School for Public Health Research

The University Of Sheffield.

NIHR School for Public Health Research (Sheffield) Stakeholder Networking Event: Tuesday 21 May 2013

Notes from the Day

PRESENTATIONS AND WHOLE GROUP DISCUSSION

Introduction to the NIHR national School for Public Health Research (SPHR)

Professor Elizabeth Goyder, Director of Sheffield SPHR
- Presentation available here http://www.sheffield.ac.uk/scharr/sections/ph/sphr

Linking SPHR to the public health policy and practice community

1. **Public Health England and potential links to SPHR**

Dr Cathy Read, Public Health Consultant, PHE Yorkshire and Humber
- Presentation available here http://www.sheffield.ac.uk/scharr/sections/ph/sphr

2. **Networks and collaborations to support evidence-based public health work: the 'Deep End Project'**

Dr Liz Walton, General Practitioner & NIHR In-practice Training Fellow
Liz described the 'General Practitioners in the Deep End' project, an initiative led by Professor Graham Watt, that aimed to bring together GPs working in 100 practices serving the most deprived areas of Scotland to share experiences and identify ways to narrow health inequalities. 15 workshops were held and these resulted in new insights into barriers and opportunities for action on inequalities as well as boosting the identity and morale of Deep End practitioners. Liz suggested that SPHR could learn from this model in various ways, particularly by:

- Recognising that public health researchers and primary care clinicians together have a powerful combination of skills & experience to help reduce inequalities.

- Taking heed of three Deep End decisions:
o Not to duplicate existing reports on health inequalities literature
o Not to provide GPs with yet another "Toolkit" or set of guidelines
o To listen to practitioners working with very deprived communities; they are an important but often neglected source of evidence.

Early discussions are underway around a potential 'Deep End England'. More information: http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

NHS
National Institute for Health Research

Overview of the SPHR Public Health Practice Evaluation Scheme (PHPES)
Professor Elizabeth Goyder, Director of Sheffield SPHR
- Presentation available here http://www.sheffield.ac.uk/scharr/sections/ph/sphr
- Details of the PHPES application process available here: http://sphr.nihr.ac.uk/in-partnership-with-practice/phpes/

Examples of local public health interventions
Bridget Strong introduced the *Sheffield Mind and Body Project* which aims to improve the mental health and wellbeing of people living in the city's least healthy communities. The focus is on those experiencing poor mental health, who have low levels of physical activity and a poor diet, and who may be overweight. They may also be experiencing physical health problems. The aim is to support people to make positive changes to their lifestyles. Bridget noted that engagement work is a strong element of the programme and that there has been good success in engaging with marginalised groups. Bridget also noted that the three-way focus of the work – physical activity, healthy eating and mental wellbeing – is innovative. The project needs support to identify key outcome measures.

Amrita Jesurasa introduced the group to a brief *smoking cessation intervention* that is planned for use within the A&E setting. The aim is to target parents of children aged less than 2 years who are diagnosed with bronchiolitis in the A&E setting. Parents will be asked about their smoking habits and provided with information and a leaflet on smoking cessation. This is an under-researched area and it is hypothesised that parents may be well motivated to stop smoking when provided with information in this context.

Roz Davies described the *'Health be me' (healthbeme)* digital empowerment organisation that offers people the opportunity to co-create their own personalised online wellbeing package. With a learn, care and share purpose and using evidence based approaches from community engagement, health psychology and technology, the organisation aims to: increase knowledge and confidence; support people to be more connected; and ultimately to empower people to take more control over their own health and wellbeing. The organisation is in the early stages and the first significant community is currently being built in Sheffield. The organisation is keen to partner with an academic institution to ensure rigorous evaluation.

Questions and comments from group discussion

Q: Where will the resources needed to fund the implementation of projects to be evaluated under PHPES come from? Will it only be possible to evaluate interventions that are already well-established and funded?
A: It remains unclear whether PHE or another organisation will be able to provide funds for the intervention costs. Interventions that have funding secured for implementation are more likely to be considered under PHPES, but practitioners with innovative and promising interventions that are not yet funded are encouraged to apply and make the case for why the intervention should be evaluated.

C: The breadth of people that SPHR needs to engage with is very wide and therefore challenging. People who attend the events should themselves spread the word and connect

others to the work of SPHR as it is a big task for those directly engaged in SPHR to connect to everyone who might be interested and relevant.

C: It should be recognised that the process of engagement with people is an intervention in itself, an opportunity to raise awareness and spread information. All contacts should be seen in this light.

