Author's response to reviews

Title: 'People pull the rug from under your feet': barriers to successful public health programmes

Authors:

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Author's response to reviews: see over
Dear Sir/Madam

Manuscript reference 2103545533167041

People pull the rug from under your feet': barriers to successful public health programmes

We were delighted to have the opportunity to address the comments of the reviewers. We found the two reviewers’ comments most useful when redrafting our submission.

In responding to the two reviewers we have addressed all the points for each reviewer as follows:

Response to the Reviewer’s report
Title: ‘People pull the rug from under your feet’: barriers to successful public health programmes

Reviewer One: Michelle C Kegler
Reviewer’s report:
General
• This paper describes the impact of staff turnover and attrition in a tobacco control program in Scotland. Data collection involved 56 in-depth interviews with program managers and intervention team members. Staff turnover has been recognized as a significant barrier in implementing public health programs, but has never been examined as carefully as in
this paper to my knowledge. Understanding how staffing challenges affect community interventions is a worthwhile undertaking.

We are pleased with this analysis of our paper, and in particular advocate that understanding the challenges faced by complexity of community programmes is essential for the practice of public health.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

- Since this paper is essentially a single case study of one project, it would be helpful to understand the project in more detail. The following details should be added:

1. What was the duration or timeframe of the project? Was it two years, five years and when did it occur?

Page 4 inserted: The programme was delivered in three phases over a three year period: firstly, the mapping phase (1998-1999) when existing community activity to tackle smoking was recorded and local participants were identified and recruited; secondly, the planning phase (spring 1999) when findings from the mapping exercise were disseminated to the local community led groups and when the interventions were developed; and, thirdly, the implementation phase (Autumn1999-Summer 2001).

2. The authors mention three phases. What kinds of activities occurred in each phase and how long did they last?

Page 4 inserted: The programme was delivered in four health promotion settings (community, schools/youth, primary care and workplaces) and comprised a range of activities, such as training health workers, young people’s videos, health fairs in the shopping centre, newspaper features, and innovative smoking cessation and well-being programmes (table 1).

Page 4 duration of the activities outlined as above: the implementation phase (Autumn1999-Summer 2001).

Table 1 Summary of intervention activity

<table>
<thead>
<tr>
<th>Setting</th>
<th>Programme activities</th>
</tr>
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<tbody>
<tr>
<td>Community</td>
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<td>Development and delivery of training programme for community workers in smoking cessation support</td>
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<td></td>
<td>Distribution of information regarding support available to those who want to quit</td>
</tr>
<tr>
<td><strong>Profile raising activities: community events, posters, local newspaper (adverts/competitions), post-card drop to every household</strong></td>
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<td>Training of health professionals in brief and in-depth intervention methods inc. motivational interviewing</td>
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<td>Provision of Nicotine Replacement Therapy through a community venue</td>
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<tr>
<td><strong>Schools/Youth</strong></td>
<td>Production of a sustainable education pack suitable for use as a teaching aid in secondary schools</td>
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<tr>
<td></td>
<td>Development and implementation of a protocol for the provision of smoking cessation support for those aged under 16 years</td>
</tr>
<tr>
<td><strong>Workplace</strong></td>
<td>Offer of health audit/support to Small and Medium Enterprises</td>
</tr>
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</table>
3. Who funded the project? Were there subcontracts or financial arrangements with partner organizations? If so, what were the deliverables and/or responsibilities?

Inserted page 4: Programme funding was provided by the local health board, and the local community agencies gave contributions in time and local administrative support. Programme responsibilities were defined through the planning process, with an expectation that the local agencies would deliver the programme in collaboration with local people.

4. How many and what types of organizations were in the partnership and what were their responsibilities?

Inserted page 4: *Breathing Space*, the first community-based public health programme in Scotland which specifically addressed smoking, was undertaken by a partnership of the local Health Board (HB), Urban Regeneration Partnership (URP) and the community health agency (CHA) between 1998-2001 (figure 1).

**Figure 1 Structure of the intervention**

[Diagram image]
And inserted page 4:
It was intended that intervention activity would be planned and driven by the local community, with leadership for the programme nurtured from within the community [28]. A previous paper explored the tensions and contradictions in implementing these principles in practice.

