

# Tackling inequalities through partnership working: the development of a neighbourhood project

**Sarah Lockyer** Bradford District Health Development Partnerships, Leeds Road Hospital, Maudsley Street, Bradford, UK and **Jane South** Centre for Health Promotion Research, Leeds Metropolitan University, Leeds, UK

The focus of this paper is on health inequalities at a local level and the implications for community-based practice. This paper describes the development of a small multi-agency project supporting families in a disadvantaged urban neighbourhood within the UK. A baseline assessment enabled primary and secondary data to be collected to inform project development and identify priorities for action. Findings revealed the scale of health need and helped focus the direction of the project. Several issues affecting implementation were identified, including the importance of good liaison between services and adopting a community development approach. This paper discusses the wider implications for the planning, delivery and evaluation of community-based initiatives addressing health inequalities. Despite the scale of need, there appears to be good potential for practitioners working in disadvantaged neighbourhoods to achieve some positive changes. Key points of learning are identified.

**Key words:** community project; evaluation; health inequalities; learning from practice; partnership working

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## Introduction

Inequalities in health are persistent and serious problems affecting the lives of many individuals and communities in the UK. The government report on tackling health inequalities 'A Programme for Action' (Department of Health, 2003) recognized the importance of focusing on areas of deprivation, co-ordinating activity across traditional boundaries and concentrating efforts in early years support, housing and fuel, education, employment and improved access to services. Translating these broad policy aims to practice presents a huge challenge for practitioners working to improve the health of local communities. For those working in areas of disadvantage, the scale and range of health and

social problems faced by local people can appear overwhelming, and too large to be tackled by health and community workers alone. There are questions about how interventions can be delivered effectively and finite resources used efficiently in those contexts. Research evidence is needed in planning and evaluating community-based projects, but few practitioners will have the time or resources to devote to conducting in-depth studies. The purpose of this paper is to examine the process of setting priorities for health action in disadvantaged, urban neighbourhoods through examining the development of a small-scale multiagency project operating in one of the most deprived areas of the UK. Drawing on primary and secondary data, it discusses issues arising for the planning, delivery and evaluation of the project. This paper starts with a brief review of the evidence on tackling health inequalities at a local level. The main part of this paper presents a study of a project to support families in an area of Bradford, West

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Address for correspondence: Sarah Lockyer, Senior Health Promotion Specialist, Bradford District Health Development Partnerships, Leeds Road Hospital, Maudsley Street, Bradford, BD3 9LH, UK. Email: Sarah.Lockyer@bradford.nhs.uk

Yorkshire. The background to this project and the methodology for gathering evidence to inform development are described. This paper looks at the initial analysis of health need in the area before moving on to examine the emerging issues for the prioritization and implementation of actions. The wider implications for practitioners working in areas of multiple deprivation are discussed through posing some challenging questions: What can be done to reduce inequalities in health at a local level? How can priorities be set? What are some of the issues affecting delivery on the ground? How can we measure success?

### Addressing health inequalities

The high levels of social and economic disadvantage seen within many urban neighbourhoods have an undoubted impact on the health status of the individuals and families living within them. In the UK, the Acheson Report (Acheson, 1998) highlighted the continuing growth in health inequalities and recommended action to address the following three priorities:

- 1) The health of families with children;
- 2) Reducing income inequalities and improving the living standards of poor households;
- 3) Evaluation of the impact of policies on health inequalities.

UK Government policy has since reflected the need to address socio-economic determinants of health and a high level commitment to reducing health inequalities has been maintained (Department of Health, 1998; 1999; 2003). Given the scale of the problem and the evident level of health need, it can be questioned whether action at community level can make a difference.

