National evaluation of Health Action Zones

Health Action Zones:

Learning to make a difference

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Findings from a preliminary review of

Health Action Zones and proposals

for a national evaluation

A report submitted to the Department of Health
June 1999

Health Action Zones: Learning to Make a Difference

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INTRODUCTION

Health Action Zones (HAZs) are a central part of the new health policy being forged in Britain in the late 1990s. They are part of a family of regeneration initiatives that are central to the government's policies of tackling social exclusion and modernising public services. In particular, health action zones are expected to be 'trailblazers'; pioneering innovative approaches to reducing health inequalities, and developing services that are more responsive to patients and users.

Twenty-six health action zones have been established in England. They vary in size and complexity but they share many common characteristics. Not least among these is their emphasis on collaboration and partnership between public and private agencies and voluntary and community organisations.

A great deal is expected of health action zones. Health Ministers have invested much political capital in them. It is widely assumed that the initiatives they promote will offer many opportunities for learning about how to tackle what have been regarded for too long as deeply intractable problems. HAZs are very much in the public spotlight. Evaluation, therefore, is essential. But the zones are complex partnership coalitions of multiple interests that are engaged in an astonishingly wide variety of activities. Moreover, HAZs are new organisational entities slowly feeling their way forward in turbulent and uncertain environments. The whole process of HAZ development is a highly dynamic one.

The complex and changing contexts to which health action zones are likely to continue to be exposed and the evolving nature of their own efforts create genuine difficulties for evaluation. Two of these are of paramount importance. The first is that the total volume of research resource potentially available to learn about HAZs is tiny in relation to the quantity and range of activities that they represent. This implies that careful choices have to be made about *how and where to focus* evaluation efforts. The second important issue is that traditional evaluation approaches are unlikely to provide completely satisfactory ways of learning about health action zones. By and large, HAZs have not chosen to implement carefully specified interventions. HAZ priorities are undergoing a continuous process of refinement that is not always clearly articulated or widely understood. Any realistic expectation of learning about health action zones requires close engagement with key stakeholders in the process of development. Evaluation cannot afford to be too distant from the messy realism of strategy development, project design and implementation. It is essential, therefore, to think very carefully about the approaches and methods that are appropriate for the evaluation of complex, community-based initiatives such as HAZs.

The main purpose of this report is to contribute to the process of making decisions about a focus and format that should be adopted for the national evaluation of health action zones. It seeks to stimulate debate among members of the HAZ community about how an independent team of evaluators can best contribute to a learning process that will improve the quality of future policy and practice development.

We would like those who read this report to help to shape the course of the national evaluation so that the community as a whole can best exploit the enormous learning potential that health action zones represent. Your views are essential.

Structure of the report

This report begins with a brief review in section II of some essential background information. First, we summarise the policy context within which health action zones are operating. Secondly, we highlight some of the most significant characteristics of health action zones in terms of their relatively high levels of deprivation and poor indicators of health status. Finally, we outline what we regard to be the most appropriate methodological approach to the evaluation of complex, community-based initiatives such as HAZs.

The most substantive part of the report is set out in section III, which presents the findings from a scoping exercise conducted during the first part of 1999. This part of the report outlines four key sets of data about health action zones. First, it summarises information about the goals and associated targets and outcomes that HAZs have set for themselves. Secondly, it presents some descriptive statistical data about the programmes and activities that HAZs are investing in to pursue their objectives. The third part of the scoping exercise provides an overview of the perceptions and reflections of a mix of local stakeholders engaged in all first wave health action zones, which were obtained from interviews conducted in the spring of 1999. We conclude section III by reviewing some of the most significant features of the finance available to, and the freedoms and flexibilities requested by, HAZs

The final part of the report - section IV - outlines the general approach to the national evaluation of HAZs that we recommend should be adopted. We begin by illustrating a simple conceptual framework for thinking about HAZs. This is followed by a list of key research questions which relate to the different components of the conceptual framework. Next we highlight a number of critical assumptions:

- the need for an approach that combines *research & development*;
- the potential for a 'theory of change' approach to provide a unifying theme for the national evaluation;
- the minimum resources thought to be required to conduct the evaluation.

We do not present detailed proposals about how the national evaluation should be conducted in the longer term. It would be premature to do so until some critical decisions about the basic orientation of the national evaluation have been taken. However, we do outline some proposals about how to take forward a programme of research within the existing contractual and resource constraints that have been agreed for the period until the end of the year 2000. We plan to conduct a 'core data collection' supplemented by more specific research modules related to: developing effective partnerships; community involvement; and, tackling health inequalities.

The report concludes by highlighting the key decisions that have to be made to take forward the national evaluation of health action zones in an effective way.

The authors

This report has been written by the existing national evaluation team. The members of the team, together with their institutional affiliations and the extent of their present commitment to the national evaluation, are shown in Box 1.

Box 1   HEALTH ACTION ZONES – THE NATIONAL EVALUATION TEAM

Name	Responsibility	Institution	Time %
Ken Judge	Coordinator	University of Kent	50
Marian Barnes	Community Empowerment	University of Birmingham	20
Linda Bauld	Health and Social Care	University of Kent	20
Michaela Benzeval	Health Inequalities	LSE Health	20
Amanda Killoran	Partnership Working	Health Education Authority	20
Ray Robinson	Economic Dimension	LSE Health	20
Rachel Wigglesworth	Research Officer	LSE Health	100
Hannah Zeilig	Research Officer	University of Kent	100

BACKGROUND

Before describing the findings from the initial stages of the national evaluation of Health Action Zones, it is important to set out three sets of background information.

- The national policy context that is guiding and shaping the HAZ initiative.
- The characteristics of the 26 Health Action Zones.
- The approach of the national evaluation.

The national policy context

On 25 June 1997 at the NHS Confederation Annual Conference, the Secretary of State for Health announced his intention to establish a number of Health Action Zones (HAZs). These would be pilot projects whose aim would be 'to explore mechanisms for breaking through current organisational boundaries to tackle inequalities, and deliver better services and better health care, building upon and encouraging co-operation across the NHS' (DH 1997/145).

In October 1997, **EL (97) 65** invited health authorities in conjunction with local authorities and other agencies to submit bids to become Health Action Zones. The guidance made it clear that successful zones would create alliances for change by harnessing the dynamism of local people and organisations and 'build on the success of area based regeneration partnerships'. The aim of new-style partnership working would 'provide added impetus to the task of tackling ill-health and reducing inequalities in health'. The guidance also made it clear that HAZ status would provide opportunities for the modernisation and reshaping of health and social services. But such restructuring should directly contribute to the achievement of population health goals and policies to reduce social exclusion. More generally, the three broad strategic objectives of HAZs were set out as being:

- to identify and address the public health needs of the local area;
- to increase the effectiveness, efficiency and responsiveness of services;
- to develop partnerships for improving people's health and relevant services, adding value through creating synergy between the work of different agencies.

Among the carrots offered to potential HAZs were new freedoms, flexibilities and resources, although these were not spelled out in great detail. The obligations included requirements: to establish partnership boards; to demonstrate community involvement; to set targets for potential achievements, including early wins; and, to set in place performance management systems that would monitor and demonstrate progress with reference to agreed milestones.

Given these expectations potential Health Action Zones were invited to submit bids by the beginning of 1998, 'which will have significant impact … and make lasting change to health and related services in local areas'. In support of these aspirations it was decided that:

- a HAZ development unit would be provided and support networks would be established and facilitated by the NHSE;

- 'there will be a commitment to share learning with others';
- a requirement was placed on HAZs to undertake local evaluation of their work;
- an independent central or national evaluation would be commissioned 'so that a clear assessment can be made of the impact of the strategies adopted by HAZs'.

Forty-one bids for Health Action Zone status were received by the DH from 49 health authorities. From these the DH granted Health Action Zone status to 11 areas from April 1998 (DH, 1998/120). In launching the 1st wave Zones, Frank Dobson described them as 'trailblazers, leading the way in modernising services and tackling inequalities' that will 'make real changes in people's experience of health services and will begin to make real progress on tackling inequalities' (DH, 1998/120). Of those areas not selected in the 1st wave, a number were asked to submit further applications, and 15 more areas were granted HAZ status from April 1999 (DH 1998/329).

Since the launch of the Health Action Zone initiative, four important policy developments have occurred that constitute key parts of the framework within which HAZs must operate. First, all successful Zones were required to submit implementation plans for approval. Secondly, the Government has confirmed the funding arrangements for HAZs, and announced a number of new monies for them. Thirdly, a *Development and Performance Management Framework* has been established. Finally, the Government advertised and commissioned a national evaluation. Given the centrality of each of these to the development of Health Action Zones, they are briefly described here.

Implementation plans

All Health Action Zones were required to submit implementation plans to the NHSE for approval. However, it was acknowledged that these plans should be 'living documents: updated as the HAZ moves forward particularly in the programme detail but also as work with communities develops the approach' (Sands, 1998). Plans were required to include:
- a vision statement;
- reasons for becoming a HAZ;
- an environmental assessment;
- overview of programme targets;
- links to key strategic objectives both DH priorities guidance and broader Government priorities;
- plans for involving new partners;
- the financial underpinning of HAZ, including plans to obtain new resources;
- plans for local evaluation;
- governance arrangements;
- programmes of work covering the life of the HAZ, with more detail for the first three years, including freedoms sought, resources committed, anticipated outcomes at end of 7 years and intermediate milestones and outputs.

In addition, Ministers set out seven underlying principles that HAZs have been asked to adopt and reflect in their plans and activities. These are set out in Box 2.

Box 2   **SEVEN UNDERPINNING PRINCIPLES**

1.   Achieving equity
Reducing health inequalities, promoting equality of access to services and improving equity in resource allocation

2.   Engaging communities
Involving the public in planning services and empowering service users and patients to take responsibility for their own health and decisions about care

3.   Working in partnership
Recognising that people receive services from a range of different agencies and that these services need to be co-ordinated to achieve the maximum benefit

4.   Engaging front line staff
Involving staff in developing and implementing strategy, developing flexible and responsive organisations and encouraging and supporting innovation in service delivery

5.   Taking an evidence based approach
Having a more structured, evidence based approach for service planning and delivery as well as clinically effective procedures and interventions

6.   Developing a person centred approach to service delivery
Developing services around the needs of people and delivering them as close to people as appropriate

7.   Taking a whole systems approach
Recognising that health, social and other services are interdependent and need to be planned and organised on a whole system basis to deliver seamless care and tackle the wider determinants of health

(NHSE, 1999)

Despite this common structure, the submitted plans vary considerably in their length and content on the range of issues described above. The Regional Offices reviewed each HAZ's plans and made recommendations to Ministers about the robustness of the plans and identified areas for further development. First wave Zones had to submit plans by October 1998, and many were asked to clarify their plans, particularly with respect to target setting, community involvement, public private partnerships and tackling inequalities in health. As a result of Minister' comments and local developments, a number of 1st wave Zones have subsequently revised their plans. Second wave Zones submitted their plans for approval in March 1999.

In Section III, below, we describe the general approach HAZs have taken in relation to a number of key topics in the plans.

HAZ funding

Health Action Zones receive modest additional funding from central Government. Current plans suggest that approximately £306 million will be spent on the HAZ initiative between 1998/99 and 2001/02. The detailed breakdown of this funding is shown in Table 1. The basic allocation for joint spending across for all 26 Zones is approximately £52 million per year.

How this is divided between the Health Action Zones is described in more detail in Section III below. In addition to the basic core funding, five other pots of money are available to HAZs with different strings attached.

- First, each HAZ receives £100, 000 per year for development support.
- Secondly, in November 1998, Tessa Jowell announced a new drugs initiative in Health Action Zone areas with HAZs being able to bid for £3.3 million additional funding for drug prevention schemes.
- Thirdly, the *Smoking Kills* White Paper announced £30 million for Health Action Zones over three years to develop new approaches to smoking cessation services in disadvantaged areas. Ministers have specified the way in which this money can be used very closely and the funds have been allocated in proportion to the core resources.
- Fourthly, Ministers have announced an *innovations fund* of £21 million over 3 years for Health Action Zones to develop new forms of intervention to achieve HAZs goals, which will be carefully evaluation in order to disseminate good practice. HAZs will have to bid for this money; the exact terms of reference and timetable have recently been announced.
- Fifthly, Health Action Zones have been 'encouraged' to submit bids to the New Opportunities Fund for *healthy living centres*, and have been told that their bids will received priority in funding decisions.

In addition to all of the above, the health authorities which make up Health Action Zones have received an additional allocation of £30 million per annum, as a 'deprivation uplift'. Finally, £1.5 million has been set aside annually to provide the central development support for Health Action Zones.

From these various pots of money the full year spend on Health Action Zones is approximately £105 million. This represents approximately 1-1.5 per cent of the revenue allocation to health authorities in Health Action Zones areas in any one year.

Table 1 Funding for the HAZ initiative

	Monies allocated for HAZ initiative (£Million)			
	1998/99	1999/00	2000/01	2001/02
Basic allocation for joint spending	**4.3**	**40.0**	**52.0**	**52.0**
EXTRA ALLOCATIONS				
Development support (£100k per HAZ)	1.4	2.6	2.6	2.6
Drugs intiative*		3.3		
Smoking Kills		10.0	10.0	10.0
Innovations Fund*		5.0	8.0	8.0
Total allocated to HAZs	**5.7**	**60.9**	**72.6**	**72.6**
Central support	0.4	1.5	1.5	1.5
Total spend on HAZ initiative	**6.1**	**62.4**	**74.1**	**74.1**
HA cash limit deprivation lift		*30.0*	*30.0*	*30.0*
Total additional NHS spend in HAZ areas	**6.1**	**92.4**	**104.1**	**104.1**

*HAZs must bid for monies
Sources: Wright, 1999; DH 1998/0524; DH 1999/0302

Development and Performance Management Framework

The partner organisations of Health Action Zones will need to meet the requirements of the performance management assessment frameworks for their agencies. In addition, however, the NHSE, in collaboration with 1st wave Zones, has established a *Development and Performance Management Framework* specifically for Health Action Zones. HAZs will be formally reviewed by their Regional Offices twice a year, in October/November and April/May. The reviews will cover:

- progress against the targets specified in their implementation plans;
- key performance and development issues, drawn from a self-assessment report submitted by HAZs based on a framework of 10 pairs of key questions in three categories; meeting core objectives, demonstrating core values and delivering core requirements;
- emerging findings from their evaluations.

In addition to the above, HAZs will be required to submit quarterly financial returns by programme on their use of national funds. The financial returns and self-assessment progress reports will be key pieces of information for the national evaluation.

National evaluation

In the spring of 1998, at the same time as the first wave of Health Action Zones was being selected, the Department of Health invited applications to undertake the central or national evaluation of HAZs. The centrally-commissioned evaluation was intended:

*…to address **strategic** issues of importance for central policy on Health Action Zones and the wider policy agenda of the NHS White Paper and the Green Paper 'Our Healthier Nation' …(and) to contribute valuable lessons to support HAZ development locally.*

The research brief highlighted the fact that Health Action Zones are expected to have a life of 5-7 years and that the central evaluation 'will need to be capable of assessing interim achievements as well as longer term impact'. Beyond this the DH recognised the very wide scope of what HAZs might try to do. Even so it was expected that 'the evaluation should be concerned with assessing processes as well as outcomes and impact, to ascertain how as well as whether objectives are achieved'.

Within this general framework, which was elaborated in considerable detail in the original research brief, the DH indicated that the evaluation should address a number of key strategic themes.

- Improving health and reducing health inequalities.
- Restructuring and integrating services for improved health outcomes.
- Securing improved value for money from all available resources.
- Building and sustaining partnerships.
- Involving and empowering local communities to achieve sustainable development.
- Exploiting freedoms available to HAZs, forging innovation, bringing together policy and implementation and influencing central policy development.

Given the uncertainty about the development of the HAZ initiative and the type of national evaluation that was required, the commissioning process was considerably protracted and it was not until the end of 1998 that a contract was agreed for a modest first phase of national evaluation. The initial contract was for two years and it was agreed that it should:

- undertake a scoping exercise to map and to categorise the different approaches that HAZs are adopting in relation to the community health improvement process and their own local evaluations;
- begin to collect and analyse baseline data that will facilitate the identification of factors that promote and/or inhibit effective ways of partnership working within HAZs;
- develop a research team with the capacity to undertake a national evaluation of HAZs;
- prepare recommendations for detailed studies of particular areas.

Overview: the policy context

Ministers clearly have very high expectations of Health Action Zones to act as 'trailblazers' both to tackle inequalities in health and to modernise health and social care. In doing this, HAZs have been given modest additional funding, some development support and the opportunity to bid for freedoms and flexibilities. In return Ministers have required them to submit detailed implementation plans, developed in an inclusive way with a range of partners and the community. These plans must have clear pathways that link problems with interventions, expected consequences, targets and goals. In addition, as a range of new policies come on stream HAZs are being asked to take the lead in developing innovative responses to them. All of this is being done within a detailed performance management framework to tight timetables. Section III below describes in more detail how HAZs have gone about addressing all of these issues. Next, however, we turn to consider the characteristics of Health Action Zones themselves.

HAZ Characteristics

... 13 million people will be helped in 26 Health Action Zones, designed specifically to tackle health inequalities in areas including inner cities, coalfield communities, struggling rural areas and places where wealth and poverty live cheek by jowl (Dobson, DH 1998/0547.)

The purpose of this section is to describe some basic characteristics of the 26 Health Action Zones. We begin by briefly highlighting the location of the HAZs and the scale and complexity of the different zones in terms their population coverage and the number of statutory organisations involved in each HAZ. We then turn to consider some of their key characteristics – in terms of health status and deprivation - and highlight some of the variations between them.

Location, population and organisation

The 26 Health Action Zones are located in diverse areas of England. They are mainly concentrated in the North and Midlands, with only four Zones in London, one in the Home Counties and two in the South West.

Table 2 shows how the 13 million people are distributed between the 26 Zones, and the organisational configuration of each of them. In total, HAZs include 34 health authorities and 73 local authorities. However, the specific organisational configuration varies tremendously between Zones. Four main categories of HAZ organisational complexity can be identified.

- The most complex HAZs have the largest population coverage and comprise multiple HAs and multiple LAs. Examples are Merseyside and Tyne and Wear.
- There are two groups of HAZs based on single HAs and multiple LAs: those that cover two-tiers of local government (County and District Councils) and primarily serve rural populations; and those more urban based HAZs covering a number of boroughs.
- Six HAZs are based on coterminous HAs and LAs areas, representing comparatively simpler arrangements.
- Four Health Action Zones are based on unitary local authorities but only part of the associated health authorities.

Table 2 HAZ configuration and population coverage

Organisational configuration	Wave	Population	Number of HAs	Number of LAs
Multiple-HA/Multiple-LA				
Manchester, Salford & Trafford	1	880,000	2	3
South Yorkshire Coalfields	1	770,000	3	3
Tyne & Wear	1	1,100,000	3	5
Merseyside	2	1,400,000	4	5
Single HA/Multiple-LA (county & district)				
North Cumbria	1	320,000	1	5
Northumberland	1	310,000	1	7
Cornwall & Isles of Scilly	2	483,300	1	7
North Staffordshire	2	471,000	1	4
Nottingham	2	640,500	1	6
Single HA/Multiple-LA (unitary)				
East London & City	1	580,000	1	4
Lambeth, Southwark & Lewisham	1	730,000	1	3
Bury & Rochdale	2	389,400	1	2
Camden & Islington	2	365,100	1	2
Hull & East Riding	2	575,500	1	2
Tees	2	557,700	1	4
Coterminous HA and LA				
Bradford	1	486,000	1	1
Sandwell	1	300,000	1	1
Leeds	2	727,000	1	1
Sheffield	2	530,400	1	1
Wakefield & District	2	317,000	1	1
Wolverhampton	2	245,000	1	1
Sub HA and unitary LA				
Luton	1	181,400	Part	1
Plymouth	1	260,000	Part	1
Brent	2	247,500	Part	1
Leicester	2	295,000	Part	1
TOTAL	**26**	**13,424,800**	**34**	**73**

Health and deprivation

The 26 Zones were selected because of their high levels of ill health and disadvantage. To date we have only used publicly available data to consider the characteristics of the Health Action Zones. As the national evaluation progresses we plan to develop a core dataset with which to monitor HAZ performance and outcomes. Here we simply wish to paint a brief picture of some of their characteristics. However, in doing this, a number of problems need to be borne in mind.

- We have employed data for health authorities. Four HAZs only represent part of health authority areas, and the information for them is therefore not as accurate as we might wish. In particular, all of the Zones that constitute only part of health authorities have poorer health and higher deprivation than their associated authority.

- Four Zones contain multiple health authorities. For the purposes of this picture we have included them as separate entities. However, in due course we will wish to amalgamate them to have a single figure for each HAZ as a complete unit.
- These data are all based on average rates for the authorities concerned. Given that a key goal of many Health Action Zones is to reduce inequalities within Zones, we are aware that this information conceals wide variations that we will need to explore.

Table 3 shows the distribution of HAZ health authorities by the ONS classification of areas. It shows that HAZs dominate the more urban and industrial areas of England, accounting for over half of the authorities in each of these families.

Table 3 ONS area classifications

Family	Number of HAZ health authorities	Total number of health authorities
Rural areas[1]	3	22
Prosperous areas[1]	1	24
Maturer area[2]	3	16
Urban centres	9	16
Industrial & mining areas	14	18
Inner London	3	4

Source: Public Health Common Dataset, 1996 (NIE, 1998)
1 Contain one health authority of which HAZ is only a city
2 Contains two health authorities of which HAZs are only parts

Table 4 shows the location of the HAZ health authorities within the distribution of all health authorities ranked by two deprivation indices: Jarman's Under Privileged Area score and the 1991 Level of Local Conditions. HAZ health authorities dominate the distribution in the more deprived quartiles. HAZ health authorities account for 15 out of the most 25 deprived health authorities on the UPA index and 16/25 with the Level of Local Conditions. Moreover, HAZs account for the top five most deprived health authorities on the UPA index and three of the top five authorities with the level of local conditions index.

Table 4 Deprivation indices

	Number of HAZ health authorities in each quartile	
Deprivation quartiles	UPA Score 1991 Census	Index of Local Conditions 1991
Bottom 25 % (least deprived)	0	0
25-50	7	5
50-75	12	13
Top 25 % (most deprived)	15	16

Source: Public Health Common Dataset, 1996 (NIE, 1998)

In order to examine the health status of the HAZ health authorities we selected a number of indicators from the most recent Health Survey for England, 1994-96 and from the ONS vital statistics for health authorities for 1996. Taken together the two datasets tell a compelling story of the poor levels of health across the Health Action Zones. Table 5 shows that for

every one of the indicators shown, the average for Health Action Zones is higher than the national average. The biggest gap - 25 per cent - being for the rate of under age conceptions. However, comparing averages conceals much valuable information. The remaining columns in the table give a flavour of the spread of health problems in Health Action Zones by showing the highest and lowest percentage of the national average and indicating how many HAZs are above the national average. For all of the health indicators between 21 and 29 of the 34 HAZ health authorities have illness or mortality rates greater than the national average.

Table 5 Health indicators

Indicator	Average for England	Average for HAZ health authorities[4]	HAZ average[4] as % national average	HAZ minimum as % national average	HAZ maximum as % national average	Number of HAZ health authorities above national average
Per cent who assess health as not good[1]	22.6	27.2	120	79	158	29
Per cent with limiting longstanding illness[1]	39.6	42.0	106	76	121	23
Per cent who smoke[1]	29.8	32.4	109	80	143	21
Per cent with high GHQ scores[1]	13.4	14.5	108	34	177	22
Per cent of births < 2500 grams[2]	7.3	8	110	82	132	24
Infant mortality rate[2]	6.0	6.7	112	48	158	23
Under age conceptions per 1000 women age 13-15[2]	8.9	11.1	125	73	199	26
SMR all age all causes[2,3]	99	109.8	111	93	128	27

1 Source Health Survey for England , 1994-96
2 Source Key population and vital statistics , 1996 (ONS, 1998)
3 All age SMRs under-estimates poor health in the London because of the high outflow of older people to residential homes outside of the region.
4 This is the unstandardised average for all 34 health authorities

Table 6 shows a very crude ranking of the HAZ health authorities by deprivation and health. There is a strong correlation between the degree of deprivation in the HAZ and the level of poor health (Pearson's correlation coefficient 0.58). In general the ranking of HAZs is much as one would expect, with the more rural and outer metropolitan areas having lower levels of deprivation and better health compared to the more inner city areas. As outlined above, however, it needs to be borne in mind that the four HAZs that are only parts of health authorities are in general more deprived than their associated authority. One further complication to this picture is the position of the London HAZs, which appear to have better health than their deprivation ranking suggests. One explanation for this might be the choice of health indicators that were readily available to us. For example, it is well known that health authorities in London have low all-age SMRs, despite high SMRs for people under 65,

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because of the outflow of frail elderly people to residential homes outside of the area. As a result these rankings must be treated with caution until we are able to gather together a more comprehensive list of appropriate indicators and calculate them for HAZ units rather than the constituent health authorities.

Table 6 The ranking of HAZ health authorities by health and deprivation

HAZ health authority	Average rank across all 8 health indicators	Average rank across both deprivation indices
Cornwall & Isles of Scilly	5.3	5.0
North Cumbria	8.3	4.0
Bedfordshire	9.7	1.5
Brent & Harrow	10.7	22.0
Leeds	10.8	16.0
South West Devon	10.9	10.0
Nottingham	12.8	12.0
East Riding	14.5	16.0
Leicestershire	14.7	1.5
Salford & Trafford	15.6	17.5
Wirral	15.8	11.5
Camden & Islington	15.8	31.5
Newcastle & North Tyneside	15.9	27.0
Walsall	16.0	14.0
Northumberland	16.6	3.0
Wakefield	17.1	9.0
Sefton	17.1	6.5
Wolverhampton	17.9	25.5
Sheffield	18.3	23.5
Liverpool	19.8	30.0
Bradford	19.9	26.0
Tees	20.3	20.5
Sandwell	20.3	29.0
Gateshead & South Tyneside	20.4	25.5
Doncaster	20.6	17.5
North Staffordshire	21.3	6.5
St Helens & Knowsley	21.5	21.0
Sunderland	21.5	19.5
Rotherham	21.9	12.5
Bury & Rochdale	22.8	17.5
Barnsley	22.8	15.0
East London & City	24.2	34.0
Manchester	26.1	31.0
Lambeth, Southwark & Lewisham	28.3	32.5

This very brief review of some common indicators of health and deprivation confirms that HAZs do represent some of the most deprived areas of the country with some of the poorest levels of ill health. As the work of the national evaluation progresses, we will discuss with colleagues in the ONS and the DH how best to acquire a broader range of health and performance indicator data for Health Action Zones, and develop rates for HAZs themselves rather than their constituent health or local authorities. We will also seek to examine variations within the Zones.

