

Health Development Agency

Evidence into Practice

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Method 1 for the production of *Effective Action Briefings* and related materials

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Executive summary

This document describes the stages for the production of Guidance materials, which may be followed by Evidence and Guidance Collaborating Centres. The process described shows how the scientific evidence base can be interrogated and then integrated with other forms of learning, notably from practice, to produce guidance materials. The method described here has been derived from two pilot studies of evidence into practice undertaken by the HDA during 2002-3. In due course other methods, particularly of gathering information about practice-based knowledge will be developed, and it is expected that some of the Evidence and Guidance Collaborating Centres will play a significant role in developing the new methods. This document should be read in conjunction with the Framework Agreement documents for the establishment of Evidence and Guidance Collaborating Centres.

Introduction

Evidence into Practice is based upon the integration of evidence, learning and locally derived practitioner knowledge and local health improvement needs.

The total cycle of the work involves the production of a number of outputs.

These outputs are as follows.

- *Evidence Briefings*: these are syntheses of systematic reviews in a number of different public health topics. These have been in development since 2001 and the first of these have been published. Further publications are scheduled for 2003. Protocols for the production of these may be found on http://www.hda.nhs.uk/evidence/meth_problems.html and <http://www.hda.nhs.uk/evidence/ebmanual.pdf> Electronic versions of published *Evidence Briefings* can be found on <http://www.hda.nhs.uk/evidence/EBBD.html#pub> Evidence Briefings are syntheses of the world systematic review literature on particular topics. The topics covered to date are obesity, HIV/AIDS, smoking, drug use, alcohol misuse, accidental injuries, Hepatitis B infection, low birth weight, sexually transmitted infections, teenage pregnancy, social support in pregnancy, mental health,

physical activity, breastfeeding, community development and health impact assessment.

- *Evidence Reviews*: these are narrative or other kinds of review or syntheses of multiple evidence sources drawn from different research traditions. The protocols for the construction of these documents are in the early stage of development and will be described in a future document.
- *Technical Reports*: these are analytic descriptions of current practice in the field relating to particular public health topics. They are derived from fieldwork reports compiled from primary research with locally based practitioners. A variety of methods may be used for their production. This paper describes one method, which may be used for their production. It is anticipated that in due course other methods to produce *Technical Reports* will be developed. Evidence and Guidance Collaborating Centres will have a key role in helping to develop these methods.
- *Effective Action Briefings*: these are summary documents, for identified professional groups which set out key pointers for change in practice. The protocol for their construction is described in this paper.
- *Case Studies*: these are examples of effective practice¹. They will serve to illustrate how practices at regional and local levels have achieved positive health impacts. A standardised template will be provided to collect information.

The mechanism of Evidence into Practice involves using defensible evidence to strengthen the capacity for change in practice. It provides a framework for strategic planning and programme delivery. Its success depends upon practitioner knowledge of local population groups/settings and health improvement needs. In brief the scientific evidence provides a framework of social scientific or biological plausibility for interventions. The practitioner knowledge and its utilization provide the basis for understanding the likelihood of success of particular interventions. From September 2002 HDA officers undertook two pilot studies of the development of evidence into practice. These concerned the promotion of physical activity in adults and the prevention of accidental injury to children. The pilot studies have involved fieldwork with practitioners, policy makers and researchers and have taken place in London and a number of regional locations. This protocol has been developed out of that pilot work. It describes the stages from the completion of an *Evidence Briefing* through to the production of guidance materials (called *Effective Action Briefings*). Doing Evidence into Practice involves collecting, collating and analyzing all forms of evidence, which includes appraised practice. It is therefore by definition a cyclical process. The background papers supporting this protocol are Kelly & Speller (2003).

http://www.hda.nhs.uk/evidence/EIP_Jan03.pdf

The stages in the process

Stage 1. *Evidence Briefing* Completed.

¹ An intervention that is able to objectively demonstrate that it has had a positive impact on changing knowledge, attitudes or behaviour or having altered service provision or changed policy in such a way that a positive impact on health has or will occur

A completed *Evidence Briefing* is logged on the Health Development Agency's Evidence Base and corporate websites and is published in hard copy. This signals that the content has been signed off by the Reference Group in that particular topic and by DH.