An understanding of the economic, environmental and social determinants of health underpins public health/health promotion strategies to tackle health problems (Wilkinson and Marmot, 1998). Although macro-level policies are seen as essential to address health inequalities, there is clearly evidence that approaches at community level are vital and complementary. Catford (2002) reported on a recent review from Australia undertaken by Queensland University of Technology on evidence-based actions to reduce inequalities. The

review concluded that successful strategies should be focused on four main areas:

- 1) Macro-economic social policies (such as reduction of unemployment);
- 2) Living and working conditions (including use of community development approaches);
- 3) Behavioural risk factors (particularly where focused on disadvantaged groups);
- 4) Health care systems.

Other reviews support these findings. A systematic review of interventions by health services (or health services in collaboration with other agencies) concluded that there was potential for interventions to reduce health inequalities, although the authors cautioned that the largest impact would most likely come from addressing economic, social and environmental factors (Arblaster *et al.*, 1996). A review of interventions to reduce socio-economic health differences found evidence that, as well as structural measures, interventions combining health education with support appeared to be effective with lower socio-economic status groups (Gepkens and Gunning-Schepers, 1996). A recent UK Government Review (HM Treasury and Department of Health, 2002) found evidence of successful interventions, particularly where they were targeted at specific groups, such as interventions to reduce smoking in pregnancy. It concluded that, as well as national policy, there needed to be action at local level with involvement from frontline staff, communities, voluntary and business sectors.

The question of the relative effectiveness of community level activities to reduce health inequalities is a pertinent one for many primary care professionals working in disadvantaged communities. Even where projects have the potential to achieve health gain, it is a recognized problem in practice that health workers can feel overwhelmed by the enormity of health need and therefore disempowered. Daykin and Naidoo (1997) found that primary health care professionals were very aware of poverty as a barrier to improving health. The challenge of working in disadvantaged areas shapes practice and different approaches have been proposed (Kai and Drinkwater, 2004). Lazenbatt *et al.* (2000) reviewed nursing interventions to tackle health and social inequalities and identified eight aspects of good practice:

- 1) Holistic view of health and social need;
- 2) Health alliances and inter-agency working;

- 3) Empowerment;
- 4) Research-based approach;
- 5) Multidisciplinary team working;
- 6) Needs assessment;
- 7) Community development;
- 8) Audit and evaluation in practice.

Overall the literature suggests that significant health gain is unlikely to be achieved without supportive policy directed at changing social and economic determinants, but community level approaches can make a difference. Catford states:

Health promotion professionals should feel optimistic that they can play a part by advocating 'upstream' strategies, including greater investment in research and policy development. In addition, they should continue to address the health needs of the most disadvantaged through their day-to-day service and practice. Progress can occur in reducing health inequalities.

(Catford, 2002: 103)

This paper discusses the development of a community-based project in a disadvantaged neighbourhood and how those involved in 'day-to-day' practice used local information to inform project priorities and activities.

## Background

The Family Support Project developed out of partnership working between local health services, a regeneration agency and the local authority. Bradford Trident, the regeneration agency, has been responsible for delivering a New Deal for Communities (NDC) programme (Neighbourhood Renewal Unit, 2003) in the Little Horton area of Bradford, one of the poorest wards in the country. The area is urban, characterized by dense housing and high levels of social disadvantage. There is a large minority ethnic community with 44% from Asian origin (see Table 2). The NDC programme is the largest within the Bradford district attracting £50 million over a 10-year period and an important element is the delivery of a Health and Social Care programme. At the same time the local primary care trusts (PCTs), namely Bradford City and Bradford South and West, have been working to government targets to reduce inequalities in health (Department

of Health, 2003). Shared goals around tackling health problems in the area led to the district Health Development Service negotiating funding from Trident and the two PCTs for a health development project. Initially the three major partners agreed to recruit a project worker to work in Little Horton for three years with a remit to reach out and support marginalized and isolated groups, particularly families and young people. A local health visitor was seconded to this post in September 2002. Following this appointment, the project expanded to consist of a health visitor (team leader), a youth worker with a remit for teenage pregnancy, and a community support worker with particular responsibility for men's health. Further consultancy and management support was offered from a local Sure Start, which borders the Little Horton area, and Horton Housing, a local housing organization supporting very vulnerable and excluded members of the community.