5. Why was the “community regeneration” partnership winding down—was it established for a different purpose?

Inserted page 6: The local area had experienced ten years of an extensive urban regeneration partnership that was coming to an uncertain end. The withdrawal of significant urban regeneration partnership personnel and resources had serious repercussions for the Breathing Space project.

6. Was the project focused on an area within a city, one municipality, multiple municipalities, or a region? What was the population size and demographic makeup? The only descriptor at present is “low income area.”

Inserted page 4 The programme aimed to produce a significant shift in community norms towards non-smoking in a low-income area with a population of 22,884, and a Carstairs score of 1.71, within a large city.
7. How many intervention teams were there and what did they do?

Inserted structure of the intervention on page 4

Figure 1 Structure of the intervention

And inserted page 4: The programme was delivered in four health promotion settings (community, schools/youth, primary care and workplaces) and comprised a range of activities, such as training health workers, young people’s videos, health fairs in the shopping centre, newspaper features, and innovative smoking cessation and well-being programmes (table 1).

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### Development and delivery of training programme for community workers in smoking cessation support
- Distribution of information regarding support available to those who want to quit
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### Primary care
- Operational and strategic input into local smoking cessation planning
- Training of health professionals in brief and in-depth intervention methods inc. motivational interviewing
- Support of smoking cessation counselling services set up through Local Health Care Co-operative
- Provision of Nicotine Replacement Therapy through a community venue

### Schools/Youth
- Production of a sustainable education pack suitable for use as a teaching aid in secondary schools
- Leaflet design project and competition involving first year pupils in local secondary school.
- Clear signage about no smoking policy adopted in local secondary school
- Funded community grant projects: posters, video, web-site design, alternatives to smoking/activity groups
- Development and implementation of a protocol for the provision of smoking cessation support for those aged under 16 years

### Workplace
- Offer of health audit/support to Small and Medium Enterprises

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**Inserted page 20: Definition of the programme phases**

**Mapping:** Activity undertaken as part of the needs assessment/audit. Aimed at gathering the views of key community members to assess smoking related activity and attitudes. As well as the engagement of key community participants.

**Planning:** Activity related to setting, revisiting and reshaping project objectives. Agreeing responsibility and leadership for specific objectives/projects and summarising/tracking current progress in order to facilitate reshaping of objectives. (Overall and subgroup level)

**Implementation:** Activities directly related to carrying out or facilitating specific project objectives. ‘Actual doing’. Including activity related to securing appropriate funding and resources to allow specific initiatives to progress and involvement of community members or workers in order to progress the objective (undertake particular activities).

Additional suggestions are ordered by paper section:
- Introduction
The introduction focuses mainly on tobacco control, with a brief mention of barriers and facilitators to community development approaches to health promotion. Since the findings focus on barriers, it would be useful to expand this discussion in the introduction (and discussion) sections.

We do not agree that only a brief mention of the barriers and facilitators to community development is mentioned.

But we have inserted on page 4 - A previous paper explored the tensions and contradictions in implementing these principles in practice [19].

We have also referred to a systematic review of the literature of community interventions conducted by the authors and refer to the wide literature on the barriers to community development in paragraphs 2 and 3 of page 3. The following references were used:


And in the discussion section
We have located the barriers in the discussion session within the literature on the indeterminate and technical aspects of work as an innovative way of considering the findings.

Methods
The methods section would benefit from clarification in the following areas:
1. 56 interviews were conducted in total over three points in time. How many were conducted during each phase and how many different people were interviewed?

Inserted page 5 table two

Table 2 Interviews conducted as part of the process evaluation

<table>
<thead>
<tr>
<th>Staff category</th>
<th>Organisation/ Setting</th>
<th>Phase of programme*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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**Key intervention team members were interviewed three times during the implementation Phase of the programme.**

2. How were interviewees selected? Was sampling of some kind used?

*Page 5* Semi-structured in-depth interviews were conducted with all participants involved in the programme and included 59 programme managers and intervention members from the agencies and the local community groups at three key phases (mapping, planning and implementation) (table 2). Interviews were conducted in person and lasted on average for one hour; they were tape recorded and explored understandings of the programme at different levels (overall programme organisation and structure, individual projects, and personal roles and responsibilities).
3. Program managers and intervention members were interviewed. How many of each?
See table 2 above
4. Data are presented from interviews with local community groups. Were these respondents not part of the intervention teams? How were they selected?

