Health Inequalities Project Casebook 2008-2012

KNOWLEDGE ➔ ACTION ➔ OUTCOMES

Compiled by Annette Haywood, Adele Oddy and Peter Roderick

CLAHRC for South Yorkshire

National Institute for Health Research
The full reports summarised within this Casebook can be accessed via the CLAHRC SY Health Inequalities webpages:

www.clahrc-sy.nihr.ac.uk/theme-inequalities-introduction.html

Health Inequalities theme Project Casebook 2008-12

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Foreword

The purpose of this Casebook is to share with a wide audience of colleagues – in local authorities, the NHS and the third sector – a number of inspiring examples of projects in South Yorkshire that have contributed to tackling Health Inequalities.

**Designed with commissioners, providers (and ultimately service users) in mind,** it is an easy-to-use and engaging introduction to the work of the Health Inequalities Theme of the South Yorkshire CLAHRC (Collaboration for Leadership in Applied Health Research and Care), set up in October 2008 as one of nine national pilot programmes with the aim of bringing researchers and practitioners together to build research and implementation projects around a set of shared priorities.

Our vision is to try and ensure that we could do research that answered the questions practitioners and service commissioners need answers to. We also wanted to work together across our different organisations to ensure that policy and practice were informed by the best possible evidence and were effectively evaluated. In essence we are asking “**what works, in what context, and why?**”

The Health Inequalities programme has focused on developing practical **projects and tools** that can have a visible impact on local initiatives. Whether it involves work on supporting and encouraging breastfeeding in deprived areas of Barnsley, evaluating the ‘Skilled for Health’ programme in Doncaster, or our work on understanding single homeless people’s access to health services across South Yorkshire, the case studies in this Casebook reflect the type of challenges and opportunities these projects have presented.

Throughout the process we have also learnt a great deal about each other – our different organisational cultures, our different needs and understanding – both when undertaking research or evaluation and when using our findings. And above all, we have kept the **focus on impact** within the theme, seeking to demonstrate the usefulness of research or evaluation in changing policy and practice, and in informing commissioning decisions.

We are very grateful to all our colleagues who contributed to the projects and case studies, and we hope this Casebook will be useful and be shared. We aim to continue to update this Casebook over the next 12 months and so we would very much welcome feedback and suggestions for further case studies.

*Professor Liddy Goyder*

*Inequalities Theme Lead, NIHR CLAHRC for South Yorkshire*

*January 2013*
1. Introduction to the CLAHRC South Yorkshire Public Health Evaluation Framework

Susan Hampshaw (Public Health Directorate, Doncaster Metropolitan Borough Council), Lerleen Willis (Sheffield City Council, Public Health)

Background

This South Yorkshire Public Health Evaluation Framework (SYPHEF) has been developed by a cross-PCT evaluation framework team. A scoping exercise to understand the evaluation needs of Public Health was undertaken by the Health Inequalities theme of CLAHRC SY in the summer of 2009. It recognised that Public Health commissioners would benefit from embedding systematic evaluation into their interventions and programmes in order to fully demonstrate the impact they were having on health inequalities and to validate the strategies which work. The evaluation framework project therefore emerged as a means for NHS colleagues in Public Health from across South Yorkshire to pool their resources and expertise to jointly produce an approach to evaluation. This approach builds on and strengthens current practice and ensures a systematic, high quality outcome. The project team recognised that there are numerous evaluation frameworks available, but judged that many of these were overly complex and often project/programme specific. The team therefore felt that there was room for a user-friendly, generic framework to guide evaluation activities and build capacity within health and social care organisations.

Summary of the Framework

The cross-organisational team recognised that there was likely to be a range of evaluation activity within Public Health across South Yorkshire and that the aims of the various evaluations were likely to differ. For example, evaluation that is part of a service-redesign processes will differ in both scale and outcome from a specific evaluation (such as understanding attendance/non-attendance within a GP practice). The SYPHEF is a theoretical framework which consists of three key elements:

☐ First, the promotion of self-evaluation (i.e. evaluation that is undertaken by people within an organisation rather than external to it), arguing that this is essential in an era when the resources for external evaluation are limited. There are considerable advantages to undertaking self-evaluation, not least of which is the potential increase in the utility of the findings.

☐ Secondly, the idea of ‘recycling data’ (i.e. the desirability of maximising the use of current/existing data by setting out to understand what this tells us about a service or intervention), recognising that the data may not exactly fit the current study but nevertheless is an extremely useful starting point for evaluation. Effectively, this is an investigative, ‘detective’ approach to primary data collection which collects and reviews existing data/evidence before deciding what additional data may be required (see inset box). Using...
existing (routine/non routine data) as a starting point means that any primary data collection is not necessarily determined at the start; instead, a more iterative process is followed.

Thirdly, the SYPHEF supports the use of an approach to evaluation which encourages mixed methods and triangulation. This might, for example, include qualitative insights into how a service/intervention is experienced by users and stakeholders, combined with quantitative data to add value, provide context, and confirm and refine the findings of the qualitative analysis.

The key audience for this work will be staff in organisations delivering a Public Health function. The SYPHEF places Public Health commissioners at the centre of the process, and advocates embedding evaluation into the commissioning process rather than using it as an afterthought.

Why evaluate?

It is increasingly recognised that evaluation can contribute to the promotion of evidence-based practice:

- It contributes to the knowledge base, telling us ‘what works, for whom, and in what circumstances’
- It provides generic lessons about how to plan/commission and implement an intervention or strategy
- It guides strategic decision making about, for example, investment and disinvestment decisions
- It contributes to service redesign
- It supports planning and commissioning processes
- It demonstrates the impact of interventions designed to tackle health inequalities.

This is supported by the Marmot Review, which advocates an evidenced-based evaluation framework for interventions that aim to reduce inequalities (‘Fair Society, Healthy Lives’, Marmot Review, 2010)
2. Does it work locally?