Stage 2. Project team established

The Programme Head or the Programme Head together with the local lead in the Evidence and Guidance Collaborating Centre (if operational in the relevant topic area) convenes the project team. This will normally consist of a project lead, and four other officers (central or Collaborating Centre based) and a Regional Associate Director. The establishment of a project team will normally have been prefigured in the HDA Delivery Plan

Stage 3. Project plan formulated

The project team formulates a project plan and budget based upon this protocol and in accordance with current HDA planning and procurement guidelines and procedures and in the case of evidence and Guidance Collaborating Centres according to the terms of the Framework Agreement and any contract in place.

Stage 4. Development of plausible recommendations for practice derived from evidence

The next stage is to produce a list of recommendations for intervention based upon the *Evidence Briefing* and the *Evidence Review* (if available). The reviews and the primary papers upon which they are based have to be approached systematically. The process begins from the pragmatic position that very few, if any, primary studies or systematic reviews will be sufficiently scientifically robust to reach an absolute gold standard methodologically. However, using the set of criteria listed below, it is possible to reach a *threshold judgement* about what is *good enough* in terms of scientific plausibility. *Good enough* means that there is plausibility (socially, psychologically, biologically or organizationally) that the interventions will have some probable likelihood of success. Plausibility and likelihood of success are conceptually and practically distinct. This stage in the process deals with scientific plausibility. The subsequent stage deals with judgements about likelihood of success.

The Project team undertakes as its first task the preparation of a list of recommendations drawn from the *Evidence Briefings*. The team has to consider the question "What, based on the known evidence in the *Evidence Briefing* and *Evidence Reviews* (if available), are the most important findings which have implications for practice and which will impact on reductions in inequalities in health?" In order to arrive at this judgement there are several things to do.

First, each member of the team will appraise independently the *Evidence Briefing* (and *Evidence Review* if available) and provide a written report based on the criteria set out below.

Second, the reports will be collated by the project lead who will produce a long list of Recommendations.

Third, the team will meet to agree the **long list** of recommendations. This will take the form of a bullet pointed list with sources referenced to in the Briefings, the Systematic Reviews and the primary papers.

To draw up the list, the individual team members will appraise each finding in the *Evidence Briefing* and *Evidence Review* in accordance with the following criteria that will be operationalized in a *pro forma*.

1. What degree of certainty is there about the strength of evidence reported in the *Evidence Briefing* (and *Evidence Review*)?
2. Does it seem likely that the findings might have validity across persons, populations, place or time? These criteria **should** be subdivided into assessment of generalisability, transferability and context specificity of the findings (including an assessment of Hawthorne or placebo effects).
3. How realistic and realizable are any implications for practice that follow from the evidence?
4. What is the burden of mortality and morbidity relating to the finding?
5. To what extent is the burden amenable to change?
6. Are potential changes long, medium or short term?
7. What factors are involved in shifting the burden of disease? (Special note should be taken of upstream or downstream type interventions)
8. Are any cost effectiveness data available about the finding, and if there are, what do they indicate?
9. Are there any obvious progressive or regressive implications in terms of inequalities in health of the finding or of the practice/policy implications that follow from it?

With the agreed long list the team will be required to refine it still further. This will not be possible on the basis of the *Evidence Briefing* or *Evidence Review* alone. It will require the team to assess at least some of the systematic reviews and probably a number of the primary papers upon which they in turn are based. They may also decide to consult primary studies, recently published but not included in the systematic reviews of the *Evidence Briefing*. The task is to arrive at a short list of about half a dozen recommendations for the next stage of the process for practitioners to work with. It may be helpful to reconvene the Reference Group at this point to assist in this deconstruction of the evidence.

In all the topic areas in which HDA works in developing the Evidence Base, a Reference Group has been established consisting of researchers, officials and practitioners. The project team (with the help of all or some members of the Reference Group) will apply the following set of criteria to the long list of recommendations to produce a short list. These criteria will be operationalized into a *pro forma*.

1. The first criterion deals with biases. This in turn is subdivided into assessment of (i) methodological bias (i.e. to what extent do dominant research designs and methods influence the kinds of results that are available? (ii) compounding bias (in reviews) (i.e. to what extent are errors in primary papers simply reproduced in

reviews?); and, (iii) content bias (i.e. to what extent does the setting of research questions in terms of topic or approach delimit the results, and what other things would it be useful to know about in research terms).

