ABOUT NIHR SPHR

The National Institute for Health Research School for Public Health Research (NIHR SPHR) helps to build a high quality evidence base for cost-effective public health practice. We work closely with local practitioners and members of the public, carrying out a wide range of research projects and programmes. There is a School-wide focus on alcohol, ageing well and health inequalities.

NIHR SPHR is a partnership between eight leading academic centres with excellence in applied public health research and evaluative practice in England. The School brings together its members’ expertise in a collaborative working relationship to:

• create an environment where first class applied public health research, focused on the needs of the public, can thrive,

• support local public health practitioners and policy makers to engage with research, and actively seek out high quality research evidence to inform their decisions,

• ensure an emphasis on what works practically, can be applied across the whole country and better meets the needs of policymakers, practitioners and the public.

Established in April 2012 with a budget of £20 million over five years, NIHR SPHR is funded by the National Institute for Health Research www.nihr.ac.uk/

The studies described here represent independent research funded by NIHR SPHR. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or Department of Health.

NIHR SPHR is a partnership between: the Universities of Sheffield, Bristol, Cambridge, Exeter, UCL; The London School of Hygiene and Tropical Medicine; the LiLaC collaboration between the Universities of Liverpool and Lancaster and Fuse; The Centre for Translational Research in Public Health, a collaboration between Newcastle, Durham, Northumbria, Sunderland and Teesside Universities.
CONTENTS

→ Introduction 4

→ Does giving residents control over decisions about their neighbourhoods improve their health? 6

→ Understanding older people's views on means-testing universal benefits 10

→ Does the availability of cheap beers and ciders encourage people to cut down? 14

→ Trial should fill vital evidence gap on good practice for diabetes prevention 18

→ Does co-locating GPs and welfare advice improve health and reduce strain on the NHS? 22

→ Young people and professionals hold contrasting views on who should deliver sex education 26

→ Identifying innovative ways to support public health decision-making by local authorities 30

→ Tool can help councils to prioritise cost-effective policies for tackling increased type 2 diabetes 34
INTRODUCTION

We are rethinking key challenges and ways to work with practitioners in a world where responsibilities have changed, opening up new possibilities, explains Jon Nicholl, inaugural Director of the NIHR School for Public Health Research.

The great challenge for public health research is to concentrate on the health of the public, rather than simply on people who are ill, the traditional focus of health services. To date, that has often involved informing individuals to help them make better choices – about what they eat, whether they smoke, whether they should take exercise.

"We strive to generate knowledge to help ensure that inequalities in income and wealth are not mirrored by inequalities of health."

However, at the NIHR School for Public Health Research, we are looking beyond that agenda. Many people find making such choices difficult. Indeed, some people’s lives pose so many problems that these options probably don’t feel like choices at all. That creates a further challenge for researchers: how do we support the health of those who struggle to behave or live well in certain environments? Poverty – and the difficulty of staying healthy when one experiences poverty – is a particular issue. We strive to generate knowledge to ensure that inequalities in income and wealth are not mirrored by inequalities of health.

That’s why, for example, this collection of case studies includes research investigating whether community empowerment could lead to health improvements for individuals in deprived communities. Likewise, another project looks at how changes in an impoverished environment can impact on choice and outcomes: does reducing the alcoholic strength of some cheap beers and wines influence choices and risk-taking and thereby improve health?
These projects acknowledge the complexities that public health research faces. It would be wonderful if our field was like clinical medicine, where a single intervention can be isolated as the magic bullet. Singular truths can sometimes be established in public health research: studies proved, for example, that smoke-free legislation cut hospital admissions. But usually it’s all much more complicated. A cycle lane is not given to an individual. It changes the environment for thousands of people and it’s hard to isolate the precise impact on health.

Often, we aim to demonstrate not only whether an intervention works but, also, in what circumstances and contexts it can work. Will what works, for example, in Bristol be as successful in Hull, given the services, behaviours, the baseline health, levels of deprivation and environmental factors, as well as local politics? A clinical analogy might be stratified medicine, which is focused on identifying which drugs work best for whom and when.

In getting to grips with complexity and context, there is little point in us hiding away in an academic ivory tower and handing down findings. The School is committed to bringing local practitioners into research, rather than simply taking research to practitioners. This approach is at the heart of our studies, for example, into programmes for preventing diabetes and improving sex education.

The School was created in the same year as the Health and Social Care Act 2012 gave responsibility for public health to local authorities. Our agenda acknowledges that the culture of public health decision-makers has therefore changed. Explicitly, our “Shifting the Gravity?” project looks at what tools and data those policymakers need to do their jobs well. Meanwhile, our research into the potential benefits of integrating welfare advice into health settings engages the coming together of NHS and council-run services as well as the linking of clinical and social prescribing. Policymakers both locally and nationally will hopefully also value our findings on how the well-being of elderly people might be affected if some universal benefits, such as bus passes, became conditional on need or income.

The School has adopted an innovative approach in terms of its research range and its engagement with practitioners. We are tackling some of the key issues facing policymakers. We are delighted that NIHR has acknowledged this progress by renewing our funding for another five years. And we hope that you enjoy these case studies that highlight both the learning and the partnerships which are springing out of this worthwhile investment.

Professor Jon Nicholl is inaugural Director of the NIHR School for Public Health Research.
NIHR SPHR’s unique research programme explores whether increased community control can enhance health and influence its social determinants in low income neighbourhoods. The findings could be of national and international significance.
W e’re in charge,” declares Linda, a resident in one of Britain’s more disadvantaged neighbourhoods. She’s delighted that residents in her area have been given £1 million to spend as they see fit to make their neighbourhood a better place to live. They are also being offered support to develop the skills and confidence they need to make these decisions. “As a community, if you are from the sort of area where you are seen as needy….,” says Linda. “You are never in charge.” Linda’s tale recalls Mark Twain’s famous short story, “The Million Pound Note”. A penniless man is given the single banknote for a month by eccentric twin brothers. One brother secretly wagers that the banknote will enable its possessor to achieve whatever he needs, without ever spending it. That brother wins the bet: the once poor man has no trouble getting food, clothes or a hotel suite, never spending a penny. Exclusive social groups welcome him - he is even asked to back a business venture. All thanks to the empowerment that the unused banknote brings.

More than a century on, Mark Twain’s fantasy is now being put to a different, more modern test by a team of researchers from the NIHR School for Public Health Research (NIHR SPHR). People living in disadvantaged neighbourhoods live around seven years less on average than those living in better off areas. They also have more chronic illness.

