COLLABORATIVE RESEARCH BETWEEN LOCAL GOVERNMENT, THIRD SECTOR, NHS AND ACADEMIC PARTNERS

LESSONS LEARNED FROM EVALUATION OF THE COUNTY DURHAM WELLBEING FOR LIFE SERVICE

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KNOWLEDGE EXCHANGE IN PUBLIC HEALTH CONFERENCE

28TH APRIL 2016

Durham University

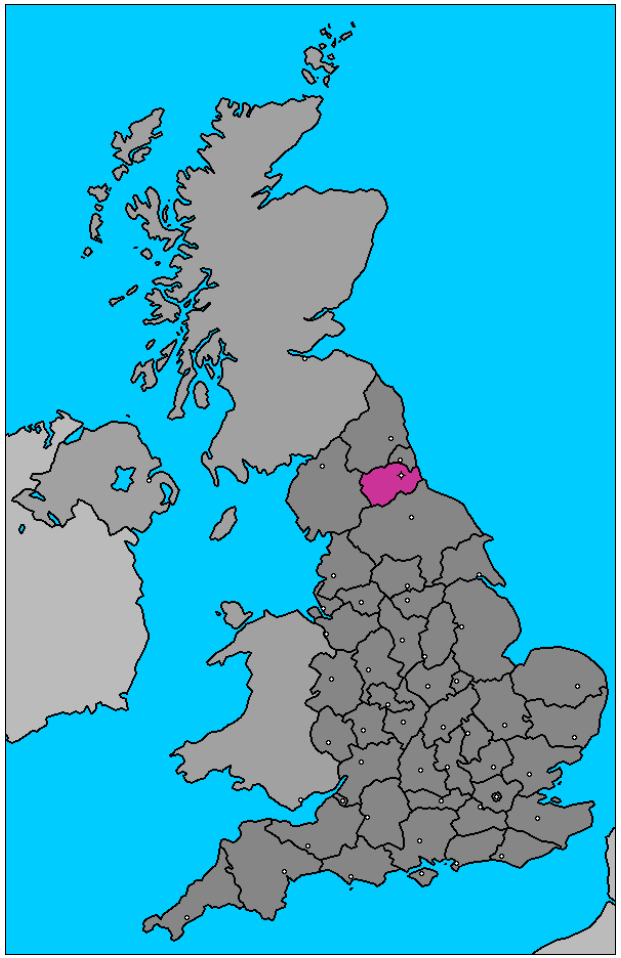
Durham County Council

wellbeing for life

OVERVIEW

- Background
- The Wellbeing for Life Service
- Evaluation design
- Early findings
- Reflections

BACKGROUND: LOCAL CONTEXT



County Durham residents can expect to live an average of 56.7 years in good health

Decline in healthy life expectancy between 2009 and 2014 (3.9 years)

Significantly higher prevalence of many long-term conditions (e.g. diabetes, CHD, stroke)

High levels of long-term unemployment (10.1 adults aged 16-64 per 1,000 population, in comparison with 7.1 nationally)

Around 29% of people in the county live in the 20% most deprived areas in England

BACKGROUND: POLICY AND RESEARCH CONTEXT

Health trainers implemented in the UK in 2005, following the public health white paper, *Choosing Health: making healthy choices easier*

King's Fund 2012 report on clustering of unhealthy behaviours; referred to health trainers and lay 'health champions' as "*an under-used and ready-made workforce to help drive the reduction of multiple lifestyle risks*"

Calls from key figures (e.g. Marmot) for behaviour change policy and practice to be addressed in a more integrated and holistic manner

Growing body of literature in relation to asset -based approaches that acknowledge and build upon strengths, skills and capacities within local communities (e.g. ABCD approach)

WELLBEING FOR LIFE

Aiming to integrate adult health improvement services through provision of individual, group, family and community-level interventions

Targeting 30% most deprived areas, as measured by income deprivation, child poverty and risk factor prevalence

Non-geographical, ‘specialist’ populations include veterans, gypsies and travellers, and older people.

Commissioned from 1st November 2014 for a minimum of two years

well being for life

THE WFL CONSORTIUM

- County Durham and Darlington NHS Foundation Trust (CDDFT)
- Durham County Council (DCC) Culture and Sport
- Durham Community Action (DCA)
- Leisureworks
- Pioneering Care Partnership (PCP)

Commissioned by DCC Public Health

EVALUATION DESIGN

Two overlapping work packages:

1. Outcome evaluation
2. Qualitative study and process evaluation

Primary outcome measures: EQ-5D™ and the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)

Final design decided through discussion between the researchers, commissioners and provider representatives, who meet regularly

Interim report details analysis of outcome data from 1st June 2015 to 31st January 2016, plus scoping interviews and initial observations


COMMON LINK
CAUTION
Work in progress

PROCESS I

Co-production as an opportunity and challenge

"It's much more of a co-production model. So it's not as if it's a sense of, 'Well these are the outcomes – go away and achieve them.' And I think actually that is valuable, but it is also more difficult. Because of course it's about how there's a commercial and contractual relationship here, so in some ways there's a market solution, but at the same time we're kind of trying to run that with some element of co-production or a partnership. I mean, although we haven't got a formal partnership with the commissioners – they are our commissioners, but it sort of like mixes both elements doesn't it? You know, is it a network partnership solution or is it a contract solution? And it is a market solution, but because… It's kind of, how easily does that sit within a public health context? Where you've got a local authority that's trying to maximise the, you know, its impact on the wider determinants of health. It's an interesting crosscut if you like. Theoretically as well as practically I think." (Provider 1)

PROCESS II

Working in partnership across sectors

"… understanding each other's cultures and the way people work, the usual things I guess that always happen in partnerships. A bit magnified in this I think, I suppose because it's five partners instead of maybe one or two. And purely just getting used to that, people work differently, organisations have different ways of working, work at different speeds, have different flexibilities. There's a [NHS] Trust and there's third sector… I guess you'd probably find people are a bit more nimble and can make decisions quickly and get on with things, whereas sometimes in the bigger organisations, the local authority, FT [NHS Trust], it's going to be a bit more difficult. But you understand that it can be difficult to make decisions, have to go through bureaucracy and massive chains of command and everything else." (Provider 2)

PROCESS III

Securing buy-in from local partners

“The [external] partners who are committed to Wellbeing for Life are significantly greater. The buy-in that we've got politically from the local authority at the moment is very welcome and valued.” (Provider 1)

Restrained optimism

“I: What is the service likely to have achieved by the end of the initial contract?