2. The second criterion deals with internal validity. An assessment needs to be made about how good the internal validity of the science is (e.g. do the outcome measures measure what they purport to measure and how accurately? How good was randomization and blinding, and was an intention treat analysis used?)
3. The third criterion is concerned with the utility of the *process* information in the evidence. Here consideration needs to be given to whether the paper/review clearly defines what the intervention was in enough detail to replicate it, whether there were any factors relating to implementation which could have affected outcomes which were not reported, and what difficulties attached to the intervention or to the project itself. Overall is there enough detail to construct a replication?
4. The fourth criterion is about the design of studies from which the evidence is drawn. In particular an evaluation of (i) whether the intervention had cultural specificity, (ii) the extent to which it was tailored to suit particular populations, and (iii) the degree to which the experimental intervention was controlled, needs to be made. The purpose is to establish the extent to which the experimental conditions correspond to real world conditions.
5. The fifth criteria involves a consideration of any cost effectiveness data or information about the resources used

It is clear that most scientific papers (and all systematic reviews) may be weak on all or some of these matters. The attempt here is not to find the perfect study or review but to see if enough information can be gleaned to have a reasonable chance of replicating the intervention.

A short list of recommendations will be drawn up on the basis of this work

Stage 4. Appraisal of the Likelihood of Success

The next stage of the procedure involves taking the short list and translating it into something useful for practitioners. Judgements about plausibility come primarily from the scientific evidence and the underlying theories and methods accompanying the scientific explanation. Judgements about likelihood of success on the other hand, will owe most to an assessment about the way an intervention might be implemented in routine practice, as opposed to under controlled experimental and /or evaluative conditions. Judgements (about plausibility) can be made on the basis mostly of *a priori* scientific criteria, whereas judgements about likelihood of success require the addition of the detailed understanding of the practical reality of the everyday delivery of services.

At this point the project lead will convene a number of appraisal of practice field meetings. The underlying purpose, the objective of this phase of the work is to integrate the best scientific evidence with knowledge derived from doing. So both the practical "how to" kind of information is important here, as well as the detailed understanding of the macro and micro political and social context in which daily practice and delivery of service takes place. What is sometimes referred to as the tacit knowledge or the

lifeworld of practitioners needs to be harnessed, including their taken for granted assumptions about the nature of practice. The principle is to elicit their explicit and implicit understandings of the environment, clients and the communities with whom they work. This in turn needs to be integrated with what the science suggests might be the best recommendations in terms of effectiveness in bringing about changes and reducing inequalities.

To work effectively at this stage the role of the evidence and most certainly the role of the producers of evidence must take second place to the learning derived from practice. It is vitally important that the tone of these meetings is right and they must not be framed so as to give the impression that the recommendations *tell* practitioners what they should or ought to do. Ontologically the status of the evidence is not prescription, but is to provide a plausibility framework that provides useful guidelines about what *might* work. The task for the appraisal of practice activity is to consider whether these things are workable i.e. to ascertain their likelihood of success. Further the activity should facilitate an understanding, if it is workable, of how it might be done. Another important element of this activity is to get the practitioners to define and develop the political and resource framework, background and context, which will define the constraints of what is possible in terms of change.

It is important also to limit the role of the producers of information, the researchers, at this stage. The reason for this is that it is very easy, where practitioners and researchers come together for the researchers, perhaps unintentionally, to claim primacy for their special knowledge and its superior status. While scientific knowledge is clearly vital to the enterprise, it should not be used to mute the voices of the people whose everyday working lives involve dealing with the subject matter of the researchers' interests. One of the purposes of this stage is to provide a voice for persons whose position in delivery bureaucracies do not allow them space and time to contribute to evidence gathering activities, but whose understandings of the issues are highly detailed and deep. The task is to value science and practical wisdom and to integrate them. The details of setting up the meetings are described in annex 1. The meetings should also address themselves to the question of inequalities in health and the implications of interventions being discussed for and on inequalities. The agenda for the day must therefore explicitly make reference to inequalities and to the impacts of interventions on different segments of the population.

The point at which the data collection will end is the point when we meet 'sufficient saturation'. This is the point at which we begin to hear repetitively the same points from successive groups and when no new ideas are emerging from the groups. Discussion by the facilitators post meetings will help to make an assessment of how close we are to sufficient saturation.

Case study material should be collected from each meeting by inviting participants to complete the standardised template. This should be returned to the meeting organiser either on the day of the meeting or by a specified date.

Stage 5 Data Analysis

What is now to hand consists of the tape/CD recordings and the notes of the meetings kept by the facilitators and the *fieldwork report* of the day. The former are the raw data while the latter constitute the basis for initial data analysis. The data will first be transcribed in full. This may be done using computer software / package or by older

hand sorting methods of analysis. The data analysis must be theoretically informed. For a description of the conceptual basis for data extraction and analysis see annex 2. The report of all the analysed data is the *Fieldwork Report*.