## Methodology

A greater emphasis than ever before is being applied to the importance of basing health improvement initiatives on evidence of need and effectiveness. This stems in part from the need for accountability and ensuring that interventions deliver benefits. Research evidence can also aid decision making and promote sustainability. It was decided that evaluation would be integral to the Family Support Project and initially some baseline evidence would be collected to inform the development of the project.

There were difficulties in collecting baseline evidence given the dynamic nature of communities and their needs, and the fast developing roles of organizations involved. The choice of methodology reflected these constraints and drew on the experience of the evaluation of the Bradford Health Action Zone (HAZ) Community Involvement Team (South and Green, 2001). The methodology was informed by Theories of Change (Connell and Kubisch, 1998) and Realistic Evaluation (Pawson and Tilley, 1997), evaluation approaches used extensively in area-based community initiatives which seek to understand the project context and identify mechanisms being used to achieve goals. Fawcett (2000) describes this approach an action evaluation where stakeholders come together to look at service

goals, to assess the current situation and outline the rationale for why things are done. Activity is then monitored and there is active participation in reviewing progress. The Family Support Project was at the early stages of development, so the focus was on setting priorities for action by drawing on wider local knowledge. As in other action evaluations, a collaborative approach was adopted and the lead investigator was also involved in supporting the project. A framework of four questions relating to project development was used to guide the inquiry:

- 1) Where are we now?  
Understanding current context and health needs.
- 2) Where do we want to be?  
Looking at priorities and opportunities.
- 3) How will we get there?  
Identifying project activities and factors influencing delivery.
- 4) How will we know whether we have been successful?  
Setting up monitoring and evaluation.

In order to undertake the baseline assessment, secondary and primary data sources were used. The process bore some resemblance to Rapid Participatory Appraisal (RPA) in the rapid nature of the process and its reliance on both secondary data and key informants to build up a picture of need (Murray *et al.*, 1994; Ong and Humphris, 1994). Quantitative data collected at national, regional and local levels, and some qualitative data on the views of local people were used (see Table 1). In addition, individual semi-structured interviews

were conducted with seven key informants: three project workers and four individuals from statutory and voluntary partner organizations (a local resident and representative of the tenants group; a community development worker; a health visitor; and a senior housing worker working with young homeless people). The rapid nature of the process within practice meant that only a small number of key informants could be interviewed so the individuals were selected on the basis of their unique knowledge of the area and their links with the project. Data from primary and secondary sources were collated, organized and summarized using the evaluation framework of four questions. Further analysis identified key themes relating to each of the four questions.

The main findings from the analysis of secondary and primary data are presented in two sections. The first section looks at how priorities were identified through analysis of secondary and primary data. It describes the population profile and presents evidence of community health needs and health inequalities. The second section draws further on data from the interviews with key informants on the direction of the project and factors affecting delivery. It ends by presenting the recommendations for the development of the project.

### Identifying priorities for action

A wealth of evidence on health needs was gathered (Table 2). Ward level census figures showed an

**Table 1** Secondary data sources

Source of data	Date	Information
Mori Household Survey: Little Horton	2002	Reported health status Local services Community cohesion Ethnicity and language
Bradford Health Informatics Service: Electoral ward profile for Little Horton	2003	Key health indicators drawn from Office for National Statistics. Included: infant mortality rate, teenage conceptions
Meridian. Bradford New Deal for Communities: Baseline study	1999	Smoking rates and other health behaviours Community participation
Bradford Community Statistics Project: Area level data for Little Horton	2003	2001 Census information Bradford Council Benefits Report, 2000 DETR (Department of Environment, Transport and the Regions) Deprivation Index, 2000
'Asking local people': Community action plan (Lamb, 2002)	2002	Residents' views on community needs, crime, housing

ethnically diverse population. The Mori (2002) survey found that English was not the first language for 41% of respondents, and of that group, 47% spoke English only slightly or not at all. The data sources confirmed evidence of disadvantage. The ward was 42nd on the Index of Multiple Deprivation, compiled in 2000 by the Department of Environment, Transport and the Regions, where 1 is most deprived and 8414 is least deprived ward in England (cited in Bradford Community Statistics Project, 2003). A recent indicator from the Council Benefits Report, April 2000, showed that 84% of children claimed free school meals in this ward, compared to a district average of 48% (Bradford Community Statistics Project, 2003). Greater health deprivation than the district average was shown in other key health indicators, see Table 2.