Could community control over financial resources, plus support to develop skills and confidence, lead to improvements in health and well-being? Could this shift ultimately lead to longer lives? That’s the question explored by NIHR SPHR’s “Communities in Control” study of some of the areas granted £1m each by the Big Local.

The study, involving researchers from the universities of Durham, Exeter, Lancaster, Liverpool, Sheffield and the London School of Hygiene and Tropical Medicine could have a major impact on public health policy both here in Britain and internationally. It could provide much needed evidence on whether community empowerment helps people living in disadvantaged circumstances to live the longer, healthier lives enjoyed by better off groups.

There is considerable evidence, particularly from Scandinavian workplace research, suggesting that greater individual control of one’s life is good for health. However, the data is much patchier on whether collective control by groups of people is also associated with better health. Some intriguing evidence comes from British Columbia in Canada. There, social psychologists have established that enhanced community empowerment seems to be associated with lower levels of teenage suicide rates among some of the country’s indigenous “First Nation” peoples. Researchers found that rates among six First Nations in British Columbia varied considerably and, in some, were no higher than for other Canadians. The First Nations with lower suicide rates among their young people were those that were culturally empowered – for example, they had successfully reclaimed their ancestral lands and gained control over their schools and education.

"For at least 20 years, successive governments have championed community empowerment, yet surprisingly little is known about whether it improves health and well-being. We aim to help answer that question”
Professor Jennie Popay
NIHR SPHR’s study offers an important opportunity to help fill this knowledge gap and contribute to more effective public policy in this field, explains Jennie Popay, Professor of Sociology and Public Health at Lancaster University and co-ordinator of NIHR SPHR’s research programme into the impact of Big Local on health and its social determinants.

“For nearly 20 years,” says Professor Popay, who is also NIHR SPHR Deputy Director, “successive governments have championed community empowerment. David Cameron’s Big Society and Tony Blair’s New Deal shared ambitions to galvanise the potential of local people working effectively together to improve their lives. Yet, despite this longstanding, cross-party vision, surprisingly little is known about whether community empowerment improves health and well-being. We aim to help answer that question.”

It is, however, early days. Many Big Local areas are just getting going, working out their agendas and ways to work together. It is too soon to assess health benefits for communities living in these neighbourhoods. Also, in the complicated world of area-based initiatives, the NIHR SPHR researchers are initially developing ways to evaluate the outcomes. “Our approach is relatively new in this field,” explains Professor Popay. “Public health research typically tries to isolate the signal from the noise, to identify a single cause. Here, however, we are taking a systems approach, asking ‘what happens’ in neighbourhoods when Big Local is introduced, what positive or negative ripples are generated by Big Local, how do they interact with other changes and what processes amplify or dampen down these ripples.

“Public involvement is not as well developed in public health research as it is, for example, in health services research. Here we are also being innovative, involving Big Local residents and people involved in supporting them, particularly Local Trust, the national organisation that oversees the programme.”

For Linda, the research process has been a good experience, so far. “Oh it’s much better than I expected,” she explains. “I thought I would get a big form emailed to me and spend many happy hours filling it in but it’s been great to actually talk to people. It has been informal and very human. It’s been really enjoyable. It will encourage other people to get involved, particularly young people.”

Professor Popay adds: “This study could illuminate the processes that are more or less empowering, how positive impacts can be maximised and negative impacts avoided that will improve the effectiveness of community based initiatives around the country.”

Linda welcomes research into her community. “There is this internalised sense of ‘Oh, it will never really be any good and it doesn’t matter what you do,’ kind of thing. Of course it matters what you do; we are not cursed; we’re just poor; it’s different and so I think, if there’s research going on that looks at the way things develop, that will be a really good kind of objective thing to refer to, so people can look at what’s happened and say, ‘Well, oh yeah, well that’s changed and that’s changed and, if that can change, other things can change as well’.”
If academics can link greater control with being healthier, that’s a big tick…

“Sometimes, people are concerned about living somewhere safe, having access to jobs, education. They might want places for young people to go, activities for older people in the community. In one area, people are limited in the jobs they can take because public transport is poor and they can’t actually get to work. They might look at community transport or moped-hire schemes so they can get to work.

“Sometimes, what comes across is a desire to get on with their neighbours, feel it is a better place to live. People want community activities, festival fun days, small grants to community groups and charities in the area, building that feeling of a community. They need skills and confidence to identify the issues and to do something about it.

“I am hoping for positive findings. If academics can prove that there is this link between having greater control over what matters to you and you being healthier, that has to be a big tick. It will give confidence and inspiration to people. But we did not commission the research so we are a natural experiment. It might prove there is no link and it is not working.

“I have not seen any findings in advance. SPHR have shared with us publicly available data – benchmarking for the communities – regarding education, health and employment. So we learned a bit and the communities can access that as well. We now have that data by postcode which we did not have previously.

“I met a researcher at an event with members of the community. I did not realise she was a researcher at first. The relationship was positive and people liked her. They have slipped in nicely, understood what the community is doing. I like the way this group are working – sensitively and in line with our research. I don’t feel they are wasting our time.”

Debbie Ladds, Chief Executive of Local Trust, which administers Big Local.

| PROJECT: | The Communities in Control Study |
| LEAD: | Professor Jennie Popay  
LiLaC, Lancaster University |
| CONTACT: | j.popay@lancaster.ac.uk |
UNDERSTANDING OLDER PEOPLE'S VIEWS ON MEANS-TESTING UNIVERSAL BENEFITS

Making welfare benefits such as the Freedom Pass and Winter Fuel Payments conditional on income or need might seem fair, but older people see them as badges of citizenship and fear being stigmatised.
ow important is it for older people that certain state benefits, such as the older person's bus pass and Winter Fuel Payments, are available to everyone of their age, regardless of need? Is this universality a vital part of citizenship, recognition and inclusion in later years that means-testing could damage, leading to reduced well-being?

Targeting resources at those in greatest need may seem fairer and has intuitive appeal, particularly in times of austerity. However, the research found that a more complex perspective is needed. There is often more to the receipt of benefits than simply a material transfer from state to individual.