Stage 6 Data Presentation and Writing Guidance

The initial trawl through the data set out in the fieldwork reports will produce key themes. Data analysis must begin as soon as possible after the data gathering at the meeting has been completed. This is to allow emergent characteristics to be included in time for the next fieldwork. Transcripts of the meetings will be passed to each participant for comment. The data analysis will consist of thematic analyses complemented by the analysis of notes and other any materials gathered in the meetings by the facilitators guided by the overarching theoretical framework.

A summary of the collated and analysed data and key pointers arising from the case study material will be presented as a *Technical Report* document. This will provide a report on the data, concepts and ideas as they have emerged along with a consideration of the implications of findings for PCTs, SHAs, RDsPH, the R&D function at DH and the policy leads at DH. The *Practice Briefing* will contain a detailed protocol of the methods used to construct it.

Draft copies of the *Technical Report* will be passed to members present at the meetings where the original data were gathered, for comment prior to their being submitted to the Reference Group for sign off and prior to publication in hard copy and on the website and PheL

In order to produce *guidance* materials the team will draw upon the *Evidence Briefing* and the *Technical Report* and its data sources (*Fieldwork Report* and case studies), and in some cases an *Evidence Review*. These three resources, plus the expertise of the reference group, will constitute the basis for the work of the team as it prepares guidance (*Effective Action Briefings*). Guidance production is driven by the very specific needs of the future users. In some cases this will be local, in some cases regional and in some cases national.

Prior to the production of guidance materials the team leader will prepare a brief detailing the audience (health visitors, teachers, local authority personnel, PCTs etc). The brief will reflect policy priorities, particular performance management imperatives, need as defined through the appraisal of practice process or some other means. In other words, the guidance will have very specific audiences with very specific requirements and the writing will reflect this.

Once a general brief has been drawn up the team leader will convene a meeting involving representatives of the user group in question (who will include some of those who were involved at the appraisal stage) for comment and further help on the preparation of the guidance. A meeting of the Reference Group will also be convened for the same purpose. In certain circumstances it may be appropriate for the reference groups and user group to convene together, and it is likely that there will be some overlap of personnel anyway.

The purpose of the meeting is to provide general direction of travel and to agree the broad shape/and content of the document. Once these have been agreed the team

leader arranges for a first draft to be made ready. This should be written by a member of the team who has been involved in the process through appraisal of practice and is thoroughly familiar with the literature and more importantly the voices of practitioners. The *Effective Action Briefing* should be targeted at a specific audience, with recommendations for effective practice. It will include reference to case studies to illustrate regional and local work.

Once the document is drafted it goes to the Reference Group, the users and members of the appraisal of practice meetings for comment. When all groups have commented and agreed the document goes formally to DH for sign off.

Annex 1 Meetings Protocol

The aim of the appraisal meetings is to test the plausibility of the evidence and elicit the likelihood of getting evidence into *local* practice. Appraising practice and considering the likelihood of success in bringing about effective interventions, public health gains rely on a multitude of environmental, social and behavioural changes. The appraisal process, that is the consideration of barriers, facilitators and solutions pull together a series of factors demonstrating an integrated approach to health improvement. The evidence-nuggets are presented as single issue interventions, and so it is important to reinforce the message that the evidence-nuggets are in themselves components of an integrated pattern of actions and events over time to bring about effective and sustained health gain and improvement.

Procedure for appraisal meetings:

Plan a maximum of 6 day-long meetings over a 6-8 week period.

Number of delegates:

A total of 20-25 persons with a remit for the health topic being appraised

Workshop balance:

It is recommended that presentations do not outweigh group work in order to make best use of the groups' attention and concentration to stay on task within the available time. Time is required to allow discussions and debate to unfold and conclusions, as far as is possible to be reached.

Venues:

It will usually be appropriate for the meeting to take place in the regions. It is probably helpful if the meetings take place in a non-university setting. Practice based settings may be appropriate (e.g. a health centre or a local authority). Community settings, e.g. Friends meeting house, new build Church/community venues which have been identified by a local contact have brought the delegates together in a more cohesive and receptive manner for discussion and debate than conference-type facilities. Community settings seem to have a greater sense of local ownership and belonging; through the course of the pilot work, community settings have seen greater group cohesion and through-put of information when compared with those meetings that have taken place in conference facilities. The atmosphere at the appraisal meetings has seen to be a critical factor in their success.

