A methodology to enhance tackling health inequalities through the work of a Clinical Commissioning Group

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Background

• Compared to England, average life expectancy (LE) in Liverpool is 3.8 years lower for men and 3.4 years for women.
• Difference in average LE between the most and the least deprived areas of Liverpool is 11.0 years for men and 8.1 years for women.
• Primary care clinicians as a driving force of the CCGs have a statutory duty to do something about health inequalities.
• But how? Do primary care clinicians have sufficient will, expertise and power to tackle health inequalities in Liverpool? [August 2012]

Aim

• To support, document and evaluate the process of addressing health inequalities by the Liverpool CCG (LCCG) while generating transferable knowledge on the actions taken.

Project design – HiCCG Model

A one-year action research composed of three streams:
1. Action Learning Group (ALG)
2. Policy Ethnography (PE)
3. (Participatory) Systematic Review

Each taking different angle to look at the same question:
What can Liverpool CCG do to address health inequalities, and how?

Expected outcomes

Contemporaneous creation of:
• Improved knowledge on what is a CCG’s role in addressing health inequalities and how that role can be pursued in the local context;
• Improved capacity within the Liverpool CCG to act upon the knowledge gained.

Context-specific evidence-based action

1. Action Learning Group (ALG):
What did we plan?

• Self-selected and self-directed group of 10-14 members who: (a) are interested and already involved in work related to health inequalities; and (b) have the capacity to influence the work of the CCG;
• Determined to learn from each other through action and reflection, while exploring the core action research question;
• 6 ALG meetings from Jan-Sep 2013 with academic support available;
• Meetings to be observed by a researcher and participants interviewed at the beginning and at the end of the project.

Where are we now?

• Recruitment is completed in February 2013 (N=16; 13 CCG’s affiliates and 3 Local Authority’s affiliates; 2 CCG affiliates stepped down in the meantime);
• All baseline interviews have been completed;
• ALG members were given access to online learning space created and populated by research team;
• To date, 3 ALG meetings have been held, with around 80% attendance rate;
• In addition to attending ALG meetings, 5 members attended a course on Realist Review method;
• Enthusiasm and dedication to participate in the group is high; Questions generated through action learning process formed a database of 67 items;
• Outcomes of the ALG will be presented at the RCGP Annual Conference, in October 2013.

2. Policy Ethnography (PE):
What did we plan?

• Ten-month anthropological study evolving in parallel to the ALG;
• Aiming to understand the processes of creating and integrating a ‘health inequalities agenda’ into the work of the LCCG;
• Using methods of:
  ✓ In-depth interview;
  ✓ Observation and participant observation;
  ✓ Informal ethnographic conversation;
  ✓ Collection and analysis of relevant documents.

Where are we now?

• Data collection started in February 2013;
• Researcher’s involvement in the ALG process facilitated access to the wider observational filed;
• Emerging PE dataset is generated through:
  ✓ In-depth interviews with all recruited ALG members (N=16, 20.5h);
  ✓ Observations of the ALG meetings (N=3, 7h);
  ✓ Observations of LCCG’s meetings and other relevant local meetings (N=24, 62h), including informal ethnographic conversations;
  ✓ Creation of relevant documents’ database;
• Key message: Even if being a top priority, strategic action on health inequalities can still easily slip through the net of complex organisational changes;
• Interim findings will be presented at the BSA Medical Sociology Group Annual Conference, in September 2013.

3. (Participatory) Systematic Review:
What did we plan?

• Systematic review of evidence on interventions to address health inequalities by clinical commissioning, applicable to the local context;
• Respondent to and with involvement of ALG members in the review process.

Where are we now?

• We are at the beginning of this work stream;
• ALG members will examine the ‘Questions database’ generated in the ALG work and discuss which questions are the most relevant for the group work to progress;
• A meeting will then be arranged with academic team to determine suitable review methods.

Discussion

Knowledge on how CCGs can address health inequalities in particular local contexts, is limited and scattered. Even if the knowledge would be readily available, we know that the knowledge does not necessarily translate into action. By creating and using the HiCCG methodological model we are seeking to test new ways of doing health services research, aiming to integrate theoretical knowledge, locally relevant international research evidence and routine population intelligence, in order to inform day-to-day process of local policy-making to address health inequalities.

Conclusion

HiCCG methodology is working so far. We expect that the outcomes of the project will provide useful knowledge and clear guidance for contextualised action on health inequalities for the Liverpool CCG. This may also be relevant for other CCGs, both in terms of the methods as well as the outcomes.


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