An Approach to the National Evaluation

One of the fundamental aims of public investment in initiatives such as Health Action Zones is to foster new developments that can then inform the wider policy and practice community. HAZs are intended to be learning organisations, which are provided with resources and opportunities in return for informing future planning and organisational development at both the local and national level. HAZs therefore have the responsibility not only to achieve beneficial change but also to communicate results in a way which helps promote understanding about how and why outcomes emerge in the form that they do. Both local and national evaluation efforts have an important role to play in communicating these results, and also, we believe, in directly supporting HAZs in their own efforts to become learning organisations. Evaluation in this context is more than the assessment of processes and outcomes and the communication of findings; it is also an exercise in assisting stakeholders to structure their own activities in a way which promotes investment in learning over the longer-term.

It is with this dual purpose of evaluation in mind that we introduce some of the theoretical assumptions that have informed the early work of the national evaluation of Health Action Zones, and which we propose should provide a foundation for future research. In our early efforts, we have been informed by an *overall approach to evaluation* which we introduce here. An evaluation approach should be recognised as distinct from research methods; an approach can encompass multiple methods. Indeed, a variety of both quantitative and qualitative methodologies are required to assess the impact of HAZ initiatives - an issue we return to later in this report.

Our approach is drawn primarily from two frameworks for evaluation which were developed to guide the assessment of social programmes operating in complex, open systems such as disadvantaged communities. The first approach has been widely used in this country, in Home Office research, and is called *realistic evaluation*. The second is a *theories of change* approach to evaluation, which is well-established in North America. We briefly describe each of these approaches in turn, and then demonstrate how we plan to employ them to inform our examination of the community health improvement process taking place in Health Action Zones.

Realistic Evaluation

Realistic evaluation is an approach which was developed to try and address some of the difficulties surrounding measurement and the determination of causality within social systems. Pawson and Tilley (1997) argue that the evaluation of social programmes takes place within a changing context in which disparate elements can have an impact on outcomes, and thus determining causality is not a simple exercise. Because cause and effect are not 'discrete events' in such systems, Pawson and Tilley state that traditional evaluation methods, such as randomised controlled trials, are inappropriate for the study of social phenomena. The authors argue that evaluation research in the social sciences has too often tried to ape natural science experiments and hence produced findings of little use to policy makers. A different approach is required for policy evaluation which instead of asking if an initiative works or not, tries to develop an understanding of *why a programme works, for whom, in what circumstances.* This approach to *realistic evaluation* can be summarised in a formula:

> **context (C)+ mechanism (M) = outcome (O)**

A *programme or initiative* is understood to include its personnel, its place, its past and its history. It creates *mechanisms* for change by modifying the capacities, resources, constraints and choices facing participants and practitioners. But the relationship between the mechanism and outcome is *contingent* on its *context*, which can be locational (spatial, geographical, institutional) and social (norms, values, rules inter-relationships). A programme/initiative works by introducing new ideas/resources into existing social relationships. As a result, evaluations need to investigate the extent to which existing structures enable or disable this to happen. A successful evaluation will identify Context-Mechanism-Outcome (CMO) configurations, which do and do not work, in order to refine policy development in the future.

With this approach to evaluation conventional 'controls' are not needed because there are potentially hundreds of small comparisons to make within and between different components of the programme. *Realistic Evaluation* refuses to treat a programme or initiative as a 'black box'. Instead it tries to increase knowledge specificity about mechanisms, context and outcomes - what works for whom in what circumstances - so that better policies can be developed in future. There is an onus on evaluators and commissioners of research to design evaluations so that knowledge about CMO configurations can be cumulative across evaluations, since one cannot expect a single evaluation, no matter how big, to have all the answers. A realistic evaluation approach shares many theoretical assumptions - particularly relating to how contextual factors and internal mechanisms influence outcomes - with another approach to evaluation developed by the Aspen Institute in the USA. We turn now to this theories of change framework, before finally outlining how the two approaches might inform an evaluation of Health Action Zones.

Theories of Change

The theory of change approach to evaluation has been developed over a number of years through the work of the Aspen Institute's Roundtable on Comprehensive Community

Initiatives for Children and Families. It was developed in an effort to find ways of evaluating processes and outcomes in community-based programmes which were not adequately addressed by existing approaches. Comprehensive Community Initiatives (CCIs), although commonly operating within urban settings in the USA, share a number of characteristics with Health Action Zones. These shared characteristics pose a number of important challenges for evaluators, and for the use of traditional evaluation methodologies. Both CCIs and HAZs aim to:

- promote positive changes in individual, family and community institutions;
- develop a variety of mechanisms to improve social, economic and physical circumstances, services and conditions in disadvantaged communities; and,
- place a strong emphasis on community building and neighbourhood empowerment.

These characteristics pose a number of challenges for evaluation, including that:

- initiatives have multiple, broad goals;
- they are highly complex learning enterprises with multiple strands of activity operating at many different levels;
- objectives are defined and strategies chosen to achieve goals that often change over time;
- many activities and intended outcomes are difficult to measure;
- units of action are complex, open systems in which it is virtually impossible to control all the variables that may influence the conduct and outcome of evaluation.

In order to address some of the complexity of CCIs while still drawing meaningful conclusions regarding outcomes, a new conceptual framework for evaluation was developed, building on the work of Carol Weiss and colleagues. This 'theory of change' approach is defined as "a systematic and cumulative study of the links between activities, outcomes and contexts of the initiative" (Connell and Kubisch, 1998). The approach aims to gain clarity around the overall vision or theory of change of the initiative; meaning the long-term outcomes and the strategies that are intended to produce them. In generating this theory, steps are taken to explicitly link the original problem or context in which the programme began with the activities planned to address the problem and the medium and longer-term outcomes intended. This framework has much in common with the CMO configurations of realistic evaluation, with the added element that theory generation is conducted by and with those involved in planning and implementing an initiative. The approach encourages stakeholders to debate how an initiative can best produce desirable outcomes by asking them to make explicit connections between the different components of how a programme works.

Carol Weiss describes the process:

The concept of grounding evaluation in theories of change takes for granted that social programs are based on explicit or implicit theories about how and why the program will work. The evaluation should surface those theories and lay them out in as fine detail as possible, identifying all the assumptions and sub-assumptions built into the program. The evaluators then construct methods for data collection and analysis to track the unfolding of the assumptions. The aim is to examine the extent to which program theories hold. The evaluation should show which of the assumptions underlying the program break down, where they break down, and which of the several theories underlying the program are best supported by the evidence (Weiss, 1995, pp. 66-7).

Weiss and colleagues also provide a number of convincing reasons why this approach to evaluating complex and evolving initiatives is an attractive one. These reasons are worth emphasising.

Firstly, a theory of change can *sharpen the planning and implementation of an initiativ*e. When used during the design phase, it can increase the likelihood that stakeholders will have clearly specified the intended outcomes of the initiative, the activities that need to be implemented in order to achieve those outcomes, and the contextual factors that are likely to influence them. These are the building blocks of any good evaluation, but they are especially useful for feedback during the implementation of the initiative and for developing a knowledge base about how and why an initiative works.

Secondly, with a theory of change, *the measurement and data collection elements of the evaluation process will be facilitated*. For example, a theory of change asks that stakeholders be as clear as possible about not only the final outcomes and impacts they hope to achieve but also the means by which they expect to achieve them. An evaluation based on a theory of change, therefore, identifies what to measure – final and intermediate outcomes, and the implementation of activities intended to achieve those outcomes – and helps to guide choices about when and how to measure those elements. By providing a framework for deciding among the various tools in the evaluation kit, the approach helps avoid the risk that evaluations will be driven by the tools themselves.

Thirdly, and finally, articulating a theory of change early in the life of an initiative and gaining agreement on it by all the stakeholders *helps to reduce problems associated with causal attribution of impact*. A theory of change specifies how activities will lead to intermediate and long-term outcomes and identifies the contextual conditions that may affect them. This helps strengthen the scientific case for attributing subsequent change in these outcomes (from baseline) to the activities included in the initiative. Although this strategy cannot eliminate all alternative explanations for a particular outcome, it aligns the key participants in the initiative with a standard of evidence that will be convincing to them. Indeed, at the most general level, the theory of change approach argues that the more the events predicted by theory actually occur over the lifetime of an initiative, the more confidence evaluators and other should have that the initiative's theory is right.

Along with clear advantages, there are naturally difficult aspects to adopting a theories of change approach to evaluation. One of these is the challenge, evident from the experience of other evaluators who have employed the approach, of gaining consensus among the many parties involved in implementing community initiatives. Eliciting theories of change amongst and between the diverse groups of individuals involved in planning and implementing an initiative can also be a resource-intensive exercise for evaluators, a point we return to in the final section of this report. Finally, the approach requires an analytical stance that is different from the empathetic, responsive and intuitive stance of many practitioners. Despite these problems, evidence suggests that skilled evaluators can and should overcome these difficulties and by doing so they enrich both the programme and the lessons to be learnt from it. Brian Jacobs, a British social scientist who has recently employed the approach in an American evaluation and has been involved in two HAZs in the West Midlands, summarises the benefits:

A theory of change articulates explanations of how a programme works, and it aids the design of the programme by building in good practice suited to the context within which the initiative operates...The approach helps to surface information about the organisational, management and political processes at work within partnerships and the ways in which these influence how stakeholders deliver programmes...None of this denies the value of established evaluation methods that have been developed to quantify changes and measure performance in programmes. Rather, it adds to the armoury of the evaluator by producing valuable new insights into the processes and contexts that make partnerships work. (Jacobs, 1999, pp 12-13)

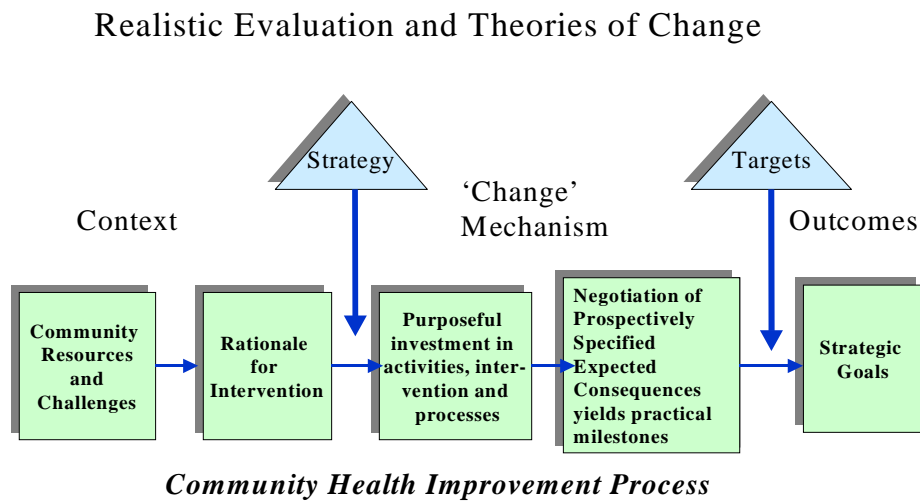*Evaluating the community health improvement process*

It is important that any evaluation of Health Action Zones makes a significant contribution to the learning that HAZs have the potential to generate. Evaluation can contribute to this learning in a variety of ways, but perhaps most importantly through helping HAZs put substantial effort into developing the strongest possible rationales for the investments that they choose to make. This implies a new role for evaluators, which has an important developmental element and involves close and consistent contact with stakeholders. We believe that a theory of change approach can be blended together with realistic evaluation to provide a theoretically-informed framework which will assist these stakeholders in developing rationales for action, as well as providing a framework within which evidence of real change can be demonstrated.

In evaluating the community health improvement process that HAZs are engaged in, our approach employs realistic evaluation methodology to emphasise the need to explore the ways in which specific change mechanisms interact with the circumstances prevailing in particular local contexts to yield observed outcomes. It also employs a theory of change approach to highlight the importance of encouraging and motivating stakeholders to engage in quite difficult and time consuming processes that:

- yield more convincing strategies or rationales for the interventions they select; and,
- enable them to specify the expected consequences of purposeful investments in activities, interventions and processes.

Figure 1 illustrates the approach we are adopting. The starting point is the context within which initiatives operate – the resources available in the communities and the challenges that they face. The first step is to specify a rationale for intervening in relation to priority issues. This strategy should be translatable into clearly defined change mechanisms – what we call purposeful investments in activities, interventions and processes. The challenge is to specify targets for each of these investments that satisfy two requirements. First, they should be articulated *in advance* as the expected consequences of actions. Second, these actions and their associated milestones or targets should form part of a logical pathway that leads in the direction of strategic goals or outcomes.

Figure 1

Realistic Evaluation and Theories of Change

Community Health Improvement Process

Within this approach, evaluation and learning occur across the entirety of the community health improvement process. Evaluators work with local stakeholders to elicit their rationales and strategies and sharpen their interventions, targets and plans. Lessons from this process become part of the community resources available to refine and develop the health improvement process in the future.

The national evaluation team has begun to apply this approach in the work which is presented in this report. A theories of change/realistic evaluation framework has informed our analysis of the HAZ implementation plans and helped shape the themes we addressed in our diagonal slice interviews with stakeholders in first wave HAZs. Perhaps most importantly however, we believe that this approach should be operationalised in *future* research as a central part of the national evaluation. In particular, we wish to explore the ways in which strategic investments made at different levels of generality add to knowledge about how and why changes in relation to HAZ goals are achieved. We therefore return to the realistic evaluation/theories of change approach in the concluding sections of this report, and outline how it will inform our proposals for future contributions to policy and practice learning.

FINDINGS FROM THE SCOPING EXERCISE

Introduction

The primary focus for the first six months of the national evaluation of Health Action Zones was a scoping exercise. It was agreed with the Department of Health that the research team would undertake some initial monitoring and mapping in order to begin to assess the extent of HAZ development and provide contextual material as a foundation for the formulation of future evaluation objectives. The scoping exercise involved the collection of information from all first and second wave HAZs, through their implementation plans, other documentary sources, meetings with stakeholders in HAZs and a series of in-depth interviews in first wave Zones. The final aim of the scoping exercise was to share findings from the analysis of this information with HAZs, local evaluators and the Department of Health in order to provide early information about progress and to agree future priorities. Findings from the scoping exercise are organised into four main sections. These are:

- From Visionary Goals to Logical Targets; a textual analysis of material from first and second wave implementation plans in relation to strategic objectives, activities and outcomes

- Programmes of Action; which outlines the HAZ programmes and activities described in the first and second wave implementation plans and analysed using a Microsoft Access database

- Findings from First Wave Interviews; which describes key themes and issues arising from diagonal slice interviews with key stakeholders across the first wave of Health Action Zones

- Resources and Freedoms; which presents baseline data in relation to the use of HAZ finances during the initial financial year of first wave HAZs, and summarises material from both first and second wave plans in relation to requested freedoms and flexibilities.

From Visionary Goals To Logical Targets

The aims and objectives of health action zones and their intended outcomes are expressed in a wide variety of ways. This diversity is compounded by semantic differences in the use of common terms such as goals, objectives, outcomes, targets and milestones. Based on a review of 1st and 2nd wave plans we have concluded that the easiest way to provide an overview of HAZ intentions is to distinguish between:

- visions,
- strategic objectives or goals,
- activities, interventions and processes
- outcomes,
- milestones and targets.

Some key definitions adopted by the National Evaluation Team are set out in Box 3.

Box 3   **KEY DEFINITIONS**

A *vision* is essentially a brief, overarching statement of the primary purpose of a health action zone.

A *strategic objective or goal* is the aim of effort or ambition. It is the purpose towards which an endeavour is directed. In our terminology a strategic objective is an expression of more specific intent than a vision statement but it is not usually expressed in terms of measurable consequences or specific timetables.

Activities, processes and interventions are a series of actions, changes, or functions intended to bring about a result. In HAZs they are often but not always described as specific projects that are contained within broad programmes or workstreams.

An *outcome* is a visible or practical result, effect or product. It may or may not be expressed in quantifiable terms.

A *milestone* is a marker of progress. It will be normally be used to monitor whether a course of action is on track.

A *target* is a specific form of a goal, outcome or milestone. However, we believe that it is best to reserve the term to express the expected consequence of purposeful investments in activities, interventions and processes.

This section has three main aims. First, to provide a brief overview of how health action zones have articulated their statements of vision and strategic objectives. Second, to review the diverse ways in which the zones have given an indication of the outcomes that they expect to result from their actions and to highlight some examples. Finally, to express some general observations about our perception of the role of targets in the complex community health improvement process that health action zones are engaged in. We postpone saying anything about activities until the next section.

Visions

Most but not all of the health action zones have a clearly identifiable statement of their overall vision contained within a sentence or two. The most immediately apparent feature of these statements is that they largely reflect the reported aims of Ministers in establishing health action zones. For example, many of the statements contain a reference to improving health, reducing inequalities and modernising services through partnership working. Others emphasise the wider social determinants of health, the need for integrating health and social services, the focus on socially excluded groups and the importance of well-being alongside health. However, not all of these features are explicitly mentioned in every plan and each of the zones has a distinctive way of expressing its vision. Four illustrative examples of clear vision statements are shown in Box 4.

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Box 4   **VISION STATEMENTS**

South Yorkshire Coalfields
By 2005, dynamic partnership working across the Zone will have improved health and wellbeing of the people of Barnsley, Doncaster and Rotherham and reduced inequalities in health both within the Zone and between the Zone and the rest of the country.

Wakefield
Our aim is to work in partnership to improve the health of the people of Wakefield and District, to reduce inequalities, and improve health and social care by integrating and modernising services.

Walsall
By 2006, the Walsall Health Partnership will have created and implemented a strategy through which the people of the borough will enjoy measurably better health and live in a community, which is thriving with sustainable development

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Strategic objectives

Twenty two of the 26 health action zones include high level or strategic objectives within their plans. As with their vision statements, these strategic objectives tend to converge around a number of key themes reflecting Ministerial policies about the overall aims of HAZs and the key means of achieving them. These strategic objectives cover:

- improving health and reducing health inequalities;
- tackling the root causes of ill health;
- empowering local communities;
- reshaping health and social care, with a particular emphasis on improving access to services;
- becoming learning organisations;
- developing effective partnerships.

While many of the HAZs only make very general statements of intent in these areas, particularly first wave Zones, others use their strategic objectives to identify more specific foci for their efforts. For example, four of the Zones – North Staffordshire, Nottingham, LSL and South Yorkshire Coalfields- - state their intention to focus on children and young people, while Sheffield explicitly mentions the need to improve access to services for Black and minority ethnic groups.

Improving health and reducing health inequalities

The most commonly articulated strategic objectives among the 22 zones that report their aims at this level of generality relate to improving health or reducing health inequalities. While many of these goals reiterate the sentiments of their vision statements, a number of Zones are more specific in terms either of the dimension of health that they plan to improve or how they might reduce health inequalities. For example:

- *South Yorkshire Coalfields* aims to enable people with physical and sensory disabilities in later life to live more independent lives;

- *Leicester* aims to reduce the worst health inequalities effectively and speedily, though the provision of better services to the most deprived.

Reshaping health and social care

Many of the HAZs articulate strategic objectives that relate to reshaping or modernising health and social care. Within these objectives a number of clear sub-themes emerge, which include: integrating health and social care more effectively; an emphasis on primary care, prevention and public health; promoting equitable access to services; and, developing more person-centred services. Some specific examples of high-level objectives about modernising health and social care are illustrated below.

- *Sheffield* -Improve equitable uptake of mainstream services according to need by:
  a) informing, educating and supporting residents in their use
  b) making services more accessible and user-friendly to encourage appropriate ad effective use by all, including minority groups.
- *Wakefield* -To develop modern, integrated, community-led, client-centred, evidence-based health and social care services which are accessible and which promote the health and dignity of users, in particular, further developing primary level services, to promote public health and reconfiguring other health and social care services to support this.

Tackling the root causes of ill health

Most of the strategic goals in this area are quite general. A number make specific reference to regeneration and environmental effects on health, others talk of the need to incorporate health into policy development across a range of areas. Illustrative examples of these objectives are set out below.

- *Hull and East Riding* -Health is incorporated as an important issue in the design and implementation of programmes across the broad front of social and environmental action by clear demonstration of inter-agency links across a range of sectors.
- Brent intends to: promote regeneration in Brent and reduce unemployment; maximise educational attainment and promote lifelong learning; increase and maximise the incomes of people and families on low income, and improve the quality of and access to housing

Community Empowerment

Community empowerment is a key objective for more than half of the HAZs that specify their goals at this level of generality. The majority of these focus on enabling local people to participate in decision making about the HAZ, need assessment, priority setting service design, planning and delivery. Only a small number of HAZs articulate strategic goals that focus on community development for health. Examples of this kind of approach include the following:

- *Luton* - intends to increase capacity for healthy living amongst communities and individuals though personal and community development;
- *Wolverhampton* - communities will be able to participate fully in planning and decision making for health and other public services, and it intends to demonstrate that all local agencies listen to and respond to the views of local people and build effective communications.

Partnership working

At least half of those HAZs that have articulated objectives at a strategic level have included goals in relation to developing the underlying partnerships of the HAZ. Some illustrative examples are shown below.

- *North Staffordshire* - To develop the commitment, capacity and capability of HAZ partners to work in new ways to reduce inequalities in health and over time integrate these into mainstream ways of working.
- *Lambeth, Southwark and Lewisham* - Develop and evaluate new models of 'whole' systems' work across multiple partnerships, to achieve greater synergy, efficiency and customer focus – not only for children and young people but across the whole service system.

Learning Organisations

As far as we have been able to identify only two of the HAZs have strategic objectives that relate specifically to promoting learning.

- *Leicester* - aims to create a HAZ that will be a vehicle to demonstrate new ways of practical and positive on the ground experimentation and identify, promote and disseminate good practice throughout the city through, for example, training and development.
- *Luton* - intends to share ability and to learn from our joint activities so that we are able to improve our effectiveness over time and share knowledge with a wider audience.

Outcomes

The way in which different HAZs have specified the anticipated outcomes of their programmes and activities varies enormously. Some HAZs have literally hundreds of statements that they call 'targets' or outcomes, whereas a minority have managed to write their whole implementation plan without a single specified outcome. Of the myriad of targets/outcomes included in the plans, however, most do not fall into the category of long-term outcomes, i.e. a change that will occur after 5-7 years. Most of the 'targets' specified in the plans are focused on the next one or two years and are concerned with changes in processes rather than outcomes. In many ways such foci are to be expected at the beginning of the life of a complex intervention such as a HAZ. What is worrying, however, is that few HAZs link these early changes to their long-term goals or specify very clearly what actual changes in specific outcomes they hope to achieve.

Most HAZs do articulate some long-term outcomes. But the degree of clarity with which this is done varies considerably by both HAZs and the kind of outcome. On the basis of a fairly crude preliminary analysis we have categorised the outcome statements into three levels to illustrate the kinds of approaches being adopted.

Level 1   The statement in the plan clearly sets out all of the information required to ascertain if the outcome change is successfully achieved.

Level 2   The statement does focus on an outcome change that could be assessed, but insufficient information is supplied in the plan to know if the change is successfully achieved.

Level 3   It is very unclear how the achievement of the outcome will be identified, assessed or measured.

Boxes 5-8 illustrate some of the outcome statements contained in the HAZ plans at the three different levels of clarity for four key goals:

- improving health and reducing health inequalities;
- reshaping health and social care;
- community empowerment and involvement;
- tackling the root causes of ill health, including lifestyles.

Improving population health and reducing health inequalities

Box 5 shows a range of anticipated outcomes that HAZs have articulated in relation to population health. In general, they are able to specify such outcomes with a high degree of clarity for indicators of mortality. The specification of anticipated changes in outcomes becomes much vaguer when HAZs focus on health as defined by quality of life or measures of wellbeing. In between these two extremes, common problems that we have noted include the failure to specify:

- what the starting point is;
- the scale of change aspired to;
- the end point;
- the specific groups or areas concerned – either as the focus of their efforts or as comparators.

HAZs specify three kinds of aspirational outcomes in relation to health inequalities. Firstly, a number of HAZs argue that because their area is so deprived or has such poor health they will reduce national health inequalities (see for example Mersey or East London) by increasing the average health of the area. Secondly, HAZs set 'closing the gap' aspirations, which aim to reduce within Zone inequalities. Sometimes, the inequality is between areas based on their level of disadvantage and on other occasions they are specified in terms of areas or groups with the highest or lowest rates of concern at present. Thirdly and finally, HAZs have outcome statements that focus on improving the health of specific groups. Examples in Box 8 including people who are unemployed, black and minority ethnic groups, and looked after children.

Box 5	**POPULATION HEALTH AND WELL BEING**

Average health
Level 1

Mersey – *Reduce by half the 130 point gap in all causes age-standardised years of potential life lost between Merseyside and England by 2010*

Sandwell – Reduce perinatal mortality rate from 10.8/1000 in 95/6 to 7.5/1000 by 2005

Leicester – reduce deaths from suicide and undetermined injuries by at least 17% by 2010 from baseline 1996

Level 2

Sheffield – Reduction in dental caries levels in 5-12 year old children (7yr target -baseline to be established in year 1)

East London & City – Reduce deaths from coronary heart disease and stroke in people under 65 in our population to the level of the best similar inner city area in the UK (7 yr. target)

Level 3

Hull& East Riding – Improved quality of life for older people (social, leisure, housing transport and access, community safety and the environment)

Walsall – By 2006 an improved sense of wellbeing amongst young people

Health Inequalities
Level 1

North Cumbria – By 2005, the rate of reduction on death rates (measured by SMRs) from all causes will be faster in the 20 most deprived wards than in the remaining 91.

South Yorkshire Coalfields – a reduction on the difference between the HAZ and other ONS coalfield areas average heart disease death rates by a third for people aged under 65 (1996-2010)

Level 2

Plymouth –Reduced rate of teenage pregnancy across city, especially in those areas where rates are currently the highest

Wolverhampton – for CHD deaths in people aged 65, reduce rates/100,000 in the worst five wards by 50%

Level 3

Bury & Rochdale – Improve mental health of those who have or are being looked after.

Tees – at the end of the HAZ to have made progress in reducing health inequalities

Reshaping health and social care

The health and social care outcomes identified in the plans fall into a number of groups. Perhaps the largest group focus on improving uptake of preventative services, particularly among disadvantaged groups. Secondly, there is an emphasis on preventing inappropriate admissions to institutions, generally by improving community services, particularly in relation to older people or people with mental illness. Finally, HAZs aspire to improve access to services, but it is very unclear how this is defined or will be measured.