There may be logistical or technical reasons that make some types of venues unsuitable. For example most hospital seminar rooms are inappropriate; there is too much ambient noise and the types of furnishing and flooring makes good acoustic recording of proceedings and obtaining good reproduction very difficult. Venues should be checked before meetings to determine acoustic and other ambience.

Accessing people, agencies and organisations to participate:

The participant list is vital to the success of the meeting. Appraisal events should gather information and knowledge from a broad range of disciplinary groups covering statutory, non-statutory and voluntary organisations and agencies. It should also take into account those working indirectly to achieve the desired health gain. For example the appraisal group may call upon commissioners, outreach workers, voluntary groups, project

coordinators, police and other emergency services, probation services, health visitors and educational welfare officers. Given the topic under review, working with the end-user e.g. children and young people may be relevant, if it is a topic area that is not covered by an existing survey of opinion and behaviours. Mixing researchers and practitioners has not been seen to work, during the pilot projects effectively. It is recommended that if desirable, a separate meeting should be arranged for researchers.

It would be inappropriate to attempt to do a random sample of members from the respective professions or other groups. Quite apart from the fact that devising the appropriate sampling frame would be technically difficult not to say impossible, it makes much more sense to use existing knowledge, information and opportunity as the basis for sampling.

Working with a locally placed individual (based in the local authority or PCT) to manage the invitee list has proven to be successful in meeting an optimum attendance and diversity of agencies and organisations being represented. Working within the PCT, or local authority the individual is networked to a variety of local groups and organisations that otherwise may not be linked into the statutory sector mailing lists.

To provide further details of who might attend, the reference group could also be consulted together with HDA programme teams, Regional Associate Directors and relevant professional associations who may be able to provide regional and local contacts.

If there is no local lead to convene the meeting, it may be appropriate to snowball the invitation. That is once a list has been drawn up, and initial contact made, these respondents can in turn be asked to suggest names and for this and subsequent meetings.

Technical requirements for the appraisal meetings

Each meeting will require:

Four facilitators (ratio of 1 facilitator to 5 participants), one of whom will lead the day. Administrative support, to cover registration and refreshments (this could be provided by local convener)] .

Recording facilities or individuals assigned to minute taking must be available for the duration of the appraisal meeting

Capturing the proceedings from plenary discussion and from group work, would ideally be through tape recording and transcription. However in the absence of such resources, it is possible for a nominated individual to minute the plenary discussions. During group work the facilitator will need to guide a scribe to keep an accurate record of points raised against the respective questions (barriers, facilitators and solutions), and classify the points as being at a macro, micro (e.g. PCT targets; formal networking opportunities) or social (e.g. cultural specificity) level.

Structure of the meetings:

Prior to the meeting: A short briefing note should be sent to all participants with joining instructions. It will be a standard document.

At the meeting:

Registration

Welcome and housekeeping arrangements - Chair- HDA lead facilitator:

Introductions to the HDA team and by the participants.

Set 'ground rules', in particular establish the importance of listening and of listening kindly, even if challenged and disagreement occurs in discussion.

Session 1 -Purpose of the appraisal meeting - Chair- HDA lead facilitator;

What is the goal of the appraisal exercise and why the participants have been convened.. The importance of hearing the practitioners voice; participants have knowledge and skills which they stand ready every day of their working lives to offer to clients, which in turn define their professional identities (e.g. teachers, health visitors, road safety officers) .

Session 2: Presentation of the evidence into practice programme; theory and approach - HDA facilitator

Standard script and set of overheads available to present the rationale for evidence into practice; the idea of evidence as a framework not a prescription,.

Refreshment Interval

Session 3: Macro environments in which participants work - HDA facilitator

Require tape recording facilities or minute/note taker

Purpose of this session is to draw out the macro or political background and context in which the participants work. It is likely that criticisms of current policies, disenchantments with local and national arrangements and the alleged failings of DH and HDA (and many others) will all find a voice. This is important. It sets not just a general context, but should draw out some of the specifics that define the various constraints within which changes in practice may or may not be possible.

Session 4: Group work; HDA facilitators and nominated scribe

Participants will subdivide into 4 or 5 multi-disciplinary groups, each working with a facilitator. The purpose of the group work is to appraise the available evidence, which will be presented in the form of evidence-nuggets. The nature of the exercise requires the participants to think about their professional circumstances and what would need to be done in order to bring about theoretical evidence into practical reality.