The most recent data available on health need was from the Mori poll (2002) conducted on 517 Bradford Trident residents to give further insight into the health needs and expectations of the

population. There was found to be a low level of perceived well-being. More positively there was evidence of social cohesion. The poll found that 48% of respondents felt part of a local community compared to the nation-wide NDC aggregate of 36% (Mori, 2002).

In addition to the Mori poll, a small-scale community consultation had been carried out (Lamb, 2002). Information was gathered via discussions, questionnaires, visits, door-to-door visiting and community events. Key findings included that crime and young people (or perceptions of what young people were doing) were seen as the two main problems in the area. Residents felt that multi-cultural integration was essential and that housing needed to reflect the needs of a diverse community. One particular issue was the despondency apparent in residents living in the flats due to be demolished.

The findings drawn from the secondary data were supplemented by the interview data from the seven key informants. All informants were asked

**Table 2** Summary of key findings from secondary data

Source of data	Key findings
Mori (2002) Household survey: Little Horton	<ul style="list-style-type: none"> <li>• 37% respondents felt their own health to be good</li> <li>• 31% reported having a limiting long-term illness</li> <li>• 55% had no-one working in the household</li> <li>• 65% stated that neighbours looked out for one another</li> <li>• 41% stated that English was not their first language</li> </ul>
Bradford Health Informatics Service (2003)	<ul style="list-style-type: none"> <li>• Infant mortality rate 1993–2000 was 10.2 per 1000 live births (district rate: 8.6)</li> <li>• Low birthweight babies made up 11.4% of total births</li> <li>• Teenage conception rate was 81.0 per 1000 (district rate: 50.7 per 1000)</li> </ul>
Bradford Community Statistics Project (2003) Area level data for Little Horton	<ul style="list-style-type: none"> <li>• 84% of children have free school meals</li> <li>• Standardized mortality rate (SMR) in Little Horton between 1993–1999 was 155.6</li> <li>• 2001 census showed population composed of: 47.3% white, 37.8% Pakistani, 4.3% Indian, 3.7% black or black British, 3.6% mixed, 1.8% other ethnic groups, 1.5% Bangladeshi</li> <li>• Housing tenure: 53.5% owner occupancy, 28.3% rented from council or housing association council, 18.2% classed private or other renting</li> </ul>
Meridian (1999) Bradford New Deal for Communities: Baseline study	<ul style="list-style-type: none"> <li>• Recorded smoking levels 36.6%</li> </ul>
Lamb (2002) 'Asking local people': Community action plan	<ul style="list-style-type: none"> <li>• Crime and fear of crime seen as an important issue for residents</li> <li>• Young people and perceptions of what they were doing were seen as a problem</li> <li>• Multi-cultural integration seen as essential</li> <li>• Housing should reflect needs of different communities</li> <li>• Despondency apparent for those living in flats about to be demolished</li> </ul>

about the main features of the community and what they saw as priority needs in terms of the broad determinants of health and well-being. The responses to some extent reflected the different roles of individual workers but important themes did emerge across the data. There was confirmation of the scale of deprivation in the community, especially in the physical environment around housing needs and lack of children's play areas. Poverty and related aspects such as isolation, family difficulties, lack of education and training, and low self-esteem were identified as significant issues within the community. Improved access to mainstream services was deemed necessary, but needed to be seen in the context that some sections of the population appeared to lack the ability to move outside the immediate locality for services.