SMALL GROUP DISCUSSIONS ON CORE SPHR THEMES

(1) Alcohol (Rapporteur: John Mooney, j.d.mooney@sheffield.ac.uk)
Programme overview available here http://www.sheffield.ac.uk/scharr/sections/ph/sphr

Key points from group discussions:
1. The need for any models produced to consider unintended consequences was discussed – for example:
- Does tightening licensing laws just drive people to the off trade where alcohol is cheaper?
- Moving youth off the streets loads to more house parties
2. Implications for social services around the mental ill health consequences of harmful drinking
3. Other aspects of social exclusion factors and how they link to consumption levels.
4. Why is the take-up of treatment services so low in Sheffield?

Feasibility and utility of the proposed studies:
- (e.g. to explore the effectiveness of local interventions so that results could be used to populate a model for likely benefits):
- Main difficulties are around current lack of an overall strategic approach
- How to obtain local sales data
- Initiatives tend to be well-meaning but sporadic and not well–evaluated
Two local examples being:
'Best Bar None' and 'Challenge 25' (the latter now used as part of guidance in new licence applications – where proof of age is asked for if customer looks under 25)

Over-riding Concepts & Organisational Barriers:
- Willingness to engage highly variable between licensees (one of whom has refused to implement Challenge '25')
- Practicality of brief interventions (e.g. using AUDIT tool to identify problem drinkers) is limited in novel settings (often still inebriated in custody suites and A & E has very low uptake).
- Stick versus carrot approaches – may be preferable: 'conditional discharge' and 'conditional cautions' though these have time and resource implications for police
- Culture clashes between DAT, NTA and PHE so risky to talk to some and not talk to others.
- Also, NTA not an authority on alcohol and DAT similar due to their expertise and political remit / targets being around drugs.

Outcomes / Intervention data that might be considered:
- Police data on cautions etc.

- A&E admissions data – either routine or dedicated surveys
- Crime reporting with age-dependent attribution scores attached to alcohol (as done for health harms in Sheffield model).

Aspects of process that should be explored:
- Attendance / take up of Brief interventions in primary care and other settings
- Prescriptions for Antabuse drug that causes nausea on drinking
- AA attendance and age-breakdowns

Other issues to consider in study designs:
- Effects of Economic downturn
- Changing legislative landscape
- Effects of cuts to social services / safety nets

Next Steps / Actions: Opportunities for on-going dialogue were identified via local partnership meetings and key individuals in coordinator roles locally and regionally. John Monney (ScHARR) will pursue these links.

(2) Ageing Well (Rapporteur: Graham Whitfield, gwhitfield1 @sheffield.ac.uk)
Programme overview available here http://www.sheffield.ac.uk/scharr/sections/ph/sphr

Key points from group discussion:
The summary sheet provided to the group provided very brief outlines of six proposed inter-related projects. Participants in the discussions considered the objectives of these project outlines.

There was an initial broad discussion around the whole issue of 'personalisation' which covered issues such as concern over 'How personalised can interventions be?' and yet remain cost-effective and clinically/socially effective - and how the balance of this calculation could be made robustly. And it was thought that the programme of work would provide a great deal of invaluable information and (hopefully) tools that could be used to assist with practice.

The more specific main points raised were as follows:
- It was thought that it would be useful for health and social care professionals (e.g. commissioners and practitioners) to have information on a range of health conditions, diseases and impairments where this is possible. So, for example, it would be useful if *Project 1* could estimate associations of advancing age and risk factors for cardiovascular outcomes and others, such as cancer(s), neurological conditions, dementia, Alzheimer's, etc. One specific point raised was about how the programme could support service providers/planners in developing more specific targeting using relevant deprivation and morbidity data for people with a range of conditions – and it was hoped that the 'risk factors' in the analyses would include (and be clear about) measures of deprivation/poverty.

- In addition to dividing the ageing population into coherent groups so that interventions can be personalised based on health status and likely benefit (rather than crude age) as per *Projects 2-3*, it was thought that there would be considerable benefit in ensuring analysis took into account the geographic/spatial context – such that *project 4* might not have a sole

focus on urban areas (or at least be complemented by work looking at the rural dimension). This would be of particular benefit in (e.g. Local Authority) areas where (for example) there are places with diverse/distinct geographical characteristics (rural/urban) and concentrations of population in terms of range of characteristics (e.g. age, ethnicity, health and wealth/poverty). Another aspect of this that was raised was the issue of where services are provided (in terms of both place and type of facility) and their accessibility at both a local and regional level and the distance/practicalities (real and perceived) of attending these – and this taking into account issues of deprivation/poverty.