This section of the Casebook is designed to give some on-the-ground examples of how CLAHRC-managed projects have brought innovative and creative solutions to bear on local health issues and needs. It concentrates on work carried out to build the South Yorkshire Public Health Evaluation Framework into the commissioning and delivery cycles of public services, and showcases situations spanning voluntary, NHS and Local Authority sectors where a thorough evaluation has proved invaluable to the stakeholders. The strength of a service, and its effectiveness in meeting both commissioner and provider needs, only becomes apparent when a rigorous evaluation has been carried out; and this evaluation must start by asking the key questions: ‘what was done?’ ‘why was it done?’ and ‘what difference was made?’ The following case studies are here presented in brief, with a focus on the impact of the evaluation for the project and for service users, including (at the end of each study) some key messages for commissioners and providers.
Case study I: Introduction to Community Development and Health Evaluation

Lerleen Willis (Sheffield City Council, Public Health), Mai Mustaphanin (NHS Sheffield)

Background

The ICDH course is a 15 week training programme developed at the end of the 1990s to train unskilled community workers to better engage with communities and improve their impact on community health. It was an example of co-production between Healthy Sheffield (Sheffield City Council) and the Health Authority. The course developers (Sheffield Community Work training group) consulted widely and worked with voluntary and community organisations to develop, fund and host the training in the communities which would most benefit. In recent years, the ICDH course has focussed largely on developing people who are unemployed, socially isolated, have long term conditions or are refugees. It aims to inspire learners to be more actively involved in their local communities and to look after their own health and wellbeing.

The ICDH course is inclusive, creative, and develops the critical, social and political awareness of learners. The learning style adopted is based on Paulo Freire’s ‘pedagogy of the oppressed’ and has been analysed using Mezirow’s theory of transformational learning. Learning is facilitated through Freire’s alternative approaches to adult education which include discussion in a supportive group, images and artefacts to explore meaning and reflect on learning experiences in a weekly learning journal. These approaches can lead to transformations in outlook and enable learners to change their thinking and ultimately their lives. Learners can achieve an Open College Network qualification at levels 1, 2 or 3. Many learners report that the ICDH course has changed their lives and helped them get back on track. For this evaluation, we wanted to understand which aspects of the ICDH course brought about these transformational learning experiences, and how they were achieved so these approaches could be replicated elsewhere.

What we did

The evaluation was based on the principles of the South Yorkshire Evaluation Framework for Public Health. It was led by NHS Sheffield’s Research and Development Manager from within Public Health and adopted a participatory approach. Members of the Community Development and Health

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(CD&H) team, as well as 2 ICDH tutors, were taught key principles of evaluation: how to conduct semi-structured interviews and how to analyse interviews using thematic analysis. They conducted 10 interviews then each isolated the themes from one interview. The R&D manager conducted the full thematic analysis of interviews.

We also used Discourse Analysis to analyse 4 learning journals which had achieved either a level 2 or 3 at OCN, as these were most likely to include critical reflections and evidence of transformational learning. This process enabled us to understand how learners’ self-perceptions changed throughout the course and which mechanisms for transformation influenced them. One member of the CD&H team learned key skills of discourse analysis and contributed to the analysis of journals. Finally, a literature review was conducted to better understand the principles of community development, transformational learning and reflection on learning which underpin the ICDH course.

**What we found out**

- 1045 learners have attended the ICDH course since 1998.
- A supportive learning group where learners feel safe is crucial to the transformational learning experiences which ICDH learners reported.
- The course helped learners to confront and talk openly about mental health issues and other difficulties which they felt were holding them back.
- Learners felt more confident and empowered to make changes to their lifestyles and to influence others after completing the ICDH course.
- The analytical skills learned enabled learners to be more critically conscious of the needs of their community and to ensure their own health and well being needs were met.
- Many learners became more active in their communities as a result of the course.
- ICDH was often a stepping stone for learners to begin working in their local community or to return to the workplace.

**Impact**

The evaluation process has itself been transformative. It has highlighted the importance of collecting systematic data which demonstrates the impact of the training programme on learners’ lives. This insight has influenced decision-making which means more time and resources will be made available in future to place evaluation at the centre of the ICDH course management process.
Data from the evaluation have also been shared with commissioners and funders to support future spending decisions.

**Benefit of partnerships**

ICDH courses are hosted by community organisations and provide opportunities for people to embrace new opportunities in a familiar location. The ICDH Development Manager trains and develops ICDH tutors, supporting them as they deliver courses in community settings. She also supports community organisations to build their capacity to deliver ICDH courses themselves, to take ownership of the courses and to recognise ICDH learners as a resource within their local community.

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**Key learning points for service**

**Key messages for commissioners:** Evaluate impact as well as process

The evaluation of impact needed to feature more prominently in the ICDH programme in general.

**Key messages for providers:** Effective evaluation relies on effective data collection

Taking the time to capture accurate and full information about learners during a programme provides an opportunity to understand how much they benefit from attendance.

**...and for both:** Invest time and resources in evaluation

The impact of the ICDH course was demonstrated by effective evaluation of the long term changes in people’s lives and their impact on their communities after they have graduated from the programme. Impact evaluation requires an investment of time and resources.
Case study II: Breastfeeding peer support

Adele Oddy and Kay Bennett (Public Health, Barnsley Metropolitan Borough Council), Angela Beaumont and Anne Amott (Voluntary Action Barnsley)

Background

Breastfeeding, both exclusively and partially, has confirmed health benefits for both infant and mother, leading the World Health Organisation in 2002 to recommend that all babies should be breastfed for the first six months after birth. The Breastfeeding Link Workers Service in Barnsley, a service based on peer-to-peer support, was commissioned to support mothers in the most deprived areas of the borough to sustain breastfeeding for as long as mother and baby wish. Barnsley’s Breastfeeding initiation rate in 2010/11 was 63% (national rate 74.5%). Whilst the commissioners had access to national research on breastfeeding peer support, they wanted to understand the experience of local service users and collect feedback on the perceived impact of local delivery. This project was supported by a midwifery researcher before the service was commissioned in 2009.