R: A measured success. It won't in two years get the population of County Durham fit and healthy, but it will leave a legacy of a very strong infrastructure around wellbeing. And it will have switched on communities to the benefits and opportunities around health and wellbeing". (Provider 3)

OUTPUTS AND OUTCOMES

Number of one-to-one clients: **1345**

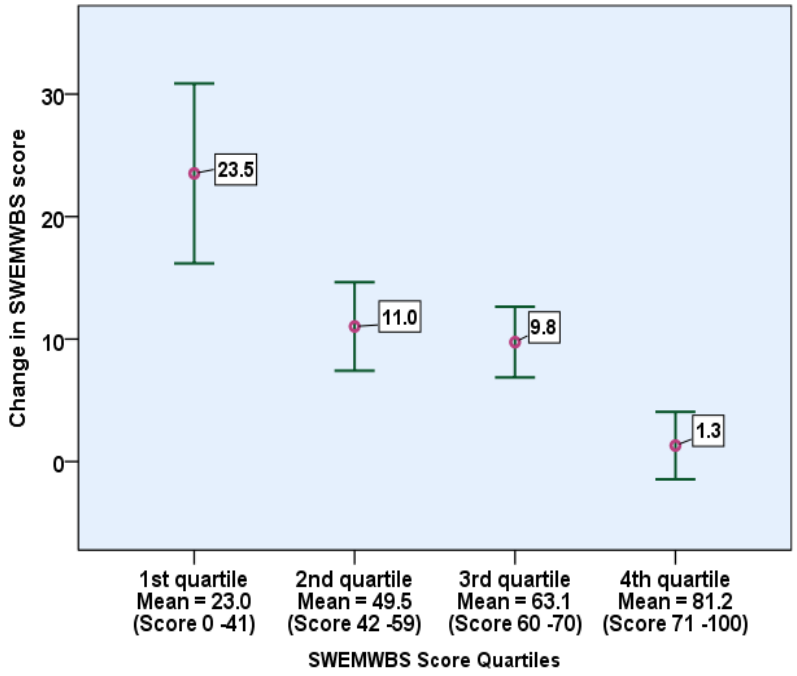
Baseline and follow-up data available: **224**

80.4% from the 40% most deprived areas

9.4% not registered with a GP

Improvements in: BMI, weight, physical activity, alcohol intake, self-efficacy, self-rated health, quality of life, mental wellbeing

Largest changes in those with the least positive results at baseline



REFLECTIONS: PROVIDER VIEW

The WFL service is building a good reputation with a clear offer; "*not the old-style health trainer service*"

Ongoing challenge associated with integration into one whole, rather than separate elements delivered by different providers

Need to start "*concentrating on the positives and celebrating success – we seem to have built some real positive momentum… We just need to keep this going.*"

Independent evaluation is "*Absolutely vital to give the impact real credibility. I think that the way the [evaluation] team have operated in being flexible, approachable and interacting with the [WFL] team have made the process very easy. For me, more regular/immediate updates on when issues are developing would be very useful to help us keep shaping and developing the service. Evaluation should be warts-and-all and we need to learn from both the good and bad – but this needs to be an ongoing process.*"

REFLECTIONS: COMMISSIONER VIEW

- The workforce is very important and requires planning across the system.
- Clear communication between individuals and organisations is crucial
- More to do with CCGs on moving from lifestyle to wellbeing and tackling health inequalities
- Important to stay the course and embed the service in the community and key settings, for example, with housing – this involves a more creative approach to co-delivery
- Must continue to see WFL as having a key role whilst recognising the importance of reducing structural health inequalities
- Recognise that a new approach takes time and patience and not to expect instant results; measures need to be appropriate

REFLECTIONS: ACADEMIC VIEW

Ongoing dialogue with WFL commissioners and providers facilitates trouble-shooting

Gained an understanding of local authority research governance procedures

Challenges: vested interests, reliance on gatekeepers, ‘evaluation fatigue’, providing timely feedback

Collaborator, independent evaluator or critical friend?

CONCLUSION

Ultimately, the WFL service and its evaluation will be enhanced by opportunities for regular knowledge exchange (KE) between collaborators

KE in this case does not involve simply transmitting information; it concerns the testing of ideas in and with practice, to enhance their relevance

Conversations across sectors help to foster reciprocity and mutual respect

Co-production – between commissioners and providers, and between academics and policy/practice partners – brings challenges and opportunities

It is central to the integrated wellbeing approach of WFL and similar services

ACKNOWLEDGEMENTS

Commissioners from Durham County Council (DCC) Public Health team:

Graeme Greig, Chris Scorer and Tony Walsh

Wellbeing for Life consortium representatives:

Carol Gaskarth, Julie Form and Lee Mack

DCC Performance and Data team:

David Knighton and Dawn Barron

Academic evaluation team:

Nasima Akhter, Jo Cairns, Sue Lewis, Lisa Monkhouse and Frances Thirlway

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Wellbeing for Life website:

http://www.wellbeingforlife.net/

well being for life

Evaluation of a Real Time Suspected Suicide Early Alert System

- Dr Grant McGeechan – Teesside University
- Catherine Richardson – Durham County Council

Altogether better

Teesside University

Durham County Council

METHODOLOGY

- A process evaluation comparing the effectiveness of a coroner led real time suspected suicide surveillance strategy with a pilot police led strategy including consent for referral into bereavement support services.

- The number of deaths logged as suspected suicides within the county during the pilot strategy was compared to those in the previous three years to establish local trends.