5. What was observed at the meetings and key events?
Page 5 paragraph 5 sets out the intention of the process evaluation and these aims were met through all the data collection methods, including the observation of the meetings and key events
The process evaluation focused upon the design, development, scope, intended purpose and implementation of the programme. In the course of the process evaluation, key themes were identified and explored in order to ascertain which aspects of the intervention enhanced or hindered the successful design, development, implementation and receipt of community based programmes.

6. “Mapping of community activity” was used as a data source. What does this mean?
These definitions are inserted in table two
‘Definition of the programme phases

Mapping: Activity undertaken as part of the needs assessment/audit. Aimed at gathering the views of key community members to assess smoking related activity and attitudes. As well as the engagement of key community participants.

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Implementation: Activities directly related to carrying out or facilitating specific project objectives. ‘Actual doing’. Including activity related to securing appropriate funding and resources to allow specific initiatives to progress and involvement of community members or workers in order to progress the objective (undertake particular activities).

7. Were the interviews conducted in person? How long did they take on average?

Inserted page 5: Interviews were conducted in person and lasted on average for one hour; they were tape recorded and explored understandings of the programme at different levels (overall programme organisation and structure, individual projects, and personal roles and responsibilities).

Discussion
The discussion should include a limitations section.
Inserted page 10: A limitation of the process evaluation is that, because Breathing Space was implemented in a disadvantaged area, it is not possible to compare staff/participant change and attrition with that experienced by programmes implemented in more advantaged communities. In addition, some
programme effects of interventions such as Breathing Space may be unanticipated and experienced after the funding, and indeed the programme, has ended. Hence the process evaluation was unable to capture the implications of staff changes for longer-term programme effects.

The authors suggest contingency plans to put in place to sustain the theory and culture of the program. This is a useful point and it would be nice to see some concrete suggestions.

Inserted page 10: The findings suggest a number of concrete recommendations that could counteract the indeterminate aspects of community partnerships. Firstly, clarity would be improved with a formal negotiation and agreement about the actual commitment of personnel, time, funding and other resources by each partner organisation, at the outset of the project. Secondly, contingency plans must be incorporated into the project design in order to accommodate change, and a comprehensive process of induction should be developed to ensure the original aims of the programme are transferred and understood. Thirdly, contingency funding could be built into the resources allocated to small community-led organisations in order to help them manage sickness absence. Fourthly, the inevitable change processes involved in such projects require effective management and communication between all partner organisations. Fifthly, a culture of mutual responsibility and accountability should be fostered in all partner organisations. Sixthly, it is important that diversity of knowledge, experiences and resources is acknowledged and valued across the partnership groups, celebrating the contribution of both lay and professional knowledges to the programme endeavour. The promotion of such inclusiveness will, it is suggested, add to the depth of understanding about the problems and generate creative and contextually relevant solutions. Finally, an increased emphasis on the diffusion of ‘what works’ through community structures will usefully inform future intervention programmes and curb the tendency of interventions to ‘reinvent the wheel’.

Also, the authors should place the findings within the context of existing literature on community coalitions and partnerships. We have provided in the discussion references to partnership and community development literature as stated in the submitted paper on page 10:

In accordance with findings from previous research we found that inadequate resource allocation and poor continuity of structures and personnel are key barriers to successful implementation of community based partnership programmes [19, 22, 24, 31-33]. As, Backett-Milburn and Wilson [34] illustrate, high staff turnover is often found in community based programmes.
Reviewer: D. J. Abatemarco
The manuscript presents the results of a qualitative process evaluation of a community intervention. The paper is interesting and well written.

- There are a number of issues that the authors should consider in revising the manuscript.

- The abstract indicates that the methods included a quasi-experimental design yet there is no description of this in the body of the paper. The abstract also describes methods that are not in the body of the paper such as: observations, focus groups and documentary analysis. Was this information part of a larger study not described in this paper? If this paper was based only on the 56 interviews how did the authors decide not to use the other data?