First, the study found that, where conditionality is based only on age, key benefits were largely taken for granted by older people. They were seen as legitimate, universal entitlements that had been earned and deserved - payback for a life of work, rather than marks of need and diminished dignity, as some regard means- or needs-tested benefits. These unconditional benefits also seemed to help provide status, respect and inclusion for older people – perhaps as jobs, parenthood and other forms of participation did when they were younger. Some benefits were seen quite symbolically. Travel passes and free prescriptions, for example, were seen as justified rewards for a life of contributing to society, for example through having paid taxes or, as some said, ‘having lived through the war’.

Older people also seemed to take for granted that everyone deserved to receive these benefits, as they were framed as recompense for a generation, rather than as benefits for individual claimants. Quite a lot of people emphasised how they used their benefits to be socially connected and to continue contributing to society, perhaps by donating some benefits, or using their bus pass to work voluntarily or to give up driving, because they felt a danger to others in a car.

Increases in the numbers of older people have raised doubts about whether such benefits should remain unconditional to this age group. So, as part of NIHR SPHR’s Ageing Well programme, researchers undertook a project to explore older people’s experiences of welfare benefits, and the potential health and well-being effects if certain benefits were rationed.

The work was led by NIHR SPHR researchers from the London School of Hygiene and Tropical Medicine in collaboration with Cambridge, Sheffield and Newcastle universities. The research team held in-depth, one-to-one interviews with older people from diverse backgrounds in different parts of England, in London, Cambridgeshire and Sheffield. They have highlighted the strength of people’s feelings about such benefits.

“These universal benefits were seen as legitimate, universal entitlements that had been earned and deserved - payback for a life of work, rather than marks of need and diminished dignity, as some regard means- or needs-tested benefits.”
Second, the study identified the risks of changing the status quo. Making benefits conditional is potentially divisive, encouraging people to judge each other - as well as themselves - and to categorise individuals as ‘deserving’ and ‘undeserving’. The interviewees revealed how applying for, and receiving, conditional benefits meant personally confronting such stigmatised views of need, dependence and questions of entitlement. They were often reluctant to apply, given the experience or expected humiliations involved. In some cases, the anxiety and troubling experiences of application processes had put people off applying for conditional benefits that would make a significant difference to their well-being.

Third, the study found potential risks to health. Some people indicated the downsides in terms of loneliness and isolation in old age if some benefits, such as the London Freedom Pass, became no longer available to everyone and some people had reduced access to transport.

Some of these issues were already apparent. For example, some bus passes are already limited to off-peak usage, creating problems for older people attending hospital appointments, especially in rural areas where there may not even be an off-peak bus. Such learning is of relevance to local authorities – which have discretion over bus passes – and Clinical Commissioning Groups which are required to ensure that healthcare providers offer good clinical access to older people.

A key project strength has been its involvement of older people at all stages. They advised on research questions, how to ask questions about the potentially sensitive topic of welfare benefits and recruitment of diverse interviewees. They helped the study to reach more isolated older people, particularly in rural areas. Older people have provided feedback on findings and how to present them, including cautioning against representing older people as a “different breed”.

The project has used interviewers who speak community languages – so some interviews have been conducted in Somali, Urdu and Punjabi. Findings have been shared locally and at a national conference with input from older people’s representatives. At a local stakeholder event in Cambridge, a presentation of the project by a researcher was followed by a contribution from an older resident who took part in discussions.
Talking about benefits...

Interviewer: “When we started, you were both saying that you didn’t feel that you got any benefits, but once we started to discuss the different things …”

Woman: “Well you see, well you see, we just thought this [free prescriptions] was something that we were entitled to automatically at 60. Well, if you call it benefits, then so be it.”
Man: “For, we never know it was benefits, you see.”

(Man, 80s and woman, 70s, Black British Caribbean)

“As I say, I think the tabloids are shaping to sort of put us in the frame as being the baddies, you know, taking all this free money. It’s not free, we’ve paid for it.”

(Woman, 60s, White British)

“I had to appeal three times just to get the DLA. And I said no. I’m not doing it. You know, you keep, you’re telling them you, yeah I’m a genuine person. You know and if they can’t, well I don’t know. I said no. It’s the aggravation … I still can’t go shopping. I can’t do me housework. A simple thing like washing up, I stand for a while and have to go and sit down.”

(Woman, 70s, White British)

“I think good thinking people believes that it’s their right to receive their benefits because they know that these were fathers and mothers who have worked hard for many years, did many jobs and created many opportunities. If these people had not worked hard, things that we see around such as new technologies would not exist. So always older and needy people should be catered for.”

(Woman, 70s, Black British African)

PROJECT: Ageing Well: Welfare Benefits
LEADS: Professor Judith Green, London School of Hygiene & Tropical Medicine
COMPLETION: July 2015
CONTACT: judy.green@lshtm.ac.uk
Local authorities recently collaborated with NIHR SPHR to test whether clearing supermarkets of cheap, strong alcohol might deter heavy drinking.
Alcohol consumption is related to its price and availability. Local authorities around the country have been considering different ways of influencing availability as part of their strategies for reducing health and social problems associated with alcohol consumption. One approach has been to encourage off-licences to remove high strength drinks voluntarily from their shelves.

The independence offered by the NIHR SPHR team of researchers is just one the school’s virtues. “It also brings extra resources at a time when local authority finances are stretched,” says Mr Sumpter. “We could not afford to do our own rigorous, in depth evaluation. Having dedicated resources is very helpful.”

Ipswich was the trailblazer for “Reducing the Strength”. For example, in 2012, the local East of England Cooperative Society - concerned about heavy drinkers and risks to staff safety, as well as wishing to demonstrate its social responsibility - took high strength, cheap, ciders and beers off its shelves. The move was mainly focused on improving public order, but public health professionals have become increasingly interested in its impact on health.

The initiative has caught on, across the country, in ways that typify a new culture of public health evidence since public health responsibilities passed from the NHS to local authorities. “People feel that the Ipswich initiative went well,” explains Matt Egan, Senior Lecturer at the London School of Hygiene and Tropical Medicine, and team leader of NIHR SPHR’s “Reducing the Strength” evaluation project. “Officials from other local authorities were able to look at the Ipswich example and see that the programme was deliverable in a way that people accepted, that was enforceable, that was not at odds with government guidance and that other agencies did not object to. These considerations are important in the development of local authority policy and can often eclipse international evidence about effectiveness.”

