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Title: A qualitative exploration of stakeholder perceptions of the implementation of place-based working and its potential to reduce health inequality.

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Abstract

Background:

Local Authorities (LAs) have statutory responsibility to reduce health inequalities and improve public health. Place-based approaches may positively influence service provision yet little is known about their implementation and potential for reducing inequality through health and wellbeing improvements. An English LA implemented a place-based working (PBW) pilot in a small geography during austerity measures in the north of England. This involved three strands (Early Intervention, Estate Services and Community Intelligence) which were introduced separately and covered overlapping geographies. Predominantly focusing on Early Intervention, this qualitative study investigates stakeholders' perceptions of the pilot and its potential to improve health and wellbeing by reducing inequality.

Methods:

Fifteen face-to-face qualitative interviews with stakeholders were completed. Thematic analysis produced context, mechanism and outcome configurations (CMOs) in a process adapted from realist evaluation methodology.

Results:

Stakeholders described PBW as holistic, upstream and cutting across departmental boundaries to engage staff and the community. Collaborative working was considered important and was aided by PBW in our study.

Conclusions

PBW has the potential to reduce health inequalities by improving health and wellbeing. LAs deliver services that affect health and wellbeing and place-based working may help develop a more coordinated response to improve outcomes and potentially save money.

A qualitative exploration of stakeholder perceptions of the implementation of place-based working and its potential to reduce health inequality

Introduction

Health and life expectancy are not solely consequences of medical or genetic factors and reflect wider social and environmental issues (1, 2). Social issues affect the likelihood of ill health, premature death and the number of years of healthy life expectancy with people on low incomes being more likely to suffer ill-health, experience declining health at a younger age and die sooner (1, 3, 4). These broader social factors such as poverty, poor housing and unemployment may negatively influence health outcomes (1, 4). People experiencing the worst health outcomes are often clustered in defined geographic areas (2) and disadvantage in early life is associated with poorer outcomes throughout life (5).

Health inequality is an entrenched and "wicked issue" (6, 7) because improving population health outcomes and finding solutions are difficult and contested (1). Health inequality places a burden on individuals and their families as well as on public expenditure. UK (United Kingdom) government concern over public expenditure is heightened during times of austerity. Individuals are increasingly presented as being accountable for their own health outcomes (8) and there is a focus on the financial burden of ill-health and finite NHS (National Health Service) budgets. This has coincided with a decline in the numbers of deaths in the UK due to infectious, communicable diseases and an increase in morbidity and mortality in diseases associated with 'lifestyle' (1). Indeed, over half of the global burden of disease consists of non-communicable diseases (9).

Reducing health inequality involves a consideration of wider social factors that affect health that extends beyond health service delivery and uptake (10, 11). It requires a coordinated policy response across government departments and their delivery partners (12). Local Authorities (LAs) have statutory responsibility for public health which includes reducing health inequality as well as for a wide range of other functions such as housing, education and transport that affect outcomes. The recognition that many of the social determinants of health were the responsibility of LAs was one reason that public health functions were returned to LAs from the NHS in the UK in April 2013 (13). Public Health England was created and sought integrated working between health and social care to address inequalities, prioritise health improvement activities and to clarify accountability for public health actions and spending (14). Since reorganisation, there have been some successes, but health improvement and public health have not received the promised priority and austerity measures entailed many LAs cutting some of the wider public health functions that were not ring fenced (15).

Austerity measures following the economic crash in 2008 meant that rationalising public services became an aim (16) as the government pursued neoliberal objectives of reducing the public sector (17) . Before the return of public health functions to LAs during the Coalition government's office (2010-2015), the preceding Labour government (1997-2010) identified the need to rein in public service expenditure and stated their intention to focus on prevention to improve outcomes by implementing a policy called Total Place in thirteen pilot areas to assess its efficacy (18). Total Place advocated that local government could save money and improve services by providing coordinated place-based services through service integration and avoiding waste by duplication (18). PBW, although acknowledged as being well-meaning, has been criticised as being of limited scope as it does not address socio-economic disadvantage and deprivation (19).