The official statistics showed an ethnically diverse community but the perceptions of key informants were that two large, and to some extent culturally different, communities existed, namely the white population and the Asian population, of whom the majority are of Pakistani origin (Table 2). While there were some shared needs in relation to education, child health, young people and access to services, there were also issues requiring different approaches. The key informants confirmed that there was a relatively a high level of social cohesion in the area, particularly within the Asian community. It was perceived that some issues, such as drug use, might be more visible in the white community and although also a problem amongst Asians, the issue is more hidden because of a greater reluctance to seek help. Two informants talked about the hidden needs of other minorities, for example, African Caribbean members of the population.

Young people in the area were perceived as being under particular stress, often suffering from depression and low self-esteem. There were few facilities for them and homelessness was a problem. Teenage pregnancy was recognized as an issue and therefore young people needed more sexual health advice, as well as developing teenage parenting skills.

## Developing the project

The key informants were asked to discuss the Family Support Project in the interviews. Team members

were asked about their aims for individual work and the work of the project overall and their responses showed a strong commitment to a community development approach with an overall aim of improving the health of the community in its widest meaning:

We want to ensure that changes are sustainable for the community;

I am aware that I must engage in a lot of community development work first to build the trust of men in the area.

All informants were asked to discuss what activities the project should be undertaking. A variety of activities focusing on work with young people and/or parents were suggested and some had already been started. Suggestions included:

- Activities to educate young people around parenthood
- Exercise sessions for all ages
- Support for breastfeeding
- Activities to support fathers
- Improving baby-sitting skills for teenagers
- Running a young persons' health drop in.

Several of the informants identified the importance of the Family Support Project working with mainstream services and networking with others working in the area. There were comments on the early approach:

During this period they have been making connections with other projects, building trust with other community workers, bringing projects together. They are doing all the right things; ...

I have been working with the Family Support Project in their first few weeks ... They have come in to see the community with an open agenda. They have made it clear that they want to see what is needed.

All key informants were asked to identify barriers and enabling factors to the development of the project. Disillusionment in the community and perceived apathy amongst young people were seen as barriers to achieving community engagement. Another barrier was having an all white team with no Asian language skills. In terms of working in partnership with other services and organizations, there was consensus that there was a need to set up

### Box 1 Final recommendations for the development of the Family Support Project

- Ensure that networks are built and connections made with professionals, organizations and community groups.
- Community development principles applied, the community consulted, informed and involved.
- Workable and uniform referral system put in place.
- Involve stakeholders so that projects are part of the overall regeneration of the community.
- Share resources and information with other groups and organizations.
- Set up monitoring and evaluation.

simple referral systems and have agreement over boundaries. The referral process was seen as a potential barrier if other front line workers were unaware of what the project could offer. There needed to be good communication and publicity to both workers and the community about the exact services being offered. The health visitor was particularly keen for both the youth and community workers to build links with health visitors in the area. Overall the interviews with key informants and workers at team meetings enabled a number of recommendations to be made for future work (Box 1).

### Discussion

The evidence collected built a greater understanding of the context in which the project was operating, helped identify priorities for action, and provided information on factors influencing practice. Gathering data on needs and local resources is seen as a vital stage in planning health interventions (Naidoo and Wills, 2000). In asking the question 'Where are we now?', the principal investigator was able to collect a range of information of value to the project development. The type of approach adopted has value in practical situations, such as the Family Support Project, where there is often little time or resources available for in-depth research prior to delivering interventions. Murray *et al.* (1994) argue that in RPA the triangulation of data from

different sources strengthens the validity of the findings. In this project the use of qualitative data from both primary and secondary sources gave a context to the more stark statistical evidence such as infant mortality rates. In addition, the health and social needs of specific groups within the area were uncovered and the data offered some clues on how best those communities could be supported. The weaknesses were the lack of primary data investigating community perspectives on priorities. Overall the results show that relevant evidence can be gathered quickly in a practice situation and used to inform project development.