This innovative ‘Reducing the Strength’ approach requires the involvement of public health evaluators such as NIHR SPHR, explains Colin Sumpter, Public Health Strategist for Camden and Islington Councils in north London. “We want to reduce consumption of the cheapest, strong alcohol – white cider and high strength lagers such as Special Brew. These drinks are very high in alcohol, cheap to buy and usually consumed in one go. We need good evaluation of the ‘Reducing the Strength’ initiative to show whether it could improve health and public order.”
NIHR SPHR’s task now is to examine the potential health impact of this innovation, as it is rolled out to more areas. Dr Egan explains: “We’re looking at Ipswich and the surrounding areas and also at Camden and Islington, getting a sense not only of the impacts from the earliest intervention but also how the initiative has been adopted and diffused in other areas and has been changed in the process.”

The research process has been collaborative: Colin Sumpter’s team does stock-takes of participating retail outlets, to check on compliance as well as impact on the sales of other alcoholic products. Meanwhile, Dr Egan’s team has been interviewing street drinkers and homeless people to discover what they drink, what they think about the change in local off-licences and how they would respond if their favoured drink is no longer on sale.

“We want to know,” says Dr Egan, “whether people shift to weaker beer, so they may get fewer units of alcohol for their money or perhaps shift to wine at a similar price per unit of alcohol. It might be that some move onto drugs. Or the change might stimulate them to rethink their use of alcohol and make them open to other help. We’re trying to assess what substitution is going on and the overall impact on alcohol sales - whether people simply go across the borough boundary and buy what they want, for example, Westminster.

“The research is helping us to understand the drinking habits of people who are homeless and also of many street-drinkers, who may not be homeless. But these initiatives might have an impact beyond this particular group. It may be like what happened with smoking, where there was a gradual build-up of practices to reduce the harm. This cumulatively led to the de-normalisation of smoking and paved the way for radical changes, such as the public smoking legislation.”
The team is also looking at the motivation of participating retail outlets, all of which require licences to sell alcohol. To what extent does volunteering for “Reducing the Strength” improve an outlet's chances of retaining its licence to sell alcohol? “We’re realising that voluntary and statutory controls are interwoven and there is not a black and white distinction between them,” says Dr Egan.

The study is also linked into a national programme of comparative research into local authority alcohol strategies. Dr Egan explains: "A real advantage from being part of NIHR SPHR is that we can conduct these local case studies and evaluations into different aspects of alcohol policy. But we have also designed our approach in such a way that we can pool our research with other SPHR centres that are doing similar work." This results in a series of "wider angle" research projects showing the range of approaches and initiatives being implemented by local authorities in different parts of the country to tackle alcohol harms.

The NIHR SPHR team did not just take the brief and disappear for a couple of years...

"They are very well connected with me and people in the council. That’s the way to do it. We can contribute to the research. They talk to the right people and they have made efforts to make their work relevant to us. The good thing is that the team did not just take the brief and disappear for a couple of years – they are more participatory than you might expect of academic researchers. That’s the way to go."

Colin Sumpter, Public Health Strategist, Camden and Islington Public Health

---

**PROJECT:** Reducing the Strength

**LEAD:** Dr Matt Egan, London School of Hygiene and Tropical Medicine

**COMPLETION:** December 2015

**CONTACT:** matt.egan@lshtm.ac.uk
TRIAL SHOULD FILL VITAL EVIDENCE GAP ON GOOD PRACTICE FOR DIABETES PREVENTION

Unique research aims to inform roll-out of national programme in 2016 that could transform health for millions and secure large savings for the NHS.
The NHS and Public Health England are planning urgent action to defuse the diabetes time bomb that threatens to blow a hole in the NHS budget.

“We hope to have identified an effective and cost-effective intervention for people at risk of developing diabetes that could be rolled out across the country for different populations, including ethnic minorities.”

But evidence is lacking on what can work cost-effectively across a range of typical UK community settings to prevent the condition.

To fill this gap, NIHR SPHR is funding a unique evaluation of an existing diabetes prevention programme under its Public Health Practice Evaluation Scheme (PHPES). It is part of NIHR SPHR’s mission to bring public health academics into partnership with practitioners who are making a difference on the ground. It is important to identify effective and cost-effective interventions for people at risk of developing diabetes that could realistically be rolled out across the country for different populations, including ethnic minorities.

Swift research is vital: Public Health England (PHE) and NHS England have announced that a national diabetes prevention programme will be rolled out from April 2016. The National Institute for Health and Care Excellence (NICE) has already issued guidance recommending a two-pronged - diet plus exercise - approach that programmes should adopt. However, the NICE guidance is based mainly on international evidence about initiatives which, in the U.S. for example, were delivered mainly in health settings and on a one-to-one basis.

In the UK, diabetes prevention programmes are more likely to be delivered in community settings, are increasingly run by third sector organisations and often take place in groups. It is important to know whether the positive outcomes, detailed in previous research, are replicated in such different situations, so the National Diabetes Prevention Programme can be made as effective as possible. Voluntary sector organisations also recognise the importance of the research, to ensure that the evidence supporting their work is as robust as possible.

There is huge potential for sound interventions to improve people’s lives and save NHS resources. Diabetes currently affects at least three million people in the UK and at least another 600,000 are estimated to have undiagnosed diabetes. Treatment is estimated to consume 10 per cent of UK NHS spending, around £10bn annually. Without action, the number affected in the UK is expected to rise to five million within 15 years, mainly due to increased obesity. Yet most cases are preventable. Between 85 and 95 per cent of people with diabetes have type 2 diabetes which can largely be avoided through healthy eating and moderate exercise.

A recent PHE survey indicates that around five million people in the UK have “pre-diabetes”. This means that they are at risk of developing diabetes (i.e. they have increased blood sugar and a much higher risk of progressing to diabetes than the normal population). These people would all be eligible to receive support from the National Diabetes Prevention Programme.
People can often reduce their risk of developing diabetes with relatively moderate lifestyle changes. Prevention programmes have typically been aimed at five per cent weight loss and moderate exercise. In two well-researched programmes, in the U.S. and Finland, the risk of people developing diabetes fell by about 60 per cent and risk reductions were retained up to 10 years after the programmes ended.

NIHR SPHR’s research, led by the University of Exeter - is evaluating the effectiveness and cost-effectiveness of ‘Living Well, Taking Control’. This is a community-based, diabetes prevention programme that complies with the NICE guidance and is already being delivered by two voluntary sector organisations, Westbank in Devon and Health Exchange in the West Midlands. The Big Lottery has funded these organisations to help people with risk factors for diabetes - excess weight and high blood glucose levels – to change their lifestyles. If this evaluation, which aims to report in 2016, proves positive in such different locations, this type of programme could be a model suitable for wide-scale roll-out.