Influenced by Total Place, one LA redesigned service provision in a small pilot area to rationalise resources and to improve outcomes. It aimed to improve services and save money, yet its focus on community empowerment and its bottom-up approach to developing services to meet service users' needs located its ethos in place-based services. This paper presents a qualitative exploration of stakeholder perceptions of the pilot's potential to reduce health and social inequality by improving health and wellbeing outcomes. Our research question explored stakeholder perceptions of the implementation of the intervention to develop our understanding of the associated contexts and processes and how the intervention might contribute to reducing health inequality.

Context

The LA included urban and rural areas. This implementation of PBW was in a rural market town with a stable population base and a low wage economy characterised by agriculture and tourism. It was a distance away from nearby cities, affecting access to further education, jobs and health services and distant from the LA's administrative centre where core functions were centralised.

PBW (called an intervention in this paper) was described as a combination of three projects (strands) that occurred in an overlapping geography (Figure 1) that were developed closely together and implemented sequentially as part of the project. A project board, chaired by the Director of Public Health, provided strategic direction and senior level support for implementation. Once PBW was embedded, the board was dismantled, although most remained involved with the implementation of the intervention.

Insert figure 1

The three strands (Box 1) of the intervention were implemented separately within existing service delivery and staffing boundaries. Early Intervention (for families with children) was

implemented first and drove the development of the project. Estate services with a small, defined geography, aimed to engage the community and implement environmental improvements. Community intelligence provided a confidential reporting system to residents and staff to encourage the reporting of anti-social or other incidents or concerns that may otherwise remain unreported.

Insert Box 1

Methods

We conducted individual face–to-face interviews to enable a detailed exploration of stakeholders' views (20, 21). We were interested in stakeholders' views on the different aspects of the intervention and participants' perceptions of the reality of their everyday work and how that differed from previous ways of working. We framed our analysis within a perspective of complex realism (22) with a qualitative adaptation of realist evaluation (RE) methodology to develop context, mechanism and outcome (CMO) configurations (20). RE explores complex social interventions by developing CMO configurations which involves a detailed consideration about the specific contexts of the intervention and the mechanisms (stimulus) that may produce changes in outcomes (20).

Fifteen key stakeholders were recruited, initially using a purposive sampling approach (23). MS initially recruited 10 participants via attendance at a project board meeting. We changed to snowball sampling (23) for pragmatic reasons following the disbanding of the project board once PBW's approach was mainstreamed in the area. Consenting participants from the project board identified others connected with the project. Five further participants were recruited (totalling 15 altogether).

Northumbria University Ethics Committee (9 December 2011) approved the study. Participants were given an information sheet, gave informed consent, assured of anonymity and entitlement to withdraw at any time. An interview guide provided focus for the discussion and enabled participants to raise matters important to them (24). Areas discussed included their work role and experiences of the intervention. Interviews were conducted by MS and digitally recorded with permission. Three participants were concerned about anonymity and did not want interviews recorded. In these cases, field notes were taken during the interviews and expanded upon afterwards as an authentic record of the conversation (25), offering a pragmatic approach to recording as much detail as possible (26). When no new data were emerging and saturation point (27) was reached, interviews were concluded.

All transcripts were proof read and coded line-by-line by MS using Nvivo version 10. For the first two transcripts, thematic data analysis (28) was undertaken by MS then reviewed by MS

and two other researchers on the project team for dependability and "confirmability" (29). This prompted useful discussion and analytical insights for consideration, enhancing the rigour of the analysis (30). The analysis was also discussed periodically (31) with AM. All remaining transcripts were thematically analysed (28) by MS methodically and comprehensively (30), including comparing data (32). Key quotations from these themes were subsequently sorted, ordered manually and synthesised into explanatory CMO configurations (20) by MS to address the research question and understand stakeholders' perceptions of the context and processes of the intervention and any influences on potential outcomes.

Further to the three participants who consented to interview but not to recording, some others sought assurances about confidentiality, suggesting some vulnerability in organisations undergoing change (33). There were risks of participant identification by others within the organisation (34), so the location, and roles ,of participants were supressed to fulfil our ethical responsibility to preserve anonymity.

Results

CMO configurations were developed from the thematic data of stakeholder perceptions. We focus on data from the CMO place and PBW and present stakeholders' views of the potential of the intervention to reduce health inequality. Data to support the findings are presented verbatim with participant number identified.