What we did

The first key challenge was to set the scope of the evaluation and agree achievable objectives which reflected the resources available. The service was supported by a CLAHRC Research and Development Facilitator (RDF) to do this. A Public Health Specialist Nurse was closely involved in shaping the evaluation, ensuring the information requirements of the commissioning organisation were met. After an exercise to map data routinely collected by the service, it was agreed that to meet a data gap, a survey of service users was required to provide structured information linked to the project objectives, collected from the full range of clients. All aspects of the subsequent evaluation were conducted by the practitioners, supported by the RDF. A self-completion questionnaire was developed in conjunction with service users and front line breastfeeding peer support workers. Piloting the survey with service users proved essential. In total 121 surveys with service users were undertaken. Findings were discussed in a workshop forum by taking each question in turn and using the data to shape the discussion; this took time, but was worthwhile. Producing a two page summary for wider circulation helped disseminate key findings.

What we found out

☐ Four out of five mums who took part in the survey felt the Breastfeeding Link Worker had helped them sustain breastfeeding. The great majority felt they had provided both practical and emotional support. Respondents felt the service to be highly appropriate to their individual needs, of high quality, friendly and extremely knowledgeable; a positive outcome for a service model based on mum to mum (peer) support.

☐ Feedback from the survey confirmed mums felt the service model (including contacting new mums 48 hours after discharge from hospital) and the associated resources (hard copy guides, DVDs and most importantly breastfeeding groups) to be appropriate.
Only half of mums who had returned to work or study whilst still breastfeeding had been supported by a Link Worker to negotiate breastfeeding provision (time/privacy to express etc.) This was an area identified where further support could be provided to clients.

Though caution has to be exercised due to sampling constraints, the survey found that for the mums who took part in the peer support programme, the average period over which they maintained breastfeeding was longer than the national and local average when participants were followed up at 6 weeks and 6 months. To increase confidence in the information quality it was recommended that systems be enhanced to report on the number of contacts and duration of breastfeeding maintained for every client the service supports.

Impact

The evidence from the evaluation was used to inform commissioning, and in July 2012 the Breastfeeding Peer Support Service was re-commissioned for an extended service period. As a result of the evaluation the service have enhanced support for mums who are planning to return to work. The importance of continuing to facilitate breastfeeding groups was confirmed as key, as many mums in the survey regarded these as a lifeline, providing not only important support with breastfeeding issues but also reducing feelings of social isolation.

The benefit of partnerships

The involvement of key stakeholders in the evaluation process ensured outputs were of practical use to provider, commissioner, and ultimately clients. In particular, co-production of the data collection tool ensured the questionnaire was fit for purpose and culturally acceptable to respondents. Although the provider felt the process was resource intensive, ultimately the evaluation was regarded as a successful and credible example of practitioner-led evaluation, which went on to have significant impact. Support provided by an external evaluation professional (in this case CLAHRC RDF) gave the practitioner evaluation a degree of impartiality and therefore increased its credibility. The process built the understanding of evaluation practice and therefore the supported self-evaluation left a legacy of learning for provider and commissioner, ultimately improving and sustaining services for breastfeeding mums.

Key learning points for service

Key message for commissioners: Get involved in the evaluation
By getting involved in the evaluation – and particularly at questionnaire design stage – commissioners can ensure the key policy/local information requirements were included.

Key messages for providers: Good evaluation can have significant impact
Quality evaluations produce results for your organisation, so don’t be afraid of building relationships with your local CLAHRC, universities/colleges, and with local commissioners, to enhance your work.

…and for both: Streamline data collection and consider evaluation at the start
Get the right data flowing by ensuring the information collected by providers enables you to judge effectiveness. Build evaluation into the project implementation plan – it’s a key ingredient in delivering a quality service.
Case study III: Skilled for Health in Doncaster
Susan Hampshaw, (Public Health Directorate, Doncaster Metropolitan Borough Council), Michela Littlewood-Prince, (formerly NHS Doncaster), Victor Joseph (Doncaster Metropolitan Borough Council)

Background

Skilled for Health (SfH) is a national tool developed by the Department of Health due to concerns about ‘health literacy’ – the ability to make sound health decisions in the context of everyday life. Low levels of literacy, language and numeracy skills make it less likely that an individual will effectively navigate the health care system to receive preventative, curative and maintenance treatments. SfH aims to address both the skill needs and health inequalities prevalent within traditionally disadvantaged communities.

Although SfH is a national programme, one of its core features was flexibility, which enabled it to be successfully implemented at a local level in Doncaster between 2007 and 2011. Whilst the commissioners had access to the national Skills for Health evaluation, they wished to understand the strengths and weaknesses of this local implementation model. As funding for SfH was coming to an end, there was clearly merit in assessing the strengths and weaknesses of this programme, and in identifying specific lessons from the scheme that could influence health improvement.

What we did

The evaluation adopted the self-evaluation approach advocated by the South Yorkshire Evaluation Framework (see above). It was led by a Public Health Speciality Registrar, with support from the SfH PH lead commissioner and the local PCT Evaluation Unit. After an exercise to identify and examine routinely collected data (existing project monitoring data including 166 feedback forms), it was agreed that a small number of interviews and 2 workshops were required to examine the impact of the programme in terms of health behaviours. The first workshop, for the provider, was attended by 16 people, while the second, for the scheme participants, was attended by 77 people. CLAHRC provided a small grant which was used to hire venues and provide a ‘thank-you’ (£5 vouchers and refreshments) to support public and patient involvement (PPI) in the project.

What we found out

- The majority of those attending the SfH programme either lived within the most disadvantaged communities or were attending venues within those communities. It was an important outcome to demonstrate that SfH was delivered into areas with the highest health, literacy and numeracy needs.

- Participants did indicate self-reported levels of increased confidence and some positive changes in health behaviour were given: for example increasing levels of exercise, eating more fruit and vegetables. Increased health knowledge did not always result in behaviour change.

- In total 583 SfH sessions have been held, making contact with 1100 attendees. The SfH programme developed over four years from a commissioned service delivered by ContinYou to a more flexible community based programme delivered by a variety of providers.
This evaluation demonstrated that the SfH programme delivered increased health knowledge. This was best summarised by this quote from a participant: “Everyone on our course came away learning and being able to better their life from different aspects of the course”

**Impact**

The evaluation identified that the use of a flexible community based programme can successfully target members of traditionally disadvantaged communities and can result in increased knowledge and behaviour change. This finding contributes to the public health knowledge base, is of real value to commissioners and has been disseminated locally.