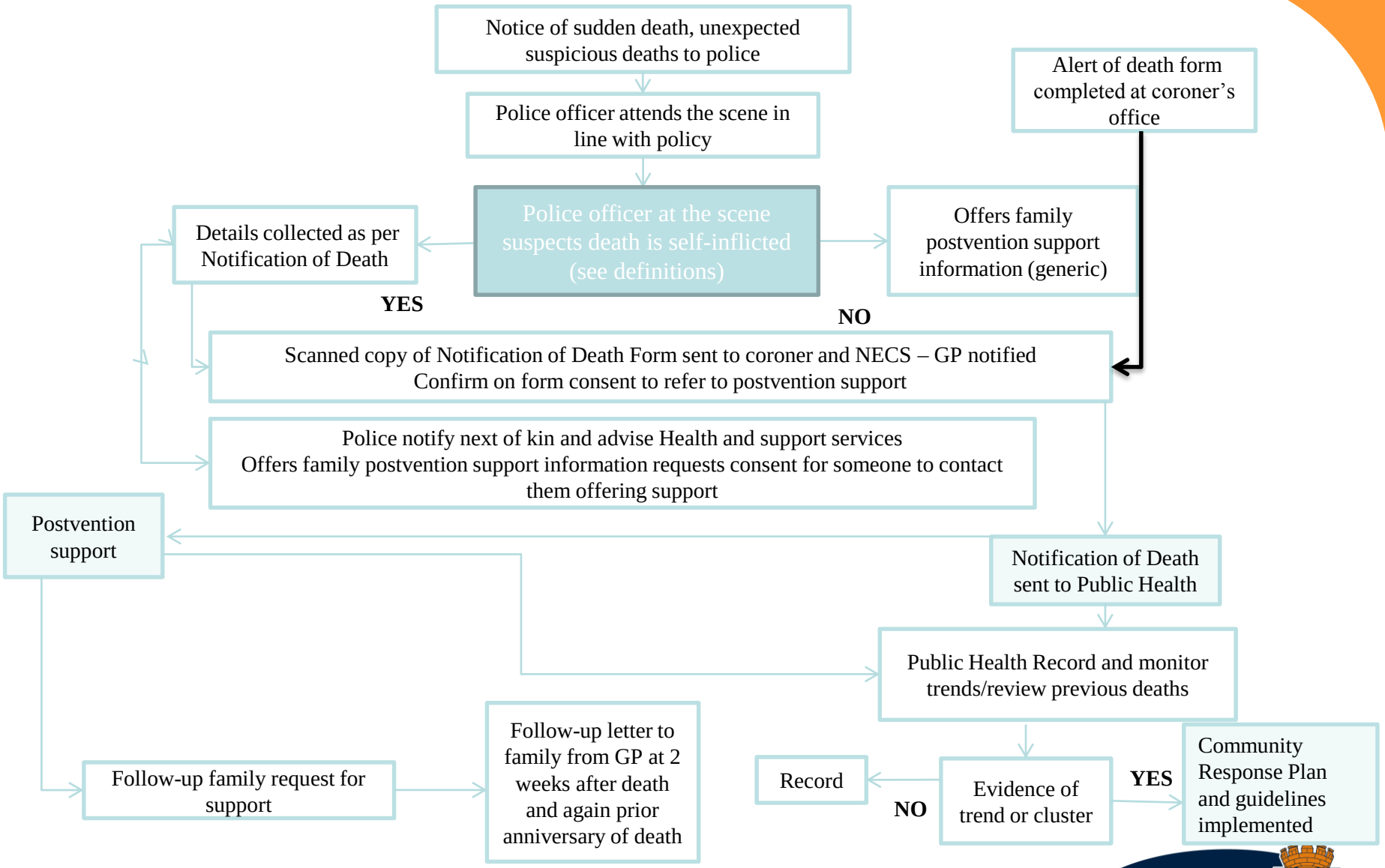
METHODOLOGY

- The time taken for a death to be logged using both systems was compared to see how soon after a death support services can engage with those bereaved.

- The number of referrals received by support services during the evaluation was compared to previous years to assess any uptake in access to support.

- A series of focus groups and interviews were held with key stakeholders to gain feedback on the barriers and facilitators to running a police led real time suspected suicide surveillance strategy.

Overview of County Durham Real Time Suspected Suicide Surveillance Strategy



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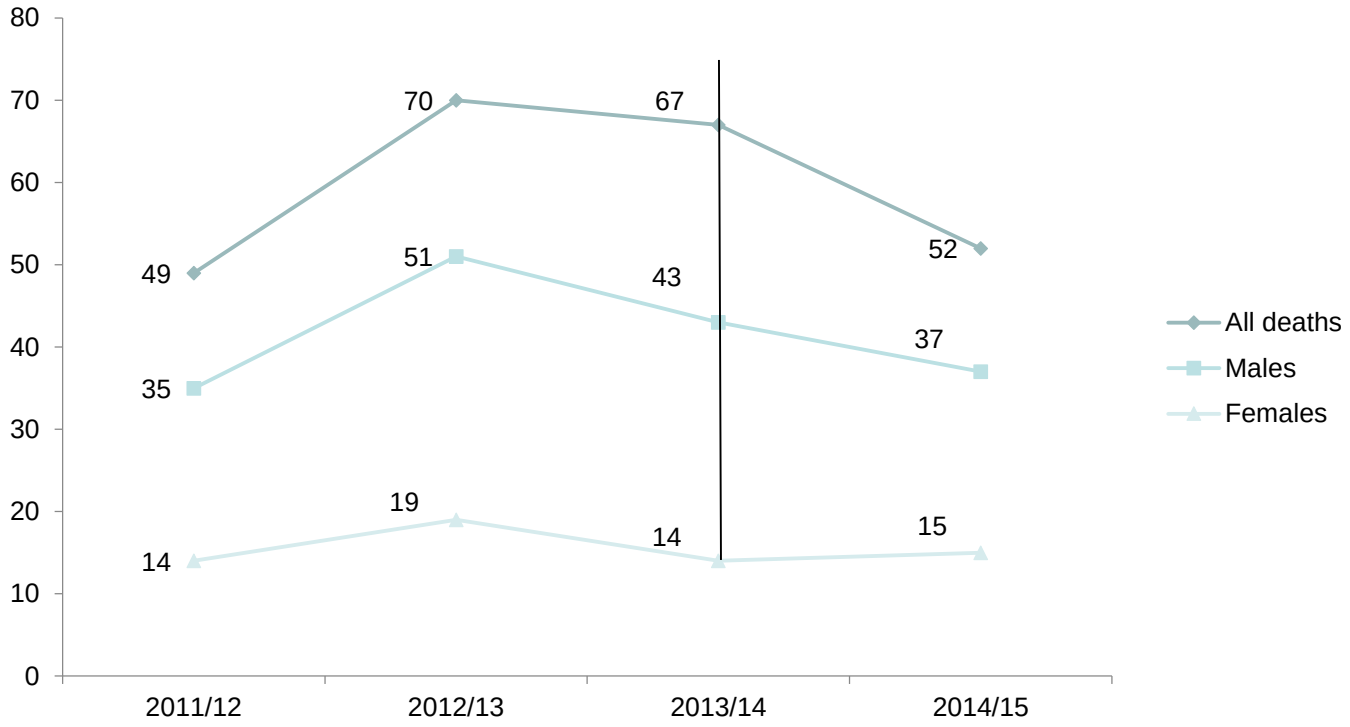
Suspected Suicides

- During the pilot strategy 52 deaths were logged within the County which were suspected to be suicides.



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Comparison of time elapsed between death and early alert logging.

Gender	Suspected suicides 2014/15	Command & Control (C&C) Reports Filed (N)	Coroner Reports Filed (N)	Notification of Death (ND) Forms Filed (N)	Delay between death and C& C Report	Delay between death and Coroner's report	Delay between death and ND form
Male	37	24	35	27	0.7 days	3.7 days	1.9 days
Female	15	9	14	14	0.6 days	2.1 days	1.6 days
Total	52 (100%)	33 (63.5%)	49 (94.2%)	41 (78.8%)	0.6 days	3.2 days	1.8 days

RESULTS

- *Uptake of offer of support*

- Of the 52 deaths within the county which were suspected suicides, a police Notification of Death form was filed in 41 cases.