It would be wrong to offer some people a prevention programme while denying this existing service to others, so designing a randomised control trial – the ‘gold standard’ test for effectiveness - could be ethically difficult. In this case, however, since there was already a waiting list to join “Living Well, Taking Control”, the programme’s impact is being tested by comparing a group of people chosen at random to start the programme straight away with a waiting list group who began the programme six months later. Whether improvements continue can also be tested, because in the subsequent six months after the main part of the programme is complete, the study carries on.

"The effectiveness of programmes designed to prevent diabetes is not well evidenced. But it’s vital that we know what works. We’re proud of what we achieve through the Living Well Taking Control programme at Westbank. We’ve developed the programme to meet NICE guidance whilst at the same time responding to local need with a design influenced from the bottom up, using a non-clinical approach. This evaluation by NIHR SPHR will provide robust evidence of our effectiveness and inform our learning so that we can improve the programme.

"An evaluation undertaken by ourselves would not have been as credible or robust as an external evaluation. This will allow us to present a more convincing case, providing the statistics and information that commissioners want to see. We are no longer able to simply stand up and say, ‘Commission us, because we are really good at this.’ We need to prove our effectiveness and provide clinical evidence."

Jaine Keable is Head of Health and Wellbeing for the ‘Living Well, Taking Control’ programme in Westbank, Devon.
Measures of success include weight loss, reduced blood sugar levels, objectively measured physical activity and self-reported measures of dietary behaviour, quality of life, mental health and well-being. Participants wear accelerometers which record any movement, providing data to indicate their levels of physical activity.

Initially, participants have four weekly group sessions of about two hours held over a month. The first establishes baseline measures and agrees goals. The second is about diet and nutrition, the third focuses on physical activity and the fourth is about mental health and areas in which people need extra support. Participants receive individual follow-up at three months, six months, nine months and 12 months and are offered at least five hours of other classes including walking groups, gym visits, cookery classes, food labelling etc. NICE recommends that people have 16 hours of contact time over the whole period. If people have other particular health needs, such as smoking cessation – they can be referred to those services.

The study is assessing the cost-effectiveness of the programme by modelling the costs of delivery against long-term savings in terms of reduced use of health services, lower personal costs and the value of longer lives in better health. NIHR SPHR colleagues at The University of Sheffield have developed a model to extrapolate the savings of, for example, weight loss throughout a person’s life, so that longer term cost-effectiveness can be evaluated without having to wait decades for evidence (This is another study funded by NIHR SPHR - see page 34 for details).

The research is keen to understand how realistic the NICE guidelines are. Is it reasonable for voluntary sector organisations to provide the support that the guidelines recommend? Does what people receive ultimately follow the guidance? How much variation is there in practice? By summer 2016, the team will be in a much better position to provide robust evidence on these issues that can feed into the National Diabetes Prevention Programme.

PROJECT: Community-based Prevention of Diabetes (ComPoD)
LEAD: Dr Jane R Smith, University of Exeter Medical School
COMPLETION: June 2016
CONTACT: jane.smith@exeter.ac.uk
DOES CO-LOCATING GPS AND WELFARE ADVICE IMPROVE HEALTH AND REDUCE STRAIN ON THE NHS?

As Clinical Commissioning Groups decide funding priorities, they want to know from NIHR SPHR whether bringing advice on benefits and debt together with delivery of medical care pays off for patient well-being and reduces costly demands for health services.
Ps are worried about the impact that economic hardship is having on many patients' physical and mental health. They often struggle to manage the extra medical needs that result from such hardship. Patients are also bringing to surgeries more non-clinical issues, such as debt and benefits problems, which health professionals lack both the expertise and time to resolve.

This perceived gulf between increasing need and available resource sits uneasily with NHS policy. The Health and Social Care Act 2012 places a legal duty on NHS England to address health inequalities, which are partly rooted in circumstances surrounding low income and poverty. So the Health Service has identified increasing uptake of benefits and welfare advice among entitled individuals and households as a key strategy. But it is struggling to deliver the policy within its resources.

Allowing GPs easy ways to signpost and refer patients for non-clinical, health-enhancing support is one solution. Co-location of welfare advice with GP services strengthens the portfolio of services available for such social prescribing. Busy GPs are released from having to tackle financial issues for which they are underqualified while letting them refer patients to easily accessed services that can deal effectively with these health-damaging but non-clinical problems.

There are other advantages. Patients can gain more timely advice in such settings than is often possible with high street provision. The heavy footfall in surgeries – and reduced stigma associated with attending a health centre rather than the Citizens Advice Bureau (CAB) - helps services reach people who might not otherwise have sought advice, notably those in poor health. There is evidence that the resulting reduced anxiety and stress associated with financial-related social worries improves mental health in these vulnerable groups and that co-location does, indeed, reduce GP time spent managing non-clinical issues. Bringing the services together also improves GP sensitivity to the broader issues that affect their patients' health.

"It's relatively easy to show that welfare advice helps people to manage their debts and can increase their incomes. It's harder to demonstrate to a CCG, with a hard-pressed budget, that such assistance improves patients' health and helps the NHS."

Welcome Information
Nevertheless, proving the value of co-location, particularly in terms of benefits to health and the NHS, is difficult. People’s lives are complicated. It is relatively easy to show that welfare advice helps people to manage their debts and can increase their incomes - estimates range from over £1000 to over £3000 additional income per client a year, reflecting the fact that an estimated £12bn a year goes unclaimed in state benefits. But it is harder to demonstrate to a Clinical Commissioning Group (CCG), with a hard-pressed budget, that such assistance improves patients’ health or directly reduces costs to the CCG.

Such proof is vital, given ever fiercer competition for those budgets. Without it, despite support from Public Health England and NHS England, the future of co-located welfare advice services looks uncertain. In some areas, notably across Liverpool, provision has increased. But other existing services are at risk of cutbacks. They face pressure to reassert their worth to commissioners and other funders.

Existing evidence of their value is largely from small scale studies, without a robust control or a comparison group, and suffers from considerable loss of participants, some of whom have chaotic lives. One study reports a reduction in GP consultations and in antidepressant prescriptions in the year after co-location of welfare services was introduced. However, with a small sample size and no comparison group, interpretation of its findings is difficult.