- It was considered that it will be important to expand the analysis in *project 3* on access to interventions to cover issues around awareness, (non) take-up and attitudes to the provision that is made and what is sought/thought important by older people themselves – this both in terms of accessibility in terms of health condition/impairment and in terms of personal preferences. It was thought that this will ensure a more comprehensive view is gained on the issue of 'access' than might be the case if the focus were more simply on which groups of people used which services. Another particular issue highlighted was that of how people are expected to/enabled to navigate existing systems/processes (and those being developed) to access services – for example, the age of 'digital by default' or telephone based provision raises a range of equality/access/stigma issues, in particular for many older people, people with particular health conditions or impairments and people living on low incomes.

- Similar to above, it was noted that it would be useful if *project 4* could investigate the concept of 'Ageing Well' in respect of a range of health conditions, diseases and impairments – and, importantly, from the perspective of living with these as an older person rather than from the perspective of chronological age (given that many older people face a challenge of being seen first as a person with a condition rather than an older person with a condition). Particular importance was placed on the issue of ageing well with dementia and Alzheimer's – and the importance of linking to other work being undertaken in this area was thought to be important at the developmental stages in particular (e.g. [JRF work on the Ageing Society](#) and more specifically about ['dementia without walls'](#)).

- *Project 5* (focussed on the impact of welfare reform on well-being in older age was considered to be very important and likely to become more so in the future given the direction of travel on the whole issue of the nature of 'welfare' and of public attitudes in this area hardening in recent years. The issue of social isolation/capital and loneliness was considered to be a key – but little explored/understood - underlying factor in the whole issue of how peoples' well-being can be developed and maintained and contribute to wider health impacts. It was also thought that developing approaches to more community based interventions involving a range of agencies would benefit considerably from this area of analysis (again this linking to policy developments and the diversification of providers of services/support). Again, linkages with wider work currently underway (e.g. JRF work on [Neighbourhood approaches to loneliness](#)) was thought important to ensure projects were developed on the back of existing and developing practice.

- Further on *project 5* – but more generally also – it was thought important to consider the potential impact of personal (health) budgets and on how agencies providing/allocating health and social care services (this diversifying over time) or funding for such services might respond to this. This was discussed in the context that – given the rapidly changing landscape - the outputs of this programme of work will need to be targeted at a wider range of organisations than was the case even only 5-10 years ago – and perhaps also at Third/Voluntary Sector organisations and older people themselves. It was noted as particularly important to ensure that outputs are not only aimed at large public sector organisations.

- The proposed population modelling (*project 6*) was considered as being of real potential for those working in commissioning and those developing future commissioning guidance. It was noted that having information on a range of key conditions, diseases and impairments – in particular those of high frequency in the population and of high cost at an individual level – would be particularly beneficial. The aspect that was thought particularly useful was the potential ability to investigate (even at an outline/rudimentary level) policy changes or changing demographics – this because much work at the moment is done on the basis of ad hoc analysis based on assumptions that are often not comparable across different places and which are not considered sufficiently robust.

(3) Health Inequalities- Big Local (Rapporteur: Sarah Salway, s.salway@sheffield.ac.uk)
Programme overview available here http://www.sheffield.ac.uk/scharr/sections/ph/sphr

Key points from group discussion:
There was a lively discussion with very mixed opinions being expressed and lots of pertinent issues being raised for the proposed programme of research.

Feasibility and utility of the study:
There were mixed opinions within the group as to the feasibility and usefulness of the evaluation of the Big Local.

Several participants saw merit in the work, recognising that it does potentially address enduring questions about how to empower the most disadvantaged communities and how to tackle persistent inequalities in health and social wellbeing.

'It would be valuable to understand how this type of intervention links to structures of local democracy'
'How to develop social capital is a key and meaningful question'

Group participants also identified some pertinent research questions that could potentially be addressed through this programme of work:

'How is this intervention different from, better/worse than those area-based initiatives that have channelled inputs via councils and had more professional inputs?'
'What support do communities need to take advantage of the initiative?'

However, some participants had doubts as to whether the intervention itself would be impactful. Participants questioned the extent to which local organisations would actually be able to benefit from the intervention and raised queries regarding the support that would be on offer and what would happen if communities struggled to make progress in defining a plan and taking action.