- A total of 32 individuals at the scene of the death agreed to share their details with the police (78.0%), of whom 16 then went on to receive some form of postvention support (50.0%)

RESULTS

- *Uptake of offer of support*

- From the 16 referrals where contact was established a total of 29 individuals were signposted on to some form of postvention support – an average of 1.81 clients for every one referral.

RESULTS

- *Uptake of offer of support*

Year	Total Number of referrals	ND form referrals	Other Referrals
2011/12	8	0	8
2012/13	32	0	32
2013/14	43	0	43
2014/15	81	32	49

RESULTS

- *Referral Routes – Postvention Support*

Service	Number of referrals (N = 16)	Number of clients reached via referrals (N = 29)
Local Bereavement Support	16 (100.0%)	29 (100.0%)
Welfare Rights	4 (25.0%)	8 (27.6%)
Complaints Advocacy Service	5 (31.3%)	8 (27.6%)
Other Bereavement Support	3 (18.8%)	4 (13.8%)
Legal Advice	2 (12.5%)	3 (10.3%)

RESULTS

- *Police Focus Groups and stakeholder interviews*

- One focus group was held with three of the seven police officers who attended suspected suicides during the pilot strategy.

- Additionally two interviews were held with key stakeholders from postvention support services.

- The focus group lasted for 45 minutes, and interviews for an average of 30 minutes.

- All interviews were transcribed verbatim and analysed using applied thematic analysis.

RESULTS

- *Police Focus Groups and stakeholder interviews*
- Two major themes emerged from the analysis of the focus group and interviews:
- *Barriers to the effectiveness of the real time suspected suicide surveillance pilot strategy*
- *Facilitating a successful real time suspected suicide surveillance pilot strategy*

Barriers to the effectiveness of the real time suspected suicide surveillance strategy

- *Lack of clarity over the pilot strategy*

> "I think it's difficult to explain to them what something is if you don't know yourself, if you are not 100% sure… do you want any further help sign here, and to be able to turn round and say well what sort of help then you are a bit stuck because I didn't know what it was." – P2 Focus Group [FG].

Barriers to the effectiveness of the real time suspected suicide surveillance strategy

- *Officers resistant to the pilot strategy*

"Personally I think it was inappropriate, I thought that at the time, certainly the two that I have gone to where I considered to be within the remit for the documents. It was very inappropriate to ask the families there and then… I thought it was inappropriate." – P1 FG

"I would agree with that, I think maybes a week or so when all the initial, you know shock is actually sunk in, then to come in with the help, but yeah I agree with you I think, I thought it was a bit inappropriate." – P3 FG

Facilitating a successful real time suspected suicide surveillance strategy

- *Pilot strategy expedites access to support*

"They do try and, I know that as a service they've always tried to get as many people in, but since the pilot, since this pilot it means that, you know I'm never in the office, I'm constantly out and about, doing these kinds of services that people wouldn't have had access to before, and I think it's one less stress" – P4, Welfare Rights [WR]

"The added value of the pilot system I think first and foremost, we are able to respond to erm incidents of suicide as they happen rather than waiting which we previously had done. And for me it was a bit trying, to work backwards as opposed to actually being there from the beginning… Traditionally people hear about us from word of mouth and that could be maybe five, six months down the line – P5, Postvention Support [PS]

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Facilitating a successful real time suspected suicide surveillance strategy

- *Alternative to Notification of Death referral route*

"I think what you are saying is a really good idea, but you could have you know your little booklet, or whatever it may be, with our form inside, fill in our form, tear it out and then… there's no way you're going to forget it, you can't fill in erm the details that we would because you need that booklet and so it's left there and then." – P3 FG

Conclusions

- The results of this evaluation would suggest that the coroner system is more consistent at identifying suspected suicides.
- However the pilot strategy was quicker with reports being filed an average of 1.4 days quicker than the current system.
- Bereaved individuals seemed willing to share their details with postvention support, with contact details collected in 78% of cases where an ND form was completed.
- The results of the focus group indicate that the pilot strategy needs more visibility within the police.
- The interviews with stakeholders indicated that services need to be aware of the potential for increased uptake of their services.

Linking Community Knowhow with Academic Knowledge through a UK Community-Campus Partnership for Health

Presenters:
Jane South, Karl Witty,
Sally Hayes, Susan Coan
Leeds Beckett University

This is the story of developing CommUNIty - our Community-Campus Partnership for Health

The presentation covers the 'why & how' and explains what happens now. It's a chance for us to share some of the highs and lows and our learning on this journey.

Thanks to…

- Hanif Malik, Hamara Centre, and Professor Mark Gamsu for their advocacy and courage to do something different
- Professor Andrew Slade, DVC, Leeds Beckett University for pump priming the original idea and enabling us to get it off the ground
- Anke Roexe, Sally Foster and Professor Michelle Briggs whose contributions have helped shape CommUNIty
- Professor Ieuan Ellis and the Faculty of Health and Social Sciences for ongoing support to CommUNIty

Where it started – our rationale

- We knew that inequalities affect health, research & education
- We respected a tradition of participatory research & practice in health promotion
- We saw an opportunity – a new policy context, new research institute
- We borrowed an idea that seemed right – Community Campus Partnerships for Health
- We aspired to do something different

Healthy Communities

LEEDS BECKETT UNIVERSITY

Institute for Health & Wellbeing

Research that meets information needs in policy & practice

- People in Public Health
- Peers in Prison Settings
- Walking for Health
- Community Health Champions
- Health Trainers
- Local government planning & evaluation
- NICE review on community engagement
- Evaluation of Volunteering Fund
- Glasgow Commonwealth Volunteers
- What Works Wellbeing

Partnerships & Public Engagement

- CommUNIty – a community Campus Partnership for Health
- Dissemination activities
- Health Together
- Active Communities for Health – national think tank
- PHE secondment
- International collaborations

Equity
Participation

LEEDS BECKETT UNIVERSITY

CommUNIty:

Working with the community to improve health and wellbeing in our communities.

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commUNIty

A Community Campus Partnership for Health

Our original aims ....

Bringing university and community know-how together

We help enrich the student experience…

CommUNIty Talks

All seminars will be held in Room NT118, 11-12pm on the dates shown unless stated.