Box 6	RESHAPING HEALTH AND SOCIAL CARE

Level 1

Mersey – Mersey agencies will be in top 50% of service providers [nationally] in emergency admissions to hospital of people aged 75 and over

Walsall – Childhood immunisation rates will exceed 95% by 2006 particularly for MMR (current rate 89%)

Level 2

Wolverhampton - reduce winter emergency admissions by 15% by 2007

Luton – To bring levels of measured access to mental health services up to average for comparable districts, including reduced in-patient admissions by 5%

Level 3

North Staffordshire – 7 year target –demonstrable improvements in access to and provision of local services

Sheffield – Increased access to health and social care and related services (7yr target)

Community empowerment

The implementation plans contain very few specific statements relating to the expected outcomes of community empowerment. While HAZs have specified aspirations for improving community involvement, inclusion and cohesion, they are unclear what they mean by success or how they will measure it. However, since few HAZs were able to involve the community in developing their plans to any significant extent, it is probably premature to expect specific outcomes to be defined. Negotiating objectives and agreeing appropriate indicators for assessing progress should be part of the process of working with community organisations. Two HAZs have taken turnout at local elections as an indicator of community empowerment, but it is not clear whether this relates directly to agreed strategies and objectives, or whether it has been selected because of ease of measurement.

Box 7	COMMUNITY EMPOWERMENT

Level 1

North Cumbria – By 2005 turnout at local government elections will have increased by 10% in targeted wards

Level 2

Walsall – By 2006 increased sense of community inclusion and involvement in making decisions about the neighbourhood reflected in increases in electoral turnout for local committee and municipal elections.

Level 3

Wakefield – more involvement of young people in decision making in the district (over life of HAZ)

Luton – To reduce inequalities in health by raising rates of community participation, perceptions of control and access to informal and formal social networks in target areas to levels higher than the average for Luton

Root causes of ill health

We have included lifestyle changes in our definition of root causes of ill health, and HAZs have clearly found it relatively easy to specify changes in behavioural outcomes. There is a wide range of very clear outcome statements relating to smoking, diet and exercise. Information for baseline data is clearly available from local lifestyle surveys and HAZs are confident about measuring change. Many of these outcomes also contain an equity dimension by focusing on changes in relation to particular disadvantaged groups or areas. A reasonable number of HAZs also specified outcome changes they wanted to achieve in broad social and economic determinants of health, such as housing, education and employment.

Box 8   **ROOT CAUSES OF ILL HEALTH**

Level 1

Northumberland – Rising level of smoking reversed amongst young women in Blyth and Wansbeck measured by Health Related Behaviour Survey (by 2005)

Sandwell – To increase % workforce qualified at NVQ 3 from 25.7% in 95/6 to 60% by 2005

North Cumbria – By 2005 there will have been a 10% reduction in the unfit housing stock in the 20 most disadvantaged wards

Level 2

Bury & Rochdale – Increase number of local people of Asian origin who work in public service (employment monitoring data)

Sheffield - Improvement in school attendance and educational achievement (7 yr. target baseline to be established in development year)

East London & City – Increase the number of people from the most disadvantaged communities who gain employment by incorporating explicit targets in local regeneration initiatives (7yr targets)

Level 3

Tees – binge drinking among 18-24s will reduce

Manchester, Salford & Trafford – reduce the number of children living in low income families

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Overall, the most striking feature of HAZ implementation plans in relation to their specification of outcome measures is the enormous variation in their quantity and quality. The best plans set out an ambitious array of outcomes that it ought to be possible to evaluate with relatively little difficulty. Other plans are astonishingly vague. Thus it will be virtually impossible to assess whether they have achieved their goals. In between, the great majority of plans have different mixes of clarity and obfuscation in the outcomes that they have specified. But a key question that applies just as much to the well-specified plans as to those that are less good is: do the outcomes that are listed represent useful targets to aim at? We are not convinced that they do. Some of our concerns are set out below.

Targets and milestones

Health Ministers have continually emphasised that the opportunities made available to health action zones - in the form of flexibilities, freedoms and resources – carry with them associated obligations to deliver change. The price of local freedom to find new ways of tackling intractable problems is a strong central emphasis on performance management. John Denham, Minister of State for Health, made these expectations very explicit in a speech …

The Government is making targeted money available and introducing new freedoms in the Health Action Zones to help them to rise to the challenge … This is money for modernisation, reform and results … In return, HAZs will report back on the progress they are making to introduce new arrangements, harness the new freedoms and meet clear targets.

Health action zones are clearly required to produce explicit targets. But there has been quite a lot of confusion about what constitutes an appropriate target. As we have already explained there is considerable scope for semantic debate about the definition of a target. As a contribution to establishing clearer and consistent thinking in this area we have argued strongly for a particular meaning to be attached to the term (see Section II). Hence, while many of the outcome measures illustrated above could be targets, they are rarely linked to activities in the form of expected consequence. In contrast, many of the HAZs do specify numerous process milestones to be achieved in the couple of years. But these are not linked to the final outcomes the HAZ wishes to achieve.

To varying degrees all of the plans are strong on identifying problems and articulating long-term objectives, and to some extent on specifying routinely available statistical indicators that might be used for monitoring progress. On the other hand, they are much less good at filling in the gap between problems and goals. Only in very rare cases is it possible to identify a clear and logical pathway that links problems, strategies for intervention, milestones or targets with associated time scales and longer-term outcomes or goals. Figure 2 illustrates the nature of the basic problem. There appears to be a significant gap between problems and goals. Interventions and their associated consequences (which we prefer to think of as targets) are not usually clearly linked to problems and goals.

Many of the 1st wave health action zones, in particular, found it difficult to specify precisely how they would intervene to address problems, and what consequences they expected to flow from such interventions and how precisely these related to their strategic goals. As a result, the 'targets' that they included in their plans were not convincing, for a number of reasons.

Figure 2
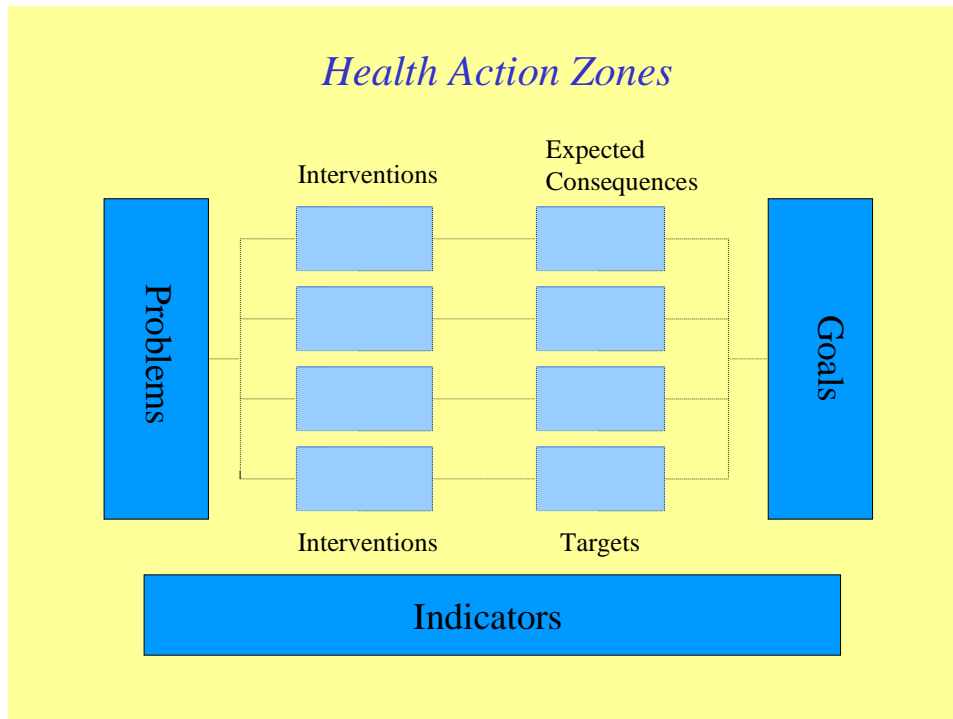
For example, many specific 'targets' were not clearly linked with strategic goals or objectives set out elsewhere in the plans. Other 'targets' were not located within a specific time scale. Most importantly, and most frequently, specific 'targets' were highlighted without any accompanying explanation of the mechanisms intended to achieve them. This omission is key. It breaks the critical link between the problems that HAZs are there to address and the ambitious goals that they rightly wish to set for themselves. It also limits the extent to which the intended outcomes in each HAZ can be perceived as part of a process of broader change, the type of change that is required to make significant improvements in health over time. This problem is not is not unique to Britain. For example, in their review of new approaches to evaluating community initiatives, Connell and Kubisch (1998) report that:

Experience from a wide range of programs (in the USA) shows that identifying and agreeing upon long-term outcomes is relatively easy, in part because long-term outcomes are generally so broad as to be uncontroversial: for example, improved high school graduation rates, greater "sense of community", or increased income levels. Likewise, identifying early activities is relatively straightforward. Intermediate and early outcomes are more difficult to specify because scientific and experiential knowledge about links between early, interim, and long-term outcomes is not well developed in many of the key areas in which (community-based initiatives) operate. Defining interim activities and interim outcomes, and then linking those to longer-term outcomes, appears to be the hardest part of the ... process (p.23).

In recent months there is evidence that the process of target setting is improving. Many of the 1st wave HAZs have made substantial changes to their plans as a result of having more time to consult with local partners. Moreover the efforts made by the 1st wave HAZs have had a useful demonstration effect. The 2nd wave plans have greatly improved the ways in which strategic goals are linked with clearly defined activities and intermediate milestones or

expected consequences. We have chosen to highlight two of the second wave zones – Walsall and Wakefield – in Box 9 as good illustrations of attempts to develop clear and logical approaches within their implementation plans. However, a number of health action zones still need to undertake further development work before their plans in general and their targets in particular satisfy the requirements of a modern community health improvement process.

Box 9   **GOOD EXAMPLES OF HAZ PLANNING**

Walsall, like many other HAZs, starts with an overall vision statement. However, in contrast to other health action zones, Walsall's plan then translates the vision into themes and from these a logical pathway is developed that links strategic and operational objectives with specific targets that move in the direction of long term outcomes. For each of the five themes there is a clear and succinct statement of vision accompanied by lists of indicators of "what will success look like" in 2002 and 2006. In addition, within each theme, there are clear summary tables for each of the 19 strategic objectives that identify 58 operational objectives. Each of the operational objectives is accompanied by information about: (a) their associated targets (100+) over varying timescales ranging from the first 12 months to the medium (3 years) and longer term (7 years); and (b) a menu of projects and activities. Walsall has produced a very clear plan, well informed by theory, that lends itself very readily to monitoring and learning.

Wakefield has also produced a very clear plan. It has identified 5 overall objectives with 26 long-term or aspirational targets and 50 well-specified projects to get the process of implementation underway. What is particularly impressive about Wakefield's plan is that it contains a very helpful description of initial programmes/initiatives. Summary tables for the initial 50 projects are grouped together by the 5 overall objectives, and for each one basic information is provided in the following format:

- *The project's purpose is ...*
- *What we are aiming to get out of this project in the long term is ...*
- *What we are planning to do in the first year is ...*
- *How will we know how we are doing on this project in the first year ...*
- *The lead organisation for this project is …*

In part, the relative under-development of a number of the plans is to be expected. The historical strength of partnership arrangements between public agencies, and the degree to which community engagement and participation are already taken seriously, can have a very significant impact on the ease with which plans can be specified in any degree of detail. Not all HAZs start with the same comparative advantages. Furthermore, as we discuss later in this report a number of representatives of 1st wave zones that we interviewed expressed a number of reservations about the nature of the target setting process.

Programmes Of Action

The HAZ implementation plans contain an enormous wealth of information about what and how HAZs have chosen to do in order to achieve their long-term goals of improving health and reducing health inequalities. Of particular importance in this respect are their programmes of action, which describe both the overall priority foci of their strategies and provide specific details of what they intend to do, at least in the initial stages. The programmes of action can be described at various levels of detail. We have chosen to focus on two key levels:

- the **programme** themselves; and
- the **activities** contained within them.

This section of the paper begins by describing the methods employed to analyse the programmes of action at these two levels. It then presents a summary of the findings.

Methods

We have analysed programmes and activities in two quite different ways, which requires a brief explanation. All of the information for both 1st and 2nd wave Zones, for programmes and activities, is stored in a Microsoft Access database. This will be a valuable resource for the remainder of the project, which could be built upon and developed to encompass other areas of data about HAZs.

The analysis of **programmes** is based on information in all 1st and 2nd wave implementation plans. In virtually all cases, HAZs incorporate all of their activities into specific programmes. We have, therefore, analysed HAZ defined programmes wherever possible. In two cases, a considerable amount of information about activities was reported in the plans outside of the named programmes. In these cases we created 'pseudo' programmes ourselves.

The analysis of the **activities**, however, has been conducted separately for 1st and 2nd wave plans. The preliminary analysis of 1st wave plans, which was presented at a workshop for local evaluators held at Northampton in February 1999, was very simple. In light of this experience, and the feedback we received from participants at the workshop, we have analysed the activities of the 2nd wave HAZs in a much more detailed, and hence not directly comparable, way. In this section, therefore, we describe the categorisation and results from the analysis of the 1st and 2nd wave plans separately. We hope to reanalyse the 1st wave activities, employing the same methodology as for the 2nd wave plans, in the near future, to allow comparisons to be made between the two waves.

Quality of the data

A number of important caveats need to be borne in mind when considering the findings described below.

First, the analysis is based on the HAZ implementation plans. For 1st wave Zones, we have used the latest implementation plans that we were able to obtain at the time of the analysis (October 1998 for all Zones except Plymouth and Luton who supplied revised plans at the beginning of 1999). We are aware that a small number of 1st wave Zones have revised their plans in the light of local developments and Ministers' comments, but we have not had time

to incorporate these changes into these analyses. For 2nd wave Zones, we have used the plans submitted to the Department of Health in March 1999.

Secondly, this analysis is entirely reliant on the information contained in the implementation plans. It is dependent on the level of detail that HAZs chose to supply about their activities, and what they chose to describe as 'HAZ activities'. In so far as this may vary between plans, this will be reflected in the data presented here. For this reason, therefore, we have not conducted any analyses by HAZ, but focused on the overall pattern across the HAZs.

One particular problem in this respect was the Tees plan. Tees describe their activities in an overview for the whole HAZ, and then in more detail for each of the four localities of the HAZ. Although there were slight differences in the specific kinds of activities in each of the localities, the thrust of their programmes was identical. Inputting all of this information for Tees severely skewed the results. For this reason, the data on Tees have been weighted (by one-fifth) to reflect the repetition of information without losing the subtle distinctions of emphasis between the different localities.

Finally, it is important to comment on the method of extracting the information about activities and coding it. For the 1st wave plans the coding and analysis was conducted entirely by one researcher. However, for 2nd wave plans the data were coded and entered by two researchers who worked together on the first plan to ensure shared understanding of categories and a shared approach to coding. We have still to conduct a check of coding consistency. Thus the details should be read as provisional findings, although we would not expect a major change in the patterns revealed.

Programmes

We have identified a total of two hundred and fourteen 'programmes' in both 1st and 2nd wave Health Action Zones' plans. This amounts to 100 for 1st wave HAZs and 114 for 2nd wave Zones. Each programme described in the plans has been allocated to one of seven major categories according to its main focus. These are:
- population groups;
- health problems;
- root causes of ill health;
- health and social care;
- community empowerment;
- internal processes;
- mixed.

The distribution of programmes between these groups and the more detailed foci within them are shown in Table 7.

Across both 1st and 2nd wave HAZs almost a sixth of programmes relate primarily to **population groups**. Of these almost half focus on young people, but a number of others target older people, black and ethnic minority groups and parents. A further twenty-eight programmes relate to a specific **health problem**. The biggest group of programmes in this category focus on mental health as a priority. The remainder of the programmes are directed at accidents or violence, cardiovascular disease, diabetes, physical disabilities and others.

Table 7 Programme types

Programme foci	1st wave		2nd wave		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
POPULATION GROUPS						
young people	9	9.0	9	7.9	18	8.4
older people	4	4.0	5	4.4	9	4.2
Black & ethnic	0	0.0	4	3.5	4	1.9
parents	1	1.0	2	1.8	3	1.4
SUB-TOTAL	*14*	*14.0*	*20*	*17.6*	*34*	*15.9*
HEALTH PROBLEMS						
Heart & stroke	3	3.0	0	0.0	3	1.4
cancer	1	1.0	0	0.0	1	0.5
diabetes	2	2.0	0	0.0	2	0.9
physical disability	2	2.0	0	0.0	2	0.9
Violence & accidents	1	1.0	3	2.6	4	1.9
Learning difficulties	1	1.0	0	0.0	1	0.5
dental	1	1.0	0	0.0	1	0.5
mental health	5	5.0	5	4.4	10	4.7
sexual health	1	1.0	1	0.9	2	0.9
Multiple health problems	1	1.0	1	0.9	2	0.9
SUB-TOTAL	*18*	*18.0*	*10*	*8.8*	*28*	*13.1*
DETERMINANTS OF HEALTH						
Housing	2	2.0	4	3.5	6	2.8
Employment	5	5.0	2	1.8	7	3.3
Education	0	0.0	5	4.4	5	2.3
Physical environment	1	1.0	2	1.8	3	1.4
Transport	1	1.0	1	0.9	2	0.9
Lifestyle	1	1.0	8	7.0	9	4.2
Substance abuse	3	3.0	2	1.8	5	2.3
Crime	1	1.0	0	0.0	1	0.5
Workplace	0	0.0	2	1.8	2	0.9
Multiple determinants	7	7.0	14	12.3	21	9.8
SUB-TOTAL	*21*	*21*	*40*	*35.3*	*61*	*28.4*
HEALTH & SOCIAL CARE						
Primary & community services	5	5.0	4	3.5	9	4.2
Acute care	2	2.0	1	0.9	3	1.4
Health promotion & education	0	0.0	1	0.9	1	0.5
General	7	7.0	6	5.3	13	6.1
SUB-TOTAL	*14*	*14*	*12*	*10.6*	*26*	*12.2*
INTERNAL PROCESS						
Strategy development	6	6.0	6	5.3	12	5.6
Research	4	4.0	1	0.9	5	2.3
Partnership capacity	6	6.0	6	5.3	12	5.6
sub-total	*16*	*16*	*13*	*11.5*	*29*	*13.5*
Community Empowerment						
General	11	11.0	3	2.6	14	6.5
Community development	0	0.0	5	4.4	5	2.3
Community involvement	0	0.0	4	3.5	4	1.9
Public information	0	0.0	2	1.8	2	0.9
sub-total	*11*	*11*	*14*	*12.3*	*25*	*11.6*
Mixed	*6*	*6.0*	*5*	*4.4*	*11*	*5.1*
Total	**100.0**	**100.0**	**114.0**	**100.0**	**214.0**	**100.0**

The largest proportion of programmes, almost a third, is aimed at addressing the **root causes of ill health**. Across the Zones the most common group of programmes in this category focuses on changing people's lifestyles, followed by employment, housing problems, education and substance abuse. However, almost a third of the root causes programmes are more general and attempt to tackle multiple causes in one programme.

The programmes that concentrate on **health and social care** account for just over a tenth of the HAZ programmes. Many of these health and social care programmes have general aims, but others relate to primary care or community services, and a smaller number to hospital services and health promotion. Another tenth of programmes are those centred on **community empowerment**. These include programmes that specifically relate to public involvement, community development, the provision of information to the public and other general community empowerment aims.

Not surprisingly at this early stage of development, there is a significant group of programmes that centre on the **process** of HAZ development. Process programmes account for thirteen per cent of HAZ programmes and include strategy development, partnership development and evaluation and research. Finally, there are a small number of **'mixed'** programmes that combine a range of approaches or which are focused on a particular area.

There was quite a high degree of consistency between the eleven 1st wave and the fifteen 2nd wave HAZs. The main differences in the distribution of programmes can be found in the greater emphasis among the 2nd wave HAZs on the root causes of ill health. In contrast there was a notably higher number of 1st wave HAZ programmes relating to specific health problems and slightly higher number of health and social care programmes. One further contrast is that the 2nd wave HAZs have four programmes focusing specifically on black and ethnic minority groups, as opposed to none in the 1st wave.

1st Wave Activities

We identified 750 activities across the 1st wave Health Action Zones, which we grouped into four broad types:
- reshaping health and social care;
- tackling the root causes of ill health;
- community empowerment;
- internal processes.

Table 8 shows the distribution of 1st wave HAZ activities between these groups, and the more detailed breakdown of categories within them. When 1st wave HAZs submitted their implementation plans in October 1998, much of their effort was focused on internal process activities (36 per cent), in particular developing strategies across a range of services and client groups, and building the capacity of the newly formed partnerships.

The second largest group of activities, almost a third, focused on reshaping health and social care. Developing primary and community services dominated this set of activities, although health promotion initiatives also figured strongly. The next group of activities described by 1st wave HAZs in their implementation plans focused on tackling the root causes of ill health. Efforts to promote community access to healthy lifestyles; for example, encouraging local shops to supply 'healthy food', promoting access to exercise, etc dominated this group.

However, HAZs were also beginning to try to promote employment opportunities, make links with regeneration activities in their areas, and to develop a range of initiatives to prevent school exclusions and bullying and promote educational attainment.

The smallest group of activities set out in the October implementation plans of 1st wave HAZs focused on empowering the local community in three ways. First by providing information to the public to promote knowledge about health and services. Secondly, efforts were being made to involve local people in the overall direction of the HAZ and the design of specific services. Finally, HAZs were planning to employ community development approaches to promote the capacity and cohesion of their communities.

Table 8 Distribution of 1st Wave HAZ activities

Activity type	Focus	Number	Percent
Root causes of ill health	Healthy lifestyles	59	7.8
	Employment and Income	42	5.6
	Environment	37	4.9
	Education	30	4.0
Sub-total		165	22.0
Health and social care	Primary/community services	184	24.5
	Health promotion	77	10.2
	Secondary care	10	1.3
Sub-total		271	36.1
Community empowerment	Providing information	32	4.3
	Involvement	22	2.9
	Community development	17	2.2
Sub-total		72	9.6
Process	Strategy development	132	17.6
	Capacity building	87	11.6
	Evaluation	23	3.0
Sub-total		242	32.2
Total		**750**	**100.0**

2nd Wave Activities

Based on our analysis of activities in the 1st wave plans described above, we decided that we needed to take a more comprehensive approach to the analysis of 2nd wave activities if we were to obtain a clearer understanding of what they were trying to change and how. To do this we categorised 2nd wave activities on four distinct dimensions.
- What, if any, health problem is being addressed?
- What are they trying to change?
- What are they doing?
- Is the activity focused on a particular population group?

Box 10 illustrates how two different 'activities' would have been coded under this scheme.

Box 10   **CODING 2ND WAVE ACTIVITIES**

The following examples are intended to show the way in which information on activities has been analysed in terms of their four dimensions: what is the health focus; what are they trying to change; what are they actually doing; what is the population group that the activity targets?

Cornwall

'District councils to work with health (agencies) to identify vulnerable older people living in their area, whose ill health is exacerbated by their housing conditions.'

- This activity addresses the **general health** of older people.
- The activity is trying to change the **evidence base** of the council and health authority.
- What they are actually doing is identifying needs through **research.**
- The activity is targeted at **older people** in particular.

Walsall

'Develop a structure that will enable local forums and minority ethnic community groups to contribute to the health agenda.'

- There is **no direct health focus** of this activity.
- The activity is trying to change **user involvement** in the design of services
- What they are actually doing is to hold a **forum**
- This activity is targeted at **ethnic minority groups**.

We identified 1036 activities across the 2nd wave Health Action Zones, after the adjustment for Tees. Below we summarised the broad pattern of activities across our four dimensions of interest.

What health problem is being addressed?

Most 2nd wave HAZs' activities do not focus on a specific health problem as shown in Table 9. In fact over half of the activities focus on the determinants of health - for example, education or employment - or internal HAZ processes. One quarter of HAZ activities focus on trying to improve health in general or address multiple health problems. There were therefore twenty per cent where a particular health problem was specified. The largest single specific problem was mental health, which applied to 8 per cent of activities. Sexual health, including teenage pregnancy, was targeted by another 4 per cent of activities, and a similar proportion specified accidents and violence. A number of other specific health problems make up the remainder.

Table 9 What health problem is being addressed?

Health problem	Frequency	Per cent
Not applicable	550	53.1
General or multiple health problems	289	27.9
Mental health	79	7.7
Sexual health/ teenage pregnancies	39	3.7
Accidents/violence	35	3.4
Others	43	4.1
Total	**1036**	**100.0**

What are they trying to change?

The activities of the 2nd wave HAZs are focused on achieving change in five broad areas. Table 10 shows that the distribution of activities between the five broad areas and the more detailed breakdown of categories within them.

Seventeen per cent of 2nd wave activities focus on changing the **determinants of health**. The most widespread concern here was around housing. This ranged from carrying out repairs to providing accommodation to people who are homeless. Tackling unemployment was also a high priority, followed by a range of activities aimed at improving education. Just over one-fifth of the activities of the 2nd wave HAZ focus on changing people's **lifestyles**. Much of this effort was concentrated on general changes in health-related behaviours, by adopting a 'settings' approach to health promotion, for example, healthy schools initiatives. Where a particular lifestyle issue was specified, HAZ focused on changing behaviours in relation to sexual health, smoking and diet.

Twenty-two percent of 2nd wave HAZ activities focus on changing **health and social care.** Most of these were very broad, emphasising the need to improve primary and community services. A range of issues was of concern here. These include improving access by developing premises and expanding the range of professionals working in disadvantaged areas; providing new ways of delivering care to particular client groups; and, ensuring more appropriate and effective emergency cover, particularly for people with mental illness. Improving access to preventive services was also a priority for change, as was providing more culturally sensitive services. The number of activities that identified changing acute care was very small.

Seventeen per cent of 2nd wave HAZ activities were devoted to improving **community empowerment.** Effort was centred on increasing the level of public participation and involvement in the HAZ as a whole and user involvement in the design of services. A slightly smaller number of activities were focused on promoting individual empowerment and community capacity.

Table 10 What are 2nd wave HAZ trying to change?

Change	Changing	Number	Per cent
Determinants	Housing	60	5.8
	Unemployment	40	3.9
	Education	28	2.7
	Workplace	24	2.3
	Local environment	17	1.6
	Income	12	1.2
Sub-total		*181*	*17.4*
Lifestyles	General lifestyles	94	9.1
	Sexual behaviour	28	2.7
	Smoking	26	2.5
	Diet	25	2.4
	Drugs	22	2.1
	Exercise	19	1.9
	alcohol	8	0.8
Sub-total		*222*	*21.4*
Health and social care services	General primary/ community care	184	17.8
	Access in the community	19	1.9
	Culturally sensitive services	13	1.3
	Prevention services	5	0.5
	Acute services	4	0.4
	Disease management services	3	0.3
Sub-total		*228*	*22.0*
Community empowerment	Participation in HAZ	50	4.8
	User involvement in service design	42	4.1
	Individual empowerment	37	3.6
	Community capacity	28	2.6
	Parental empowerment	20	1.9
Sub-total		*177*	*17.1*
Internal processes	Evidence base	96	9.3
	Partnership development	79	7.6
	Staff culture	28	2.7
	infrastructure	25	2.4
Sub-total		*228*	*22.0*
Total		**1036**	**1036**

At this stage of the development of 2nd wave HAZs, just over one-fifth of activities emphasise the need to change the **internal process** of HAZs. The biggest group of activities in this category was related to research and learning, in particular, improving the evidence base for projects and gathering baseline information. There was also seen to be a need to develop partnerships and change staff culture. For example, in relation to partnership working HAZs were trying both to expand the range of partners involved in the initiative and to strengthen the links and capacity of the existing partners. There was a general recognition that HAZs need to invest in changing the culture and knowledge base of staff, both professionals and frontline workers, to empower them to participate in decision making and work more effectively across organisational boundaries. The infrastructure of the organisations, and particularly improving information technology, was also seen as a priority for investment.