**The benefit of partnerships**

This evaluation helped demonstrate that it was possible to undertake self-evaluation with limited resources, and that this approach could build evaluation capacity for Public Health staff. SfH providers were also very much part of the process, in that a number of these workers acted as co-facilitators in the participant workshop. This proved very valuable: the providers could translate where appropriate, for example, to support the groups such as the Doncaster Chinese Elders. The participant workshop also included a large number of adults with learning disabilities, and it was helpful to have workers that were familiar to the participants, to aid accessibility. The overall outcome was that the process built the understanding of evaluation practice of both commissioners and providers.

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**Key learning points for service**

**Key message for commissioners:** *Start evaluating at the beginning*
In the SfH project extensive monitoring data was collected, much of which was inappropriate: find suitable and more meaningful ways of collecting data from providers by asking how you will evaluate the service from the start.

**Key messages for providers:** *Engage with commissioners to maximise flexibility*
The SfH evaluation revealed that a flexible community-based approach supported programme delivery, for instance replacing onerous monitoring paperwork with regular feedback/reflection points.

**...and for both:** *The value of evidence from a good evaluation*
The findings from this evaluation produced useful evidence; but above all the stories of individual behaviour change have the potential to provide powerful messages to both commissioners and providers of services.
3. Responding to local need

Across South Yorkshire there is a diverse range of health needs. Tackling health inequalities requires us to think creatively about some of the less obvious barriers to better health, and to treat our communities as unique places in which the local geographical, demographical and social make-up all play their part in determining the health outcomes of our population. This section of the Casebook shows how CLAHRC projects have responded to local need and brought a research-based approach to bear on some of the specific health issues the region faces. These examples utilised data from local sources to inform practice, service delivery and commissioning decisions where there was little other available evidence (for instance, NICE guidance). It demonstrates the power of research to understand local communities and their needs, and makes the case for greater investment in strategic intelligence and partnerships between academic institutions and commissioners/providers, in order to provide in-depth analysis and evidence-based public health interventions which work.
Case Study IV: Consanguineous marriage

Sarah Salway (University of Sheffield), Parveen Ali (Sheffield Hallam University), Oliver Quarrell (Sheffield Children’s Hospital), Giles Ratcliffe (NHS Rotherham), Serish Bibi (Pakistan Advice and Community Association), Jack Hiscock (Sheffield Children’s Hospital)

Background

The practice of marrying close relatives, commonly cousins, is common in many cultures, offering significant social and economic benefits. However, this practice increases the risk of rare recessive genetic disorders because closely related individuals are more likely to carry the same unusual genes than unrelated people. At a population level, this increased risk translates into higher levels of infant mortality – a key public health outcome measure - and severe, life-long disability. Clearly, for the families concerned such conditions can have devastating consequences. Nevertheless, only around 20% of cousin couples are at risk of having a child affected by a recessive genetic disorder, and even when both parents carry the same unusual gene, the chance of each pregnancy being affected is 1 in 4. Therefore, most babies born to cousin couples are healthy. In the UK, cousin marriage is found occasionally among the majority White British population, but is more common (and often preferred) among a number of minority ethnic populations; the largest being those who identify as ‘Pakistani’ or ‘British Pakistani’. Research shows that most people at risk have poor understanding on which to base informed decisions and little contact with genetics services. Sheffield and Rotherham are both home to large Pakistani communities. Recent years have seen growing recognition among local practitioners, commissioners, patients and the public, of the need to understand and address this gap in service provision. A multi-partner working group has been established, and in Sheffield a strand of the Infant Mortality Action Plan has been devoted to this area of service development.

An international consensus on the need for a multi-pronged approach is emerging, involving: (1) family-centred genetics services for at-risk individuals and families; (2) training for health and social care professionals, and (3) community genetic literacy intervention. However, interventions are in their infancy in England and important questions remain regarding how such a response should be implemented in practice. The current project sought to combine best available evidence with local insight to inform the development of a culturally appropriate response to this complex issue.

What we did

Three strands of work were undertaken by a team including university researchers, commissioners and practitioners:

1. A formative review of existing service interventions in four localities across England involving: informal face-to-face and telephone interviews with staff involved in commissioning or delivering the services (12 people), review of relevant documentation, participant observation at relevant events (5 people) and ongoing email discussion with key actors over a six month period.

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2. A community level consultation and insight exercise to explore local knowledge and attitudes involving: interviews with key informants (18 people) and group discussions with local people in Sheffield and Rotherham (50+ people).
3. A service level mapping and audit to examine current patterns of data recording and service referral and take-up involving review of patient records across various departments of Sheffield Children’s Hospital Foundation Trust.

What we found out

Findings from the work have been described in detail in CLAHRC reports available [here](#). The key findings were as follows:

**Messages from our review of services elsewhere:**

- Potential synergies between the three strands of recommended intervention were recognised, but only one site showed sustained activity across all three.
- Three sites had developed an enhanced genetics offer focused on ‘at risk’ consanguineous families. Key challenges are staff recruitment and cascading to extended family members.
- Community genetic literacy work is very varied with little evaluation. Mistrust among community members is a persistent concern.
- Efforts to equip the healthcare workforce have primarily consisted of voluntary face-to-face training. Though well-received, this is not always linked to wider service development and lacks clear messages for practitioner roles and actions.
- Cross-cutting challenges include: identification of appropriate outcome indicators; sustainability; evaluation approaches; community engagement; and conveying information about population and individual level risk accurately.

**Messages from our community consultation and insight work:**

- Significant numbers of local people appear to be aware of the link between cousin marriage and infant death/disability, but there is widespread uncertainty and partial understanding.
- Most respondents were unaware of the existence of genetics counselling services and felt that people would go to their GP if they wanted information on this topic.
- Reactions to new intervention at community level are likely to be mixed, with some people showing a clear appetite for information and others significant opposition. Establishing trust and recognising diversity within local populations is crucial.

**Messages from our service audit in Sheffield:**

- Information on consanguinity is not currently recorded systematically or comprehensively.
- Uptake of genetics services among Pakistani individuals may be lower than equivalent White British patients (though data recording limits a rigorous analysis).
- Practitioners recognise the need for an enhanced offer to address current inequities.