Weds. 28th October	**Crime Prevention** Presented by PC Mark Bottomley, Police Liaison Officer
Weds. 11th November	**The Maternity Needs of Asylum Seekers and Refugees** Presented by Rose McCarthy, National Streams Coordinator City of Sanctuary Maternity Stream
Weds. 18th November	**Arts and Mental Health in Leeds: The Current Picture** Presented by Tom Bailey, Development Worker, Arts and Minds
Weds. 25th November	**Who cares? - Why we Need to Support Unpaid Carers** Presented by Sian Cartwright, Health Development Manager & Val Hewison, CEO, Carers Leeds
Weds. 2nd December	**Alzheimer's Society in Leeds and our New Service** Presented by Tracy Brierley, Service Manager Leeds, Alzheimer's Society & Lynn Welsh, Memory Service Support Team Manager, LYPFT
Weds. 9th December	**Challenging Homelessness and the Perceptions of Homelessness** Presented by Andrew Omond, Assistant to the Directors, St. George's Crypt – This talk will take place at St. George's Crypt and just 10 places are available, to book a place please e-mail community@leedsbeckett.ac.uk
Weds. 16th December	**Health on the Margins - Gypsy and Traveller Health Status in the UK** Presented by Ellie Rogers, Partnerships Manager, Leeds Gypsy and Traveller Exchange (GATE)

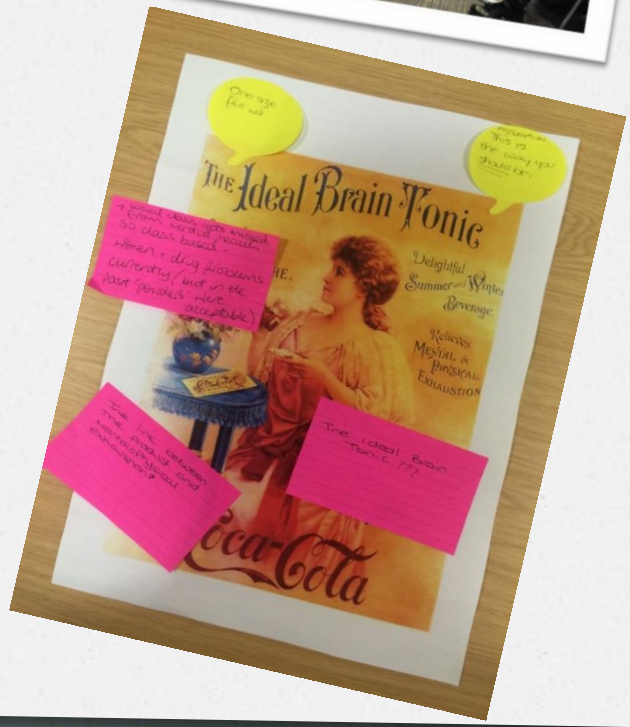
For more information on Leeds Beckett University's CommUNIty Initiative please see our website www.leedsbeckett.ac.uk/community.

Contact us at community@leedsbeckett.ac.uk or via twitter @LeedsCCP **#CommUNItyTalks**

We facilitate community based placements and student projects…

We support widening participation…

We've successfully bid to deliver ESRC Festival of Social Science events three years running…



Not everything works…

Timebanking model – not yet!

Placements & student projects

Budgets & funding

No reception/nice space

Bureaucracy, systems,

The struggle of the website

What makes it work?

- Relationships, relationships, relationships
- Community organisations willing to collaborate
- Respecting knowledge
- Dedicated members of staff – trusted point of contact
- Senior support which opens doors
- Working with the willing - not imposing on university staff

Concluding remarks

- Relationships are the critical building blocks
- Work with the possible, link with the willing
- Prepare for the messy – it's not neat
- Values around equity and participation underpin the work

Thank you

If you want to keep in touch

https://www.leedsbeckett.ac.uk/community/

E-mail us: community@leedsbeckett.ac.uk
Tweet us: **@LeedsCCP**


Inspiring success

Teesside University

Extra Life: working together to produce health for all in workplace settings

Presenting Authors: Professor Janet Shucksmith (Teesside University), Richie Andrew (Middlesbrough Council)

Contributing Authors: Sarah Dinsdale

(Teesside University)

Sarah Slater, Sue Perkin (Middlesbrough Council)

Extra life


Overview of presentation

- **Background**
  - Workplace settings, but focus on whole population in those settings
  - Whole system/settings approach
  - Co-production approach
  - Extra Life in Middlesbrough
- **Process evaluation of early implementation**
  - Methods
  - Key results
- **Benefits and early impacts**
- **Moving forwards**

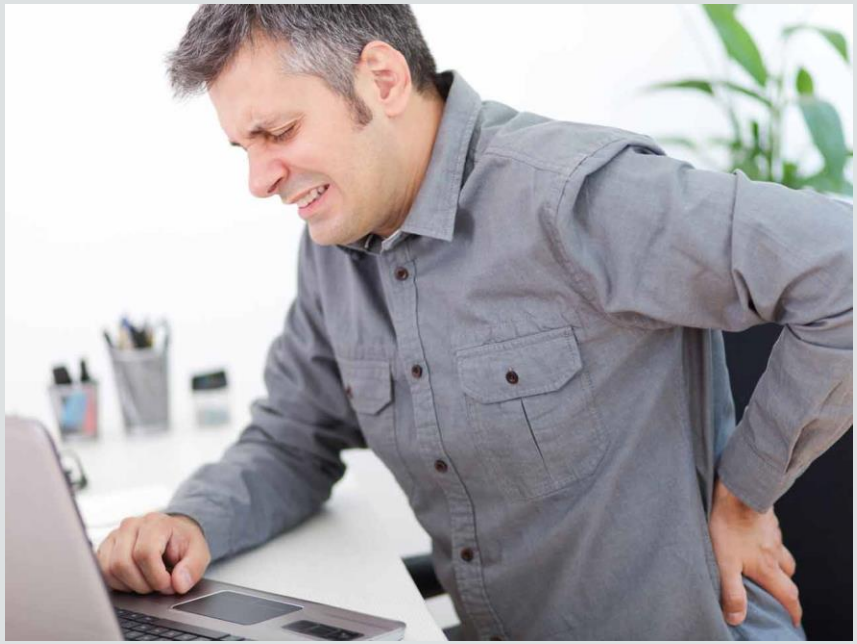
Extra life


Workplace health

In UK in 2011:

- 131 million days per annum lost through sickness absence/injury
- Musculoskeletal problems caused largest number days lost
- Depression/anxiety accounted for 10% days lost

(ONS 2012 Sickness Absence in the Labour Market)



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- Costs of ill health in workplace huge
- Healthier, happier work force = cost savings, improved productivity, reduced absence, improved recruitment and retention of staff and students
- Nevertheless organisational investment in employee health and wellbeing varies (employer centric- employee centric organisations)

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- Emphasis not just on ‘workers’ in these settings, but also on populations in and around - students, patients and communities these institutions serve
- The workplaces are therefore important ‘settings’, but interest not confined only to workforce

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Whole system/settings approach

- *Health is created and lived by people within the settings of their everyday life, where they learn, work, play and love*" (WHO 1986).