What are they doing?

In order to achieve the range of changes described above, 2nd wave HAZs were employing a variety of methods as shown in 11.

The **provision of goods and services**, while the single biggest category, only accounts for about 35 per cent of activities. The two main groups of HAZ activities here include: the promotion of group support, for example, peer education; and the provision of direct human services, for example, the employment of a community worker or a new primary care service. Other types of provision include supplying information in a variety of forms, for example, a resource centre or NHS net. Less common was the provision of physical goods, such as fruit and milk in schools and free access to leisure services. Some HAZs were giving grants to community or voluntary groups for a variety of purposes and projects.

At this stage of development many HAZ activities (17%) relate to **organisational development.** HAZs were developing links with the business sector, establishing internal cross-agency working groups for a variety of purposes, setting up learning networks for particular groups of staff, training staff in community development techniques or running cultural awareness programmes. There was also a heavy investment in developing new information systems and IT links between partner agencies.

Just over 7 per cent of the HAZ activities were related to **community involvement**. We identified three main mechanisms that HAZ were adopting in order to do this. First, staging conferences or establishing fora to consult with the community in general or specific population and client groups about the activities of the HAZ or services in their area. Secondly, engaging users in the design, planning and delivery of a wide range of services. Finally, involving the public in the evaluation of both the HAZ and specific programmes.

Over one-quarter of 2nd wave HAZ activities are currently focused on **strategy development** across a whole range of services and client groups. Indeed the most frequent statement of action in the implementation plans was 'develop a strategy'. Other activities involved implementing the plan of action, and linking in a strategic way with other government initiatives. Less commonly HAZs were trying to raise new funding and, in some cases, work with the DH to change legislation. Over 12 per cent of HAZ actions were contributing to **learning** both across the HAZ and within agencies. A large proportion of these activities were background research, often involving reviewing of services or a needs assessment. A smaller proportion of activities was focused on designing evaluation methods. Finally, the smallest group of activities focused on **communicating** the HAZ agenda to the public, via multi-media.

Table 11 What are 2nd wave HAZs doing?

Activity	Detail of activity	Number	Percent
Provision	Money	12	1.1
	Information	48	4.6
	Group support	117	11.3
	Direct human services	157	15.0
	Physical goods	22	2.1
	Job creation	11	1.1
SUB-TOTAL		365	35.3
Organisational DEVELOPMENT	Partnership development	28	2.7
	Partnership capacity	90	8.7
	Information Technology	24	2.3
	Staff development	31	3.0
SUB-TOTAL		173	16.8
Community INVOLVEMENT	Conferences/fora	38	3.7
	User representation	37	3.5
SUB-TOTAL		75	7.2
Strategy DEVELOPMENT	Strategy development	216	20.8
	New funding	9	0.9
	Change legislation	4	0.4
	Implement plan	17	1.7
	Link with government initiatives	16	1.6
SUB-TOTAL		263	25.4
Learning	Research before	100	9.7
	Evaluation	29	2.8
Sub-total		129	12.5
PR/COMMUNICATION		31	3.0
TOTAL		**1036**	**100.0**

Is the activity focused on a particular population group?

The final dimension of activities we investigated was whether HAZs were focusing on particular population groups. Although there were a vast range of targeted groups, from homeless people to people with mental health problems, none of these accounted for a significant proportion of activities. The only population focus that is worth commenting on is the age groups which HAZs were prioritising, as shown in Table 12 Over 22 per of activities were targeted at children and young people. Whereas older people were the focus for just over 8 per cent of the total.

Table 12 What population group is targeted?

Population group	Frequency	Per cent
All	711	68.7
Young people and children	236	22.8
Older people	88	8.5
Total	**1036**	**100.0**

Cross-cutting Perspectives

There is considerable scope for more sophisticated analysis of programmes and activities but we have attempted very little so far. However, to illustrate the potential of the database we present three examples of cross-tabulations of either different categories of activities or programme types and particular categorisations of activities.

Table 13 shows the relationship between what the HAZs are doing and the type of change they are trying to achieve. For example, more than half of the activities that are aimed at changing the determinants of health or lifestyles involve the provision of goods or services. On the other hand, only one quarter are focused on strategy development. In contrast, a third of activities aimed at changing health and social care are focused on developing strategies.

Table 13 In what ways are HAZ activities aiming to achieve each type of change?

	Percentage of each type of change group devoted to:					
Type of change	**Provision**	**Org Develop**	**Community involve**	**Strategy develop**	**Learning**	**PR & commun**
Determinants of health	52.8	7.8	1.7	26.1	6.7	5.0
Lifestyles	55.6	8.5	0.9	24.2	7.2	3.6
Health & social care	31.9	18.3	5.2	37.6	6.6	0.4
Community empowerment	30.1	14.2	27.8	17.0	5.7	5.1
Internal process	9.2	32.0	3.5	20.6	33.3	1.3
Total	**35.3**	**16.7**	**7.1**	**25.5**	**12.5**	**2.9**
N =	*365*	*174*	*75*	*263*	*129*	*31*

One-third of activities to promote community empowerment involve the provision of goods or services. In the main this is the employment of community development workers and various other group support schemes for specific client or population groups. The second biggest group of activities aimed at empowering communities – just less than one-third - are currently focused on involving local people in decision making about the HAZ or specific service developments. Not surprisingly, efforts to change internal process focus on organisational development, strategy development and learning activities.

Table 14 illustrates what HAZs are trying to change within each programme type. It highlights a number of features that are entirely to be expected. For example, over 60 per cent of activities in the programmes which focus on tackling the root causes of ill health focus on changing the determinants of health or lifestyles; and over half of the activities in the process programme focus on changing processes, etc. The biggest groups of activities in the programmes that focus on population groups or specific health problems are related to changing health and social care and changing people's lifestyles. Community empowerment is also quite a strong feature of population group programmes, emphasising the range of ways that HAZs are trying to involve specific groups in the development of services for them and/or promote their empowerment.

Table 14 What are HAZs trying to change within each programme type?

	The proportion of each programme type devoted to				
Programme Focus	**Determinants of health**	**Lifestyles**	**Health & social care**	**Community empower**	**Internal process**
Population groups	14.0	24.9	28.8	19.1	13.2
Health problems	19.8	22.1	33.7	7.0	17.4
Root causes of ill health	31.2	30.5	15.9	9.7	12.8
Health & social care	7.8	13.3	47.8	11.1	20.0
Community empowerment	10.3	14.5	4.8	35.9	34.5
Process	0.0	3.3	23.1	19.8	53.8
Area/mixed	13.6	9.1	6.8	22.7	47.7
Total	**17.5**	**21.4**	**22.1**	**17.0**	**22.1**
N =	*181*	*222*	*228*	*177*	*228*

Table 15 shows that the mix of things that HAZs are doing within each programme type is also reasonably predictable. Thirty to forty per cent of the non-process programmes involve the provision of services or goods. Approximately one quarter of activities across all programme types is devoted to strategy development, reflecting the early stage of HAZ plans. The percentage is higher for health and social care programmes and lower for community empowerment. Organisational development is also a significant feature of most programme types, especially process programmes and those aimed at community empowerment, where new ways of involving community and voluntary groups are seen a key strategy for the future. Different kinds of learning activities are also a reasonably consistent feature of most types of programme.

Table 15 What are HAZs doing within each programme type?

	The proportion of each programme type devoted to					
Programme Focus	**Provision**	**Org Develop**	**Community involve**	**Strategy develop**	**Learning**	**PR & commun**
Population groups	38.9	13.2	7.4	26.5	12.5	1.6
Health problems	40.7	9.3	4.7	24.4	16.3	4.7
Root causes of ill health	40.6	12.8	3.8	28.4	12.2	2.2
Health & social care	34.4	12.2	7.8	32.2	10.0	3.3
Community empowerment	29.9	27.2	12.2	15.0	12.9	2.7
Process	15.4	31.9	12.1	25.3	9.9	5.5
Area/mixed	25.0	22.7	6.8	20.5	18.2	6.8
TOTAL	**35.3**	**16.7**	**7.1**	**25.4**	**12.6**	**2.9**
N =	*365*	*174*	*75*	*263*	*129*	*31*

This brief review of health action zone programmes and activities is not intended to be exhaustive. The HAZ plans themselves are continually changing and it is right that they should do so. What we have tried to do in a relatively simple way is to convey something of the diversity of HAZ activities. The most important implication of the wide-ranging scale and nature of what HAZs are attempting in relation to evaluation is that careful choices have to be made about where to focus scarce research resources. This is our crie de couer. For the national evaluation to provide value for money and to contribute real learning then hard choices have to be made. Our hope is that this report will help to ground those choices more firmly in what is happening on the ground.

Findings From First Wave Interviews

As the preceding sections of this report illustrate, it has been possible to gather detailed information and conduct analysis relating to the overall objectives, programmes and activities of both first and second wave Health Action Zones from their implementation plans and related documents. However, these plans merely begin to reflect some of the complexity which HAZs represent. An impression of key issues affecting HAZs could only be gained from discussions with individuals working within each Health Action Zone. As a result, a series of interviews were conducted with stakeholders within each first wave zone. These interviews sought to probe more deeply the real issues affecting HAZs and to gain some sense of the progress made in the first year of their existence. Initial analysis of these interviews has yielded valuable insights into both the challenges and opportunities facing the first wave.

Methods

In-depth interviews were conducted within each first wave HAZ in March and April of 1999. These were 'diagonal slice' interviews, meaning that respondents were sought who occupied a diverse range of roles within the HAZ. Letters were sent to each HAZ lead in early 1999 asking them to identify individuals who fit into one of eight categories. These categories included the lead or director of the HAZ, people who were peers of the lead (including for instance, the chief executives of health authorities), representatives from local authorities and the voluntary sector[1], and others closely involved with implementing key HAZ programmes. A minimum of eight people were interviewed within each HAZ, by a member of the national evaluation team.

The interview schedule was semi-structured, and lasted an average time of one hour. Each interview was taped. More than ninety interviews were conducted, of which only forty-three were fully transcribed, due to time constraints[2]. Material from those interviews which were not transcribed was included in the analysis through structured discussions between members of the evaluation team immediately following the interviews. The relatively short time frame available for interview analysis and the limited number of full transcripts available does mean that findings should be interpreted with some caution. The overall analysis of interviews was guided by a thematic approach in which we aimed to capture the main messages which we received from respondents. These messages may in some instances differ from those expressed by particular individuals or from the prevailing view in particular HAZs. Despite these methodological caveats, we believe that the material we collected vividly captures some of the most salient issues facing the first wave of Health Action Zones, and the individuals working within them.

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[1] One voluntary sector representative was interviewed in each HAZ. This means that the views of the wider community in first wave HAZs were not captured in these early interviews. Our proposals for future evaluation efforts include a community involvement component. It is important that readers keep in mind therefore that findings from the interviews in first wave HAZs primarily reflect the views of those working in statutory organisations, and often those in management positions. Naturally this will affect the types of responses obtained to our questions.

[2] All interviews with HAZ leads were fully transcribed.

Themes

The interviews began with a series of questions relating to the role of the individual interviewee in the HAZ partnership, and the context within which their particular HAZ was operating. This provided valuable background information to inform our interpretation of responses to subsequent interview questions. It also assisted us in beginning to construct a picture of the varied geographical, organisational and professional contexts within which first wave HAZs are located. However, as this contextual material is so varied, we do not report it here. Instead, we present a synthesis of responses relating to key themes in the interviews. These themes are:

- Goals
- Strategies
- Targets and Implementation
- Partnership Working
- Involving the Voluntary Sector and the Community
- Critical Next Steps
- Challenges and Obstacles

Themes and Theories of Change

Interviews with key stakeholders included a series of questions relating to the goals, strategies and targets. These questions sought to capture the interviewee's own perceptions and understanding rather than a recitation of what was contained in the implementation plans. The rationale behind this set of questions was based very much on the theoretical approach which informs our research, which relates to realistic evaluation and theories of change. This examines the links between the context in which HAZs are located, the activities they have planned and the outcomes which they hope to achieve (Connell and Kubish, 1998, Pawson and Tilley, 1997). This approach is described in more detail in a subsequent section of the report.

An important first step in this process is to establish what key actors believe to be the *intended outcomes* of the HAZ. We attempted to capture this in our questions relating to goals. Once these outcomes have been articulated, it was important to try and surface the *underlying assumptions or rationale* behind these long-term goals, which we addressed in our question relating to strategy. Finally, we sought to determine how stakeholders perceived the process of determining the interim outcomes necessary to achieve their final goals. In other words, how had they experienced the process of attempting to agree the *prospectively specified expected consequence*s from the programmes and activities they had chosen? This question on target setting was asked primarily to HAZ leads, although the issue of targets, and the difficulties HAZs had experienced in setting targets, was raised by respondents in relation to several interview questions.

In asking questions relating to goals, strategies and targets, we sought to encourage stakeholders to make explicit their understanding of *how and why* HAZ programmes will work at this early stage in HAZ development. Interesting findings relating to the difficulty in linking aspirations to concrete strategies and identifiable targets emerged, and are discussed here.

Goals

Establishing and articulating long-term goals is not always an easy process, particularly given the breadth of the HAZ agenda. The experience of those individuals we interviewed across first wave HAZs reflects this fact, and many people told us about the amount of time and energy that had been invested in identifying and agreeing the objectives for the seven year lifetime of HAZs. Despite initial problems in focussing on the longer term however, interview findings suggest that the vast majority of respondents in all eleven first wave Health Action Zones were able to identify long-term goals when asked. In most cases, these reflected the goals described in the implementation plans - usually those we have identified as 'strategic goals' earlier in this report. Two of these were most frequently mentioned by interviewees: improving the health of the population; and reducing health inequalities.

Improving the health of local people was interpreted by respondents in a variety of ways. In many cases, the long term goal of improving health was described as aiming to improve the quality of life, or aiming to change the lifestyles of local people. In HAZs where a particular population group was targeted, the goal of improving health was described in relation to them. So for example in Lambeth, Southwark and Lewisham, the aim which several interviewees articulated was to improve the health of children and young people.

Reducing health inequalities was another central goal, mentioned by the majority of respondents in all zones. In some cases, there was a clear strategy to target the most deprived wards in the HAZ in an attempt to reduce inequalities within the area. As one interviewee put it:

I think that the long term goals that certainly those of us who are involved from the City Council side have, I think, is that we want to make sure that people living in some parts of the City don't have a much higher rate of dying prematurely than some people living in other parts of the City. That issue of heath inequalities is the overriding goal that motivates many of us.

In other HAZs, the aim was to bring the HAZ as a whole closer to national morbidity and mortality statistics; one respondent, reflecting on the extent of deprivation and related health problems in their local area, stated that their aim was at least to 'become average'.

A third key goal, mentioned almost as frequently as improving health and reducing health inequalities, was developing and improving partnership working. In most cases, this related to inter-agency partnerships. The need to involve communities and the voluntary sector in decision-making over the long-term was also frequently articulated as a goal by respondents in the first wave zones. As one interviewee in East London and City put it, a long-term aim was to 'give communities real power'. This articulation of community involvement as a key long-term goal was particularly prevalent amongst interviewees from the voluntary sector, local HAZ co-ordinators and some HAZ project leads. As one interviewee told us:

Involving local people in the process ...has to be key to achievements. I think it's key that in any of the initiatives we develop, we talk to local people, we involve them in the process, we support them in becoming fully involved in the initiatives that we are putting in place, the actions to improve health at the very local level.

The aim of modernising services or reshaping health and social care was much less frequently mentioned than the goals of improving health, reducing health inequalities, developing partnership working and involving the community. This may suggest that improving health and reducing health inequalities have become the primary focus in this early stage of HAZ development, rather than beginning to tackle structural change to services. A range of other long term goals were also mentioned by interviewees, including improving access to services, improving people's living environments, improving efficiency in resource use across health and social care, and others.

The goals listed did reflect the different positions occupied by interviewees. Thus Chief Executives of Trusts and Health Authorities more frequently mentioned the need to reshape services, while representatives from the voluntary sector or community groups emphasised the goal of meaningful community involvement. Similarly, individuals responsible for implementing certain programmes within the HAZ were more likely to articulate long-term goals of relevance to their particular work stream.

Realistic Goals?

There is genuine scepticism amongst those involved in the first wave Health Action Zones regarding the ability of HAZ to achieve tangible, measureable improvements in health and reductions in health inequalities within the seven year lifetime of the zones. Although there was general recognition that the seven year period provided the opportunity to begin to make real changes, interviewees were quick to point to the range of economic and social factors which could influence the health of local people which may not be within the 'power' of the HAZ to influence. In addition one interviewee described the need for a 'cultural shift' in the way in which services should be delivered in order to achieve health improvements:

HAZ is incredibly ambitious, incredibly ambitious. I mean it wants a paradigm shift in terms of how health and social care are delivered, and thought about. Seven years is nowhere near long enough, they are at the very beginning of that process really. It is a fundamental, cultural, attitudinal change in terms of institutions, and how they would and related with each other...At some level it is about empowerment, ultimately it is about empowering organisations....[its about] a wholly different culture really and it is about trying to make that cultural shift.

Despite reluctance to agree that long-term goals relating to significant reduction in health inequalities and improvements in health would be evident within five to seven years, many respondent were quick to point out that the long term goals specified within their implementation plans should be achievable. An adherence and belief in the goals described in the plans was particularly prevalent amongst those in leadership positions or those who had been closely involved with writing the plan, whereas representatives of the voluntary sector and others were more sceptical regarding whether goals were achievable.

Some specific goals relating to improvements in health were however described as achievable within five to seven years. Thus in one HAZ, the example of reductions in teenage pregnancy rates was described as a realistic goal within the lifetime of the HAZ. Others argued that while changes in disease rates, such as coronary heart disease, might not appear in the first few years of the HAZ, progress towards related indicators such as reduced blood pressure levels, reduced smoking or improved exercise rates could be realised.

Other goals which were described as realistic across all the first wave zones related to what could be described as *process* issues or intermediate goals. These included achievements around partnership working, beginning to involve the community and improving access to services or the take-up of services. For example, one person we spoke to described their HAZs' goals around interagency working, improving access, developing community involvement and beginning to address lifestyle issues as realistic within the next 5 to 7 years. Another interviewee described early progress towards what she saw as achievable goals:

I have to be grown up about it to see what is realistically achievable….It has already come a long way in a year for me to see the executives talking to each other, getting health and social services to talk to each other, let alone getting the boroughs to talk to each other and it is an enormous achievement to get as far as that.

Achieving new ways of working was both described as a realistic lifetime goal for HAZs and an essential prerequisite for long-term health gains. In a number of areas, the HAZ was described as an opportunity to 'speed-up' or 'kick-start' the process of partnership working which already had a considerable history between some organisations around some issues in the HAZ. Achieving the long-term goal of truly integrated working by realising goals related to setting-up joint information systems, establishing pooled budgets or even merging organisations was seen as possible within 5 to 7 years. These new ways of working and new structures would then need to continue beyond the initial HAZ lifetime to achieve the tangible improvements in health and reductions in health inequalities aspired to by the HAZs. Thus in some areas with well-developed relationships between agencies, the HAZ was described as the further development of an approach they were already committed to and did not see the likelihood of abandoning at the end of year seven.

Consensus

There was general consensus around long-term goals in the HAZs. Most interviewees reported that the organisations involved in putting together the implementation plan had invested considerable time and energy in agreeing their long-term objectives, and maintained a high level of commitment towards achieving them. A common response when asked about consensus was that overall goals or objectives had not been difficult to agree upon, but the specific means required to achieve them was the source of considerable debate. Thus one HAZ lead said:

I believe that there was a consensus around the plan and the programme. I've never been conscious that the bid wasn't agreed on. I think how we tackled it has been the subject of disagreement, but not the actual content and the aims.

One factor which contributed to broad consensus around long-term goals was local knowledge of problems and needs in the community. In Sandwell, a long-standing campaign to highlight the root causes of ill health was described as a contributing factor in agreement regarding the issues which needed to be tackled, and therefore the overall objectives which needed to be set. Thus both problem identification and long-term goal setting were tasks which the HAZs described as less difficult than agreeing how to tackle them through programmes or initiatives. This gap between context and aspirational goals was evident from the implementation plans, and it is interesting that interviewees themselves identified this problem. As a city councillor in another area told us:

Where I think that needs to be worked through is the consequences of setting those objectives and if it has implications for how resources are currently directed....then any consensus will see itself under some pressure. But I think there is a genuine consensus around the objectives and it was important to achieve them before being able to go any further.

The only significant divergence of views around long-term goals reflected *either* the differing perspectives of interviewees*, or* the time-scale of becoming a HAZ. Firstly, those individuals in leadership positions, such as HAZ leads and Chief Executives, were quick to respond that there was consensus around long term goals. In contrast, those who had not been involved with the original bid or not closely associated with key decision-making groups in the existing HAZ structure were less willing to accept that there was consensus. It was also present amongst some individuals who were new to the HAZ structure; in other words, people who had been appointed to work within the HAZ some months after the bid had been accepted. Thus, position within HAZ structures, involvement in the bid and the stage at which individuals had become associated with the HAZ all impacted on perceptions of consensus.

Secondly, there was some evidence that the process of becoming a HAZ may also have contributed to a lack of consensus around goals. Many interviewees made some mention of the speed with which the original first wave bids had to be submitted, and how the process had made it difficult to involve a wide range of partners. In the case of community groups, involvement during the bidding process was minimal in most HAZs, and thus their 'ownership' or understanding of the key long term goals was described as problematic. As with the issue of community involvement overall, the tension between the need for quick results - in this case agreement around a plan - and inclusive decision-making was evident in relation to establishing long-term goals for the HAZ.

Strategy

We see the development of local strategies as critical to the future success of HAZs. A clear strategy provides the logical pathway that links local problems or issues, the activities chosen to address those issues and the intermediate and long term goals which the HAZ aims to realise. Asking stakeholders to make explicit the assumptions or rationale linking problems, activities and goals can be difficult, but is a central component in constructing a plausible theory of change (Weiss, 1995).

When we asked stakeholders to describe the strategic thinking behind their Zone's long term goals, many found this difficult to do. Several did not feel able to respond to the question at all. One explanation for the difficulty was due to differing perspectives. As with goals, those individuals who had been closely involved in putting together the implementation plan or who were in leadership positions within the HAZ were able to identify clear strategies, whereas others who were not as closely involved felt less able to identify underlying rationales. A number of interviewees from the voluntary sector felt they had not been involved in determining the strategy for the HAZ - despite large stakeholder conferences - and had only become involved after a draft of the implementation plan was available. Shared ownership of strategies was limited.

The examples which interviewees did offer are perhaps better seen as elements of strategic thinking rather than clearly developed strategies. In many cases these examples were not explicitly linked to the HAZ's long term goals or the programmes designed to address them. Despite these difficulties, four broad elements of strategic thinking did emerge across HAZs. These related to:

- Partnerships
- Needs-assessment
- Balancing early wins and long-term change
- Linking the HAZ to the wider agenda

Partnerships

As well as being described as a long-term goal in its own right, partnership working was mentioned time and time again as an important *means* to achieving the goals of the HAZ. Partnership strategies took many forms. Some interviewees emphasised the importance of building on existing relationships between agencies which were already strong but would benefit from further development as part of the HAZ. Thus in Sandwell for instance, the HAZ programme was described as evolving (at least in part) out of the work of Healthy Sandwell 2000, a partnership between local agencies that had been in existence for more than a decade. Partnership as a strategy to achieve long-term goals was also described in terms of forming new relationships between agencies, and developing new ways of working. As one representative of a community health council told us:

I think it's got to be, to tackle some of the very big, the inherent health problems of the borough by getting the agencies to work together in much more effective ways and I think

breaking down the barriers between agencies and using the resources more efficiently has got to be the key to achievements.

In relation to inter-agency partnerships, another tactic which was described by some interviewees was the importance of building effective leadership within the HAZ governance structure. One HAZ lead characterised this process as 'building critical mass', or developing a core group of leaders from different organisations who would be highly committed to driving forward HAZ programmes and initiatives. He said:

The most really successful organisations are ones which get the biggest proportion of their employees driving positive change, but even then, at the heart of that successful organisation, there's probably between 10 and 20 real movers and shakers who are really making a difference. A HAZ needs the same thing….it needs some seriously good people in these co-ordinating roles and particularly in the central co-ordinating role. I think we've got a good mix and a fighting chance that we're building that critical mass…. If we can weld together enough key hitters who are determined to make a go of it, then almost all of the barriers will become less difficult to tackle.

Partnerships between public and independent sector agencies and community groups were also mentioned as an important strategy by a number of those interviewed. In Manchester, Salford and Trafford, for instance, one interviewee emphasised the importance of 'building capacity' amongst voluntary and community groups by supporting them and helping them to develop within the HAZ, in order to achieve long-term change.

Needs-assessment

A second recognisable element of strategic thinking which a number of HAZs viewed as central to achieving their goals was needs-assessment, or, as some described it, the related strategy of evidence-based planning. In the broadest sense, this involved identifying the needs of local communities within the HAZ and gathering sufficient information about them to adopt a strategic approach to planning appropriate interventions. In Sandwell public health reports over a period of 10 years had been locating health problems within an analysis of the root causes of ill health and thus much of the basic needs assessment had already been done. The emphasis on building an evidence-base is hardly surprising given that it is one of the founding principles of HAZs. What was interesting in the interviews was the way in which different actors within particular HAZs described the place of needs-assessment in realising long-term goals.

Needs-assessment was described by some interviewees as a tool for identifying the areas within the HAZ that required targeted initiatives (usually the wards with the greatest deprivation). It was also described as a means of identifying the gaps in existing service provision, and planning HAZ activities to fill that gap. As one interviewee told us:

Some of them [initiatives] are responding to local needs. Services for disabled children, certainly in X, were very poor. In the sense that there were not very many of them, I mean, compared with other local authorities, they were without the level of respite services

available in other authorities...[so]..there are some areas where there are identified local gaps.