All the qualitative data informed the overall thematic analysis of the process evaluation and it is the aspect of staff attrition that was articulated through the in-depth interviews that informs theoretical analysis of concepts of technicality and indeterminacy that are presented in this paper. The study design included a before and after quasi-experimental design to determine the effectiveness of the study and is reported elsewhere and we reference this in the paper. See page 4

The project outcomes of the quasi-experimental evaluation are described elsewhere [30]. In particular, they indicate that the Breathing Space programme did not achieve its intended aims. That is, there was little evidence of a major impact of the programme. Findings from the process evaluation of the project implementation not only provide important insights which help us to understand the failure of Breathing Space, but may usefully contribute to learning for future practice.

- The findings suggest that numbers of staff dwindled. The paper does not describe how many or from which agencies/organizations.

Inserted page 6 Staff turnover and attrition constituted a major issue for respondents. Over the life course of the programme, the number of individuals associated with the design, development and implementation of Breathing Space decreased considerably. While respondents acknowledged that “things are always going to happen within a project that’s spanned over such a long period of time" (CP3), by the end of the programme they lamented that there were “few members of the original team left” (I13).

Attrition was ascribed to several factors, of which the most important was organisational change within the programme’s partner organisations. The local
area had experienced ten years of an extensive urban regeneration partnership that was coming to an uncertain end. The withdrawal of significant urban regeneration partnership personnel and resources had serious repercussions for the *Breathing Space* project. This insecurity was further compounded by re-structuring in the health board (HB). Of six original intervention team members employed by the HB only two retained involvement throughout the three year initiative. Moreover, of three original community intervention team members (employed by the CHA and URP) all were either on long-term absence or resigned during the course of the programme. At a managerial level, two managers at the CHA, two at the URP and five different HB staff had responsibility for Breathing Space over its life. All these changes were exacerbated by uncertainties over core funding in the partnership and associated staff cut-backs in all three partner organisations:

- The introduction and background make a good case for the importance of the research conducted in this study. However, in the final paragraph of the background the paper’s purpose is noted as to describe the process evaluation. The background would be more complete if it included a description and definition of process evaluation.

Inserted page 4: Typically, process evaluations use qualitative methods to document and analyse the early development and actual implementation of strategies or programmes, assessing whether strategies were implemented as planned and whether (and why) expected outputs were produced. We also provided on page 5 a description of the data collection methods: A comprehensive description of the intervention was undertaken as part of the process recording/evaluation. The process evaluation focused upon the design, development, scope, intended purpose and implementation of the programme. In the course of the process evaluation, key themes were identified and explored in order to ascertain which aspects of the intervention enhanced or hindered the successful design, development, implementation and receipt of community based programmes.

A range of qualitative data collection methods was used in the process evaluation of the programme, including: observation (at programme meetings and key events); in-depth interviews (with key stakeholders including programme managers and workers); focus groups (with programme implementers and young people); and examination of official documents (minutes, reports, budget statements, policy documents and key correspondence) and monitoring of local newspapers and community publications.

- In the third paragraph of the methods the authors state that the transcripts of the interviews were used in conjunction with other data sources what other data? The methods should include a detailed description of all data used in the study and an explanation as to how the data were merged and analyzed.
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and for page 5 for the analysis of the data:

Analysis of the process data was informed by a grounded theory, constant comparative approach. Interview transcripts were read and re-read by members of the process evaluation team in conjunction in conjunction with data obtained from the other research methods (observation of key meetings and examination of official documentation), which assisted in the identification of thematic categories prior to the analysis of interview data and throughout the analytic process.

Thematic categories were identified in the combined datasets. Inter-rater reliability of coding procedures was established through frequent meeting of team members. The robustness of both pre-identified and emergent categories was tested by reference to the individual cases, and conditions and circumstances of these formulations were compared and contrasted. A qualitative software package (NUDIST) was used to assist in the management and combination of the combined datasets (from observation, mapping of community activity and interviews).

- Additionally, how was it determined that the programme lacked fidelity? It is unclear from the paper how the programme failed.