**Impact**

The findings from this project have informed a number of inter-related areas of work with local and wider impact:
1. Development of a service specification for an enhanced genetics offer by the Regional Genetics Service. A new Genetics Outreach Worker came into post in November 2012.

2. Writing of a successful bid to Jeans for Genes (Genetics Disorders UK) for a participatory, action research project (2013-4) to develop an approach to enhancing community genetic literacy, being led by Pakistan Advice and Community Association. A community development worker will be funded for one year.

3. A linked project with NHS Leeds has developed a community level educational leaflet that will be made available via a Creative Commons licence for use in Leeds, Sheffield, Rotherham and beyond.

4. Writing of a successful bid to Sheffield Children’s Trust for research to improve the approach to cascading information to extended family members (to begin in 2013).

5. Design of face-to-face and online training modules for health and social care professionals (currently in development).

Integrated action is still needed to provide genetics support to affected families, raise the competence and confidence of wider health and social care professionals, and enhance understanding and engagement at community level.

**Benefits of partnership**

Strong coordination across community, primary, secondary and tertiary care is important to ensure effective referrals and consistent positive messages to patients and the public. Reflexive practice and systematic evaluation are key to ensuring ongoing improvement in this emerging area of practice. The project’s partnership approach involving researchers, commissioners and practitioners ensured that the work addressed meaningful, real-life questions while drawing on broader perspectives from research and practice, and that findings were directly applied to new service development. More broadly, collaborative working has ensured that a developmental and evaluative approach to new services is being pursued. The project was a key pump-priming investment, enabling progress across all three strands of work as recommended by WHO with ongoing work currently being overseen by a multi-agency working group.

**Key learning points for service**

**Key message for commissioners:** The approach should be multi-professional and sustained

Interventions in this area should be underpinned by a commitment to addressing inequalities in service access and promotion of informed reproductive decision-making. Gains at population level will only be achieved over the longer term with sustained investment.

**Key messages for providers:** Provide culturally competent care

Effective intervention requires not only an understanding of complex patterns of individual and population level genetic risk, but a commitment by practitioners and organisations to provide culturally competent care, free of ethnocentric assumptions.
Case study V: Identifying and understanding the barriers to cardiac care
Punita Chowbey, (Sheffield Hallam University), Hilary Piercy (Sheffield Hallam University), Lerleen Willis (Sheffield City Council, Public Health), John Soady (NHS Sheffield) Permjeet Dhoot (NHS Sheffield), Sarah Salway (Sheffield University)

Background
The coronary heart disease (CHD) literature suggests differences in diagnosis, investigation and treatment between people of South Asian origin and White comparator groups in the UK. It is well recognised that heart disease presents differently in different populations but the impact of this has not been adequately explored. There is also an indication that differences in revascularisation (heart surgery) rates may exist, with lower rates in people identified as South Asian. The reasons for these differences are not well understood. Against this background, this consultation project was conducted by the Centre for Health and Social Care Research (Sheffield Hallam University). The overall aim of the project was to identify factors that may impact on the diagnosis and treatment of CHD in Pakistani women and may thereby have contributed to the lower than expected rate of revascularisation, identified in this population in an equity audit conducted in NHS Sheffield in 2008 for the period 2004-7.

What we did
In-depth interviews were conducted with six Pakistani women suffering from CHD, and two group discussions (12 people) were held with elderly Pakistani women in two localities in Sheffield. Six semi-structured interviews were also conducted with experienced clinicians working at different points along the CHD pathway. A framework analysis approach was used to analyse the women’s data. The clinician data was analysed using an adaptation of the ‘Pathways to Care Model’ in which the care pathway is conceptualised in terms of levels with progression from the community level through key stages in primary and secondary care.

What we found out
Pakistani women with CHD face substantial difficulties in relation to their diagnosis and treatment. Five key areas were found to have particular significance in relation to their illness experience and disease management:

- social circumstances
- communication
- presumptive diagnosis
- engagement with procedures
- chronic disease management

Mapping these against the Pathways to Care Model provides a useful starting point for identifying how these factors impact upon movement through that pathway, and gives a basis from which to identify priority areas for further detailed exploration and attention.
Impact

The findings of the project were disseminated widely among academics, practitioners and community members with CLAHRC SY and beyond. The findings have also been incorporated in teaching materials through seminars and workshops. Discussions are on-going with clinicians across the care pathway with an objective of working together for best patient outcomes. The Cardiac Network in Sheffield have taken an active interest in using the findings for service improvement: for example, it recently agreed to change the cardiac contract monitoring dashboard to report by gender and South Asian uptake. The findings from this project are forthcoming in the Journal of Ethnicity and Inequalities in Health & Social Care.5

The benefit of partnerships

This study was a product of an earlier partnership to enhance the research capacity of the public health teams in Rotherham and Sheffield, initiated by the team but conceptualised jointly and led by Sheffield Hallam University. The partnership provided a focus to the study and ensured that the findings were meaningful for health professionals and commissioners. Close working with the NHS Sheffield also ensured that the findings were disseminated widely at various specialised networks such as the Cardiac Network. The project worked closely with community members and organisations which facilitated accessibility of respondents from minority ethnic and marginalised communities. It also helped to raise the issues around CHD at a small scale within the Pakistani community.

Key learning points for service

Key messages for commissioners: Establish close working partnerships
Close working partnership between stakeholders – including academics, NHS Sheffield, and BME communities – ensured a focus on impact for providers, efficient data collection, engagement with communities, and rapid dissemination to relevant specialised networks.

Key messages for providers: Be aware of the social barriers to effective CHD care
Pakistani women have difficulties with cardiology investigations. Preparing them to engage more meaningfully with those investigations can potentially increase the likelihood of successful completion.

…and for both: Improve the effectiveness of CHD prevention
Chronic disease management is a key element of secondary disease prevention; but while there has been substantial development around other chronic diseases (e.g. diabetes, with Sheffield’s development of diabetes specific community champions, patient-led care planning approaches and the DESMOND programme), there is a need to develop effective models of CHD care for Pakistani women.