Most commonly, needs-assessment strategies involved gathering existing evidence about local *health* needs. Thus in some HAZs particular conditions such as heart disease, cancer or strokes were targeted as available evidence suggested that they were particular problems amongst local people. Bradford's programme to tackle diabetes was informed by information about the level of undiagnosed diabetes in the city which required action. In the South Yorkshire Coalfields, a programme relating to Disability in Later Life was put together to tackle specific disabilities related to work in heavy industry which were a particular problem in the region. In Lambeth, Southwark and Lewisham (LSL), the tactic of 'early intervention' was mentioned by a number of interviewees as underpinning their programme focus on children and families. Early intervention through a range of initiatives in health, education and related areas was described as a means to achieving life-long benefits. LSL's focus on young people was based on an assessment of need amongst local communities - where there are a high proportion of families with children - and subsequently the available evidence of what types of initiatives would be most appropriate to address these needs.

Balancing Early Wins and Long-term Change

Another element of strategic thinking which was expressed by some interviewees was the practice of balancing short and longer-term goals. In other words, a number of HAZs had tried to tailor their implementation plan and construct their programmes in a way that would both lay the foundations for long term improvements in health, as well as deliver early, identifiable successes. Achieving the balance was described as important because it was felt that only by demonstrating their ability to succeed in the short term would HAZs receive the resources and support to continue to implement their longer term agenda. As one interviewee told us:

We have tried to develop a range of programmes, that have enabled us to achieve both early gains – which the government are very keen to see- as well as invest in the long term processes and organisational change that we believe will enable us to deliver against health inequalities. So we have organised our programmes into essentially 2 halves, the first six programmes underpin the work of all the others...it's those that will help us deliver the long-term agenda... The second 6 are care-group focussed....So we tried to be pragmatic, a bit of both really.

The strategy of balancing the long and short term also relates to target setting, which we address in the next section. In fact, the theme of 'early wins' and the pressure interviewees clearly felt to achieve them was evident from responses to many of the interview questions.

Linking HAZ to the Wider Agenda

One form of strategic thinking that was evident amongst some interviewees in first wave HAZs was the need to link local HAZ programmes and initiatives with the broader reform agenda. HAZs were described as one of a series of changes taking place across the country,

involving both the public and independent sector and local people. Some individuals, particularly those in leadership roles, were very aware that HAZs needed to be sensitive to broader developments and the ability to adapt to the changing policy environment might be key to achieving long-term goals. As one interviewee told us:

The thing I think is important is that the Health Action Zone is one of a series of government initiatives... people need to understand the context, there is linked legislation to this, there are modernising local government reforms linking to this agenda, the social exclusion stuff links into this agenda...And I worry that in the HAZ initiative there might only be a handful of people who've read the link legislation and understand it...it is right at the top they've done it, up at the Chief Exec level and it needs to be broader.

Some HAZs had attempted to link the HAZ to a wider policy context by choosing programmes which they felt would specifically link to the government's priorities. Themes such as social exclusion and parenting were provided as examples. In those HAZs where other area-based initiatives were in place, such as Education Action Zones, interviewees argued that one of their strategies was to link up with these both on a local level for planning and provision, and at a national level by taking on board any messages from the centre about how area-based initiatives should relate to one another.

Most clearly, there was a strategy voiced in many first wave zones to try and link the HAZ with other changes related to health, particularly PCGs and HimPs. 'Creating synergy' and clarifying relationships between these two health improvement frameworks was perceived as an important strategy by many of those we interviewed, particularly within Health Authorities. We return to the relationship between HAZs, Himps and PCGs in the section on 'Partnership Working' which follows.

Targets and Implementation

Setting targets and determining how to begin to achieve them has been a difficult process for the first wave Health Action Zones. This is evident from the implementation plans, a number of which have been revised in 1999 to reflect comments from Ministers and the NHS Executive. The difficulty with targets was also evident from our discussions with key stakeholders in HAZs across the country. As one HAZ lead told us:

I think we are struggling because I think there is an expectation that you can set targets around this agenda more positively than we have been able to up to now. That's not that we don't want to set targets, but we are finding it very hard to do.

It was evident from the interviews that there was a general perception that targets were important, but that many of those involved with the HAZ were still unclear precisely what constituted a target or how they differed from the long-term goals of the HAZ. Other interviewees were generally sceptical about the ability of the HAZ to meet many of the 'milestones' set out in their implementation plan while others were concerned about issues of measurement and how they would determine when and if targets had been reached.

Interviewees identified a number of *reasons* why targets were problematic. In addition, they described *tensions* around the process of both determining targets and beginning the process of trying to meet them. Finally, they acknowledged that there were some *positive aspects* of target-setting, and offered some valuable insight into how the process should be managed in the future.

Reasons

Interviewees identified a number of reasons why targets were problematic. The first, and most frequently mentioned difficulty concerned the *time frame* within which the first wave Zones had been expected to develop and submit their plans. Particularly amongst those first wave HAZs who had been asked to reconsider aspects of their plan and prepare a revised version, there was a general feeling that the targets (or absence of targets) in the first plan had been due to limited time for planning and seeking agreement from partners. Both agreeing goals and setting the targets was perceived as a process which required considerable discussion amongst a range of stakeholders, and HAZ leads in most first wave zones felt that there had been inadequate time to have that debate. As one interviewee told us:

I don't think we have had sufficient time to debate around the health, health outcomes, health inequalities...most of us recognise the need to have that debate. We recognise why we are where we are and where we want to get to and how we want to get there, type of debate. But it is really yet to be had in any depth.

Target-setting was also difficult due to the perceived *need for a firm evidence-base* on which to formulate them. This was most clearly the case when the targets proposed were to be quantifiable, such as reducing the incidence of smoking or of teenage pregnancy within a specified time-frame. It was acknowledged that in order to aim to reduce or reform something, reliable information about a base-line or starting point was required. While first wave HAZs had begun to gather this information in line with their view that need-assessment was an important strategy, it was described as a time-consuming and often difficult process.

Finally, including targets in the plan and subsequently developing specific targets within programmes was described as difficult due to the *concerns about the wider context in which HAZs were operating*. Several HAZ leads were nervous about setting targets which they felt would not be achievable if events extraneous to the 'core business' of the HAZ got in the way. For example, a Chief Executive told us:

You have to say OK, on the basis of the best evidence, we are trying to hit that target. There would appear to be some known factors or routes for doing that...but actually, you don't have a clue, you cannot control all the variables. Let me give you an example....Unemployment. You get a big recession in these seven years, the evidence is that it will blow any progress, so, you cannot allow for all the variables with this to say yeah, on the basis of this evidence we will do these sorts of things.

Concerns about attribution are inherent in community initiatives such as HAZs, in which a broad set of circumstances may have direct bearing on programme success which the HAZ has little power to affect (Kubish et al, 1995). Stakeholders we spoke to were clearly

concerned about this issue within the context of committing to targets which they could meet. This concern highlights the need to link targets more explicitly to identified local problems, HAZ programmes and long term goals - an issue which we raise again in this report in relation to future research.

Tensions

Interviewees identified a number of tensions around the issue of targets. In the broadest sense, these involved finding the balance between the *bottom-up* nature of HAZs and *top-down* requirements for accountability and evidence of success. Within a theory of change framework, this is commonly described as a 'product-process' tension (Connell and Kubish, 1998). The concept of HAZs was launched with the expectation that it would include a wide constituency in each local area, and would tackle a broad agenda based on the multiple factors affecting health. As one interviewee put it, the HAZ in many ways needs to be 'an organic process'. On the other hand, the public money involved in implementing HAZ initiatives and the legislative and other frameworks involved mean that the HAZs are accountable to central and local government and need to demonstrate consistent progress. This tension between the HAZ process and the products expected and required was voiced by interviewees in relation to target-setting.

Firstly, interviewees expressed frustration that the process of building partnerships and involving the community took time, whereas targets were expected to be specified in the early stages of HAZ development. As with the issue of long-term goals, there was wide-spread acknowledgement that existing targets in the plans had been set with minimal involvement from either the voluntary sector or community groups. Secondly, there was admission by a number of those we spoke to that targets were being selected and set with little reference to overall objectives or specific HAZ programmes, but rather due to general concern about new performance management requirements and other messages from the centre. A City Councillor expressed this:

I don't have any problem with targets. I mean, the problem is ... is, are you choosing something to measure because it's easily measurable? Or are you choosing something because you believe that that is an adequate indicator of the real change you are trying to achieve? For example, it is possible to measure performance against a whole range of outputs, activities and so on ..... But that doesn't necessarily tell you very much about outcomes and what is really being changed. I think there is a real risk that targets might become based too much around outputs and focused around issues ... I mean, it would be a disaster if, you know, waiting lists became the crucial target for us to deliver on.

Positive Aspects

Despite some of the problems and tensions around targets, interviewees did acknowledge that there were positive elements. Firm targets were described as a useful lever for efficiency, in that they assisted in planning how to allocate and use HAZ monies. Targets were also seen as valuable in local evaluation efforts, with some first wave having already introduced

assessment or appraisal frameworks of their own. Overall, including targets in the planning process was acknowledged as a useful means of specifying what the HAZ expected to achieve, how achievements would be measured and what types of learning could emerge from achievements.

Learning from the HAZ planning process - with targets as an integral component - was something which a number of interviewees emphasised as important. There was genuine hope that the relatively long lifespan of the first wave zones would permit real learning to take place. Targets and milestones could assist this learning process by providing the HAZs with a framework for identifying which initiatives had produced which results, and when. Being able to identify and acknowledge failure to reach some targets would be an important component of this learning; one interviewee in Tyne and Wear alluded to the 'western cultural block to recognising the value of failure' and commented that, even when projects failed, the people involved in it felt considerable pressure to try and make it look like some form of success. Along with the need to admit failure to reach some targets, other interviewees pointed out that the process of planning and target setting would need to be *reviewed and revised* through the lifetime of HAZs in light of changing circumstances. Real learning would require flexibility. As one HAZ lead said:

We can not aim to do everything in year one of the plan. It cannot be all front loaded. Let us set ourselves a target that at least each year we will refine our thinking and we will develop new measures of success.

Partnership Working

In their implementation plans, the first wave HAZs described the partnership arrangements they were putting in place, both in terms of governance structures and arrangements for improved joint-working and communication between individuals, groups and organisations. A discussion of governance arrangements can be found later in this report. In order to complement the descriptive material available from the plans, the first wave interviews included a series of questions which sought to elicit stakeholder's impressions of how partnerships were developing. The issue of partnerships with the community and voluntary organisations was also considered and is dealt with in a subsequent section. Findings relating to partnership working generally can be divided into the following themes:

- Different starting points
- Establishing governance
- Integration, synergy and decentralisation
- Engaging the whole system
- Building organisational capacity

Different starting points

Each HAZ has its own unique legacy of partnership arrangements and experiences that have provided very different starting points for HAZ partnerships. Consequently HAZ status has generated different visions and perceptions about the prospects for improving partnership

working. Early experiences suggest that the different levels of organisational complexity of the HAZ and the size of the population covered are important factors influencing many different aspects of partnership working. Understanding their own social, political and cultural context is likely to be a crucial task for HAZ partnerships if they are to effectively manage the strategic change process in the future (Pettigrew, 1994).

For a number of zones, HAZ status was viewed as a stimulus for addressing poor relationships between key players. It was perceived by one large complex HAZ as the opportunity to unify fragmented organisational structures in the region; and at a scale that could achieve 'a whole systems approach' which was judged to be vital to affect real impact on inequalities and the modernisation of services. In another area, the particular configuration of the HAZ partnership was reported to have been strongly influenced by the NHS Executive regional office, with the HAZ being perceived by some as a step towards Health Authority mergers.

Some HAZs felt that they were already building on sound working relationships at certain 'axes', particularly at the interface of health and social care. HAZ status now provided the opportunity to 'broaden and deepen' partnership working to many other areas such as education, the youth justice system, employment and regeneration.

Co-terminosity between the HA and LA was cited as a factor that had considerably helped collaboration. In these HAZs, the platform of real and long standing co-operative relationships meant that HAZ status could now provide for a 'quantum leap' in the nature of inter-agency working. In one HAZ, the systematic discussion of the annual reports of Directors of Public Health over a number of years was viewed as influential in raising awareness and educating key players about the problems and strategies for tackling inequalities. This process had been particularly important in securing political commitment and support within the Local Authority.

Establishing governance

HAZ partnerships comprise a diverse set of players as well as embedded organisational practices. However, these players have committed themselves to a common agenda and have come together within new partnership structures. The governance arrangements put in place during the first year of HAZ status are a formalisation of partnership arrangements within the HAZ and in principle set some new 'rules of the game' for future collaborative behaviour (Ostrom, 1990).

At the time of the first wave interviews, HAZ governance arrangements were still in the process of being fully established. Partnership Boards, some form of executive group, various combinations of programme and workstream groups, and local HAZ groups, were the central elements of these arrangements. Early concerns were expressed about whether the emerging arrangements were appropriate. In particular it was felt that there was potential overlap and lack of clarity about the role of particular groups and lines of accountability. However there was a strong sense that the arrangements were evolving and would need to be revised, and in some cases this was already taking place. One HAZ defined its revised arrangements as a reflection of the move from planning mode to implementation.

In one HAZ, at this early stage of development, there was felt to be considerable demarcation, protectionism and defensiveness among the different partner agencies and a general mistrust of each other. In another HAZ, while apparent consensus was being displayed in partnership meetings, disagreements were being confronted behind closed doors. In a HAZ with reported mature working relationships between the Health Authority and Local Authority, the introduction of the HAZ structures meant that new players felt disadvantaged. The Board was perceived as a 'rubber stamping exercise'. A number of new organisations 'found themselves on the Board and were wondering why they were there'. The Health Authority and Local Authority were seen as dominating the Steering Group; 'others didn't say much'.

There was wide acknowledgement that it would take time to build relationships and a sense of trust between partners. One respondent made the comparison to a marriage; a partnership which is constantly changing and works better in some contexts than in others.

The notion that partners and individuals were not yet engaging in the HAZ as shared multi-agency endeavour was expressed across the HAZs. People were still thinking about what was 'in it' for their agency or area. One respondent who had visited many of the first wave HAZs referred to the need to think 'HAZ-wide':

What they are doing at the moment is that they are thinking in their own organisations and acting in the HAZ and they should be thinking in the HAZ and acting in their organisations....they have to learn to act for each other and they are nowhere near that yet.

This idea of the need for a 'HAZ culture', based on a commitment to the 'big picture', was a theme reflected in other aspects of partnership working.

Within governance arrangements, leadership and commitment by managers at a senior level across agencies were cited as a strength in some HAZs, and/or perceived as essential for securing both long as well as short term outcomes. In one HAZ, managers were viewed as inspirational leaders and strong advocates in their own organisations. However, in contrast, in another HAZ it was reported that although the 'great and the good' had signed up there was little evidence of them taking this commitment back to their organisations or bringing the resources of their agencies to the table. Individual leadership had also proved important, with one HAZ lead cited as 'being the one keeping the thing on the rails'. As we mentioned above, the need to build a 'critical mass' of strong leadership through a core group of senior managers was cited in one HAZ as an important strategy to achieve change.

There was also recognition of the fact that networks of personal relationships had a role to play in making the partnership work. They were viewed as key to ensuring the necessary linkages were made and commitments engendered. As one interviewee told us, 'You work on connections. You work on the uncodified knowledge of the system not on the codified'.

Integration, synergy and decentralisation

Many HAZs highlighted the importance of ensuring that the HAZ impacted on mainstream strategies, particularly the Health Improvement Programme. Little explicit reference was made to linking to Community Plans, although specific Local Authority strategies were viewed as central to the HAZ. Concerns were expressed about the need to ensure linkage and co-ordination with the multitude of other area-based initiatives, such as SRB, Sure Start, Education and Employment Action Zones. However, at the time of the interviews there was much uncertainty expressed about how integration and synergy could best be achieved.

It is clear that the HAZ partnerships are positioned within a complex and evolving web of interagency planning mechanisms. In some HAZs, very vibrant established networks of working relationships across organisations were evident. However, there was some acceptance that arrangements were overly complicated and that there was a need for rationalisation. This position is captured by one respondent's comment:

What we haven't got clear yet is how to avoid unnecessarily bumping into each other every working day of the week because we have all got so many membership cards of partnership now.

Not surprisingly HAZs based on co-terminosity between the HA and LA, appeared to be more advanced in their thinking about more integrated and coherent partnership arrangements for their areas.

Different views were expressed about the purpose of the HAZ in relation to the Health Improvement Programme and other initiatives. HAZ were referred to as 'leading' the HImP, a 'vehicle for implementing the HImP', and/or as a 'catalyst for strategic change'. For example, the Chair of one Partnership Board was very clear that the extent to which HAZ had mainstream impact was the key to success. The HAZ was intended to be distinct and have its own identity. It represented the 'leading edge of the HImP'. It provided the 'space' to do things differently. However as yet it was felt that the HAZ was not 'well mainstreamed' and that 'they were struggling to make it work and make the links'. Potentially it was felt that the HAZ could feed the learning from other more specific and geographically focused initiatives into the 'broader debate'. HAZ could be 'an integrative focus' owned by everyone.

In a small number of HAZs overarching forums with responsibilities spanning a broad range of areas, including regeneration, the HAZ and other initiatives were being seen as a way of securing better integration and synergy. These forums were based primarily on existing multi-agency bodies. Such forums were viewed as the potential focus for generating 'Visions' or comprehensive strategies for areas.

For example 'a new civic partnership' was planned to provide the overall framework for both the health and regeneration partnerships in one HAZ. The intention was to instigate structural changes which would include the creation of a single public health agency between the HA and local authority, and provide for the rationalisation of resources between health and local government, through for example the sharing of Information Management and Technology.

The Health Authority Chief Executive referred to a 'virtual structure' with constructive tension remaining between agencies and a 'structural reconfiguration', rather than formal re-structuring.

Flexibilities were being sought in some cases that allowed for the recognition of some 'hybrid' unifying document for both health and local government and other partners because as one respondent commented:

.…while there is a push there for joint working, actually we are still required to do the community plan, the children's plan, the Health Improvement Programme and the HAZ Implementation Plan whereas if the HImP is truly a health strategy in its broadest sense, it should be all encompassing and the HAZ should be the vehicle through which that is implemented and it shouldn't be about compartmentalising for government departments or other organisations.

There was acknowledgement in a number of HAZs that the process so far had been very 'top-down'. As a means of securing a more 'bottom-up' approach, several HAZs were attempting to build on local infrastructures provided by regeneration initiatives, as well as taking advantage of a range of consultative mechanisms in local government and the emerging PCGs. In a large complex HAZ, partnerships had been established based on local authority boundaries, and built on existing Healthy City and regeneration fora at sub-district level. In another HAZ, the establishment of local HAZ groups was viewed as a crucial next step, based on new PCG boundaries. However considerable concern was expressed about PCGs' lack of capacity to take on this role given their emergent state and the scale of their agendas.

A Health Authority director commented:

I think the weakness is that there is not necessarily the capacity at the local level to take on this huge extra responsibility. We wouldn't have done this. We would normally have gone for local HAZs and PCGs have being doing their job for a couple of years...Our Primary Care Groups are different to the majority...in that they have got to be 'Primary Care Groups Plus' because they are expected to get immediately involved in the HAZ and their capacity is not there.

More widely, the role of PCGs was perceived as important to the progress of the HAZ. However, although PCGs were only newly established, their was some concerns expressed that they had not been sufficiently involved, and there was a great deal of uncertainty about the specific nature of their future role.

Engaging the whole system

The breadth of membership of Partnership Boards and executive forums (Steering Groups for example) varied considerably across the HAZs. The early use of various consultation methods and other processes had attempted to engage a much more extensive range of stakeholders within the HAZ process. The ease and degree of success clearly varied, in part influenced by the level of sophistication of current infrastructures designed to support stakeholder, including community consultation. In one HAZ, for example, although the timescales were tight, one respondent commented that 'its like a big village', the key players

are on first name terms, they've been here a long time and they've been working together a long time so they weren't guessing what the issues would be.'

Open processes of bidding for HAZ funds had been adopted in a number of HAZs. However in some cases there was frustration and acknowledgement that this had fostered the image that HAZs were about another 'pot of money'. It had distracted attention and efforts from more systematic strategy development and looking at the resources of the whole system. The process had not always been well managed, with lack of clarity over timetables and approval criteria, and this had led to distrust and frustration between partners.

Certain players were highlighted, across the HAZs, as yet to be fully brought on board. Limited community involvement was most frequently mentioned; an issue which is dealt with in the next section of this report. The active involvement of the private sector was viewed as a particular priority in some HAZs, however there was considerable uncertainty how this could be achieved. Attracting the contribution of acute trusts beyond areas relating to hospital reconfiguration, was also viewed as difficult. Tyne and Wear appeared unique in its establishment of a NHS Partnership within the HAZ governance structure that was judged to have achieved some early important successes.

Building organisational capacity

General concerns were expressed relating to the managerial capacity required to sustain the momentum. In practice the same comparatively small number of managers were at the core of both the HAZ and the full range of other initiatives. The need to respond to many initiatives within tight timescales was very demanding and time intensive. Also, those taking on HAZ responsibilities alongside their 'day jobs', including those involved in programme groups, lacked support.

Nevertheless, HAZs reported that efforts and investments were being made to develop the infrastructure for partnership working. In addition to the appointment of HAZ directors and/or co-ordinators, small-designated teams or 'central offices' were being established, staffed by secondments and/or new posts such as communications managers. In contrast, a number of HAZs were placing emphasis on strengthening existing management capacity, including designation of senior management time, rather than the creation of a specific HAZ team. One HAZ was distinct in engaging a management agency. This had the remit of project management, co-ordination of workstreams, capacity building and providing administrative and secretarial support to the Board and Executive. Information Technology and Management were identified by a number of respondents as an important area that could yield future benefits for the operation of partnerships. The capacity for wide and systematic communications both across organisations and externally was acknowledged as an area that needed attention.

Involving the Voluntary Sector and the Community

Partnerships between formal bodies or organisations such as local authorities or health authorities and 'the community' raise rather different issues from those involved in the establishment of partnership arrangements between formal bodies. While the issue of community involvement more broadly arose throughout the interviews in relation to a variety of the questions asked, interviewees did make specific reference to the place of both voluntary and community groups in HAZ partnership arrangements and commented on the extent to which these groups were involved. Findings relating to community involvement in HAZ partnerships are discussed here, firstly in relation to the voluntary sector and secondly in relation to community and user groups.

The voluntary sector

Past experiences of working across public sector/voluntary sector boundaries have demonstrated some of the tensions, frustrations and lack of understanding that can arise when very differently constituted bodies, that have very different organisational cultures, seek to work together (e.g. Craig and Manthorpe, 1999). Some of these tensions were clearly evident in the emerging partnerships across first wave HAZs, and were voiced in interviews with voluntary sector representatives. One example concerned the fact that, at face to face level, language can be used to distance and exclude. As one voluntary sector interviewee said:

I noticed that [when] the voluntary sector people…walk into the room, the way that the technical language, the public health language is used to put you in your place and patronise you. It is a very frightening process; they would not have us there if they did not have to.

Not only is there often a lack of understanding of the different worlds each inhabit, there is also a tendency for the more powerful organisation to force the smaller less powerful organisation (in this case voluntary agencies) to resemble it, and to accommodate to its values and processes before working together. Dimaggio and Powell (1983) have described this as a process of institutional isomorphism. This creates problems for voluntary sector bodies not only because they do not have the organisational and material resources to match those of large public bureaucracies, but because to act in a similar way to a statutory body removes from them the flexibility and diversity which constitute one aspect of the *raison d'etre* of the voluntary sector.

On the other hand, statutory agencies can feel that the voluntary sector people are deliberately staying outside the partnership, trying to gain HAZ resources without being willing to be accountable to the HAZ partnership or trying to shape HAZ goals to their own agenda rather than work with the statutory agencies to establish common goals. One particular source of tension between voluntary and statutory organisations is whether voluntary organisations can legitimately represent local communities. In one HAZ an elected member reported that:

.…the voluntary organisations somehow feel that they and they alone are there to represent the community voice and obviously local authority members would disagree with that. They would say that they are the representative which is a more legitimate role in so much as they are actually elected. There is a concern that sometimes the community and the groups within the community are used in order to further other people's agendas. .…We have communities

…who are the subject of several government initiatives….invaded by professionals and including the professionals who work in the voluntary sector who are desperate to give some sort of legitimacy to what they are doing..

In contrast, the voluntary sector in other HAZs were viewed as playing a vital role at a range of levels. For example in one HAZ the umbrella organisation supported and co-ordinated voluntary bodies and community groups for children and young people across three boroughs. The effective co-ordinating role of this body was perceived as enabling specific groups to be widely involved in early programme and project planning.

The wider community

The differences and difficulties experienced by voluntary organisations may be even more evident when statutory bodies seek to work with community or user groups. The community sector is rarely organised and highly diverse. Community groups representing particular interests or based in different cultural identities may be in direct opposition to each other. Community based organisations may be non-existent or may come into existence to pursue specific objectives, then disperse or re-form in different ways. Small community based groups are likely to be even more poorly resourced than voluntary sector bodies and highly dependent on the energies and commitment of volunteer activists.

Relationships between large public bureaucracies and community organisations cannot be considered to be equal partnerships. User groups in a previous study rejected the notion of 'partnership' with health and social services organisations precisely because of the unequal power relations involved, whilst officials regarded some user groups with which they were working as chaotic and badly organised (Barnes et al, 1999a and b). Nor can it be assumed that the policy objectives of statutory organisations will be consistent with the objectives of community groups. Not all community organisations will want to work within systems defined and dominated by statutory bodies, preferring to maintain their distance in order to concentrate on advocacy and campaigning. Others are prepared to co-operate with official bodies, whilst remaining cautious about the tensions and conflicts that can arise from working with considerably more powerful organisations. One interview respondent recognised the danger of official bodies coming to co-opt the community to achieve their objectives:

The community, we are in danger of describing the community as a branch office of all these public organisations, if we are not careful.

The diffuseness and diversity of both sectors: the voluntary sector and the community sector contribute to some uncertainty about the distinction between them. In some areas voluntary sector or CHC representatives claim to speak on behalf of the community and this role is accepted neither by 'communities' nor the officials in health and local authorities. In many HAZ areas 'the community' is itself diverse and there are varying levels of organisation amongst different community groups. Elected local authority members regard themselves as representatives of the community and may question the need for mechanisms for participatory democracy when representative structures are in place:

….the idea that somehow the communities ought to drive the agenda seems to me to be an abandonment of our responsibilities. It is almost as if we are saying we are the people who have been entrusted with doing this, and have been elected and appointed to these posts and yet we don't know what to do, so we are asking you.

On the other hand local authorities in some HAZ areas were considered to have better developed community links than did the Health Authority and this was seen as a strength to build on.

The interviews with key HAZ respondents reflect the early stage of development of relationships with community organisations in this context, although in some areas (as we have seen) there are pre-existing relationships to build on. Some talked of the need to overcome the paternalistic perspectives of statutory agencies before effective community involvement could be achieved. There was evidence of rhetoric not reflecting reality in the extent to which community organisations were being included as partners. Some HAZs have, as yet, not really gone beyond one day events and information giving and thus to talk of 'partnership' with communities is highly premature. Some interviewees quoted tight timescales as a reason why community based organisations had not been involved in developing plans and in partnership structures at the start of the HAZ. The danger is that it may be even harder to join a club that is already formed. But where community or user groups have been involved in setting detailed plans there are also examples of early succeses:

Some of the steering groups were excellent involving all the right people across the HAZ, some were brilliant, some of them didn't. The disability one for example was excellent. It had all the right people involved, came up with an excellent plan and with some sensible targets.