We referred to the outcomes of the quasi-experimental design with the reference –see page 4 insert

The project outcomes of the quasi-experimental evaluation are described elsewhere [30]. In particular, they indicate that the Breathing Space programme did not achieve its intended aims. That is, there was little evidence of a major impact of the programme.

We also link these outcomes to the process evaluation and stress the importance of finding out why programmes do not work as well as the outcome as follows on page 4

Findings from the process evaluation of the project implementation not only provide important insights which help us to understand the failure of Breathing Space, but may usefully contribute to learning for future practice.

- The paper is unclear as to how this is to be considered a community-based intervention. The intervention seems to be a multi-agency based intervention and less a community intervention. It appears that the lack of fidelity to the intervention had more to do with the hierarchical nature of agency leadership and the loss of the original leadership of the programme. Typically community interventions would include individuals
and organizations that represent more that agency directors and leaders. Again, this sounds more like a multi-agency coalition than a community based intervention. If it were more community-based it would have been less dependent on hierarchical leadership and thus there would have been others in the organizations to have taken the roles of those who left. Thus, this paper describes stakeholder change more then the failure of a community intervention. Community interventions generally include community engagement and ownership.

Please note the insertion on page 4 where the roots of the intervention is described and we state that the programme was generated by the local community.

Page 4: The programme was initiated in 1998 by the local health sub-group of the local urban regeneration partnership, both of which are managed by local people. The local groups contacted the local health board for help in tackling the high prevalence of smoking in their local community.

The point of the paper is to explore how community development approaches and partnerships with the community can be undermined by the indeterminate aspects of the community partnership. So whilst it was a community ‘grown’ intervention it was undermined by these other factors. Please also note the insertion of figure 1 which demonstrates that the intervention was in fact more than agency directors and leaders. Also the phases illustrated by the insertion of the definition of the programme phases- table 2 illustrates the community engagement phases and involvement of local community workers in the mapping, planning and implementation.

- Lastly, a description of the lack of programme fidelity explaining how the programme did not succeed would make the paper clearer.

We referred to the outcomes of the quasi –experimental design with the reference –see page 4 insert
The project outcomes of the quasi- experimental evaluation are described elsewhere [30]. In particular, they indicate that the Breathing Space programme did not achieve its intended aims. That is, there was little evidence of a major impact of the programme.

- Process evaluation usually includes more than qualitative data and describes how the programme attempted to meet its objectives. This paper would be stronger with a description of the intervention and the process evaluation findings.

Inserted a description of the intervention in table 1 and inserted page 4
The programme was delivered in three phases over a three year period: firstly, the mapping phase (1998-1999) when existing community activity to tackle smoking was recorded and local participants were identified and recruited; secondly, the planning phase (spring 1999) when findings from the mapping exercise were disseminated to the local community led groups and when the
interventions were developed; and, thirdly, the implementation phase (Autumn 1999-Summer 2001).

And also page 4
The programme was delivered in four health promotion settings (community, schools/youth, primary care and workplaces) and comprised a range of activities, such as training health workers, young people’s videos, health fairs in the shopping centre, newspaper features, and innovative smoking cessation and well-being programmes (table 1). We also define process evaluation and state the intended purpose of the process evaluation inserted page 4:

Typically, process evaluations use qualitative methods to document and analyse the early development and actual implementation of strategies or programmes, assessing whether strategies were implemented as planned and whether (and why) expected outputs were produced. And on page 5 paragraphs one and two: A comprehensive description of the intervention was undertaken as part of the process recording/evaluation. The process evaluation focused upon the design, development, scope, intended purpose and implementation of the programme. In the course of the process evaluation, key themes were identified and explored in order to ascertain which aspects of the intervention enhanced or hindered the successful design, development, implementation and receipt of community based programmes.

A range of qualitative data collection methods was used in the process evaluation of the programme, including: observation (at programme meetings and key events); in-depth interviews (with key stakeholders including programme managers and workers); focus groups (with programme implementers and young people); and examination of official documents (minutes, reports, budget statements, policy documents and key correspondence) and monitoring of local newspapers and community publications.

We hope that you will find the revised paper suitable for publication and find our revised response to the reviewers’ comments acceptable, and look forward to hearing from you in due course. We apologise for the delay and are grateful for your patience.

Yours faithfully,

Deborah Ritchie