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5 Piercy, H.; Chowbey, P.; Soady, J; Dhoot, J; Willis, L; Salway, S. (forthcoming) ‘Care pathway approach to identifying factors that impact on diagnosis and treatment of heart disease in British Pakistani women’, Journal of Ethnicity and Inequalities in Health & Social Care
Case study VI: Single homeless people’s access to health services
Maureen Crane (Social Care Workforce Research Unit, King’s College London), Tony Warnes, (University of Sheffield)

Background

Single homeless people are among the least healthy members of society and have high rates of health and substance problems. There are numerous difficulties in meeting their health needs because they have unsettled lifestyles and neglect their health. They are less likely than the general population to be registered with a GP, and many face barriers in accessing health-care because of service inflexibility, staff attitudes and the difficulties that health staff have in treating people with complex and multiple needs.

The arrangements for providing health services to homeless people vary greatly. Some homelessness organisations have agreements with a primary care practice to provide GP or nurse-led sessions in hostels, while some encourage registration with nominated practices. The aims of this study were to identify: (i) current arrangements for delivering health services to single homeless people in South Yorkshire; (ii) the strengths and weaknesses of the current arrangements; and (iii) gaps in health-care provision for the client group.

What we did

An inventory of all temporary accommodation projects and day or drop-in centres in South Yorkshire that target single homeless people was compiled, and 36 schemes were identified. The manager of each project was then contacted to ascertain the arrangements for their service-users’ access to primary health, mental health and substance misuse services, and the managers’ evaluations of the arrangements. Finally, interviews were conducted with 61 single homeless people in Doncaster, Rotherham and Sheffield to determine their perceptions of their health problems, their use of health services, and whether their health needs were being met.

What we found out

There was much evidence of health problems and untreated conditions among the homeless people interviewed. 78% reported physical health problems, 79% mental health problems, 46% alcohol problems, and 54% illegal drug use. Exceptionally high rates of smoking and poor nutrition were also evident.

Only 38% of those interviewed were registered with a local GP – many others relied on either a specialist Homeless Health Care team (that operated in one of the study areas) or a walk-in health centre. Most with physical health problems were having treatment, but more than one-half with mental health or substance misuse problems were not receiving treatment. Likewise, almost one-half reported dental problems and one-half of these were not receiving treatment.

Those in contact with the Homeless Health Care team were more likely to have had health screening and vaccinations, and to be linked into mental health and substance misuse services where applicable. It is likely that these teams are more aware than GPs of the health needs of single homeless people, to have links with specialist agencies, and to have the skills and time to be proactive with clients who resist services.
Three-quarters of the homelessness project managers surveyed believed that the arrangements for accessing medical care for their clients were working well, but they reported great difficulty in accessing mental health and dental services for their clients. Access to substance misuse services varied greatly.

The managers said that they needed more intensive help to support clients with mental health issues, including better access to crisis intervention support. They also acknowledged that their staff needed more advice and training in recognising physical and mental health problems, in motivating clients with complex needs to accept health-care, and in carrying out health promotion work with homeless people.

**Impact**

The CLAHRC programme, which includes representatives from all South Yorkshire PCTs, has been instrumental in ensuring access to services, supported the sampling frame and developed the recommendations of the study were brought to the attention of senior commissioners in the NHS and are acted upon. In Barnsley, for example, 92 staff working with single homeless people received training on ‘dual diagnosis’ following the study, and recognition of the unmet dental problems of the client group were documented in Barnsley’s 2011 *Oral Health Needs Assessment* report.

**Benefits of Partnerships**

The aim of this project was to understand the health care needs of local single homeless people and to identify gaps in existing health service provision for them. It brought together academic researchers with expertise and experience of working with homeless populations, homelessness sector service providers, and local public health practitioners who saw the collection of better information in South Yorkshire as a priority. Combining researchers' and practitioners' perspectives ensured that the project both provided robust evidence and was directly relevant to the commissioning decisions of the health service and local councils. Whilst there may be only small populations and insufficient resources to collect data in individual council areas, a shared project across South Yorkshire provided information which could be used by all the partners.

**Key learning points for service**

**Key recommendation for commissioners:** Improve screening and act strategically

Strategies need to be developed to address the unmet needs of the transient homeless population, with improved and systematic health screening – especially targeting those with long histories of substance misuse.

**Key recommendation for providers:** Collaborate with a full range of health professionals

Increased collaboration between NHS staff and homelessness service-providers would mean dedicated health professionals actively supporting homelessness projects to deliver health services and health promotion activities.
4. Bringing evidence together ... and then letting it loose

This section focuses on two primary activities: evidence synthesis and research dissemination. The evidence-base for a health intervention should be the primary reason a service, project or initiative is chosen and commissioned. However, it is often the case that commissioners and providers have to deal with a complex and sometimes confusing set of data on the effectiveness of policies and services. Academic researchers have a background in analysing complexity and solving such problems, and the work showcased below demonstrates how bringing a large and varied evidence literature together to form synthesised conclusions can benefit the work of practitioners in making wise choices. At the opposite end of the scale, it also shows how research can be let loose, being deliberately designed as accessible and malleable, suitable for sharing across a wide audience. This may include NHS leaders, community nurses, by publication in academic journals, on social media and via eye-catching publicity campaigns for the general public.
Case study VII: Health benefits of Welfare Advice Services

Peter Allmark (Sheffield Hallam University), Susan Baxter, Liddy Goyder, Louise Guillaume (Uni. of Sheffield)

Background
Poverty is positively associated with ill health. It might be thought, therefore, that alleviation of poverty would improve health. One measure that alleviates poverty is the provision of welfare rights advice services offered, for example, by the Citizens Advice Bureau. Some local health commissioners in the UK have pioneered the provision of such services on the belief that they would improve health by alleviating poverty. However, systematic reviews of the literature have shown limited evidence for mental health improvement and none for physical health. The authors of these reviews emphasise that this finding is based on a lack of evidence for or against the intervention working, not evidence that it does not work. Nonetheless, the lack of evidence makes it difficult to defend commissioning the intervention on health grounds.