- A settings approach '*involves a holistic and multi-disciplinary method which integrates action across risk factors. The goal is to maximise disease prevention via a "whole system" approach*'. (WHO 2014)

- Human beings exist in complex environments - aspects of these environments can help improve, or be detrimental to health (Paton, Sengupta and Hassan 2005)
- Focus on modifying context and culture within setting, rather than delivering specific interventions to individuals

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Co-production

- Using assets-based approaches like co-production instrumental if want to successfully shift balance of health and social care and develop public services focused on prevention and independence
- Co-production recognises that people have ‘assets’, e.g. knowledge, skills, characteristics, experience, friends, family, colleagues, communities – can all be brought to bear to support health and wellbeing
- Co-production places people at heart of service and involves them in it, from creation and commission to design and delivery, assessment etc

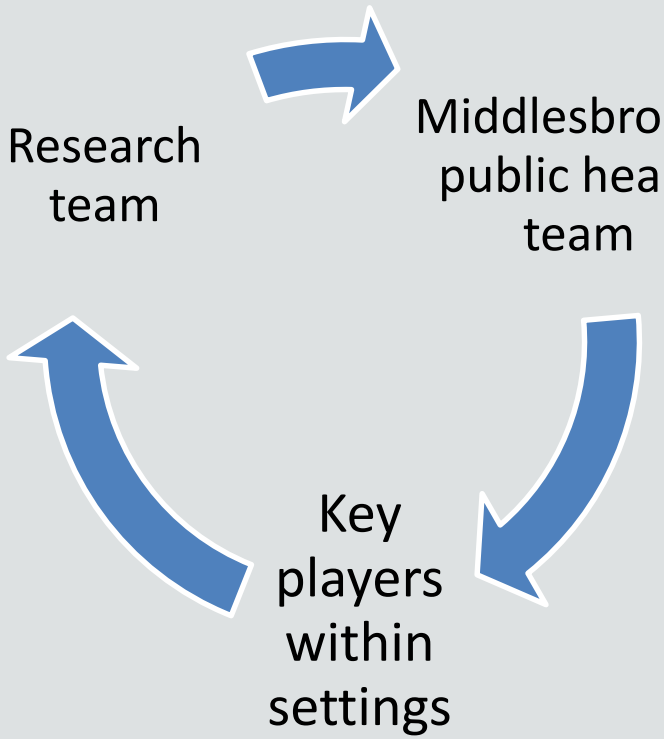
Extra life

- *5 Step Public Service Transformation Model*
- ***mapping***,
- ***focusing***
- ***peopling*** strategy with co-producers inside and outside organisation
- ***marketing*** it to sceptics
- ***growing*** it within and beyond organisation

Governance International

Extra life


- Involvement of all parties throughout = outcome that is 'owned' by everyone
- Recognises that sustainable cultural change within large organisations must involve 'buy in' at all levels.
- Acknowledges existing needs and assets, and involves staff themselves in producing change



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Extra Life in Middlesbrough

- Settings approach started in 2013 led by Middlesbrough Borough Council Public Health team
- Initial focus on three large local employer organisations - more now involved
- Unusual in that it connects major employers across the town
- Health Needs Assessment carried out in each setting; led by research team in collaboration with PH and key players in settings
  - Online surveys, focus groups, exploration of existing data
- Led to development of strategy and action plans

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Settings include:




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Extra life Standards

Process	Structures and systems in place to promote a culture of health and wellbeing	Training and development	Communication	Health Champions	Consultation	Staff and service user engagement	Measure and Evaluate
Leadership	Lead by example to promote positive health and wellbeing throughout all levels of the organisation	Resources	Top level decision making and buy-in	Commitment	Accountability	Policy Development	Organisational structure
Activities	Provide access to a range of opportunities and activities linked to positive health and wellbeing	Quality health and wellbeing services and support	Improved behaviour and lifestyle choices	Offer of services based on need	Delivery and support of campaigns	Services available and accessible to all	Promote and integrate ways to deliver health-led activities
Connected	Develop strong partnership links to achieve shared health and wellbeing goals	Internal and external partnerships	Joined up working	Sharing of knowledge and best practice	Active engagement in Healthy Settings Network	Collective role in delivery of town wide objectives	Wider community engagement in health and wellbeing
Environment	Ensure working environments support positive health and wellbeing of all	Secure, safe and healthy environment	Quality catering provision	Availability and access to facilities	Physical activity opportunities	Promote sustainable travel options	Promote / display Extra Life brand to raise awareness

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Process evaluation of early implementation

- Qualitative evaluation of early implementation and potential of Extra Life, through consideration of key individual's views and experiences
- Aim to capture barriers and facilitators to early implementation
- Explore key learning around working in collaboration (between public health, the settings and the research team)

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Methods

- 9 semi-structured interviews with key individuals involved in early establishment of Extra Life, within first three settings, including PH team (n=4), and organisational leads across the three settings (n=5)
- Data from interviews analysed thematically

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Key results

Understanding and sense making

- Organisations invited to engage with Extra Life due to size, reach and natural fit with programme
- Engaging with programme seemed to make sense to organisations
- On-going challenges in relation to understanding concept of Extra Life among those tasked with driving this forwards
- This then had implications on their ability to convey Extra Life to others

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Commitment levels and buy-in

- Organisational leads often seen as natural person for job, due to role, skills or interest
- On-site support of PH team (knowledge, skills, networks) seen as vital for success
- Capacity key issue: often 'projectism' evident, with Extra Life being responsibility of only few individuals
- Extent to which organisations engaged individuals both at operational and strategic level varied - programme might have insufficient momentum, or lack of 'clout' to give it precedence, and ensure Board level 'buy-in'

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Collaborative working

- Benefits of improved networks, and stronger brand
- Challenges in terms of bringing together different backgrounds, ideas and understanding
- Interviewees told us about communication barriers, and organisational sensitivities that required negotiating

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Benefits

- Not possible at this point to pass verdict on success or otherwise of approach in terms of health gains
- Highlights potential for prevention and early intervention across settings
- Strengthens corporate, social responsibility of organisations in delivery of health and wellbeing for employees and wider community
- Needs assessments have assessed, described and communicated local health and wellbeing needs of populations to inform action
- Have also influenced strategic stakeholders in establishing leadership structures in 3 organisations to champion health and wellbeing in and across organisations
- Improved networking and joined up working, both across and within organisations. New organisations have signed up

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Early impacts

- Piloting cervical screening for staff on site
- Health and wellbeing hub development
- Week dedicated to Stress Down Campaign across the 3 organisations
- Influencing full commercial catering review/Middlesbrough Food Plan
- Development of on-site community growing project
- Increasing availability of water coolers
- Festival of Wellbeing
- Increasing access to “Time to Chat” services in setting
- Review and development of Health & Wellbeing Strategies
- Incorporating health needs of settings into new commissioned services such as 0-19, sexual health and mental health services

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Moving forwards

- Monitoring and evaluation seen as critical for sustaining momentum
- Evidence around ***effectiveness*** of these types of whole-system, tailored and co-produced approaches is limited, due to challenges of evaluating conceptually complex and multi-component approaches of this nature
- How should we measure costs and benefits?