There is a recognition of the need to build partnerships at grassroots level (either within neighbourhoods or with particular user or identity groups) and that effective partnerships at Board level will depend on establishing such bottom-up relationships:

I think it's key that in any of the initiatives we develop, we talk to local people, we involve them in the process, we support them in becoming fully involved in the initiatives that we're putting in place, the actions to improve health at that very local level. And as a result we begin to genuinely empower those communities….we can then use community involvement to get people involved at locality level in community partnerships.

Another requirement for representative input is the existence of community forums (such as the Ethnic Minority Forum referred to in Sandwell) and for such forums to have sufficient resources to enable them to build effective links with relevant communities. Where there is a commitment to building partnerships with communities through community development approaches there is also a recognition that this will require cultural change on the part of health and local authorities. As one respondent described it:

We have had very paternalistic government in this area and the process has been 'we will either do it to you, or for you', that moved on to 'we will do it to you, or for you and then ask you how you felt about it'. We have to make that next leap now and say we want you to help us work out what you need and want and then we will work with you. We are in the middle of that shift, it is happening in some areas and not in others.

We have referred elsewhere to a concern about different and sometimes conflicting messages coming from central government in relation to a range of policy initiatives to which health and local authorities are being asked to respond. Some referred specifically to the way in which this may affect their capacity to build effective partnerships with communities. One interviewee talked of different initiatives, driven by different agendas, and the potential for this to get in the way of achieving objectives:

I think one of the barriers to achieving HAZ goals was if we are forced to maintain the demarcation lines between those different initiatives, it would be far more dynamic and effective if, at the neighbourhood level, we could pull those kinds of initiatives together.... And that would help me in terms of getting community development and involvement, community participation teams, from all the different agencies working together.

In addition to a perception of different agendas at central government level, interviewees also identified local 'territorialism' and different community development philosophies operating within local authority and health authority contexts. One interview referred to a perception that health promotion specialists had 'gone native' whilst the local authority community development team was seen as being driven by the need to perform in relation to SRB outcome indicators. Building partnerships with communities in the context of HAZ will obviously be affected by differences between statutory partners in relation to the appropriate nature of the role communities may play within HAZ and how new relationships may best be built.

Critical Next Steps

Interviews in the first wave HAZs took place at a time when the first full year of HAZ status was drawing to a close. Resources for the following financial year were in the process of being allocated between programmes, and a number of important decisions were being taken about future development. Interviewees were asked to reflect on what they saw as the critical next steps for the HAZ. Many of the next steps required echoed the issues which stakeholders had raised in earlier parts of the interview. While this meant there was considerable repetition, it also revealed how important some of the overriding themes -such as the need to develop community involvement- were to those people working in first wave HAZs across the country.   The critical next steps which interviewees raised can be summarised in six broad categories: implementation; resources; developing effective partnerships; communication and evaluation.

Implementation

At the time of the interviews, the overwhelming priority for the first wave Health Action Zones was clearly to make the decisive move from planning to delivery of HAZ work. This was commonly expressed as the need to 'get projects on the ground' and to be seen to 'make a difference'. The emphasis on delivery of observable outputs was generally a response to the pressure to keep up momentum and the high level of local commitment that had been demonstrated in the early stages of the process. The view expressed below was typical:

We need to have one or two reasonably good success stories in the next few months and to use them as a communication tool to people, the general public but also front line staff. We can then say this is what HAZ is about and give useful examples.

First wave HAZs are at varying stages of development in terms of project proposals. However, there was a clear sense that some programmes had been easier to establish than others (particularly those that built on existing projects or ways of working). There was genuine frustration about the delay in agreeing protocols, funding and management arrangements for some programmes and interviewees were anxious to begin to implement these 'slow starters'. As one interviewee put it:

Getting the programme boards up and running as quickly as possible, and ensuring they are clear about their brief and their need to deliver the work programme against the targets and milestones agreed. If they don't get that right we are not going to get any more support from the government or anyone else.

Resources

Managing resources was perceived by many interviewees as an immediate priority over the coming months. The majority thought that the next step was to gain funding approval for specific initiatives and to 'get money moving and flowing to the right projects' in order to implement the action plans. While HAZ finances were generally described as a positive - uniting partners in efforts to take forward agreed programmes – some interviewees reported that the relatively small amount of funding on offer had actually been a source of some tension between the organisations involved in the HAZ. Finances had become the focus of most of the discussion amongst partners in one particular HAZ, and arguments about allocation had become - as one interviewee described it - ' a huge source of distraction', which had to be overcome. Dealing with issues of how to allocate resources between partners and between HAZ activities was a concern in many HAZs.

Resource issues were also raised in relation to what was perceived as a slow response from the centre in relation to the freedoms and flexibilites which HAZs had requested; an issue we discuss below.

Developing Effective Partnerships

It was clear that as well as maintaining the commitment of the HAZ stakeholders through early results, there was a more general requirement to continue to develop effective partnerships. The critical next steps in terms of improving partnerships were described as organisational development, involving new partners, and involving communities.

One of the key organisational issues was that of developing a shared understanding among agencies and players of what the HAZ represents and what its purpose is. This process was described as encouraging partner agencies to make HAZ part of their core business. As one interview explained:

We need to ensure that the investment programme does not become a separate set of initiatives from the mainstream business of the health authorities and the local authorities. To ensure that these programmes themselves interlink and support each other.

As part of this process, some level of cultural change was needed within partner organisations. This change was required at all levels, but particularly amongst the front line staff, whom many interviewees thought needed more fuller engagement and training.

Another critical process which interviewees reported as requiring immediate attention was linking HAZ work with the many other new initiatives, particularly HimPs. There was a need to ensure mechanisms to facilitate this such as joint planning and monitoring structures. The integration and involvement of the new Primary Care Groups (PCGs) in the partnership was most frequently mentioned as essential to the successful progression of the zones, which had been frustrated due to the timing of their introduction. There was also an emphasis on closer working with other partners such as businesses, police, Training and Enterprise Councils and the voluntary sector in particular. The comment below illustrates this:

The next step will be to involve the business community more and private partnerships and to involve the Voluntary Sector hopefully in a different way, and this is not in order of preference. But I think the other thing to do is to embed in all of these the opportunity for ordinary people to become actively involved and make decisions about their health and their environments

Again, a great deal of emphasis was placed on the need to find and develop better ways of community involvement at all levels in order to facilitate local ownership of Health Action Zones and health improvement in general. Interviewees in general believed that getting the mechanisms right in terms of HAZ governance structure was essential to greater accountability to the community.

Communication

The need to improve communication was also frequently described as a critical next step. A number of respondents placed importance on establishing shared information systems in order to harmonise data between agencies, especially local authority social services and health services. Others described a need to improve strategies for communication between the different work programmes in each HAZ which were perceived as poor:

They need to simplify action because there is an awful lot of duplication going on and not terribly good communication between them. There have become fifteen branches and forty eight twigs and it actually needs to come back to four or five really strong streams of work.

At a more general level, the desire to communicate the distinct nature of HAZ to a wider audience was expressed by a small number of interviewees. Some HAZs had already distributed newsletters or information leaflets to their local population, while others had used the local media to disseminate early information about health action zones. Other HAZs had public information campaigns planned, or had recently appointed communication officers who would be responsible for future efforts. Better communication both with employees within the HAZ and with the wider public was described as an early priority in a number of first wave zones.

Evaluation

Formalising arrangements for local evaluation was another early priority. While some had invested specifically in evaluation either internally or with local higher education institutions, others were yet to finalise frameworks for monitoring or evaluating their programmes and initiatives. The process of developing outcome measures was seen to be critical in order to be clear about what HAZs expected to achieve in the medium to long term, but there was considerable uncertainty expressed about which measures would be appropriate and whether new ones would need to be developed. There was also considerable anxiety amongst some HAZ leads regarding the new performance management framework and expectations regarding targets and issues of measurement from central government more generally. One said:

I think one of the things which would be helpful to have, if there is going to be some sort of monitoring framework applied to us, either for finances or performance management and so on, then we need to know what it is and need to know about it quickly.

In relation to performance management, there were clear messages from those we spoke to that the agreed framework should be as non-bureaucratic as possible. Excessive monitoring and 'form-filling' was described as a possible barrier to implementation, as it would further add to the pressure on existing staff and resources.

Challenges and Obstacles

In order to conclude our discussions with stakeholders, we asked them to reflect on the varied obstacles or challenges facing the HAZ. Responses suggest that the first wave are encountering a variety of different challenges as they confront the inevitable difficulties involved with working across organisational boundaries to deliver an ambitious agenda Again, many of the same issues were raised in response to 'challenges' as were mentioned in other parts of the interviews, confirming the importance of some of the overriding themes we have identified thus far. In broad terms the challenges and obstacles which interviewees raised can be divided into two main types:

• Challenges which are a consequence of specific contextual issues peculiar to the area / history of different HAZs,
• Challenges which were attributed to a variety of issues related to the relationship between HAZs and central government.

Contextual Challenges

The large geographical region covered by some HAZs was identified as a major obstacle for several first wave HAZs. Those located across a large area were increasingly complex organisations, within which it was reported that it was proving hard to achieve real synergy when attempting to cross institutional boundaries. The notion of 'seamless' working was little more than an illusion in these HAZs. One interviewee commented:

..its so big its just…hard to get agreement on everything and if you're agreeing something in one place, you've then got to think about other places as well.

As a result of this, achieving integration between the different organisations within the HAZ was a formidable challenge. HAZs with complex configurations of partners were described as facing many more obstacles to progress than those which are smaller or involve fewer organisations. Transaction costs were perceived as high and negotiation between partners was described as time-consuming.

Social and economic factors were also identified as possible barriers or challenges to progress within the first wave HAZs. Each HAZ faces very specific social and economic concerns, many of which are unique to particular parts of the country. Changes in the local or national economy were of particular concern. Problems such as poverty and homelessness were mentioned:

I think it is possible to live in other places …and I think if you can manage to walk past the people living in blankets in the streets, you could actually probably never see poverty, whereas in --- , partially because it is a smaller area, it is quite easy to see the levels of deprivation that exist. There is a kind of cultural awareness of these problems

Economic factors were perceived as key to alleviating poverty, and there was scepticism about the extent to which HAZs could make significant changes in the health of communities in which endemic poverty remained a problem. As one interviewee told us:

I'm a little bit pessimistic…well you know, at the end of three years …most people will still be poor and no amount of initiatives are going to take away that fundamental fact of life.

Within certain HAZs, traditional rivalries were also part of the 'social' context which caused some difficulties, or were identified as weaknesses potentially threatening the effectiveness of the HAZ. For instance, in some places, there was a history of poor relations between councils now 'united' within HAZ boundaries. These difficulties were perceived as possible future obstacles to progress, despite early attempts to work together within the new structure. More obviously, long-standing differences in perspective and processes between the health authority and local authority were mentioned as problems, as were poor Trust/health authority relationships. Despite initial success in partnership working around the HAZ, there was a perception that once larger sums of money entered the equation - in subsequent years of HAZ status - or if services had to be significantly restructured or terminated, then fissures between the partners could begin to appear.

In economic terms, equitable distribution of the monies pertaining to the HAZ project between the various organisations within different HAZs was also described as challenging. Linked with this, was the uncertainty voiced by several respondents concerning how to apply for money, or how to access HAZ funds. One interviewee from a local authority put this succinctly:

If I was working for the SRB I could have had my funds spent by now because the procedures are there, but with this, the procedures are new

There was a sense that the 'newness' of HAZs meant that procedures for application and access were not well-established, causing uncertainty and a certain level of inertia, which was preventing projects from getting off the ground.

Challenges from the Centre

Interviewees identified a number of barriers and challenges to HAZ working which they attributed to messages from or the expectations of central government. In some cases these challenges were perceived as stemming from changes in related areas of social policy, in other instances they involved messages from Ministers or the Department, and in other cases concerned communication from regional offices.

One frequently mentioned issue was the size and speed of the reform agenda, of which HAZs were just one small part. Many people mentioned the stress which had been caused by the numerous initiatives which they felt had been 'dropped on them'. This meant that they felt pressured on various levels, in terms both of prioritising which initiatives ought to be concentrated upon (for instance, GPs involved with both PCGs and the HAZ) and the time-scale within which people were working. A vivid description of what these multiple initiatives feel like to the people working 'on the ground' is captured in the following terms:

....central government keeps opening a trap door and throwing down another initiative on top of (us).

The concerns also focussed around the demands that these initiatives placed upon a comparatively small number of managers. There was an issue of 'capacity' which a number of interviewees raised, involving concerns that HAZs and other changes were meant to become part of the day to day business of organisations, but that the resources to implement these changes were relatively limited. As a result, staff were at risk of becoming overburdened. In more specific terms, some anxiety was expressed at local levels about the structures which were in place and their ability to encompass the HAZ agenda. The speed of reform and the time-frame in which HAZs were expected to develop and deliver was also described as challenging in terms of organisational capacity. There was a sense that the emphasis upon working to tight deadlines was counter intuitive and slowing people down as well as stifling the creativity within HAZs. The time-scale was also said to cause particular problems by frustrating coherent action:

..I think the time scales throughout have been unhelpful to an inclusive process....there have been various deadlines which come along and things have to proceed very quickly after long gaps of inactivity.

Many people from different HAZs were also concerned that they were failing to receive *clear messages* from central government, or that these were not being disseminated properly. Often, this was attributed to a failure of communication. One respondent said that he felt that communication techniques had become too 'professionalised' and that rather than formal conferences or 'glossy' pamphlets being used, more direct modes of communication might work more effectively (such as telephone calls or letters).

There's been some frustration at various points about region and the centre really not knowing what role they're in.

Closely allied with this obstacle, was the worry that if clarity was not achieved then there was a real danger that the HAZ concept could dissolve into a series of piecemeal projects rather than maintain the coherence which is required.

Another, connected, worry around the lack of clarity from the centre concerned general haziness about freedoms and flexibilities. There was a real sense of frustration that many of the freedoms HAZs had been promised had not materialised, particularly around issues like pooled budgets and Section 28a. Many of those we interviewed reported that they had been asked to specify the freedoms they required on more than one occasion, had spent considerable time and effort justifying their requests, and then had been faced with lengthy delays before any response was received. First wave interviews were taking place at the time when a meeting was eventually held between the HAZs and the Department to clarify a series of issues around freedoms and flexibilities. Despite this, some HAZs more than others felt they were being prevented from making early progress due to the limits of current legislative and other frameworks. As one HAZ lead said; "Any delay on freedoms and flexibilities will, in fact has already, affected the time scale of implementation of our plan."

A number of other challenges concerning the relationship between a central agenda and local efforts were raised by interviewees but have already been addressed in other sections of this report. Many of these related to the tension between the 'bottom-up' nature of HAZs and the 'top-down' pressures from government in terms of accountability and managing the pace of change. This was particularly evident in relation to the need for evidence of 'early wins' which would demonstrate the success of some HAZ initiatives, which numerous interviewees highlighted as potentially at odds with the need for longer term investment. The whole issue of community involvement was also frequently mentioned as a challenge for current and future HAZ development. There was almost universal recognition amongst interviewees that investing in relationships with the voluntary sector and community groups within the HAZ would take time, and could not be delivered in any meaningful way within the time-frame anticipated by central government.

Despite the considerable challenges and obstacles which stakeholders identified, it is important that findings from these first wave interviews be interpreted within the context of general enthusiasm for the concept of Health Action Zones which was communicated to us across the country. The vast majority of people we talked to were excited by the potential for innovation within HAZs, and the opportunity for real learning which they afforded. Interviewees expressed a high level of commitment to the HAZ and real hope for its future contribution to the community health improvement process. The challenge, as one doctor we spoke to described it, was to sustain this optimism over time:

I think it's going to be maintaining the enthusiasm... that's got to be sustained because we're talking here about seven to ten years...and that enthusiasm and drive has got to continue and it's got to come from something which is a project into the mainstream

Summary and Conclusion

In order to begin to address the range of issues raised in first wave HAZs and the variety of perspectives which emerged, it has been necessary to deal in some depth with findings from our interviews with key stakeholders. It is therefore useful to conclude this section of our report with a summary of some of the key messages which emerge from discussions with those working in first wave HAZs across the country. We summarise findings in relation to our interview themes of: goals, strategies and targets; partnerships; and critical next steps and challenges in first wave HAZs.

Goals, Strategies and Targets

Identifying long-term goals for the HAZ was something which interviewees found relatively easy to do. There was a high level of consensus across HAZs in relation to the most commonly stated goals, which related to improving the health of the local population, and the reduction of health inequalities in particular. There was also a strong emphasis on building partnerships and promoting community involvement. We found rather less emphasis on modernising and reshaping health and social services, although this was described as a key aim by some stakeholders. There was widespread acknowledgement of the scale of the ambition represented by the health-related goals in most implementation plans and considerable scepticism regarding how much change could actually be achieved within five to seven years. Different types of stakeholders expressed diverse views about feasibility. Senior managers of statutory organisations, for example, were on the whole more optimistic than community and voluntary sector representatives. Despite the divergence of views, there was some consensus that the intentions expressed in HAZ implementation plans were the right ones, and that progress towards the achievement of some goals, particularly those related to issues such as developing new partnerships, would be made within the lifetime of the HAZ.

Questions about the strategic approaches being adopted in pursuit of high-level goals did not tend to elicit clear or convincing responses. Well-developed strategies linking problems and goal with purposeful interventions and practical milestones or targets were largely conspicuous by their absence. Interviewees were however able to articulate some elements of strategic thinking or specific tactics around the process of partnership working, needs-assessment and priority-setting; seeking early wins in order to maintain the momentum for investments in longer-term change; and establishing links between the HAZ and other initiatives and policies.

Interviewees expressed considerable uncertainty and some resistance to the emphasis placed on the role and importance of targets in the planning process. A number of reasons were given to explain why the issue of targets was problematic. These included: the relatively short time scale for producing plans; the relative absence of evidence about the effectiveness of interventions, and in some instances, a genuine fear about the risk of failure. Interviewees also identified a number of tensions around the issue of target setting; most notably the fact that pressure to produce short-term targets was perceived as inconsistent with taking community involvement seriously. Despite problems, many of those we spoke to accepted that a reasonably sophisticated approach to targets could provide a useful framework for ensuring accountability and promoting learning in HAZs, provided that there was genuine scope for adaptation in the future.

Partnerships

The concept of partnership working is central to HAZ development, but raises a series of complex issues relating to the role of individuals and organisations in the community health improvement process. One of the most striking findings from the interviews related to context - there is a remarkable diversity of existing partnership arrangements, cultures and expectations across the first wave. HAZs really do start

from different places in this respect. In so far as we believe that the variable context of partnership working is of interest in its own right, there is a rich vein of evaluation opportunity in relation to this theme which is waiting to be mined.

One component of partnership working is governance arrangements. In relation to partnership boards in particular, interviews revealed some doubts as to whether the proposed mechanisms would be robust enough to develop and sustain new ways of working. There was general agreement amongst interviewees that it would take time to build real leadership across agencies and organisations. In addition, there was widespread recognition that HAZ partnerships were working within an intricate web of local planning arrangements and that much remained to be done to produce greater synergy between organisations and to make the most of scarce human resources. Interviewees expressed concerns about the capacity of existing structures and organisations, and reported that the process of partnership building was often experienced as a top-down rather than fully inclusive process. We found widespread support for and commitment to a whole systems approach tempered by the recognition that real community involvement is not yet a common experience.

Experience to date in involving the voluntary sector in HAZ development reveals marked differences between areas. A few HAZs seem to have brought the voluntary sector fully into the development process, while others have encountered serious difficulties. In some cases, these difficulties have centred around issues of accountability and representation, including concerns about who should be seen and heard as the legitimate voice of the community. These difficulties are perhaps even more marked in relation to community and user groups. The rhetoric of partnership is not yet matched by reality in relation to these groups. Indeed, given the fundamental inequalities in the distribution of power and resources between the different sectors, the issue of community involvement in partnerships will continue to pose challenges for HAZs.

Critical Next Steps and Challenges

When asked about the next steps required for HAZ development, stakeholders identified six main sets of issues. These included implementation, resources, developing effective partnerships, communication and evaluation. In relation to implementation, there was widespread agreement that tangible progress in the form of practical project development was a top priority, and it was clear that interviewees felt early successes were required to maintain commitment and momentum. In a number of HAZs, it was clear that allocating and organising resources was an immediate priority and an important prerequisite to successful implementation.

Further development of partnership working was also described as a critical next step. Indeed, widening participation to include new partners and deepening the involvement of existing partners was mentioned as a priority almost everywhere. Improved communication between partners and within organisations was a related priority for stakeholders; it was felt that improving communication to front-line staff and middle managers in particular was required if HAZ objectives were to be achieved. In addition, better means of communication with the wider community was described as a priority in some HAZs. A final issue which interviewees described as a critical next

step was evaluation. There is still some uncertainty about local evaluation arrangements that needs to be resolved as quickly as possible. In many HAZs a number of groups are making good progress in thinking about their own evaluation priorities and methods but many people are still looking for clearer guidance about links between performance management and guidance about the intentions of the national evaluation.

A number of issues were identified as challenges and obstacles facing HAZs, the majority of which related directly or indirectly to themes touched on earlier in interviews. Both local factors and factors relating to relationships with central government were mentioned. In some HAZs, initial enthusiasm is being increasingly tempered by realism about the size of the task they face, both in terms of inter-organisational relationships and the deeply entrenched poverty of the communities they aim to assist.

Concerns about the national context within which HAZs operate were described by interviewees as relating to the enormity of the modernisation agenda that is particularly felt in the most disadvantaged areas. Stakeholders in first wave HAZs made frequent references to excessive expectations from the centre, lack of clarity and consistency in messages received from different parts of the NHSE, and failure to deliver promises relating to freedoms and flexibilities. Despite these genuine reservations however, the overwhelming majority of people we spoke to remain genuinely enthusiastic about the potential for health action zones to make a real difference to their communities. The most significant challenge is to find ways of maintaining a clear sense of purpose and to sustain and support the HAZ community in its ongoing development.

Resources And Freedoms

In order to achieve their objectives, Health Action Zones need to develop new ways of working which traverse current organisational boundaries. Their ability to do this will be dependent upon a range of factors, but two of the most crucial are the *resources* available to them, and the extent to which existing barriers to innovation can be tackled through the provision of new *freedoms and flexibilities*. As part of the initial scoping exercise, the national evaluation aimed to collect basic baseline data on HAZ resources and freedoms. Information relating to resources was obtained only in relation to first wave HAZs, in the knowledge that development funds were just beginning to be allocated in second wave Zones at the time of data collection. As the first wave implementation plans did not include detailed finance data in all cases, information relating to resource allocation was collected by means of a separate postal questionnaire. In relation to freedoms and flexibilities, it was possible to extract basic descriptive data relating to which freedoms HAZs were requesting from both first and second wave plans and documents provided by the NHSE

Our analysis of information relating to resources and freedoms is limited to a *basic description of current arrangements* and some emerging issues. We felt it was important to address both themes as part of our scoping exercise, but recognise the limitations of our initial analysis. Research relating to HAZ finance and the economic dimensions of HAZs more broadly will be required in the future, as will a more in-depth examination of freedoms and flexibilities, and their possible implications.

HAZ Resources

The resource component of the scoping exercise concentrated on trying to establish a clear picture of the financial allocations in each first-wave HAZ (by project and programme) for the year 1998/99 and their planned allocations for 1999/00. It sought further to identify budgets from which funding was drawn, e.g. central allocations, Health Authority allocations, specific NHS programmes, external sources and the amounts of these allocations devoted to management costs. Further, information was sought on various aspects of general financial management arrangements and approaches to additional income generation.

Data collection

It was decided by the research team that finance information would be collected from each HAZ by a postal (e-mail) questionnaire. After discussion with national HAZ finance and performance management leads at the NHS Executive, a questionnaire was designed and piloted with three HAZs. The questionnaire was revised in the light of comments received. On 29/30 April 1999 telephone contact was made with all but one of the remaining first wave HAZ sites in order to establish who was best placed to complete the questionnaire and to inform them that a copy would be sent to them by e-mail or fax. A copy of the questionnaire was posted to the final HAZ as contact could not be made by telephone or fax.

Each HAZ was asked to complete the questionnaire as fully as possible - recognising that they would not have full data on all questions - and to provide their returns by 14 May 1999. Four questionnaires (including pilots) were received by that date. During the following week, up to two follow up calls were made to the remaining seven HAZs. By 21 May responses had been received from a further five HAZs, making a total of nine responses from the 11 first wave HAZs. Analysis has been carried out on these responses.

Total HAZ financial allocations for 1998/99 and 1999/00

The total HAZ financial allocations for 1998/99 and 1999/00, as reported in the nine returns received to date, are shown in Table 16:

Table 16 Total HAZ financial allocations for 1998/99 and 1999/00

HAZ	1998/99 (£)	1999/00 (£)
East London, The City & Hackney	527,000	3,189,000
Lambeth, Southwark & Lewisham	706,000	5,400,000
Luton	219,000	1,082,000
North Cumbria	n/a	1,153,000
Northumberland	294,000	4,755,600
Plymouth	n/a	n/a
Sandwell	401,000	2,048,000
South Yorks Coalfields	620,000	3,137,000
Tyne and Wear	906,000	4,780,000

As far as the 1998/99 allocations are concerned, some HAZs provided data on actual expenditures and variances from planned allocations. Where this data were provided, it indicates that underspends were substantial, e.g. Sandwell had an underspend of £115,047 on an allocation of £401,000; South Yorks Coalfields forecast actual expenditure of only £190,000 from a budget of £620,000). Lambeth, Southwark and Lewisham explain that where slippage has occured against planned spending, this money will be ring-fenced for the projects involved and carried forward to future years. This arrangement has been agreed by the health authority with the NHSE London Office.

Most of the HAZs make clear that the allocations for 1999/00 are planned allocations and are subject to revision over time.

Project and programme funding

There was a substantial variation in the level of detail and quality of data on individual project and programme funding provided by the HAZs. Moreover, heterogeneity in the composition of individual HAZ programmes means that their budget reports and expenditure plans comprise diverse categories of expenditure. The absence of a common accounting framework makes comparisons between HAZs programmes almost impossible at this level of analysis. To achieve an accurate picture of comparative HAZ spending on particular programmes, it will be necessary to carry out detailed discussions with HAZ officers responsible for financial management. The situation will improve when HAZs are expected to make quarterly returns showing planned and actual expenditure on a monthly basis for each project, as part of the performance management arrangements. But even then, the sheer diversity of the programmes and their multiple sources of funding will make this a complex task. It is also our understanding that the financial returns for PM purposes will focus on the use of central allocations, and will therefore only provide a partial picture.