What we did
We conjectured that the lack of evidence was not mainly the result of poor quality or insufficient research but rather of the complexity of the area. The path by which an intervention to help someone with debt or claiming benefits leads to improved health would be, if it exists, complex and time consuming. It is not surprising that research trials set up to find health benefits in a short period of time failed to do so. This complexity is increased by the fact that so many other things might be happening in the period of measurement that could affect health for good or ill, such as unemployment, campaigns against welfare benefit fraud, increases in crime and so on.

One way of dealing with complexity is the construction of logic models (also known as impact or conceptual models). These illustrate complex chains of reasoning or causation by mapping factors and the relationships between them. Often these models are constructed by experts in consultation. However, recent work by members of our team has shown that it is possible to use systematic review techniques as the basis for logic models. So what we did here is a systematic review of the evidence, as others had done before us, but then used that evidence for the construction of a logic model.

The details of the systematic review are published in an open access form elsewhere. In brief we found, as had the earlier reviews, limited direct evidence of health benefits from the intervention. However, we then used that evidence to construct a logic model (simplified at Figure 1).

What we found out
The model illustrates potential pathways between the intervention and improvements in health and wellbeing. The first box details the nature of the intervention, whilst the second shows the primary outcomes of the intervention; that is, an outcome which occurs soon after the intervention and is usually the aim of it (such as having your loan payments achieved). The third box shows secondary outcomes for which there are some evidence and which are likely to be linked to improved health or wellbeing (such as an improved ability to manage finances). The fourth box shows the outcomes we were finally interested in – in this case, improved physical health and wellbeing.
Health benefits of Welfare Advice Services: a logic model

**Intervention**
- What
- Where
- Who
- How

**Primary Outcome**
- The aim of the intervention

**Secondary outcome**
- A benefit of the intervention

**Tertiary outcome**
- Health benefit
- Mental health
- Physical health
- Wellbeing

*e.g.*

**What:** benefit and tax credit check  
**Where:** CAB/legal services office  
**Who:** CAB Volunteer  
**How:** eligibility and entitlement calculation

**Loan payments achieved and managed**

**Improved ability to manage finances**

**Improvement to:**  
- Physical health
- Wellbeing

**Key**
- Good volume of evidence
- Intermediate volume of evidence
- Small volume of evidence

*Figure 1: Potential links between advice interventions and health outcome (taken from Allmark et al. (2012), simplified by Peter Roderick; full diagram here)*
The model also illustrates the strength of evidence for the existence of these pathways. For example, there is strong evidence (e.g. from large scale qualitative studies) linking the intervention to successfully obtaining increased welfare benefits; the evidence is less strong (e.g. from one or two qualitative studies) linking increased welfare benefits to reduced smoking; the evidence is very strong linking reduced smoking to improved health.

Why does this matter? We've said that research that directly seeks to find health benefits from Welfare Advice interventions has thus far found little. In creating a logic model we have looked behind this bald finding. We have found evidence that the intervention triggers various pathways that may result eventually in positive health effects.

**Impact**

The project was reported in an open access article in October 2012. The project – and particularly the logic model – has been presented at various forums, and we are aiming to ensure two impacts from the model:

- Commissioners of health services in South Yorkshire are aware of this work and draw upon it in making decisions about whether to fund this type of intervention.
- That researchers draw upon the model in constructing their evaluation of the health effects of welfare advice services (we note particularly that the evidence linking the ‘intervention’ and ‘primary outcome’ (see diagram) is, in most cases, not strong; it would therefore make sense to focus attention on these links)

**The benefit of partnerships**

The project was a demonstration of the power of bringing together academic approaches to evidence synthesis and literature review with the needs of commissioners (Derbyshire and Rotherham PCTs) to effectively evidence and inform its voluntary sector commissioning activity and approach to welfare rights advice. The effective partnership working was funded by Derbyshire PCT and the NIHR, and CLAHRC SY would also like to acknowledge the participation of other partner organisations, also thanking Jo Abbott, Consultant in Public Health at Rotherham Public Health.

### Key learning points for service

**Key recommendation for commissioners:** Develop a thorough evidence synthesis approach

Evidence synthesis is crucial in developing understanding of potential impact of complex interventions, and effective partnership with academics delivers the skills and experience to go deep into the evidence.

**Recommendations for providers:** Look beyond local evidence

Bringing local evidence and published evidence together is really useful in terms of understanding the impact of your service, and in this particular case benefits organisations could work more closely with health services in an MDT-type approach, together with patients/clients.
Case Study VII: The Keeping Warm in Later Life (KWILLT) project

Angela Tod (Sheffield Hallam University, Catherine Homer (NHS Rotherham), Adelaide Lusambili (formerly NHS Rotherham), Jo Abbott (Rotherham Public Health), Jo Cooke (CLAHRC SY), Kath McDaid (National Energy Action), Anna Cronin de Chavez (Sheffield Hallam University), Amanda Stocks (Director A J Stocks Ltd)

Background

Cold weather kills. But as well as causing ‘excess winter deaths’ (EWD), a lack of warmth at home can have a negative impact on health. It can prompt acute events such as heart attacks and strokes, and can exacerbate underlying chronic illness including respiratory conditions.  

NHS Rotherham has historically had concerns about the health burden of the local older population, vulnerable to the negative health impact of cold weather, and they also wanted to prevent avoidable NHS use and costs associated with cold. Levels of fuel poverty – the number of households in which more than 10% of income is spent on heating and fuel – were rising, with rates for this indicator stubbornly holding at 18.2% in Rotherham (above the national average of 17.0% for 2010), alongside a similar pattern with excess winter deaths, of which there were 166 in 2010. There was an indication that those most in need were not accessing some affordable warmth interventions, for example Warm Front. Furthermore, NHS Rotherham was aware that they had high levels of older people with chronic health problems, making them susceptible to cold-related illness and EWD. The study area also has non-traditional and old housing stock, which creates challenges in terms of energy efficiency. With this in mind, the KWILLT project aimed to explore factors helping or hindering vulnerable older people in keeping warm at home.

What we did

The study was conducted in Rotherham between September 2009 and November 2011. It was funded by the National Institute of Health Research and hosted by NHS Rotherham. This mixed-method research included:

- In-depth individual interviews with 50 older people
- Hourly temperature and humidity measurements made over seven days (taken in the room the participants spent most of the day in and the room they slept in)
- Interviews with 25 health and social care staff who work with vulnerable older people.