The need for fresh, robust evidence has been marked by a request from north London’s Haringey Council for an evaluation of the impact of its welfare advice hubs that are based in primary care settings. These hubs are run by the Citizens Advice Bureau and funded by the CCG. Most CAB clients seen in these practices have benefits-related problems, with the other big issue being debt, followed by a smaller number of housing, court and immigration issues. Last year, these co-located Haringey CABs helped clients to gain over £1m, so they have easily proved their financial value to patients. The research team’s job is to assess their impact on patient health and demand for health services.

"Co-location of welfare advice with GP services strengthens the portfolio of services available for social prescribing. Busy GPs are released from having to tackle financial issues for which they are underqualified while letting them refer patients to easily accessed services that can deal effectively with these health-damaging but non-clinical problems."
The evaluation project is a partnership between NIHR SPHR and the NIHR-funded Collaboration for Leadership in Applied Health Research and Care (CLAHRC) North Thames. Led by academics from UCL, the study is asking whether or not having welfare advice in the health centres improves mental health and reduces how often patients attend the GP. It will also assess whether financial strains are reduced, financial capabilities of users improved and whether those people receiving such help find it easier to cope with their financially difficult circumstances. The NIHR SPHR/CLAHRC team hopes to provide interim results before the CCG makes its next decision on funding Haringey’s co-located welfare advice services.

“GPs and mental health trusts say they often spend considerable time dealing with social issues, such as debt and benefits, which people with mental ill health may bring to them, eating into the time available to treat mental illness. So we’re seeking other ways to provide this advice. Does it help the NHS if advice services are located nearer to these people in need - in various health settings – and not just on the high street?

“The research input is brilliant. It’s helping to develop robust evidence on the effectiveness of advice hubs in health settings to secure future funding and maybe scale up this initiative across the borough.

“NIHR SPHR brings academic robustness while we provide researchers with experience of the real world. It’s a marriage of research excellence and practical experience, with everyone benefiting. Having research expertise embedded in the public health team also helps us with guidance around other areas of our work.”

Tamara Djuretic, Assistant Director of Public Health, Haringey Council
Everyone wants school provision, but many pupils are uncomfortable with their own teachers playing this educator role, finds an NIHR SPHR project that aims to create a pioneering sexual education programme for schools.
Ensuring that all young people know what they need to know at the right time about sex is a difficult but vital challenge. That's why NIHR SPHR has developed a major project to design a well-evidenced sexual health and alcohol education programme for secondary schools in England.

This project, pooling the combined expertise of researchers across NIHR SPHR, is of great significance. Existing guidance leaves the content of sex education largely up to schools – some provide very little teaching, others a great deal and the learning contexts vary considerably. This guidance dates from 2000, since when the Internet has multiplied the information available to young people.

The need for effective sex education is considerable. Teenage conception rates in England have fallen but they are still high compared with other European countries. Rates of sexually transmitted infections are high for those aged 16 to 24. There is also evidence that some young people have early unsatisfactory relationships that they regret.

Many steps are required for creating this education programme that has considerable ambitions: to improve young people's health and sexual health, to impact favourably on inequalities, be acceptable to stakeholders, and capable of being implemented faithfully, at scale, sustainably, and cost-effectively.

First, the study has reviewed the evidence on the effectiveness of sexual health and alcohol education and analysed data from a national survey of sexual attitudes and lifestyles. It has investigated what young people and practitioners say about how schools tackle sex education and considered different models of sexual health and alcohol education.

This work is helping to identify key elements of good practice. It is feeding this learning back to young people, practitioners and people who commission sexual health services. Then, the goal is to design a programme and, eventually, test it to make sure that it fits everyone's needs.

The study has found little research that throws light on interventions targeting both alcohol and sexual health together, so the NIHR SPHR work so far is focused more on sex education. School programmes vary greatly but generally they appear to produce improved sexual health outcomes. Based on what survey respondents report, they are associated with older age at first sex and with a lower likelihood of both unsafe sex and sexually transmitted infections. Women who have had school-based programmes are less likely to experience unwanted sex, abortion or distress about sex. All this suggests that high quality school-based sex and relationship education has enormous potential to improve young people's health.

However, emerging evidence suggests that young people and professionals hold contrasting views on who should deliver sex education, which raises important questions for policymakers. Pupils are typically uncomfortable when sex education is delivered by teachers, who may be poorly trained in the subject and easily embarrassed. Moreover they dislike the blurred boundaries inherent in current practice, with their teacher perhaps giving them a history lesson one day and discussing intimate sexual matters the next. They also worry about how trustworthy teachers are with confidential information and whether their teachers' views of them will change if they speak openly in sex education classes.
For these reasons young people appear to prefer external sexual health experts, including peer educators, appreciating their expertise, confidence and the fact that they do not have a pre-existing or ongoing relationship with them. Practitioners, however, generally believe that teachers should deliver sex education, for the very reason that pupils don’t want them to – because they already have a relationship with pupils.

Practitioners also feel that teachers are a more sustainable option since they are already embedded in schools. Perhaps one solution is to have a teacher who is fully trained and has specialist expertise in sex education. If this teacher only delivered sex education it might resolve the issues students reported in relation to blurred boundaries.

Many young people find the content of sex education disappointing and some boys, in particular, feel that it is not sufficiently explicit to prepare them for sexual relationships, which may be one reason why some turn to pornography. Boys were frequently found to be disruptive in sex education classes, and there was some evidence that this was a means of masking their anxiety and attempting to prevent any exposure of sexual ignorance. As a result, however, many girls reported feeling harassed and unable to engage in the class. These findings suggest that those delivering sex education need to have sensitivity to the differing vulnerabilities of young men and women and that, perhaps, at least some classes need to be single-sex. Young people want the content to be straightforward, positive, to reflect sexual diversity and the range of young people's sexual activity and to include discussion of relationships and feelings. They also want sex education to include discussion of sexualities and sexual activities other than heterosexuality and heterosexual intercourse.

Practitioners agree that sex education curricula should consist of age-appropriate, core subjects but be flexible, with provision bespoke to each school and its local needs. The evidence suggests that programmes should not focus on abstinence, as such programmes do not lead to positive behavioural changes. However, multi-faceted sexual risk reduction interventions, those targeting social disadvantage and school-based or school-linked sexual health services may reduce teenage pregnancies. Whatever the intervention, all agree that young people should be involved in both its development and its evaluation, to ensure its relevance and acceptability.

