all participants in the interviews
- Confidentiality and anonymity – no personal identifying information has been used in the reporting the data
- Secure information management – security was maintained through password protected university systems

Limitations of the Evaluation

The evaluation has sought to identify and bring together a range of perspectives in order to highlight what has worked and what might be done differently. Nevertheless, in all evaluations there are limitations to what can be achieved, with the limitations in this instance listed below;

- The evaluation team were reliant on regional staff and delivery site partners to access clients and in-house data relating to the project. Staff changes, reductions in staff hours at the regional level and delivery issues limited the time and attention that was afforded to the evaluation. The evaluation team were also conscious of overburdening staff with requests for information when delivery needed to be done.

- The evaluation team were not always cognisant of the range of activities that were being undertaken within the delivery sites despite repeated contacts seeking updates and further information during the lifetime of the evaluation. In addition, the evaluation team were not able to access one delivery site until after the end of the project limiting the scope of the evaluation, with contact details withheld at the regional level due to staffing-related issues.

- Both delivery partners only worked with a small number of participants hence there is a limited data set. The data would have been richer had the evaluation team been able to talk to more service users as well as being able to compare client experiences across both sites. However, sensitivity was needed in terms of where some of the older people were at on their journeys and their willingness/availability to discuss their experiences.

- The evaluation team were supplied with in-house monitoring data but this too had limitations. For example, the delivery teams were expected to use tools to measure changes in service user's self-related quality of life. There is a partial data set related to this from one site however, the collection of this data was suspended by the worker when service users became distressed and upset when asked to report upon this.

- The evaluation team were not supplied with NHS numbers for all clients from either delivery partner. Whilst we had NHS numbers from some of the clients in Doncaster, data sharing and information governance requirements were not clarified therefore we were unable to access health service usage data and cannot comment upon any potential reductions in health service usage.

- There was no follow-up after discharge from Eatwell and Livewell therefore it is not possible to judge whether any positive changes reported during the intervention were maintained.

- The lack of quantitative data at follow-up means it is not possible to comment on the potential social value or return on investment of this project. For future work, consistent data should be collected at baseline and follow-up on outcomes such as quality of life, functioning, general health or wellbeing, as well as health service use and costs, so that the potential social value of the intervention can be demonstrated.

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7. Appendices

Appendix 7.1 – Service Users and Carers Interview Schedule

Welcome and introduction; explaining what will take place and ensuring that all participants have had the necessary information and agreed to take part (consent).

The participants will have the opportunity to introduce themselves and say something about themselves.

Using a flexible semi-structured approach, we will encourage older people and their carers to talk about the following things:

- How they got involved in the project and what it is about
- Their experience of the project
- The effect they think the project is having on those in contact with it including themselves if they wish to openly reflect on their own experience

General questions:

Tell us about how you got involved in the project.

How did you hear about it?

What were your expectations of the project?

Can you describe your involvement in the project?

What do you think about the project generally?

What specifically is working well?

What do you like about the way that it works?

What difference is the project making to older people and their carers who come into contact with it including yourself? How? Why? Can you think of any examples?

Are there any instances when the project is not meeting yours or other people's needs? Why do you think this is?

Is the project important? If yes, why is the project important?

What do you think would happen to the older people and carers involved in the project if it didn't exist?

Do you think that the support the project offers to older people and carers is available elsewhere? If not, why? Can you give more details/explain further (whether yes or no)?

What sort of things could be improved about the project and how?

Interview wind-down:

Thanks for coming.

Any questions or further comments?

Appendix 7.2 – Stakeholder Interview Schedule (face to face OR telephone)

Introductions

Stress that we want to talk about the project in a general way rather than trying to obtain specific information about any of the people referred into the project/involved. If names or identifying factors come up in the conversation, then reassure that the information will be anonymised.

Background/Introductory information

Please could you tell me about your role/what you do?
How are you connected to the Eatwell and Livewell Project?

Questions relating to the project

What do you know about the Eatwell and Livewell project?

Probes:

- How did you find out about it?
- What type of connection have you had with the project? In what capacity? (referral? Information-seeking? Joint working?)
- Who did you first speak to? Why did you make contact with (this person)?
- What happened next?
- What do you understand/know about the project?

What impact has the project has on the people who you have referred to it?

Probes:

- Do you know what happened after you had made the referral?
- Have you had contact with the individuals that you referred in? If not, why?
- What changes have you seen in their situation/circumstances? Which of these might be as a direct result of her involvement with the Eatwell and Livewell project?
- How do you think the project has supported the people who have been referred? Is this different in any way to existing provision?
- Is the project engaging with people in a different way to existing services?
- Why is the project important? What do you think would happen to the older people involved in the project if it didn't exist?

Can you describe the Eatwell and Livewell approach?

Probes:

- How is it different? What makes it unique?
- Do you think it is effective? If so, how and why (what features make it so?)

We are interested in trying to determine outcomes and indicators for all of the people who have engaged in the project.

What difference is the project making to those who come into contact with it?

Can you describe/give examples of how the project has had an impact upon the older people involved?

Can you describe/give examples of how the project has had an impact upon carers?

Can you describe/give examples of how the project has had an impact upon volunteers?

Can you describe/ give examples of how the project has made better/more effective use of health resources?

Closing questions

Is there anything you would like to say about the Eatwell and Livewell project which we have not discussed/talked about?

Thank you for your time etc., etc.

Appendix 7.3 – Volunteer Interview Schedule

Introduction:

Housekeeping – toilets, refreshments, fire alarm

Welcome and introduction; explaining what will take place and ensuring that all of the volunteers have had the necessary information and agreed to take part (consent).

The volunteers have the opportunity to introduce themselves and say something about themselves.

Using a flexible semi-structured approach, we will encourage the volunteers to talk about the following things:

- How they got involved in the project and what it is about
- Their experience as a volunteer
- The effect they think the project is having on all of those who come into contact with it i.e. carers, service users and themselves

Tell us about how you got involved in the project.

How did you hear about it?

What were your expectations of the project?

How have you been involved so far?

What is your role?

What do you do?

What do you think about the project generally?

What specifically is working well?

What difference is the project making to the people who come into contact with it? How?

Why? Can you think of any examples?

Are there any instances when the project is not meeting older people's/carers needs?

Why do you think this is?

Why is the project important?

Tell us what it is like to be involved.

How does this make you feel?

What works well for you?

What do you think would happen to the older people and carers involved in the project if it didn't exist?

Do you think that the support the project offers to the older people and carers is available elsewhere? Can you give more details/explain further (whether yes or no)?

What sort of things could be improved and how?

Can you describe/ give examples of how the project has made better/more effective use of health resources?

Thanks for coming.
Any questions or further comments?