The baseline assessment took place at the early stages of the project development. The process assisted the practitioners involved to clarify the project's goals and objectives, as indicated in action evaluations (Fawcett, 2000). The scale of health need and the evidence of health inequalities in the neighbourhood were clear. Professional awareness of community problems and the impact of poverty were reflected in the data. At the same time, areas of community strength, for example, the high level of community cohesion, were highlighted and could be utilized in delivering the project. In reflecting current practice, the project was set up to involve and work with communities and voluntary organizations as well as local professionals. Some new opportunities to develop services or to extend ways of working with other partners were also identified. In terms of levels of intervention, it can be noted that the Family Support Project is working in a context where there are national and local policy measures to address poverty and disadvantage. It was important for the project, as a small-scale enterprise, to identify the specific contribution it could make to improving health in the locality. The focus was on providing support to marginalized groups, especially families. Although the project does not specifically address social and economic determinants of health, it is working in partnership with a local regeneration organization which has influence on housing, employment, environment and education in the area.

As well as the assessment helping identify need (Where are we now?), and defining goals and objectives for the project (Where do we want to be?), it also examined implementation and the contextual factors influencing practice (How are we going to get there?). Partnerships and the importance of collaborative working emerged as the strongest theme

and many strong links had already been made. Partnership working gives a 'value-added' dimension to the project and it is unlikely, given the scale of health need, that project objectives could be achieved without this collaborative approach. Partnership working is not without its problems (Hudson *et al.*, 1997). The genesis of the project was influenced by inter-organizational partnerships but the delivery is dependent on inter-professional partnerships – what Hudson (2002) calls the Achilles' heel of partnership working. The issue of professional boundaries and the need for robust referral systems were highlighted by key informants. Rather than professional protectionism, this is about preventing duplication and working together effectively for the benefit of the community. Some of the project work is aimed at greater uptake of services, therefore a better understanding of roles and improved communication can help achieve those goals.

The need to ensure that local preventive and curative services match need, and individuals are able to, and do, access those services, were the key concerns, and the one that is reflected in current UK policy (Department of Health, 2003). The baseline assessment was able to identify groups where there were specific needs, and was able to throw some light on different needs within and between ethnic groups in the area. Arblaster *et al.* (1996) identified the use of needs assessment to help targeting as one of the characteristics of successful interventions to reduce health inequalities. They concluded that attention needed to be given to the delivery of interventions in terms of the target group, context and cultural issues. For the Family Support Project, the local context and cultural issues were emphasized in the interviews. The multi-ethnic nature of the area (and city) can present challenges for health professionals. In this project there were potential cultural and language barriers between the project team and part of the community for whom English was not the primary language. Link workers have the potential to help improve access and utilization of services (Gillam and Levenson, 1999). A development worker with appropriate language skills has since been recruited. The baseline assessment also highlighted some of the health issues within different ethnic populations. There are undoubtedly risks of failing to address 'hidden' problems within communities and Ouseley (2001), commenting on community

relations in Bradford, called for more honesty about the issues affecting communities. Insufficient attention to cultural issues is likely to limit the effectiveness of interventions.

Community development approaches that seek to utilize community strengths, build capacity and recognize diversity within communities (Amos, 2002) were recognized as the appropriate way forward. There is a long tradition of using community development within health promotion (Tones and Tilford, 2001; Gilchrist, 2003) and it is increasingly regarded as a useful approach within primary health care in the UK (Fisher and Gillam, 1999). The concept of community practice encompasses ideas around changing power structures and facilitating equality of opportunity, cultural diversity and social inclusion (Banks, 2003), and these aspirations are directly relevant to the work of the Family Support Project. Gradually, trust has been built with groups and individuals, and needs are assessed both informally and formally. For example, women-only exercise classes have been organized by the project as a response to local demand, as has an after school club for children and day trips in the summer for families. In the initial phase of the project, whilst waiting for premises, it operated from the Hutson Street Project, which has a 20-year history as a community organization and includes a nursery, a very popular community canteen and well-used training rooms. This particular project is remarkable for the fact that its users are representative of the local population and include old and young, and represent the diverse ethnic population. Links with Hutson Street are still very strong and the Family Support Project runs some of its groups there. The Family Support Project also uses community rooms in several schools and a Pakistani community centre for its activities.