"Everyone wants schools to lead on this subject. School programmes are associated with older age at first sex and a lower likelihood of both unsafe sex and sexually transmitted infections. Women who have had school-based programmes are less likely to experience unwanted sex, abortion or distress about sex. High quality school-based sex and relationship education has enormous potential to improve young people's health."

"Everyone wants schools to lead on this subject. School programmes are associated with older age at first sex and a lower likelihood of both unsafe sex and sexually transmitted infections. Women who have had school-based programmes are less likely to experience unwanted sex, abortion or distress about sex. High quality school-based sex and relationship education has enormous potential to improve young people's health."
In young people’s words

The following quotes are taken from existing studies of young people's views of their sex and relationship education which were reviewed by the research team as part of this study

“I think a lot of teachers are actually embarrassed ...”
(Forrest et al 2002, p207)

“You want someone who's not from the school or someone who actually does it as a job and knows what they're talking about and you know can be professional about what they are telling you and ...”
(A llen 2009, p41)

“If your teacher who's a grown up can’t talk about it, how are you (supposed to)? That gives you the impression that, oh I'm not really supposed to talk about it.”
(Macdonald et al, p450)

“Yes, some people are too scared to say things so they cover that up by being noisy and disrupt the class.”
(Strange et al 2003, p206)

“They didn’t talk about the emotional part of having sex. They didn’t really talk about how sex will affect you as a person and how it affects your emotions.”
(Rye et al 2015, p103)

“All they ever do is talk about the dangers of sex and that, and nothing about the pleasure.”
(Measor et al 2000, p126)

“We discuss contraception and sex but not what to do when having sex. We don’t know.”
(Measor et al 2000, p100)

“Ah, they never really talked about sex (...) Like the sperm goes up the fallopian tube, hits the egg ... we don’t care about that.”
(Langille et al 2001, p250)
NIHR SPHR has been looking at what supports, including health economics tools, can help inform difficult decisions, amid the complexities of council politics.
When a local authority recently considered creating extra cycle lanes, officers in the transport department were keen to hear the public health case. “But we hit an immediate stumbling block,” explained an official. “The first question the public health people asked was: ‘What’s the problem you are trying to solve?’”

“But we don’t always think like that in councils,” added the official. “Local authorities don’t always work on solving problems. Quite often, we just provide services. There are lots of reasons why we might create cycle lanes. They might be a good way to get people to use what is at the end of the cycle lane. They might be a tourist attraction or a recreational tool, something to do on a Sunday with the family or perhaps just a way of reclaiming a disused railway line when we don’t know what to do with it. On the other hand, cycle lanes can also help prevent health problems – perhaps cutting road accidents or getting people to become more active and reduce obesity.”

It’s a big challenge to help evaluate and prioritise these diverse factors to support local authority public health decision-making. That’s why NIHR SPHR researchers led by Durham University, a member of the Fuse partnership, are working with several local authorities around England – to understand what supports might help such decision-making. It’s part of NIHR SPHR’s research into how the assignment of responsibility for public health to local authorities can shift priorities in councils towards improving population health and addressing health inequalities.

The council official explained: “We are trying to quantify, for example, whether we should put public health money into cycle lanes or smoking cessation or employment supports or leisure centres or sexual health services. The local authority is full of people competing for resources. It’s all very political. No single piece of evidence decides a policy – it springs out of different pressures. We’re all learning and the universities are starting to realise that it’s not just about reading their evidence and saying ‘Here’s the answer’. What they can tell us might be just a bit of the answer.”

"If we want to work with councils, we must start with their political priorities and build these into decision-making tools. Supports must be seen to make a difference rather than adding more complexity to a local authority." 
Professor David Hunter, Durham University

They might be a tourist attraction or a recreational tool, something to do on a Sunday with the family or perhaps just a way of reclaiming a disused railway line when we don’t know what to do with it. On the other hand, cycle lanes can also help prevent health problems – perhaps cutting road accidents or getting people to become more active and reduce obesity.”

“There is not massive enthusiasm among elected members to be involved with academics. If SPHR can build that connection and develop research that really assists councillors, it will be a great achievement.”

Local authority public health official
So what are helpful ways to inform investment decisions? The NIHR SPHR research is ongoing but, as a first step, the team has examined whether traditional health economics tools are useful. The research team has held workshops in three local authorities to demonstrate and explore the application of various tools.

The team has found different levels of usefulness for the tools, depending on the locality, explains David Hunter, Professor of Health Policy and Management at Durham University. “Two of our sites saw a use for these tools. In another, they were seen as less useful. An issue is that the tools don’t always fit in with, or express, the sometimes complicated political strategies and values of council members. Some see the tools as by-passing their decision-making structures. Members feel that they know the territory and know the issues. They may not want people coming in and suggesting that they do things differently. A big learning point for us is to understand that these tools can only complement decision-making.”

Professor Hunter sees councils as very engaged with their public health responsibilities: “Councils have long defined themselves as public health organisations – managing housing, roads, the environment and so on. They are not resistant to the notion of public health; far from it. They simply attach a meaning to it – more of a social justice definition – that is much broader than what has come over from the NHS and the narrower values that are sometimes embedded in these tools.

“We found that elected members want local data and local circumstances to be built into models. If we want to work with them, we must start with their political priorities and build these into decision-making tools. Supports must be seen to make a difference rather than adding more complexity to a local authority.”

The NIHR SPHR team also observed different relationships between public health officials and council politicians in the three areas studied, with some being more successful than others. An official from one council demonstrated how there can be problems: “There is quite a stark clash of ideologies between council politicians and traditional public health as practiced by the NHS,” he said. “If you ask politicians to do something about food, they say: ‘Don’t ask me to do a five-a-day campaign. Ask me to do something about food poverty and people queuing up to get food.’

“The local authority is full of people competing for resources. It’s all very political. No single piece of evidence decides a policy – it springs out of different pressures. We’re all learning and the universities are starting to realise that it’s not just about reading their evidence and saying ‘Here’s the answer’. What they can tell us might be just a bit of the answer.”

Local authority public health official
“I hope the work with Durham can help resolve this tussle between the medical and social approaches to public health. There is not massive enthusiasm among elected members to be involved with academics. If NIHR SPHR can build that connection and develop research that really assists councillors, it will be a great achievement.”