Place and place-based working

Characteristics of the place were identified as being important to the intervention as a location and as a place where many staff lived. Consequently, the development and implementation of the intervention recognised that many front-line staff lived within the town's boundaries. This potentially provided staff with additional incentives and commitment to the intervention:

> "…trying to get this idea of staff fulfilling a broader range of roles but being as much members of their communities..." (8)

The low turn-over of staff meant that established working relationships already existed:

> "…being in the job for quite a few years now, you get to know professionals very well ..." (12)

However, the intervention was credited with enhancing these relationships:

> "…we already were a cohesive group, but it's just taken us to the next level…" (13)

PBW was identified as being a different way of working that relied on cooperation and a shared purpose to improve outcomes:

> "…it's only if all, if the stakeholders decide to change the way they deliver and use their resources that you get impact…" (11)

Due to its evolving, localised nature, it was not initially clear what the intervention was. Its status as a pilot intervention meant that there was no clear vision statement:

> "…some of the focus in the early days it could have done with a strategy…it didn't have that…steering group meeting, that first one I went to, people weren't really sure..." (4)

Some participants reported that councillors and people in the community, perhaps because of the place-based focus, originally thought that it was a regeneration project:

> "…we've had to constantly…manage expectations…Because they got it all mixed up with regen[eration]…" (6)

However, others indicated the intervention was distinct from regeneration. It was not based on a dedicated, time-limited funding source for housing or environmental improvements. It was based on staff as a place-based resource, working better together in the community:

> "…all these lovely schemes, but in three years the funding stopped and they all said the same thing at the beginning, they'll self-sustain. And, no they never did. …I think this [intervention] probably can because it's not really about the resource investment it's about the the officer investment in time and the engagement and making sure we keep talking to each other…' (10)

Involving schools and social services at the monthly Common Assessment Framework (CAF) panel aimed to promote early contact between professionals and encourage working together. Participants considered this beneficial for improving collaborative working to

provide better support for families:

> "…overall it has improved links and overall it has improved working together…I think we're all like trying to support families better." (12)

Improved collaboration across services was attributed to the intervention:

> "…this is breaking down barriers…people are starting to realise that to get a better service, you've got to work together… rather than just being centred on one service trying to do their little bit…and this is where there's the change…" (4)

> "…I think it's just the shift with the [intervention], the work of CAF, that's been integral to the work…and how we all work collaboratively together…" (9)

CAF professionals endeavoured to lever-in more local consultations, to save service users' time and travel which may contribute to improved health service access:

> "…it's difficult getting, sometimes getting people like the [name] team up …They do come and do some of the appointments up here but I do think that's an issue..." (12)

Potential to reduce health inequality

Participants indicated the intervention had the potential to reduce inequality because it focused on wider social determinants of health, had a collaborative PBW, more responsive approach and was empowering for service users (Box 2).

Insert Box 2

Collaborative early intervention aimed for intervention before crisis to meet families' needs, and it was suggested that it was more engaging and less stigmatising for service users:

> "The families that I did ask seem very happy, there's probably less stigma…And the CAF process in [Area]…really helped and we do well at supporting families through the CAF process..." (12)

The CAF panel's flexibility to administer small financial grants demonstrated that poverty and deprivation featured in some families' lives:

> "…having a CAF resource panel to have a little pot of money that if a family needs …to buy a second pair of glasses for a child who keeps forgetting… that makes a difference to that family member…" (9)

PBW, a difficult concept for staff to grasp initially, focused on a collaborative approach to service improvement and integration for the benefit of the service user:

> "… we were trying to find ways of…doing things in a different, more productive way for families… they weren't getting a good service …we spent a lot of time… looking at how we could make things better…quite often we had to re-visit…go over old ground in order to kind of re-confirm what we'd decided to do…It's about thinking, well if I can't deliver, who else can. And if another agency can deliver and I can help that agency …" (13)

Austerity was important, but saving money was considered an outcome of improved service delivery. However, this is hard to evidence and there was no process within the LA to attempt to measure it.

Discussion

Main findings of this study

This small study provides insights of stakeholder perceptions of the development, implementation and contexts and processes of PBW, focussing on its potential to aid collaborative working to contribute to reducing health inequality. Stakeholders suggested that collaboration between staff supports the successful delivery of public health interventions. In our study, it appeared that PBW engendered this and engaged service users (according to stakeholders) with a more bottom-up approach to service delivery.