For example 'Given that the evidence suggests that a particular kind of intervention/activity has worked in the following circumstances, what would you need to be done to make it work in your local situation?'. This should be used for the next prompt which is 'If this would not work, what would?'.

The facilitators' role is to ensure that everyone is given a voice and ensures key points are recorded for feedback.

Questions to lead group work will include *given the evidence for effective practice, what are the barriers to and facilitators for change, and in a local context what are the solutions to change?*

Common factors that have appeared over the course of the pilot project have included the following:

- **Political drivers and imperatives** for activity planning; what is driving the content and shape of the work plan, e.g. NHS targets, Public Sector Agreements, local strategic action plans
- **Decision and influence**; who holds local power to make and influence decisions for change and how can these decision points be accessed
- **Partnership**; who works together - local politicians, PCT, highways authority, transport, town planners, local authority, emergency services, schools, health visitors, nursery nurses, voluntary agencies; what is understood by 'partnership' and what currency does it hold to each involved party; what is the critical dynamic between the PCT and LA to bring about sustained partnership working; what is the role of voluntary sector in planning and delivery
- **Budget**; who manages the budget lines; which sectors are/need to be accountable
- **Stakeholders**; who are they and do they actively include community, frontline staff and the voluntary sector
- **Consultation** ; is it comprehensive in breadth and depth across people, place and time
- **Commissioning**; what is the process – evidence based or historical; does it take account of national, regional, local evidence of need, evidence of effectiveness and the available cost-effectiveness information; is there a local evidence base of effectiveness and need
- **Shared data and information services**; are there interoperable service data collection and information systems; what is realistically required to achieve shared data services
- **Performance management**; do performance targets relate to public health promotion and prevention practice
- examples of local good practice;
- implications for the proposed intervention with respect to inequalities and the degree of change which might reasonably be expected.

Lunch to be offered during session 4 (working lunch or break)

Session 5: Feedback from group work - HDA lead

Facilitator or nominee to feedback on key points raised in relation to the barriers, opportunities and solutions.

Session 6: Summation of key points, concluding remarks and close - HDA lead

Case study template to be distributed, completed prior to leaving or returned by a specified date.

Evaluation sheets to be completed by all participants.

Post workshop:

The facilitators will then meet together to share notes that the team leader will use as a basis for writing up as a fieldwork report of the meeting. All original notes should be retained. The fieldwork report will be circulated to all participants, requesting comments as appropriate.

Annex 2 The Conceptual basis for the analysis

The overarching theoretical position is that neither the individual nor the social structure is paramount in social behaviour. Human interaction is the result of the complex interplay between agency and structure (Kelly, 2000). Social structure defines the parameters of human behaviour. Humans also carry around in their heads ideas about social structure to which they orient their own conscious behaviour. Out of the complex mass of such human interactions, patterns emerge which constitute the social structure. Social structure is not static, but rather evolves materially and in peoples understanding of it. One of the most important aspects of the social structure is the division of labour. In particular the social aspects of the division of labour define the limits of people's lifeworlds and the potential for changes in their lifeworlds. The division of labour in turn defines the variegated nature of inequalities in relation to general power and status and wealth in any given social arrangement. These inequalities directly impact on health. We distinguish therefore between the determinants of health (which are the broad structures and institutions of society such as education and employment) and the determinants of inequalities in health (which are the consequence of the impact of the social structure on the lifeworlds of individual people). As we are interested in real material change, the focus is on the lifeworlds of people and the ways we may change these. Lifeworlds are experienced through space and also through time. So we are also interested in ideas about the lifecourse both in the biomedical sphere (such as how low birth weight affects subsequent adult health), but also how the lifecourse is experienced through stages of growth, development, attachment and loss in the social/psychological sphere and as played out within the division of labour.

This means that the data extraction should not only seek out common themes as they emerge in the data, and which the initial notes kept by the facilitators gives initial insight to, but these themes need to be read against our need to articulate ideas about lifeworlds, experience of inequality, and structures impacting on life worlds, and the way this may be plotted through the life course. Of course, as most of the primary data will be from those who mediate between our ultimate client group, the ordinary public, and the organs of the state and of service provision, there is a sense that we will be one step away from the real client group. However, given our task is to provide a means whereby interventions are more effective at assisting and helping those individuals, then this does not matter. The point is that the analysis must be driven by this theoretical position.

KELLY, M. P (2001) 'Disability and community: A sociological approach, in G. L. Albrecht, K.D. Seelman and M. Bury (eds) *Handbook of Disability Studies*, Sage, London: 396-411.