The baseline assessment both examined the current situation and looked to the future. Part of that process involved setting an evaluation framework and agreeing appropriate indicators of success (How can success be measured?). There are advantages in collaborative evaluation involving practitioners (WHO Europe Working Group on Health Promotion Evaluation, 1998). The discussions that have been part of the process have helped team members define objectives and have thrown up several important issues about project activities and gaps. It has also ensured that monitoring and evaluation are an integral part of the project.



**Box 2 Learning points for practice**

- It is important to address the more immediate health needs of the most disadvantaged whilst participation in partnership working will also contribute to a positive up-stream strategy.
- Identify the strengths of the community and use them to full advantage (eg, a relatively high level of social cohesion).
- Build uptake of services through community development approaches. This can include matching services to local need and recognizing and overcoming language and cultural barriers and the issue of hidden need within communities.
- Use a multiagency/collaborative approach and build on links already made. It is important to foster inter-professional trust and robust referral systems.

Evaluation of interventions addressing health inequalities raise significant methodological issues about how and what to evaluate. Although some systematic reviews have been carried out, there are methodological, practical and ethical constraints in using positivist evaluation methodologies in assessing interventions that tackle health inequalities (Lazenbatt *et al.*, 2000; Springett, 2001). Springett (2001) argues that issues for health promotion evaluation are unique as health promotion is a process of change and not treatment. While traditional evaluation approaches are not necessarily aimed at benefiting communities, she argues that evaluation should be about learning with ‘the emphasis no longer on proving ... but improving’ (Springett, 2001: 148). The evaluation of the Family Support Project reflects some of these challenges and points of learning have been identified (Box 2). Although this study was able to identify key contextual features at the start of the project, there cannot be a true ‘blank sheet’ as local services, regeneration initiatives and national policy have a continuing impact on the health status of the population. The project processes which are reliant on partnership working, multi faceted activities and community development approaches, make control groups measuring intervention effects impossible. There is, however, a real need for evaluation

to chart the success of the project against its own goals and objectives and to capture learning.

**Conclusion**

Like many projects, the Family Support Project is a small scale project hoping to make a difference in an area of multiple disadvantage. Undertaking a baseline assessment enabled the project to define priorities and develop activities targeted at need. Despite the scale of need, there appears to be good potential to achieve some change at community level. One of the strengths of the project is the multi-agency approach and many working links have already been made. Partnership working gives a value-added dimension to the project and adds to its effectiveness in relation to longer-term objectives. Since the original assessment, the project has expanded and now has seven workers, they have engaged with many community projects and run sessions at a variety of venues in the area. Referral systems, particularly between the project and local health visitors and general practitioners, have been improved and a home support service is now provided. Key recommendations (Box 1) are being implemented. While at this stage in the project’s development there is no measure of its effectiveness, there is an understanding that the project is built on evidence of local need and incorporates the elements of good practice identified by Lazenbatt *et al.* (2000).

Key points of learning have emerged (see Box 2) which have relevance to other such small-scale initiatives where professionals are seeking to work effectively to reduce health inequalities in disadvantaged urban communities. The use of an action evaluation framework offers a mechanism to aid project development and delivery. Health practitioners face enormous challenges in tackling health inequalities at a local level and these challenges should not be underestimated. However, local practitioners and services have the potential to make an important contribution to improving health in disadvantaged neighbourhoods. It is important to focus positively on the day-to-day work which can help address the more immediate health needs of the most disadvantaged whilst at the same time keep an awareness that the participation in partnership working will also contribute to a positive up-stream strategy.

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