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Thank you. Any questions?

Acknowledgements:

- Lisa Anderson, Sarit Carlebach, and Pat Watson at Teesside University
- Becky Gaines, and others at MBC public health team
- Leads within each of the settings

Extra life

KNOWLEDGE MOBILISATION FOR IMPACT

THE ROLE OF STAKEHOLDER ENGAGEMENT

Robert Borst
Annette Boaz, Maarten Kok, Stephen Hanney, Theresa Jones, Alison O'Shea, and Subhash Pohkrel
Kingston University London & St George's University of London
Brunel University London

www.healthcare.ac.uk

The problem

- Retrospectively, interaction and context seem important for the use of research
- Stakeholder engagement as promising approach

- Stakeholder engagement most often studied in retrospect
- Unclear what context actually entails

Aim of this study

- Aim of our study was to prospectively track stakeholder engagement activities in a large European multi-country tobacco research project

- ... and see how context plays a role in these dynamics

About our study

- Our study is called SEE-Impact and is funded under the MRC's economic impact programme

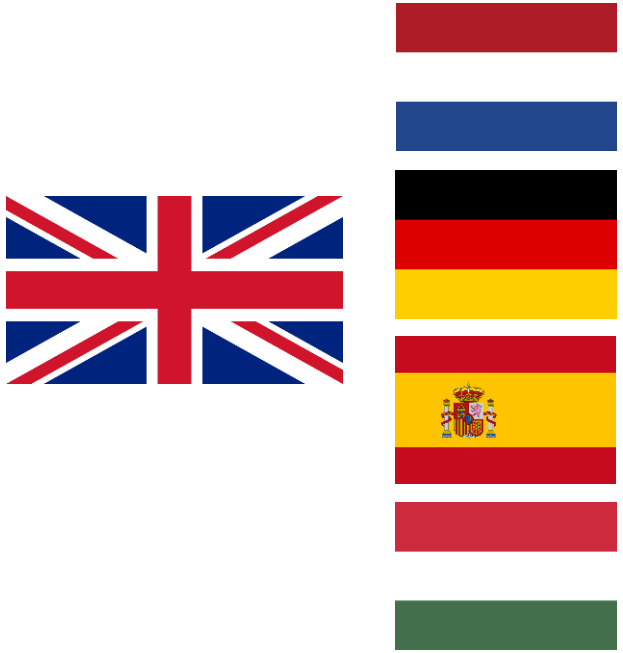
- We study the stakeholder engagement activities in the tobacco research project.

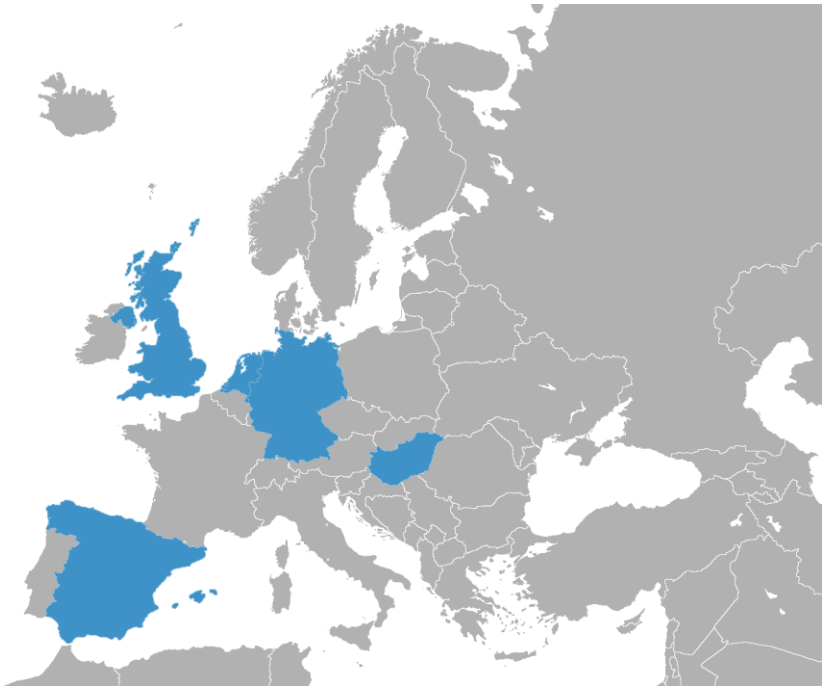
The project that we study

The project that we study:

- Aims to assess the return-on-investment (ROI) of anti-tobacco policies by using a tool
- Is based on earlier work for NICE
- Is funded under FP7