As the main purpose of this preliminary report is to map HAZ development over their first year, and resources are not available for more detailed investigation of project spending allocations at this stage, an analysis of project and programme funding has not been attempted here. This will be an issue for subsequent evaluation efforts.

Additional sources of funding

The HAZ approach is based upon a 'multiplier' principle. That is, limited amounts of central government funding are being provided in the expectation that they will generate self-sustaining activity and additional funding from sources other than central HAZ allocations. Central allocations are, in essence, pump-priming investments. For this reason, we asked the HAZs about their plans for generating additional funding.

Most of the HAZs reported that it was still very early in the programme and that their plans for the generation of additional funds were not yet formulated with any precision. Some reported that additional income generation was being approached on a project-by-project basis. Nonetheless, some early trends were discernible.

A number of HAZs were clearly focusing on specific NHS and other public sector sources of funding, e.g. smoking cessation, drug prevention, central funding to support an extension of NHS Direct, SRB projects, local Education Action Zones, the New Opportunities Fund of the National Lottery. These were the most frequently cited potential sources of additional funding.

Four HAZs (North Cumbria, Tyne and Wear, South Yorks Coalfields and Lambeth, Southwark and Lewisham) referred to potential partnerships with the private sector. Lambeth, Southwark and Lewisham referred to "systematic exploration of partnerships with

commercial agencies via Business in the Community" and also mentioned discussions with the Employer's Forum on Disability about drawing private sector resources into their employment programme. South Yorkshire Coalfields reported three all-day meetings with a major private sector company exploring the potential for collaboration. Tyne and Wear reported on assistance in kind from Boots the chemists who have provided pharmacy support in assessing the potential for walk-in clinics and imaginative use of pharmacies.

More ambitious schemes were still at an embryonic stage. For example, Northumberland reported their intention to appoint a funding facilitator to investigate European sources of funding.

Management costs and additional costs attributable to HAZs

We asked about the management costs associated with setting-up and running the HAZ during the first year. Northumberland pointed out that HAZ expenditures have been excluded from the NHSE's definition of management costs. However, taking a broader view, most of the HAZs identify the £100,000 sums allocated to 'development support' as management costs. These are, however, only what are referred to as the *direct* costs; most of the HAZs point out that there have been other categories of additional management costs.

Predictably the HAZs have found it difficult to provide precise quantitative estimates of these additional costs – incurred in terms of time and resources – devoted to HAZ development. However, the fact that many of them have chosen to explain the nature of their extra commitments in some detail suggests that this aspect of their early work has been important to them. The comments from the South Yorkshire Coalfields HAZ are indicative of the general line of response:

"The process of developing the HAZ programmes has demanded a huge time commitment from a large number of very senior people. This is impossible to quantify, but to give you an idea of the scale, the list below is of memberships of formal meetings in HAZ structure – Executive Board has bee meeting 6 weekly for 1-2 hours; Co-ordinating Group has been meeting 3 weekly for 2-3 hours; Strategic Advisory Board has met twice for 4 hours. In addition, there have been Programme Area Steering groups, Stakeholder Conferences, two all-systems HAZWorks events, 3 local HimP/HAZ Steering Groups....."

Another rather different perspective on the additional costs is provided by the Plymouth HAZ:

"There has been a major time and cost resource committed by us and partners in trekking up and down to London, Leeds, Grantham and York for HAZ events, far more than any of us have ever been to before".

None of the above is really surprising. HAZ development involves complex partnership working and can be expected to generate considerable extra management (or governance) costs. From an evaluative point of view, these costs need to be considered in relation to the benefits generating by the HAZ programmes. The difficuly in quantifying these costs does, however, suggest that any serious attempt at their measurement will need to develop a bottom-up approach to costing, possibly through the use of time diaries or similar instruments.

Efficiency savings

One of our initial hypotheses was that HAZs could be expected to generate efficiency savings as a result of, *inter alia*, developing common support systems, achieving reductions in the duplication of services and adopting common budgetary frameworks. In view of this, we asked each HAZ if they expected any efficiency savings to materialise from the HAZ and, if so, to explain their nature and their expected scale.

The prevailing response was that some efficiency savings were to be expected, but that it was far too soon to estimate their size. Lambeth, Southwark and Lewisham said that expected savings were not yet quantifiable, but that evaluations will include an assessment of the potential benefits of new ways of working. South Yorkshire Coalfields reported a range of service reviews but said that it was too early to anticipate the level of savings. Plymouth suggested that additional expenditures might be incurred in the short-run, as common systems were put in place, and that they could not anticipate the level of savings.

The only HAZ to be specific about efficiency savings was Tyne and Wear. They reported efficiency savings through " £5.5m primary care prescribing costs unlocked in Year1 (recurring)". They also reported that primary care counter fraud measures have been consolidated across Tyne and Wear, with anticipated savings, and that savings were expected through joint purchasing.

Northumberland reported that they did not expect to make any efficiency savings in the traditional NHS sense of the term. Rather they were aiming to increase the *effectiveness* of spending by targeting it better on identified needs and by being more responsive to the public's needs as part of the overall aim of improving health.

Financial management and accountability

The inter-agency partnership working upon which the HAZ approach is based clearly involves new lines of management and accountability. Most HAZs seem to be well advanced in setting up the systems necesary to cope with these new responsibilities. Typically, a multi-agency partnership board has been formed with the responsibility for formulating plans and monitoring expenditure. Formally, HAZ financial accounting arrangements are included within the overall accounting arrangements of the health authority which remains formally accountable for the use of HAZ funds.

The NHSE has produced its *Health Action Zones: Development and Performance Management Framework* that will require HAZs to submit quarterly financial returns to the RO lead on the use of national funds. Clearly, this will be the main instrument of financial management at the national level. Future economic evaluation efforts will need to link in with the NHSE framework, as we suggest in the final section of this report.

Freedoms and Flexibilities

A review of first and second wave implementation plans reveals considerable variation in terms of the number and scope of additional freedoms HAZs wish to exploit. Four Zones do not specify explicitly what new freedoms are requested (Bradford, Manchester, Salford and Trafford, North Cumbria and Leeds). In contrast, Tyne and Wear, East London and City and Leicester City each specify over 20 new freedoms that they would like to acquire. The following account does not seek to provide a comprehensive listing of all the new freedoms listed in each HAZ programme; rather it seeks to summarise some of the main areas in which these additional freedoms are requested across the national programme.

New budgetary freedoms

Twelve HAZs request the ability to *pool budgets* between the health authorities and local authorities. Bury and Rochdale and Wakefield specifically request freedom to transfer resourcs between capital and revenue budgets. Apart from the general advantages this is seen as providing for integrated planning. Specific reference is made to pooled budgets for education and training purposes. The ability to move savings from one agency to another is also seen as important.

Ten HAZs (Three 1st wave and seven 2nd wave HAZs) have requested the ability to *carry forward income* so that they can plan expenditures over a three-year period rather than being restricted to the annual planning cycle. Bury and Rochdale would like this freedom to apply to all partner agencies. This is seen as being consistent with the three-year national settlement arising from the Comprehensive Spending Review.

The opportunity to use funds more flexibly, and benefit from *additional resources* as result of health action zone status, has been requested in a number of zones. Camden, Wakefield, Hull and East Riding HAZs request more flexibility to develop investment partnerships with the private sector, especially for capital projects. Three other HAZs want greater flexibility to match funding; one example is Sheffield and Merseyside, who want to use HAZ and NHS cash to match fund bids for European Structural funds. HAZs also want to explore the opportunities for generating funds (e.g. innovations fund).

Seven second wave HAZs requested a range of *tax and benefit freedoms*. A number of these freedoms aim to enable a smoother transition for people to move from benefits into work, particularly in relation to incapacity benefit, or as an incentive for training (Tees, North Staffordshire, Sheffield). Two HAZs mention flexibilities in housing benefits; Cornwall intend to set aside benefit restrictions to allow people with special needs easier access to rented accommodation; Sheffield want freedom from housing benefit regulations to allow street drinkers to go into hostel accommodation whilst still maintaining their own tenancies. The freedom to pay users and members of the public for community involvement work was a freedom requested by four of the HAZs (Leicester City, Wakefield, Walsall and East London and City). There was a concern that this compensation for HAZ work should not prejudice benefit entitlement or represent perverse tax incentives.

This summary of budgetary freedoms is not exhaustive. There are a number of other specific examples in the HAZ implementation plans, such as allowing local organisations greater freedom from individual audit requirements as long as the local NHS remains in balance (Bury and Rochdale, Tyne and Wear), and a request for the relaxation of GMS regulations in order to allow payment to GPs for extra work in relation to HAZ (South Yorkshire Coalfields, Leicester City).

Joint working

The governments emphasis on partnership working is reflected in a number of requests related to improved joint working. Six HAZs (Sandwell, Bury and Rochdale, Leicester City, Walsall, North Staffordshire) want to harmonise HA and LA strategic planning cycles to suit local partnership approaches and a further five HAZs are keen for early testing of the flexibilities of Partnership In Action, across health and social care boundaries (Brent, Wolverhampton, Merseyside, Wakefield, Cornwall and Scilly).

Four HAZs request the flexibility to *coordinate planning and reporting between initiatives*; Bradford wants to link the HAZ programme with various employment initiatives; Walsall want better planning between SRB, HImP, crime reduction strategy and Drug Action Teams' plans; Leicester request common outcome monitoring for government priorities and future regeneration programmes. Tyne and Wear want to allow Health partnerships to act as JCCs, or to remove the requirement for JCCs to approve section 28(a) payments. East London and City also wish to explore new flexibilities around the role of the JCC, while Leicester City and South Yorkshire Coalfields request that section 28(a) payments to be given directly to individuals in order to purchase care.

Primary care

A variety of new freedoms are requested in relation to primary care. Brent and East London and City HAZs request the extension of LIZ freedoms in connection with the *development of premises* and other initiatives. East London and City, along with Wakefield, also wants GPs to be free to form consortia among themselves and with others such as Housing Associations, in order to undertake primary care property developments. Sandwell requests the extension of LIZ freedoms for its own primary care capital programme. Other requests around primary care premises focus on freedoms for health authorities to take leasehold interest in GP premises (Walsall, Camden). Sheffield list a range of freedoms around GP list requirements which would enable additional reimbursements to be made covering the delivery of primary care to vulnerable groups (e.g. shadow lists for unregistered patients).

Six of the health action zones request greater freedom in *prescribing* and managing medicines. In Plymouth, Merseyside and Hull these flexibilities relate to an enhanced role for community pharmacists, whereas Wakefield and Walsall want freedom to give nurses and health visitors prescribing responsibilities and greater scope for giving advice to vulnerable groups. Cornwall requests freedom to remove perverse incentives which influence prescribing choice for dispensing doctors, by guaranteeing a dispensing income. Staff development flexibilities, mainly for nurses, are requested by Nottingham and Wolverhampton.

HAZs list a number of other specific requests in relation to primary care. For example, Bury and Rochdale wish to expand existing smoking cessation strategies by allowing the provision of free nicotine replacement therapy beyond one week, while Plymouth request flexibility in the use of funding to develop dental services. Along with other examples, some HAZs make specific reference to PCGs in relation to freedoms and flexibilities. Specifically, flexibility over the ways in which PCGs are established is also requested by three first wave HAZs. Sandwell request that their PCGs reflect natural communities and not to be restricted to populations of 100,000 people. They report considerable friction arising from the denial of this request and mention how this has been resolved for the meantime by setting up three sub-PCGs. Tyne and Wear request exemption from central guidance on PCG membership. Northumberland also request freedom over the role and membership of PCGs.

Freedoms related to housing

Some specific freedoms in relation to housing are raised. Sandwell and Wakefield wish to use housing *capital receipts for housing repairs* as part of the Social Enterprise Scheme. Sandwell also wishes to develop an equity release scheme in order to fund health-related, housing repairs and improvements. South Yorkshire Coalfields also wishes to undertake housing improvements from housing capital receipts. In addition, it wants to amend building regulations so that all homes in the HAZ are built to a standard that will enable design

changes in the event of the owner becoming disabled. Wakefield wishes to cap negative housing subsidy and Leicester requests freedom to undertake low cost home repairs for elderly owner occupiers.

Other requests

Both the 11 first-wave and 15 second wave HAZs have submitted some highly specific requests for additional local freedoms. A number relate to the need for early development in HAZs of reforms which will shortly become more mainstream, such as the development of shared information systems across agencies. A number of requests however, are highly individual to specific HAZs and reflect local needs. Selected examples include:

▪ Sandwell has requested an annual meeting with the minister throughout the life of the HAZ. It also wishes to authorise the planning authority to require new nursing home applications to include a statement of need.

▪ Tyne and Wear wishes to allow the local authority to ban tobacco advertising ahead of the 2005 target date and to allow the local NHS to enter into specific discounting deals with pharmaceutical companies independently of the PPRS.

▪ South Yorkshire Coalfields wishes to grant the LEA power to introduce health education as a core curriculum subject, and Hull and East Riding want to influence sex education policies in schools.

▪ Cornwall hope to explore the potential for schools to pool resources with statutory agencies to cement new partnerships between support staff in special schools and specialist NHS staff who care for many of the pupils.

Future freedoms and flexibilities

As findings from our interviews in first wave HAZs illustrate, there has been some confusion and frustration around the granting of requested freedoms in the initial stages of HAZ development. However, some freedoms have been agreed. For example, the Department of Health (press release 20/1/99) have announced their intention to introduce more flexible arrangements for developing *primary care premises* in HAZs which include;

• Allowing Health Authorities to acquire joint venture freehold interest in land intended for private sector premises development;
• Applying a deprivation or needs factor to current market rent ;

A number of policy themes are currently being explored by the NHSE for freedoms and flexibilities in Health Action Zones and the LGA New Commitment to Regeneration. Although these proposals appear to be at an early stage of development, likely priority areas for freedoms include;

- partnership flexibilities including pooling of resources and longer term budget allocations;
- joined-up planning to streamline management information and other administrative burden;
- the use of benefits.

New and augmented finances, freedoms and flexibilities are the principle means available to HAZs to support innovative ways of responding to the health needs of their local populations. How these will be used to best effect remains uncertain. But it is clear that the national evaluation ought to pay close attention to how these new opportunities are exploited. The HAZ performance management arrangements have a particular interest in this issue and we will be exploring ways in which we can use that process to inform our understanding of developments in this area.

FUTURE RESEARCH PLANS

The most cursory review of health action zones cannot avoid the conclusion that they are complex partnership entities with huge ambitions that are seeking to achieve significant social change. Evaluating the HAZ initiative and learning from it therefore poses very substantial challenges. We relish the prospect of responding to this challenge. But we very strongly believe that it will only be possible to generate effective learning from the HAZ initiative if scarce evaluation resources are focused in a purposeful way. Across the 26 health action zones, we have identified in excess of 200 distinct programmes and almost 2,000 discrete activities. When this level of complexity is combined with very real constraints on the availability of research resources, it will be impossible for all potentially valuable investments to be monitored, let alone evaluated. Choices will have to be made. The Department of Health has the key responsibility for making these choices but its decisions should be informed and guided by the views of members of the wider HAZ community. The main purpose of this section of the report is to make recommendations and suggestions about what the priorities should be.

We begin by outlining a conceptual framework for thinking about health action zones. Using this framework as a guide we then identify key research questions for each of the building blocks that are integral to the conceptual approach that we advocate. This is a critical part of our approach. At this stage it seems likely that debate and discussion about the broad thrust of our proposed approach will be more valuable to the Department of Health than very detailed comments on particular aspects of our proposals. However, we are particularly keen to elicit views about alternative or modified ways of conceptualising health action zones and to identify critical research questions that we may have omitted.

Until some key decisions have been taken about the longer term direction of the national evaluation and the resources that will be made available it seems inappropriate to develop very detailed research plans for all aspects of the conceptual framework that we outline. However, it does seem essential to set out certain key assumptions that guide our thinking. Beyond that, we have an existing contractual obligation to conduct the first phase of the national evaluation of health action zones between now and the end of the year 2000. We set out in more detail how we plan to use our existing resources to fulfil this requirement. Finally, we conclude by highlighting the key questions that we want the HAZ community to comment on and the Department of Health to decide about at the earliest opportunity.

The General Approach

The general approach that we want to adopt is set out in the form of a conceptual framework, a set of key research questions, and a number of critical assumptions.
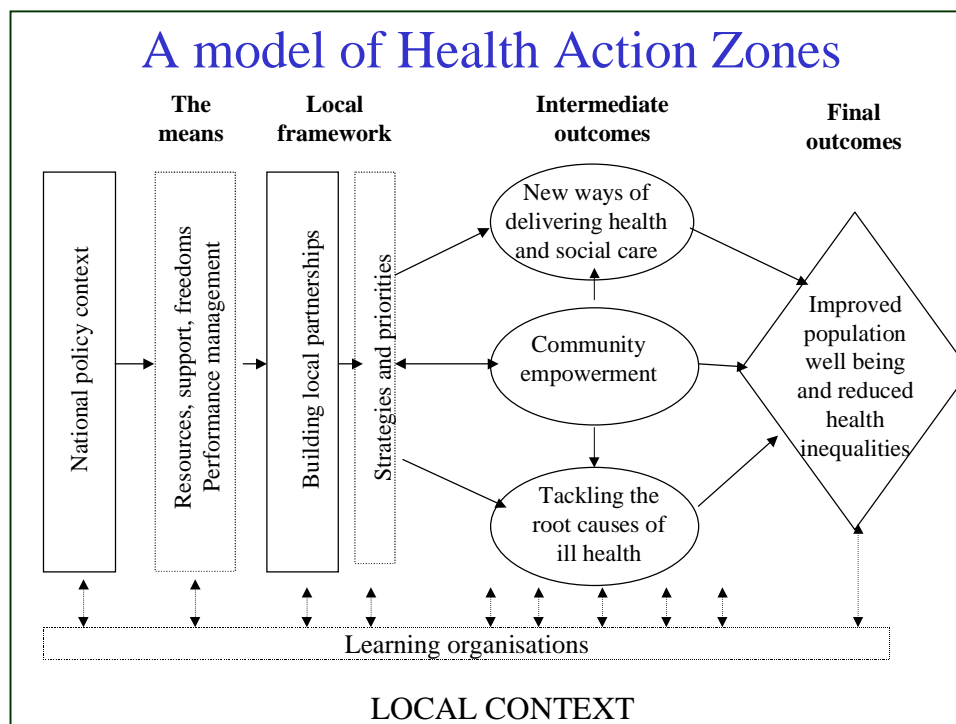
Conceptual framework

Figure 3

Figure 3 illustrates the complex relationship between the different components of the HAZ. It represents the interaction between the partnership process, intermediate goals and final outcomes. How HAZs are addressing and developing each of these has been described in detail in the scoping section above. Here we simply wish to illustrate how they all fit together, and use this framework as a guide for setting out what we identify as the key research questions in the next section.

The model of Health Action Zones begins with the *national policy context* in which HAZs are being established and implemented. More specifically, it highlights the some particular policy incentives and levers available to HAZs. These are **the means** by which HAZs operate. They constitute a range of opportunities, in terms of the *resources, freedoms and support* that are open to HAZs, but also with some associated obligations, most clearly articulated in the *performance management* framework. Within the bounds of these two policy envelopes, local HAZs have considerable autonomy to develop and implement their plans.

Underpinning the whole HAZ enterprise is the **local context** of each Health Action Zone. The economic, social, political, cultural and spatial environments within which HAZs operate create both opportunities and barriers for their developments. Examples might include: the characteristics and capacity of their local communities; the physical features of their neighbourhoods; the existing infrastructures and agency relationships; the politics of local organisations and historical links or tensions; the existence of other strategic partnership initatives; and the enthusiasm and skills of individual players in the local health and social care economy.

Against this background, each HAZ creates its own **local framework** within which it develops its community health improvement process. This has two key foundations: the *partnership* relationships and the *strategy and priorities* that are developed to achieve their goals. The way in which partnerships are formed and work together to assess their needs, develop their strategies and deliver their services is fundamental to the success of the HAZ initiative. The partners must agree their aims and objectives, consult regarding the means to achieve these objectives, and make decisions regarding the structures involved. Crucially, they must decide on an appropriate balance between the different mechanisms/intermediate outcomes they pursue to achieve their goals. As discussed elsewhere, having a transparent rationale for the choice of specific investments, which is underpinned by clear theories of change concerning how the interventions will achieve final outcomes, is fundamental to the success of the community health improvement process.

The **intermediate outcomes** component of the conceptual framework involves a variety of developments that are focused around three main themes: *new ways of delivering health and social care*; *community empowerment*; and, *tackling the root causes of ill health*. These outcomes are goals in their own right, since they constitute the results of the process (i.e. that services were put in place or groups formed). However, they also represent the means of attaining the **final outcomes**, which are improved population health and well being, and a reduction in health inequalities for the people of each HAZ.

The final element of the conceptual framework is the role of HAZs as *learning organisations*. The Government has established HAZs as trailblazers, and placed a strong requirement on them to evaluate what they do, and learn from their actions. Not only are HAZs expected to improve the community health improvement process in their own areas, but also to generate learning that can inform national policy development. It is crucial that the national evaluators work with local HAZs to facilitate such a learning and development process in the ways outlined elsewhere in this report.

Key research questions

The evaluation approach that we have argued is necessary requires more than a simple measurement of outcomes. In order to understand not only *whether* HAZ objectives are achieved, but also *how* they are achieved or *why* they are not, it is necessary to pose a series of evaluation questions. These should reflect the various contexts within which the initiatives are operating and the assumptions or hypotheses underpinning the national and local change strategies proposed. Based on our collective experience to date, we have identified a number

of key research questions that are associated with the different elements of the revised conceptual framework outlined in the previous section. We suggest that these should provide a framework within which the next stage of the national evaluation should be conducted.

The questions are not meant to be exhaustive. However, they are intended to cover what we perceive to be the issues of central importance in relation to:

- the national policy context within which HAZs are expected to operate;
- the opportunities and obligations made available to them in the form of means
- the local contextual framework within which partnerships and learning organisations can be developed;
- the intermediate objectives of modernising services, promoting community involvement and tackling the root causes of ill health; and,
- the primary outcomes of interest to citizens and policymakers - better population health and well being especially for the worst off.

National policy context

- How consistent, clear and feasible are policy messages, guidance and advice from the DH/NHSE to health action zones? In particular, are policy messages in respect of HAZs consistent with the overall direction of health policy?
- How well integrated with other central government initiatives (such as SRB, New Deal for Communities, Education Action Zones, Sure Start etc.) is HAZ policy?
- To what extent have central-local relations changed in ways that encourage or inhibit innovation and risk-taking at the local level?
- Is there any evidence that national policy learning benefits from local experience with HAZs?

The Means: opportunities and obligations

- Has an appropriate balance been struck by the DH/NHSE in offering finance, flexibility and freedoms to HAZs in return for quite tight performance management of detailed implementation plans?
- What mix and level of freedoms, flexibilities and resources are necessary to support and sustain local partnership working?
- What level and type of performance management is required to satisfy national and local stakeholders that HAZ objectives are being pursued?
- In what circumstances do specific freedoms and flexibilities make the most effective contribution to achieving HAZ objectives?
- To what extent has new finance facilitated positive changes in terms of leveraging extra resources, removing blockages to innovation or reshaping mainstream services?

The Local Framework

- Which baseline characteristics of the local environment – such as economic and social conditions, political culture, history of interagency working - have greatest significance in terms of helping or hindering HAZ development?
- What are the most distinctive aspects of partnership working that best facilitate local policy, strategy and practice development?
- What are the most effective ways of ensuring that HAZ partnerships are integrated within other wider local partnership processes?
- What are the relative costs and benefits of partnership working?
- To what extent do all the 'partners' within the HAZ feel able to influence the development and implementation of HAZ strategy?

Learning organisations

- In what ways do different styles of learning within and between organisations contribute to the community health improvement process?
- What different approaches are adopted by HAZs to the management, monitoring and evaluation of interventions, activities and processes?
- What different approaches are adopted by HAZs to promote policy and practice learning by local stakeholders?
- To what extent can different styles of learning organisation across the HAZ community be identified?

Intermediate Outcomes, Strategies and Domains

- What variations can be observed in the general strategic direction of HAZ programmes?
- To what extent and how are local stakeholders able to articulate a clear rationale for the strategies adopted by HAZs and to specify the expected consequences of the investments they make?
- What evidence is there that different strategies are capable of sustaining momentum and building the capacity for enduring change?

Reshaping the health and social care system

- What similarities and differences in approach to the modernisation of the health and social care system are being adopted by HAZs?
- To what extent have HAZs promoted the development of closer relationships between health and social care agencies in ways that yield better services for users?
- In what ways are health and social care interventions seen as an effective means of achieving desired changes in population health and well being?

Promoting Community Involvement

- What strategies are being developed by HAZs to promote community involvement to achieve increased accountability, improved health, more sensitive services, more cohesive communities and to enhance reciprocal learning?
- What is the impact of community involvement on the achievement of process objectives and substantive goals?
- Can HAZs create the conditions within which community involvement becomes genuinely empowering?

Tackling the root causes of ill health

- What similarities and differences in approach are being adopted by HAZs to tackle the root causes of ill health?
- In what ways and over what period of time do key stakeholders expect HAZ activities to achieve desired improvements in population health outcomes?
- In what ways do HAZs try to place health issues on to the policy agendas of other agencies?
- What level of success do HAZs achieve in influencing changes in health-related policies and practices that lie outside the traditional health and social care system?

Population health and well-being

- What baseline indicators can be identified or developed to describe variations in the health and well being of local HAZ populations?
- To what extent can changes be observed in these indicators during the lifetime of the HAZs?
- To what extent can changes in outcomes of primary interest to stakeholders be attributed to specific aspects of HAZs?
- What is the impact of each of the key building blocks of HAZs (as illustrated in the conceptual framework we have adopted) on key goals and outcomes?
- What are the implications for future policy and practice development of a comparative analysis of context-mechanism-outcome configurations across HAZs?
- What contribution has the HAZ initiative made to the national policy goals of modernising health and social services and reducing health inequalities?

In practice, a number of these questions might be addressed in the context of an individual sub-project. Conversely more than one sub-project may address the same questions by focusing on specific aspects of HAZ activity. For example, projects might be designed around particular population sub-groups that are the focus of attention in a high proportion of HAZs. Thus projects might focus on HAZ strategies for improving the health of children and young people, and those focusing on mental health issues. These projects could address:

- the effectiveness of strategies for engaging young people and people living with mental health problems in HAZ governance structures (accountability),
- the extent to which strategies have led to closer relationships between health and social care providers and better services as experienced by users, and
- (in the case of mental health) the extent to which the flexibility of approach local actors are seeking is consistent with the National Service Framework for mental health services, and , in the case of children, how the need for flexibility might relate to 'quality products'.