In contrast, such problems were less acute in the other two sites, studied by the NIHR SPHR team. Professor Hunter explained: “The Director of Public Health (DPH) in one of our field sites clearly understood the local authority context, unlike the DPH in the first site. She began to introduce a new way of thinking around public health because she had a different relationship with elected members/officers, because her negotiation skills were better than some counterparts elsewhere, and because a centralised model of public health meant that she could retain oversight of the budget. We hope that our research, including the current follow-on study, will identify approaches to evidence that can support such productive relationships.”

| PROJECT: Shifting the Gravity of Spending? Exploring methods for supporting public health commissioners in priority-setting to improve population health and address health inequalities |
| LEAD: Professor David J Hunter, Fuse, Durham University |
| COMPLETION: September 2016 |
| CONTACT: Lisa Monkhouse, lisa.monkhouse@durham.ac.uk |
NIHR SPHR is working with Doncaster, adapting its diabetes prevention model locally, in order to help provide evidence for the next round of decision-making on public health commissioning.
Public health specialists within Doncaster Council plan to use a new tool in their commissioning process to compare the cost-effectiveness of different obesity and diabetes prevention programmes.

"It's very useful to know what the various cost savings might be against, for example, a do-nothing approach, especially in this economic climate. We could not do this without the support of our academic partners."

Rachel Manners, Public Health Specialist, Doncaster Council

“...This tool will feed into our decision-making process, contributing alongside our local evaluations, our review of evidence and stakeholder consultations,” explains Rachel Manners, public health specialist with Doncaster Council. “It's very useful to know what the various cost savings might be against, for example, a do-nothing approach, especially in this economic climate. It should help make the case for some of our commissioning decisions.”

The number of people with diabetes in the UK rose in 2013-14 by 125,000 adults, rising to an all-time high of 3.9 million, most of the cases being of type 2 diabetes, which is largely preventable. Failure to reduce the surge in cases is resulting in devastating health complications, including amputation, blindness, heart attack and stroke. The cost to the NHS is nearly £10 billion a year.

This deteriorating picture explains why NIHR SPHR has developed a diabetes prevention model so that the cost-effectiveness of national and local diabetes prevention programmes, such as the one in Doncaster, can be tested. It could help prioritise public health spending. The model is internationally unique in being the first with the capacity to compare a wide range of interventions within a single framework. It has been developed by the University of Sheffield, in collaboration with UCL and the universities of Cambridge, Exeter, Lancaster and Liverpool. Other stakeholders have been closely involved, including patients and clinicians, in conceptualising and planning the research as well as examining its findings.

Potential gains from successful interventions can be huge – the model can track costs for every year of a person's expected life, to make a cumulative total. For example, the cost of diabetes management ranges from around £80 to £1,500 per year depending upon which medications someone is taking. However, those figures don’t cover the costs of complications of diabetes, such as kidney failure (around £30,000) and amputation (around £11,000 in the first year). It has been estimated that a 50 year old with diabetes will die, on average, six years earlier than someone of the same age without the disease.
NIHR SPHR’s diabetes prevention model, which is adaptable to local circumstances and local policies, can look at a broad range of interventions to compare their cost-effectiveness. The School has examined the potential effects of implementing a soft drink tax (20 per cent on sugary drinks); promoting a new supermarket opening in a deprived area and therefore increasing the supply of fruit and vegetables; promoting healthy choices in a workplace canteen; community-based interventions, such as weight loss and cooking classes aimed at disadvantaged groups; and screening people for high blood sugar who are therefore at greater risk of diabetes, in order to focus support for healthy living, exercise and diet on the most vulnerable to disease.

The model, which can track the impact of interventions on people right through until death, has found that all these policies to prevent diabetes are likely to be cost-saving in the long run and are effective in improving health. Screening for type 2 diabetes with intensive lifestyle education for high risk individuals is particularly cost-saving and gives the largest health gains over a lifetime. However, this approach is also the most expensive and the payback is longer term, because the health benefits don’t outweigh the costs of the intervention for several years. Alternatively, sugary drink taxation is also highly cost-effective. Because there are no local implementation costs, it has the benefit of being cost-saving within the first year of implementation. The policy seems particularly to benefit people with low socio-economic status.

“We also used the model to look at the costs and outcomes from targeting different high diabetes risk subgroups with an intensive lifestyle intervention,” explains Chloe Thomas, one of the NIHR SPHR researchers. “This included people with high blood sugar (“pre-diabetes”), people of south Asian backgrounds, people aged between 40 and 65, people thought to be at high risk using a common diabetes risk score, people from low socio-economic backgrounds and people with a high body mass index score. We found that targeting people of south Asian ethnicity or those with high blood sugar counts was most cost-effective but for different reasons. Whereas diabetes incidence was reduced when those with high blood sugar were targeted, the primary reasons for cost-effectiveness when those of south Asian ethnicity were targeted was a reduction in cardiovascular disease and a delay in diabetes diagnosis.”

As with all models, the issue, once the maths is sorted out, is inputting the right data and creating a tool that displays the results in an accessible user interface. Rachel Manners explains: “It’s really important to understand how to use the tool and how it can support commissioning decisions. People like me, public health practitioners from an NHS background, may be more accustomed to this type of approach than perhaps colleagues from a local government background. In public health we are bringing new approaches to evidence in local government.”

“The model is internationally unique in being the first to have the ability to compare a wide range of interventions within a single framework.”
The support that the collaboration offers is, says Ms Manners, also helpful, given the current financial climate: “It is really valuable that academics can develop this in partnership with commissioners. With limited time, resources or analytical expertise to develop something like this, the support of academics is invaluable.”

Chloe Thomas sums up the hopes of the research team: “We don’t want to dictate which public health interventions policymakers should implement. But we would like policymakers to use a version of the model adapted to suit their situation to help them evaluate what is cost-effective and support their decision-making. We are now adapting the model and making a financial planning tool for NHS England to help them to evaluate the National Diabetes Prevention Programme.”

| PROJECT: | Estimating the impact of diabetes prevention on public health: using modelling to aid translation of knowledge into action |
| LEAD: | Alan Brennan, Jim Chilcott, ScHARR, University of Sheffield |
| COMPLETION: | Ongoing (using additional funding sources) |
| CONTACT: | Chloe Thomas c.thomas@sheffield.ac.uk |
“They are very well connected with me and people in the council. That’s the way to do it. We can contribute to the research. They talk to the right people and they have made efforts to make their work relevant to us. The good thing is that the team did not just take the brief and disappear for a couple of years – they are more participatory than you might expect of academic researchers. That’s the way to go.”