Ongoing dialogue and meaningful consultation between staff are necessary to enable them to fulfil their duties and avoid adverse impacts on public health (35). The diverse range of services that LAs are responsible for positions them as key strategic players addressing public health but central government controls how LAs spend most of their money (36). This may limit the potential for creative collaborative decision making and action.

According to stakeholders, some consolidation of staff relationships and roles occurred. Many already knew each other which provided a solid footing and agency of service users and staff operated within existing structural constraints. A learning, transformative organisation that maintains accountability and responsibility yet allows staff flexibility (agency) to use professional judgement and is responsive to service user needs arguably affords a greater potential to address the social determinants of health. In our study, PBW appeared to offer the potential to improve working practices during austerity through

partnership working which may operate as a mechanism to counter some of the effects of health and social inequality.

What is already known on this topic

Returning public health responsibilities to LAs is not a panacea for consistent approaches and policy (37) and the environment frames (and influences) interactions between individuals and groups (38). Delivering public health improvements relies on collaborative working with partners (39) as public health is multifaceted and complex (40). Collaborative working derives out of necessity to address specific issues because of its complexities and because it is time consuming to develop relationships (41). Adaptable structures may be advantageous to an intervention's implementation and to cultivate collaboration (42).

What this study adds

Based on stakeholder perceptions, we describe the effects of PBW in a small community and how it was credited with enhancing established working relationships to implement a new model of service delivery. We considered how place may affect relationships at an organisational level and explored collaborative working and the potential to reduce inequality from participants' perspectives. The intervention, complex and dynamic, involved multiple partners and the engagement of service users. Adapting a realist evaluation (20) approach facilitated an exploration of stakeholder views of how contexts and mechanisms influenced outcomes. It enabled learning ("knowledge cumulation") (not reproduction) (20) about what worked to be gathered and adapted to support roll out within the same (or different) LA.

How place affects collaboration is perhaps less well researched than place effects on health. We considered PBW that fitted within existing service delivery remits and avoided boundary (or other) reorganisations that can be costly, divisive and distracting. A fluid boundary may aid PBW's implementation. We concluded from stakeholder descriptions that it represented a pragmatic approach, focusing on collaboration and cooperation for the benefit of service users by developing more bottom-up, holistic, person-centred approaches, strengthening and developing existing partnership working with due regard for professional working practices and domains. Redesigning services may be undertaken during austerity and organisational transition. In our study, it involved structure and agency at an individual, professional and organisational level which suggests that LAs need to be progressive to fulfil public health responsibilities and capitalise on the opportunity to refocus action on structural determinants of health. PBW may help LAs to develop services to meet their public health responsibilities during austerity.

Limitations of this study

This was a small-scale qualitative study concerning one LA, with a relatively low turn-over of staff and residents. It focused on one initiative in one LA locality and was based on stakeholder perceptions.

Authors' contributions

MS drafted the paper and both authors revised it.

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Early Intervention – covered town's school catchment areas and focused on a small number of families who were below levels of statutory engagement and who were at risk of their needs escalating.

Estate Services – focused on one estate and involved residents in planning and prioritisation of environmental estate services (grass cutting, litter picking etc.)

Community Intelligence – confidential reporting in confidence system for staff and residents to a designated LA officer. Developed in town and extended LA wide.

Place-based services
Bottom-up approach
Person centred
Improve outcomes
Save monev

Place and place-based working

Collaborative: "...it has improved links and...working together so you're not just thinking,oh, I'll refer it into Children's services it's not my area..." (12)

Empowering: "...empowered...the resident's group...a general confidence about how they operate." (13)

Community led: "...community...setting its objectives and operating the way it...wanted to...doing it local." (13)

Voluntary: "...never in all the CAFS that I've done...had anybody say no..." (9)

Potential to reduce health inequality: address some social determinants of health

Improved outcomes: "...not necesssarily going to save money, you just get better outcomes." (6)

Early Intervention: "......get in early...stopping families from hitting that higher end threshold...." (9)

Community Intelligence: "...report came in...children...were getting drugs and the drink...that's been addressed" (3)

Estate Services: "...more cost effective...engaged more with the community...made sure that we'd be multi-skilled..." (10)

Estate Services - targeted area, clearly defined estate boundary in the town

Early Intervention - town's school catchment areas

Community Intelligence - LA wide