The findings from this stage were tested in six focus groups. Three were with older people (24 participants in total) and three were with staff (19 in total). This use of different data collection

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techniques in each stage allowed us to triangulate findings, expand and verify the data, and thus increase the rigour and transferability of the findings. In the final stage of the study we held a large consultation event with over 100 local, regional and national representatives from public sector, charitable and voluntary groups, where we discussed and expanded upon study findings.

**What we found out**

- Knowledge and awareness were low across the study participants, both the public and staff, with regards to safe temperatures, the health impact of cold and how to use heating efficiently.
- Older people’s values and beliefs interact with contextual factors (such as health, housing, low income) and barriers (such as difficulties with technology, lack of knowledge and disjointed services and systems), with the result that they often end up being cold at home.
- The diversity of older people at risk of living in a cold home needs to be effectively understood. To this end we developed a model which used six ‘pen portraits’ to describe how different groups of older people can end up being cold at home.

**Impact**

The findings informed our local response to the Cold Weather Plan for England (Department of Health 2012)\(^8\), and our approach to meeting the Excess Winter Death and Fuel Poverty targets in the Department of Health Public Health Outcomes Framework (Department of Health 2011)\(^9\); they also highlighted the need for collaborative effort in localities to overcome some of the obstacles vulnerable older people face. An Affordable Warmth Strategy Group will help bring about the required partnership, systems, boundary spanning approaches and capacity development in staff and communities needed to reduce excess winter deaths. Greater focus is also needed to ensure affordable warmth interventions achieve the desired outcome of safe indoor temperatures for older and other vulnerable people. Key actions required include identifying vulnerable populations, developing partnership schemes and develop community knowledge and resilience resources.

The project has been widely disseminated at national and international level, and through academic, public health and policy conferences. We have been asked to present at policy meetings and workshops held by the Department of Health, local Health and Wellbeing Boards and area assemblies. The study findings have been used to develop a range of resources including:

- Pen portraits, used extensively in staff training by e.g. the NHS, Fire and Rescue, home care, and community organisations: see the KWILLT website.

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Key learning points for service

Key message for commissioners: Target your winter warmth strategy

By taking action on excess winter deaths and fuel poverty you can make an immediate impact on the health of your population and on the burden created for people and NHS services because of the negative health impact of cold weather.

Know your local population, identify who is vulnerable to excess winter death and fuel poverty and have systems in place to help them prepare and respond to cold weather e.g. data sharing agreements and referral schemes.

Key messages for providers: Get referral systems right and don’t assume anything

Systems need to be in place to identify those who are vulnerable, and mechanisms should be agreed for referral to the help they need. Examples include the South Yorkshire Hotspots Scheme.

Boundary-spanning roles and investing in the development of community resilience schemes can help: for example, the Snow Angels.

Challenge any assumptions you may have about whether people are cold at home and why. For example, some of the most vulnerable people were younger participants living in private housing and not experiencing fuel poverty. Don’t assume being cold at home is not your business and that someone else is doing something about it.

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10 This case study presents independent research commissioned by the National Institute for Health Research (NIHR) under its Research for Patient Benefit (RPB) Programme (Grant Reference Number PB-PG-0408-16041). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health. The KWILLT team would like to acknowledge the contribution of all the study participants who shared their experiences and views so generously. In addition we are grateful for the ongoing support of the Collaboration for Leadership in Applied Health Research and Care - South Yorkshire (CLAHRC SY), in particular Jo Abbott, Consultant in Public Health at Rotherham Public Health. Kwillt was an adopted project of the Health Inequalities Theme of the CLAHRC SY.
Conclusion

These case studies give just a small sample of work currently being undertaken in South Yorkshire to bring researchers and practitioners together and tackle health inequalities – many more examples can be found on our website. The Health Inequalities Theme of the South Yorkshire CLAHRC has spent five years investing in, and leading, projects which seek to understand and mitigate against the differing and unequal health issues facing our population, and the examples collected here show the power of evidence-based evaluations and interventions to change attitudes, policy and practice.

A common theme across all the case studies is the notion of building capacity to do research and evaluation jointly between researchers and practitioners. This means building skills in the individuals in both academia and the NHS or Local Authority, and strengthening partnerships to undertake more work together through building a trusting and ongoing partnership.

The theme is trying to tackle an enormous problem: that of health equity. If you take the train between York and Barnsley – calling at Leeds – you can expect the life expectancy to drop by 1.5 years every five stops along your journey (2007-09 data); and the differences are even larger within each town and between socio-economic and demographic groupings.

So there is still much work to be done. At the end of each case study the contributors have identified key messages for commissioners and providers from their work. Several overriding themes emerge:

- Commissioners need to build evaluation in at the start of a service or initiative, and consider how they will be able to appraise any new commissioning activity for its effectiveness and – above all – its equity.
- Providers need to be proactive and get involved in research and evaluation – these activities are not ‘inspections’ or ‘performance reviews’ so much as opportunities to shape services and increase fairness in health outcomes.
- Evaluation and research-based activity doesn’t need to be costly, neither does it need to place an unnecessary burden on providers to churn out endless data. Streamline your information collection, structuring it around what is already there.
- Joint work with people that matter, shaped by them, makes the research more meaningful and useful. CLAHRC call this ‘coproduction’, and it means working with researcher and service users when and where you can.
- Research helps identify barriers to equitable health care delivery – and shows us how to overcome them. Therefore it is everybody’s business.
- Health inequalities are complex, and an evidence-based approach may have to synthesise a large number of studies and draw on expert knowledge of the literature.

Above all, this Casebook has shown that the benefits of evaluation are worth sharing. Research and evaluation is a waste of time if it is not disseminated. All of the cases presented here have been a result of cooperation, and have used local partnerships, academic channels, NHS and local authority networks to distribute their findings for the widest impact.

Peter Roderick, on behalf of the CLAHRC SY Health Inequalities Theme Management Group and Jo Cooke, Programme Manager CLAHRC SY. January 2013
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