'Isn't it arrogant to assume that giving money will amount to giving people control?'

'Even a large sum of money like this will not address the real underlying issues, such as poor housing, it will inevitably be 'tinkering'; yes, past area-based initiatives failed to see any lasting change, 'crime and grime', not much movement in underlying factors that are perpetuating inequality'

Participants also raised concerns about the varied nature of the intervention and the problems this causes for designing an evaluation that can yield clear results with wider applicability:

'I would be inclined not to do it'
'It is very difficult to do in practice' 'It is unclear that any learning can come out of such a varied intervention'
'How will it be possible to generate systematic knowledge that can be extrapolated elsewhere?'
'It is not clear what the intervention is'

Concepts:
Participants felt that the concept of 'control' is important and interesting, but that there is a need to unpick the various related concepts of: root causes; resilience; social capital; social control – they are not all the same thing and are related in different ways. This discussion suggested that the programme's intended work to develop logic models and clarify concepts and understandings held by different stakeholders is considered appropriate.

Outcomes that should be considered:
Participants identified the following as outcomes that the research should examine:

- Sustainability of the intervention
- Risks and knock on effects
- Costs that have to be picked up elsewhere, e.g. councils ended up having to pay for the sustainability of lots of initiatives that were started under New Deal for Communities (an earlier area-based initiative)
- Education, skills and training for local people are key outcomes
- Local people's perspectives on wellbeing
- Links to statutory bodies; to what extent are people better able to navigate services; to exercise their rights to resources
- Measurement of individual progress; levels of engagement
- Perhaps identifying good mid-point outcome measures is the key (e.g. Look at Altogether Better evaluation approaches; it may be most important to focus on the processes of empowering/increasing control and to take it as given that if this is achieved then positive health/wellbeing outcomes will flow from this)

Aspects of process that should be explored:
Participants agreed that understanding the ways in which implementation of this type of intervention happens in practice is very important and identified the following as elements of the process of implementation that the research should examine:

- Processes of developing control (through narrative data)
- The support that organisations require and are able to access
- The listening process; the facilitation process; how are people engaged and their voices heard; who is involved
- Relationships both within and beyond the neighbourhoods and how these change over time both positively and negatively as a result of the intervention
- Inclusion/exclusion/domination (dangers of charismatic leaders; of a few people dominating the process)

Other issues to consider in study design:
-   Mobility of the populations and how this may affect change in indicators over time

Next Steps / Actions: Several participants were keen to be kept informed on progress. Sarah Salway will maintain contact and provide regular updates on the work.

(4) Tools and resources for practitioners (Rapporteur: Steve Ariss, s.ariss@sheffield.ac.uk)

Key points from group discussion:

Some common problems:

The purpose/role of evaluation is often not explicitly stated or fully understood
- internal or external
- developmental
- to support wider implementation (e.g. mainstreaming a pilot)
- value for money or cost-benefit analysis (often a commissioner's priority)
- service-user benefit
- 'need to know how well we have done'
- evidence for where things have not gone well (often political or 'human resources' implications: e.g. pointing out poor performance)
- something that 'needs to be done at the end'
- evaluation Vs. research (generalisable evidence v local learning) evaluation informing commissioning and procurement processes

Difficulty navigating through various iterative processes e.g.
- understanding project/programme theory
- weighing alternative approaches (<u>what</u> to evaluate & <u>how</u> to evaluate)
- developing evaluation framework
- allocating resources
- prioritising resources (money and involvement of key personnel)
- deciding timing
- evaluation activities & analysis of evidence
- selecting outputs and audiences
- implementation of findings

Status of "evaluation" versus "research". Low status of evaluation can lead to various difficulties
- evaluation is often seen as a minor afterthought

- poorly funded
- too much expected
- lack of engagement/commitment
- too little time allowed
- potential usefulness not appreciated
- mistrust, fear, suspicion (confusion with performance monitoring)

Some important considerations:

Importance of dealing with people rather than technical toolkits

Stakeholder identification and involvement to identify:
- key questions/key perspectives
- different expectations
- different objectives
- different perspectives

Politics + Art of evaluation (can be as important as the science)
Some skills required:
- understanding value of a wide range of methodologies and approaches
- defending methods
- navigating various systems to be able to deliver an evaluation
- the ethics/governance/practicalities
- engendering trust & cooperation
- designing 'real world' data collection (around existing systems and people)
- diplomacy (honesty without blame)
- "Selling"/marketing <u>evaluation</u> i.e. identifying what needs evaluation + then persuading those responsible for delivery/commissioning programmes