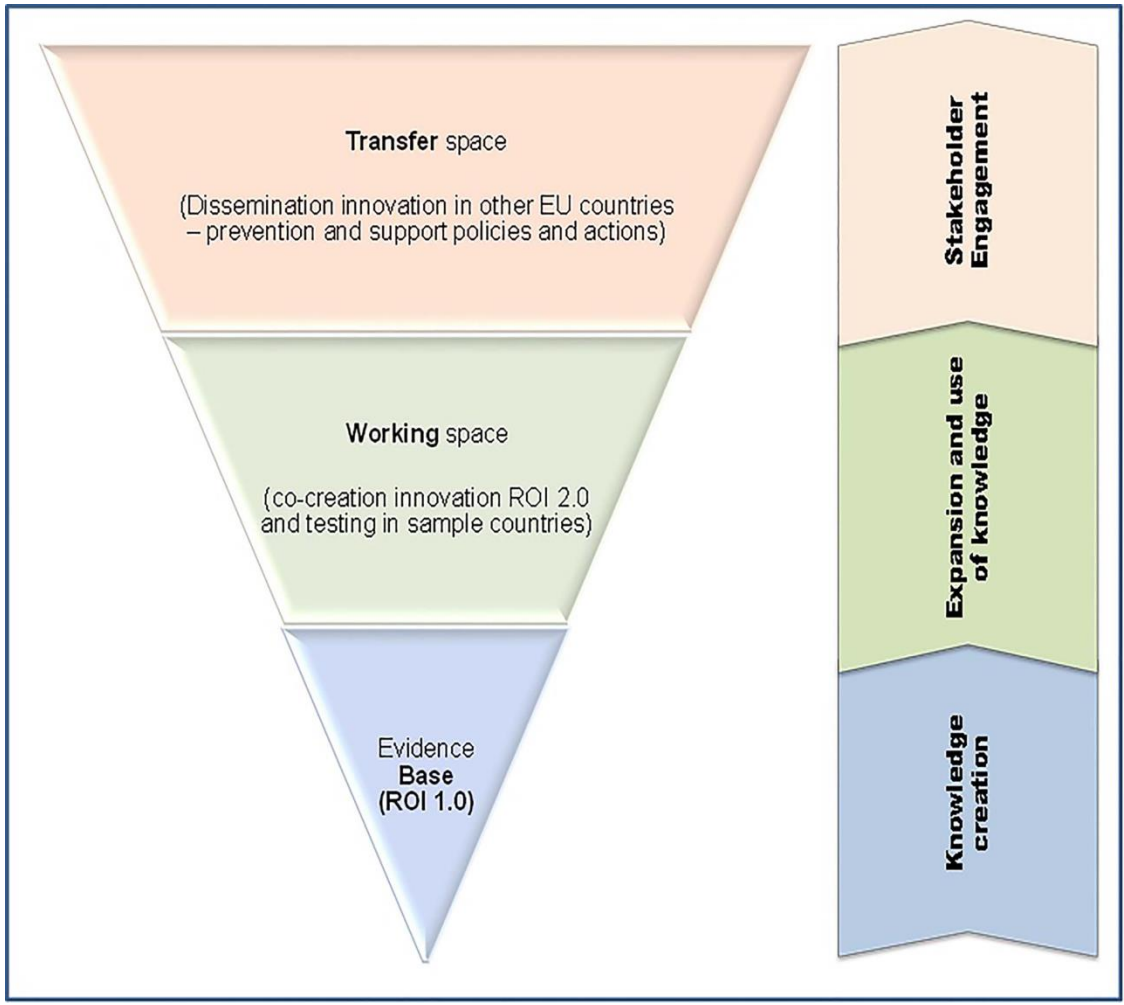
The tobacco research project



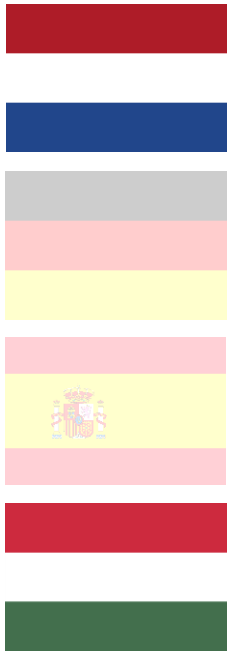


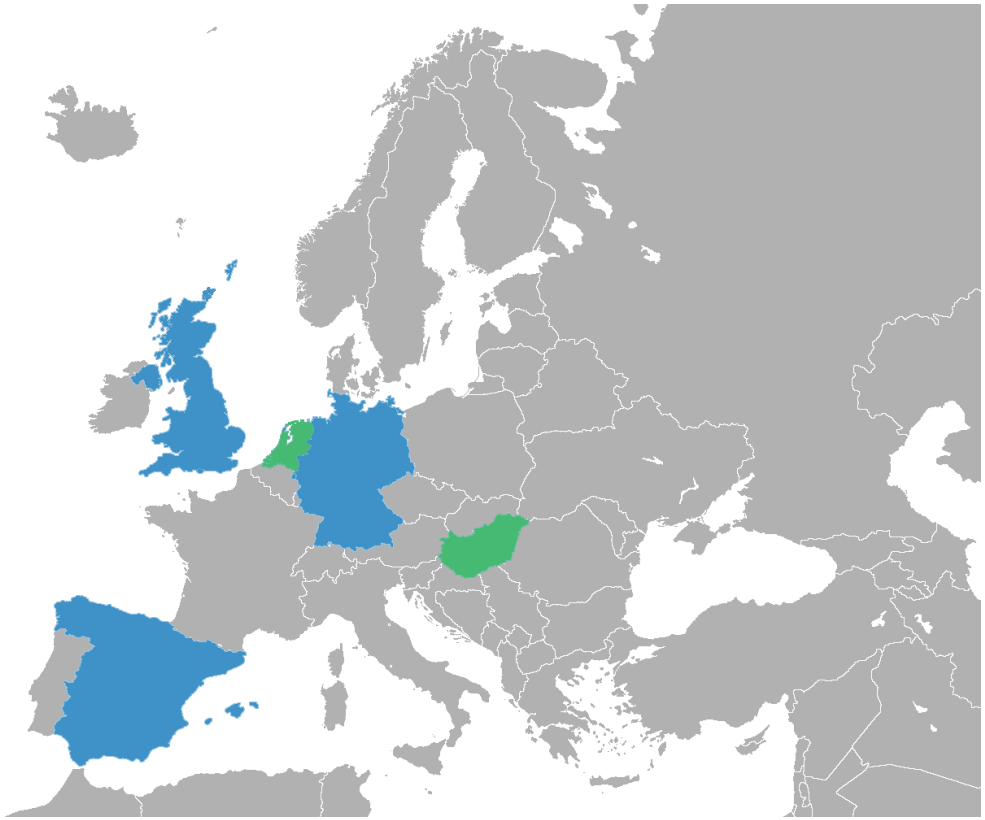
Why study this research project?

- **Explicit theory on change**
- **Stakeholder engagement playing a central role**
- **Multi-country**



Today's focus





Our theoretical approach

- **Framing how knowledge is translated into action inspired by ANT**

- **Actor-scenario perspective**
  1. Explicit idea of how knowledge is translated into action
  2. Starts with the active role of the user
  3. Users put forward a scenario of the future in which they assign roles and responsibilities.
  4. They bring knowledge or research results into this scenario

- **Example of such a scenario...**

  "This study shows that he should do this, they should do that, the budget should be increased, and advertisement should be forbidden."

What did we do

Prospective multi-method study:

- Semi-structured interviews
- Observations

We asked the stakeholders to make explicit their scenario about how the results of the research project will be used

Results

Stakeholders had different scenarios

- Different people would play a key role
- Difficulties with envisioning potential users
- Converging and diverging

Generic users

- Unable to identify ‘generic’ actors in practice.
- Unclear responsibilities

Similar elements of context

- Past events, political climate, governance structure, other local circumstances

Convergence in Hungary

Roles and responsbilities in Hungary:

- Named specific policy makers
- National Focal Point for Tobacco Control (FPTC OEFI)
  - Specific person
- Koranyi Institute for Pulmonology
- National Public Health and Medical Officer’s Service (ÁNTSZ)
- National Health Insurance Fund (OEP)
- Rarely mentioned the Secretary of Health

Divergence in the Netherlands

Roles and responsibilities in the Netherlands:

- “The policy maker”
- Municipality Health Service (GGD)
- Municipality Government
- National Institute for Public Health and the Environment (RIVM)
  - Chronic Diseases Model (CZM).
- Trimbos Institute
- Rarely mentioned the Ministry of Health (VWS)

Reflections

- Actor-scenario mapping seems a promising approach to enriching our understanding of both stakeholders and context, and interaction between them.

- Mapping actor-scenarios helps to envision how research results might be used, who the key stakeholders are in that process, and how they may play a role.

- It shows how context is constructed in that process and how elements of context play a role.

Thank you!

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