Choosing evaluation methods and approaches
- criteria for deciding which programme/intervention should be evaluated
- commissioners and practitioners can be exposed to various alternative methods and approaches, which will have variable appropriateness

Possible ways forward for SPHR:

Need to support thinking about evaluation
1st: Need to identify drivers for council decision- making as starting point
(Build on existing projects exploring use of evidence/decision making)

Study day for councillors?
- Learning about how to get evaluation done (learning by doing?)
- Needs - officers and elected members + PH practitioners
- Need to understand the important outcomes for difference groups
- Needs consensus building process or understanding differences?

Develop training materials/capacity building rather than a "toolkit"?
- Need to have key principles
- Signposting

- Know which tools might be useful/of interest
- Informing commissioning practices

Additional thoughts
- "Kitemarking" evaluations/training – role for SPHR
- Converting evaluation results into a useful resource – outputs/guidance/recommendations
- Mechanisms for selling the benefits of evaluation/capacity development/delivery?
- Supporting decision making (existing toolkit repository?)

(5) Patient and public involvement (Rapporteur: Jonathan Boote j.boote@sheffield.ac.uk)

Key points from group discussion:

The value of PPI for the School
- There should be a clear statement of the School's commitment to the value and principles of public involvement in the work that it undertakes
- This should include recognition of the ways in which public involvement can add specific value to the design and conduct of public health research, for example the public's contribution to the design and evaluation of public health interventions

Importance of PPI at all stages of the research process
- It was thought that the public should be encouraged to have a role in the following stages of the research cycle, (and the School should have processes in place to make such involvement happen at these specific stages):
  - Prioritisation of topics that the school could focus on
  - Designing public health interventions
  - Designing evaluations
  - Doing the research
  - Advising on the research

Different levels of involvement within the School and within different 'population groups'
- It was thought that the School should clearly differentiate between the involvement of the public in the strategic work of the School, and the involvement of the public in specific research projects.
- Different types of people (or people with specific health conditions) have different needs and will need to be involved in different ways. The School therefore needs to be flexible and mindful of different types/methods of involvement for different types of people. User-centred design was mentioned as a useful approach to involving the public in intervention design, with the South Yorkshire CLAHRC having particular expertise in this area.

Involvement of the general public and the involvement of people with specific conditions
- The School should be clear when the involvement of the 'general' public is sought for a specific project, and when the involvement of people with specific conditions is sought. The mechanisms and means by which such people are identified and recruited will necessarily be different.

Use of existing networks and organisations, to share existing knowledge around best practice
- The School should make use of existing links/databases of groups within the region, such as the RDSYH database of voluntary groups, the Sheffield City Council Help Yourself database, Trust databases of people interested in getting involved in research, Health-Watch, and the South Yorkshire Cohort database. Mention was also made of the University of 3rd Age, the Expert Elders initiative, POPPS, and GP practice user groups. The James Lind Alliance was mentioned as a useful organisation with expertise in involving the public in the research prioritisation process.

Strategies for going beyond 'the usual suspects'
- The School should of course make use of existing networks but, equally, thought should be given to reaching out to those people not already part of existing networks. Community engagement techniques could be used for such a purpose. One delegate mentioned that there are 400 community health champions in Sheffield which could be utilised for outreach work. One delegate suggested that the School could consider training young people to become community champions, or commissioning existing local groups to undertake community outreach on the School's behalf. Another person mentioned the launch of the 'Healthbeme' website which could be used to publicise involvement opportunities.
- It was suggested that novel community engagement methods could be used, such as road-shows in schools or care homes, or the use of social media such as Facebook and Twitter. The School could also have a public-facing website, including advice for the general public on maintaining well-being.

Public involvement in School activity should be evaluated
- The School should consider an on-going internal or external evaluation of public involvement in its activities, to contribute to the evidence base around the impact of public involvement on research processes and outcomes.

Questions on public involvement that delegates had for the School
- Is there a national lead for PPI within the School to co-ordinate strategy and policy?
- How are ideas generated by community groups taken forward by the School?
- How does the work of the School link in with Sheffield City Council's strategy on public health?
- Has the School established a payment and expenses policy for the involvement of the public at both the strategic and the project level?

The SCHARR SPHR team would like to thank all the participants for their valuable contributions.

Contact details for participants are available from v.walker @sheffield.ac.uk