These are presented as examples only of the way in which research questions might be addressed in specific projects. It may also be useful to consider some comparative projects which enabled comparison to be made between HAZ and non-HAZ initiatives to achieve similar objectives - particularly in the context of initiatives likely to result from the publication of the White Paper *Our Healthier Nation*.

Critical Assumptions

We believe that the research questions we have identified could be approached in a wide variety of ways. Indeed, multiple research methods will be required to address many of them. However, it seems premature to set out detailed research protocols at this stage. We need further guidance from the Department of Health about its perception of the main priorities and an indication of the resources likely to be available to pursue them. For the moment, we simply want to outline our general thinking about how the national evaluation should be conducted. In particular, there are four critical assumptions that lie at the heart of our thinking.

The first is that there should be a dual role for evaluators involved in complex and evolving initiatives such as health action zones that places as much emphasis on development – at least in the early stages – as it does on research. Secondly, we believe that although multiple research methods are highly desirable and will be employed, a central overarching conceptual strand to the evaluation is needed. We propose that a distinctive blend of lessons learned from realistic evaluation and the theories of change approach have much to commend them. Thirdly, we are convinced that a strong commitment to dissemination has to be built into the whole evaluation endeavour from the outset. Opportunities for learning from health action zones must not be missed. We do not elaborate on this point here but we do want to highlight the fact that we want to have the encouragement and the capacity to distil learning and to produce regular reports in various media throughout the lifetime of the HAZ initiative. Finally, to adopt these three approaches in combination will require more resources than we presently have. It is important to signal very clearly that we are highly constrained at present in our ability to make an effective contribution. We think that it is important to give some realistic indication of what is required.

A Dual Approach

As we described at the beginning of this report, one key component of the methodological assumptions underpinning our research is the recognition that the evaluation of Health Action Zones requires a *dual approach*. Evaluation in the context of HAZs is not limited to an assessment of processes and outcomes and a communication of findings. It is also an exercise in assisting stakeholders to structure their own activities in ways that promotes

investment in learning over the longer-term. In other words, evaluation in this context is about *development* as much as it is about monitoring and assessment. Recognition of this dual role for evaluators is central to understanding our proposals for future research.

In arguing that the evaluation of Health Action Zones must include a developmental component as well as an assessment of processes and outcomes, we are again assisted by the experience of those who have applied a theory of change approach to the evaluation of complex community initiatives (CCIs). The Aspen Institute volume *Voices from the Field* offers this description of the changing role of evaluators in CCIs:

One activity that appears to characterise the task of the CCI evaluator is to assist the various initiative stakeholders to gain clarity on the overall vision or 'theory of change' of the effort: that is, on long-term outcomes and the strategies that are intended to produce them. The evaluator...can then help an otherwise under-specified initiative to identify the interim outcomes or markers of progress that correspond, at least theoretically, to those longer-term outcomes. Once these steps occur, a review of measures can be undertaken by the evaluator in collaboration with the community and the funder. These activities clearly depart from the evaluators traditional role and place evaluators in the midst of process-product and inside-outside tensions. For example, evaluators often find themselves playing a quasi-technical assistance role that includes strategic planning, information referral, project reporting, and public relations (Aspen Institute, 1997, pp. 71-2).

Thus as the experience of theories of change evaluations suggests, the dual approach requires that evaluators engage with some of the fundamental tensions which exist in complex initiatives such as HAZs. The first of these is a product-process tension, mentioned elsewhere in this report and relating to the need for HAZs to think strategically in order to achieve early successes as well as long term change. *Evaluators need to be engaged in development with HAZs to help them balance this product/process tension.* The second tension is referred to as an 'inside-outside' tension, and involves issues of power, authority and relationships. HAZs are meant to be locally driven and owned initiatives to transform disadvantaged communities and yet they are financed, guided supported and evaluated by actors and institutions from outside the community. *Evaluators have to balance some of these inside-outside tensions by conducting the evaluation in partnership with local people and external organisations, as well as making the findings from their efforts available and meaningful to those inside and outside the HAZ.*

In order to illustrate how proposals for future research efforts will be shaped by this dual approach to evaluation, we briefly outline here our key assumptions regarding the role of evaluators in balancing both inside/outside and product/process tensions.

Inside andOutside Perspectives

Given the range of individuals and organisations involved in HAZs, there are a number of tensions both within and outside the HAZ that the national evaluation will need to   recognise

and engage with if findings from our research are to be useful and meaningful. We have highlighted many of these emerging tensions in previous sections of this report. The fact that HAZs involve such a diverse set of relationships means that the national evaluation team will need to conduct future research *in partnership* with local people and organisations, as well as with regional and national organisations.

The type of research we propose to engage in both for the remainder of our existing contract and in our proposals for longer-term projects, will involve regular and consistent contact with local stakeholders working within Health Action Zones. This will include contact with stakeholders as participants in our studies (particularly with reference to our proposals for further studies around community involvement, which we outline below) as well as a key audience for our research findings. In addition to regular contact with those within HAZs, there are a number of other key actors with whom we need to establish and maintain regular links as we conduct our research. These include:

- The NHSE, both centrally and in the regions
- The Department of Health
- Local evaluators
- Those conducting complementary evaluations

We believe that we have already made good progress in establishing these links, but that they will need to be sustained and expanded in future evaluation efforts. Some early examples of the type of linking activities we aim to engage in are:

- Conducting regular regional research and development workshops for HAZs, in partnership with the HAZ Development Officer
- Establishing links with regional office leads in order to make the most effective use of performance management arrangements
- Co-ordinating workshops to support projects established under the HAZ innovations fund
- Making effective use of existing mutual support mechanisms within HAZ communities to engage in action research which will be of immediate use and relevance to local people

In order to build strong links with stakeholders within and outside HAZs, regular dissemination of research plans and findings will be required. We expect to have other opportunities to discuss with our sponsors in the Department of Health how best to ensure that the continual process of learning that will emerge from HAZs is disseminated as effectively as possible. In the meantime, we would like to extend the process of sharing learning that has already taken place by making the fullest possible use of electronic networks, publications, conferences and seminars.

Process vs. Product

Creating the capacity for change in HAZs requires a substantial investment in people, institutions and services. Such investment usually takes many years to produce tangible results. At the same time however, stakeholders are aware of the need to provide evidence of success as quickly as possible. HAZs need to demonstrate to people both within and outside the HAZ that initatives are yielding results, in order to maintain enthusiasm and the faith of funding organisations. In our first wave interviews, this tension between balancing 'early wins' and investment in long-term change was clearly expressed by local people.

In adopting a theories of change/realistic evaluation approach, the national evaluation team has argued that linking the challenges faced by communities with the long-term improvements in health they wish to achieve requires a systematic approach to planning. This approach involves clearly specifying the rationale or strategy for intervening, selecting the appropriate form of intervention and then being able to demonstrate outcomes from these interventions both in terms of expected consequences (specified in advance) and strategic goals. In order to develop and maintain this planning framework, stakeholders require developmental support not only from regional and central organisations, but also from evaluators. Part of the investment in HAZs as learning organisations must link strategic approaches to planning with evaluation efforts.

From a developmental point of view, the national evaluation team has already had the opportunity to provide some support to HAZs around target-setting. As a result of our involvement in this aspect of HAZ planning, as well as from the findings of our scoping exercise, it has become increasingly clear that continued work is necessary in this area. However, work on targets needs to be located in the broader community development process, particularly with reference to strategy development. We see an expanded role for the national evaluation in strengthening and refining the overall strategic development of HAZs; a theme we now turn to in further explaining our future approach to evaluation.

A Unifying Theme

Any reasonably comprehensive approach to the national evaluation of health action zones will have to address many different questions even if they are not exactly the ones that we have suggested. These questions will almost certainly require many different research methods and approaches. For example, we see a role for action research, participant observation, documentary review, statistical analyses, cost-effectiveness studies, numerous qualitative approaches, tracer studies and many other forms of enquiry. Nevertheless, we believe that there is particular merit in adopting an overarching or unifying approach or theme to guide the research. In this respect we have found it useful to have in mind a model of the community health improvement process from which theories of change can be elicited.

For example, on the basis of the developmental work that we have been engaged in to date, we have concluded that HAZ targets and milestones should be regarded as an integral part of a community health improvement process:

- That begins with *stakeholder ownership* of a needs assessment and priority setting process
- And perceives targets as the *expected consequences* within specified timescales
- Of *purposeful investments* in processes, activities and interventions
- Directed at achieving *strategic goals*
- Which may require *achieving synergy* arising from multiple interventions.

The approach we are adopting was introduced and illustrated at the beginning of this report (see Figure 1). It is based on studies of realistic evaluation in the UK and a 'theory of change' approach well-established in the USA. The starting point for our conceptual thinking about how targets fit into a community health improvement process is the context within which initiatives operate – the resources available in the communities and the challenges that they face. The first step is to specify a rationale for intervening in relation to priority issues. This strategy should be translatable into clearly defined change mechanisms – what we call purposeful investments in activities, interventions and processes. The challenge is to specify targets for each of these investments that satisfy two requirements. First, they should be articulated *in advance* as the expected consequences of actions. Second, these actions and their associated milestones or targets should form part of a logical pathway that leads in the direction of strategic goals or outcomes.

During the course of our initial scoping exercise, and as we have had more opportunities to work with individual health action zones, we have sharpened our thinking about how we might develop practical ideas about using the theory of change approach with HAZs. One of the main features of the approach is that it involves persuading stakeholders to articulate what are often uncertain and implicit notions about what they want to do and what might flow from the actions they choose. But different stakeholders have different views and so these have to be reconciled before a shared theory of change can emerge. Facilitating and encouraging stakeholders to engage in this process of articulation and negotiation is a time consuming business. It is inconceivable that it could be consistently applied across all HAZ activities. However, we believe that there is merit in seeking to apply the approach to key parts of the community health improvement process on a selective basis. We want to suggest three ways in which this might be done.

Figure 4 presents a simplified picture of the logical pathways that underpin the existing HAZ planning process. HAZ plans tend to start with a vision statement that highlights its primary goals. This is then often translated into a set of strategic objectives, which in turn yield programmes or workstreams and activities usually in the form of projects We argue that these should generate targets in the form of expected consequences. But whatever the precise form in which targets are specified, all HAZs are in the business of trying to achieve desired outcomes from early wins to long-term sustainable changes. We believe that such a model of the planning process offers three opportunities for developing a theory of change approach that will provide a unifying framework for much of the national evaluation.

Figure 4

From Vision to Outcomes: Eliciting Theories of Change
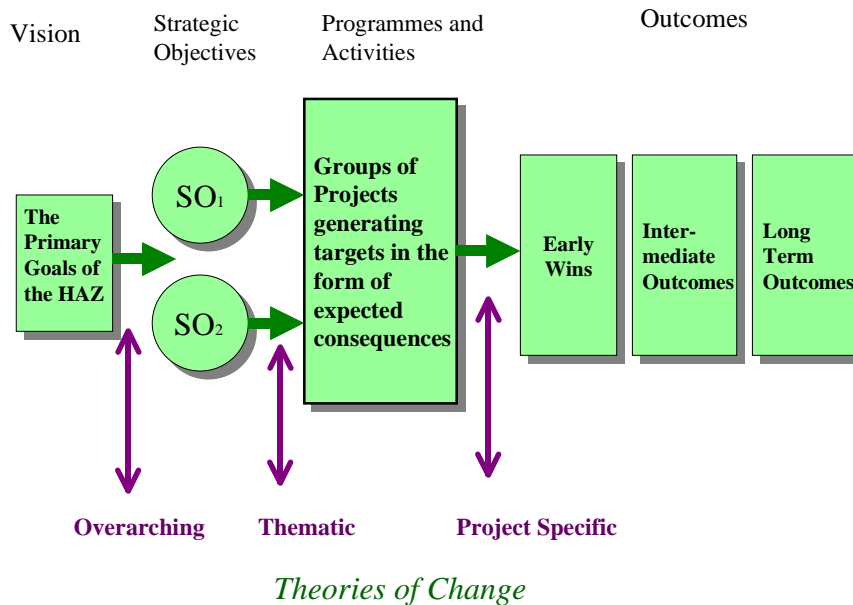
Theories of Change

First, a project specific approach to theories of change might work with selected projects to develop and refine over time the clearest possible ideas about the expected consequences of selected courses of action. The best opportunity for working in this way might be with projects that are supported by the HAZ Innovations Fund. These projects will be expected to have substantial local evaluation effort invested in them and to be designed in ways that lend themselves to the theory of change approach. We would like to have the opportunity to support and co-ordinate these efforts.

Secondly, we think that there is an opportunity for adopting a thematic approach to the use of the theory of change concept. Here the unit of analysis would be selected strategic objectives that a number of HAZs have in common such as tackling health inequalities or promoting community involvement. Here the idea is to identify and recruit a number of HAZ leaders to participate in a collective process of thinking through the rationales for different forms of interventions in relation to common problems. We would then aim to develop joint data collection instruments for monitoring the degree to which expected consequences of investments materialise. A couple of illustrations of how this idea might be taken forward in a modest way are set out in the next section.

Finally, we think that there is real scope for adapting the theory of change approach to work in a very strategic way with HAZ Partnership Boards. We would like the opportunity to persuade some health action zones to invite us to work with them to clarify high-level strategies and plans. The aim would be to find effective ways of monitoring performance and revising plans as evidence becomes available about what does and does not work in different kinds of settings.

Resources

To address at least some of the key research questions in each of the conceptual boxes that we have identified, and especially to do so with adequate reference to the development, unifying and dissemination functions that we have emphasised, will require more research resources than are currently invested in the national evaluation. Within the existing brief for phase 1 of the national evaluation we have been able to create a multidisciplinary team consisting of 8 researchers but most of these are able to contribute only a small proportion of their time to the HAZ evaluation. In fact, we are only able to call on 3.5 whole time equivalent researchers. Given the scale of the HAZ initiative this is in our view completely inadequate. We acknowledge that hard choices have to be made about the nature of the investment that might be appropriate for the national evaluation of HAZs. But an essential starting point would be agreement about a sensible budget constraint. We believe that a sum of 0.5% of the annual general investment in HAZs would be a good target. In 2000/2001 the total amount of general finance available to HAZs is expected to be close to £100 million, which implies an investment of £500k for national evaluation. This is a very similar figure to that proposed in the original research brief issued by the Department of Health in the spring of 1998. Such a sum would allow us to double the effective size of the research team, although detailed thoughts about its composition will have to await guidance from the Department of Health about a new research brief.

To aid the process of thinking about the best mix and type of research resources that we need to deploy we look forward to discussing and developing detailed project designs to address the broad range of questions that we have posed. We expect that such debate will help us to identify both the nature and type of additional resources required to conduct longer term evaluation. Additional specialist input may be necessary in, for example, specific policy areas such as mental health or housing policy, or to increase both our resource and strength in particular research methodologies. But the intention would be that additional specialist input be sought from the institutions already represented within the research team (University of Kent, LSE, University of Birmingham, HEA and the future Health Development Agency) in order to retain a coherent and co-ordinated programme of research.

Phase one of the national evaluation

Figure 5

Research Plans for the Current Contract Period
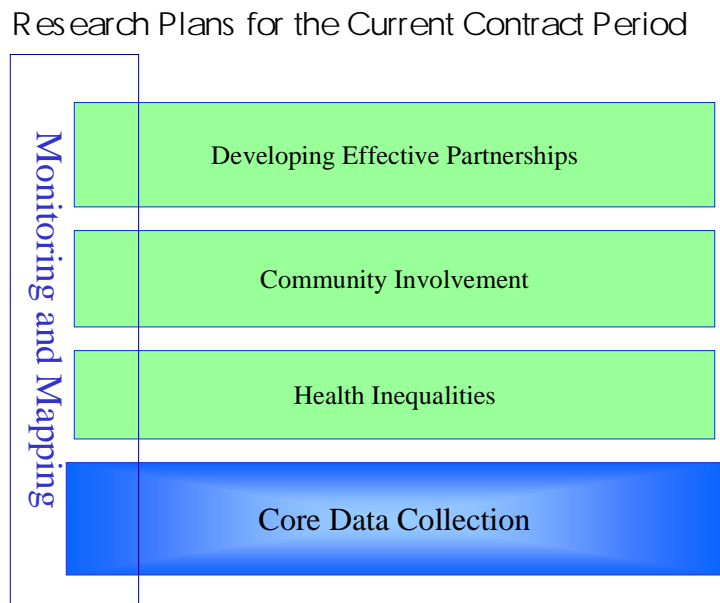
The existing research team was commissioned to conduct the first phase of the national evaluation of health action zones for a two-year period from January 1999 to December 2000. The top priority during the first few months of 1999 has been to complete this report. Its purpose is to try to ensure that decisions about the future of the national evaluation are grounded in more detailed knowledge about what health action zones are doing, and informed by ideas about how they might be evaluated. However, until the process of deciding about the longer-term future of the national evaluation has been completed we are committed to taking forward preliminary stages of the research.

Figure 5 illustrates the current approach to mapping and monitoring the activities of health action zones. It consists of two main elements. One the one hand we want to develop a 'core data' collection capacity that is as flexible as possible to changing circumstances. On the other hand we have selected three research modules relating to themes that are particularly central to the way in which HAZs are unfolding:

- Developing effective partnerships;
- Promoting community involvement; and,
- Tackling inequalities in health.

Core data collection

The primary aim of the core data collection is to facilitate an economical overview of how all Zones are progressing. It seems important to retain some flexibility about how we might best do this. For the moment our plans are not cast in stone. But we do need to move on to the next stage of the research during the remainder of the summer. Any changes in the approach that we are thinking of adopting, therefore, need to be agreed quickly.

At present we tentatively propose to develop the core data collection in five ways. First, by conducting interviews with a selection of key actors at regular intervals. Secondly, by continuing to collect and analyse documentary material from health action zones and strengthening the Microsoft Access database that we are developing to store and analyse this material. Thirdly, by obtaining and analysing performance management reports and statistical returns. Fourthly, by compiling and monitoring a series of baseline statistical data. Finally, by seeking to participate in as many developmental and learning group activities as time permits.

We do not have the resources at present to repeat diagonal slice interviews similar to those described in Section III in all twenty-six Health Action Zones on a regular basis. However, it does seem essential to maintain regular contact with all HAZ directors/co-ordinators. In addition, we think that it is important to establish close liaison with and to elicit information from HAZ Leads in NHSE regional offices. We propose to interview second wave HAZ directors and regional office leads in the autumn of 1999, and the autumn of 2000. We plan to repeat interviews with first wave HAZ directors in the spring of 2000. In conjunction with these interviews, we will investigate the possibility of observing/participating in partnership board meetings. The precise content of the interviews and the nature of any associated activity will be determined after we have had an opportunity to take account of discussions with the Advisory Committee and the Department of Health.

We are convinced that there will be continuing value in strengthening the Microsoft Access database that we have begun to develop. First, we need to update information about HAZ programmes and activities on a regular basis. Beyond that we would particularly like to add information about partnership and governance structures, planned objectives and targets, and local evaluation arrangements.

We think that there will be real value in linking our efforts with those currently being invested in the performance management of HAZs. This will help to avoid duplication and the imposition of unnecessary information requirements. We want to make the maximum possible use of the HAZ performance management process. The mid-year progress report, the annual report and review and the quarterly monitoring returns will all be rich research resources. Moreover, we will be particularly interested where HAZs and regional offices choose to make full use of the 'Development and Performance Framework' with its 10 pairs of key questions. We plan to discuss how best to establish effective links with the local implementation of performance management when we visit regional office leads in the autumn.

Another important aspect of the core data collection involves the compilation of baseline data to describe and monitor the changing characteristics of HAZs. There are a number of important developments planned in this area. For example, one of the intentions of those responsible for performance management is to develop high-level performance indicators and there are a number of other related developments planned by the NHSE. There are also continuing discussions initiated by local HAZ evaluation teams about the possibility of special collections across all HAZs to complement routinely-available data. We intend to collect and analyse as much data as possible and to participate in any discussions that are held about what further investments might be appropriate.

Finally, we do not intend to neglect the value of participating in various group activities that might add colour and texture to the core data collection. We are committed to working with Christine Wallace, the national HAZ development officer, to plan and facilitate regular research and development workshops, which will provide valuable learning opportunities. However, we hope to be able to participate in a much wider range of events and activities that will add to our overall stock of knowledge about HAZ developments.

Developing Effective Partnerships: a comparative case study analysis

From both a theoretical and practical perspective HAZs can be viewed as developing a new form governance that involves testing new types of strategic partnerships concerned with 'managing' networks of organisations. HAZ partnerships are attempts to transform the way local public sector organisations work together with communities and with the centre to develop and implement strategies designed to secure community health improvement.

A comparative case study based on two HAZs and two non-HAZs is proposed to investigate in detail HAZs as a new form of governance. The study will aim to define the new governance processes that are established through HAZ status, and examine how and why they prove effective or not in bringing about inter-organisational development and action. It will address the following specific research questions:

- What new partnership mechanisms are established through HAZ status designed to promote public health?
- What inter-organisational developments and action result and why?

Case study design

The comparative case study design will involve:

- Comparison of the HAZ case study partnership mechanisms and their organisational consequences over time.
- A parallel study of 'shadow' non-HAZ areas. This will enable some assessment of the distinctiveness of HAZ partnership mechanisms (new multi-organisational governing processes), and also how processes relating to Health Improvement Programmes and associated joint planning arrangements in these non-HAZ areas are developing and advancing public health goals.

The HAZ case studies will be selected to represent different types of HAZs with scale and complexity used as the primary contextual variable. It is proposed to select one 'single HA/multi-LA HAZ' and one 'coterminous HA/LA HAZ' (see page for categories of organisational configuration). 'Shadow' non-HAZ areas will be comparable as far as possible in terms of level of deprivation as well as scale and complexity. Based on DH initial analysis of a range of health and socio-economic indicators of deprivation forty-five HA areas were eligible for HAZ status. Given that twenty-six areas were successful in gaining HAZ status, the shadow non-HAZ case studies will be selected from the remaining nineteen areas.

The major advantage of selecting HAZs from the two categories chosen (i.e. single HA/Multi-LA, and coterminous HA and LA) is that comparison will be possible with the Health Improvement Programme mechanisms in non-HAZ areas which are statutorily required at the level of HAs. It will therefore be possible to examine the added benefits and costs derived from HAZ partnerships in comparison with partnerships based on Health Improvement Programmes processes alone.

In terms of Realistic Evaluation/Theories of Change, this comparative case study design represents a particular Context-Mechanism-Outcome configuration that will test how governance processes operate in 'simple' and 'complex' networks.

This indepth study, together with evaluation of partnership working through the core process evaluation, will contribute to addressing the research questions set out above. This would include analysis of data collected through the NHS Executive Development and Performance Framework relating to partnership working (such as 'partnership and synergy', and 'leadership, accountability and governance'). This work will provide a platform for future evaluation of partnership working. Options for the further phases (from January 2001) would include the expansion of the number of case studies with either one or two HAZs from each category of organisational configuration, as well as (and including) the follow up of existing case studies.

Stages of case study investigation

The case study investigation will involve three main stages.

Stage 1 Profiling of 'new' HAZ partnership mechanisms within context (Summer 1999)

This stage will aim to identify the new and distinctive HAZ partnership mechanisms established through HAZ status. Particular attention will be given to describing the full range of contextual factors operating in each area. This stage will define the multi-organisational governing processes and public health strategies in HAZs, and determine how these differ from the previous position (i.e. prior to April 1998). The differences and similarities between HAZ and shadow non-HAZ areas would also be determined. A simple 'HAZ governance model' of each local system will be produced showing how in principle key partners work together to develop and implement public health programmes (particularly contributions to *Our Healthier Nation*), and the contextual factors that influence this process. This model would be discussed and developed with each case study. It will provide a tool to be refined and further tested through subsequent stages of the study.

Profiling will primarily be based on documentary data collection and analysis. In addition semi-structured face-to-face interviews will be conducted with three or four stakeholders in each case study.

Stage 2: In-depth study of HAZ partnerships (late 1999/early 2000)

In-depth investigation of the HAZ partnership will be conducted to assess how the new governing processes are operating in practice and extent to which they are building multi-organisational capabilities that can take forward community health improvement strategies and programmes. This will include examining the functioning of the governance arrangements and stakeholders views about their contributions and perceived costs and benefits. The degree to which HAZ partnerships influence and are strategically integrated into mainstream processes of strategy and organisational development will be assessed. Stakeholders views on the nature of national/local relationships will be also be elicited.

This will test and further develop the 'governance model' of the HAZ system defined in stage 1. Particular attention will be given to the factors that helped or hindered progress. This will help determine the appropriateness of the partnership mechanisms, given the distinct strengths and challenges relating to the particular contexts and the strategies being pursued i.e. whether and why they are 'fit for purpose'.

In the non-HAZ case studies the development and operation of Health Improvement Programmes and associated joint planning arrangements will be investigated in a similar way. Comparison will be made with HAZ partnership mechanisms. Information about HAZ partnerships will be shared with non-HAZ informants and explicit comparative assessment undertaken.

The data will be collected primarily through semi-structured, face-to-face interviews with key stakeholders representing three distinct perspectives.

- *Policy makers in wider government creating the conditions for local partnership working:* approximately eight representatives covering the NHS Executive (head quarters, case study regional offices); case study inter-government regional officers; a member of the DTER Coordinating Unit and a member of the Social Exclusion Unit.

- *Participants in strategic management of the HAZ Partnership:* approximately eight to ten individuals from all sectors involved to some degree in the formal governance arrangements in each HAZ.

- *Participants in local partnership action:* approximately five key individuals in each HAZ including frontline staff and community and voluntary workers involved in specific schemes and initiatives addressing the needs of deprived neighbourhoods and socially excluded groups.

Interviews will be supplemented by documents relating to local schemes and any evaluation reports. All interviews will be taped and transcribed for subsequent analysis. In addition observation will be undertaken through attendance at national and HAZ case study meetings and events. Ongoing documentary data collection and analysis will cover case study progress reports, minutes of Board and Executive meetings, updated strategies, any early local evaluation activities etc.

In the non-HAZ areas the investigation will be less intensive. It will involve in-depth face-to-face interviews a more selective core group of people involved in the development and implementation of Health Improvement Programmes and joint planning processes.

Stage 3: Theme-based follow up (Autumn 2000)

The extent to which further organisational development and changes have taken place and public health programmes advanced will be assessed through follow up approximately nine months after the in-depth investigation. Particular emphasis will be given to themes and issues identified at stage 2 including those identified as barriers or factors enabling progress. It will involve face-to-face and telephone interviews with a small number of stakeholders in each HAZ.

The extent to which inter-agency governing processes have changed and developed and their consequences in the non-HAZ case studies will also be assessed based on semi-structured interviews with core stakeholders.

Analysis, reporting, dissemination

Analysis will be undertaken at each stage to inform subsequent fieldwork. The intention will be to provide feedback and test findings with individual case studies to support ongoing learning and development of governance processes locally. The study will also contribute to wider research and development activities.

A final draft report will be prepared which will be discussed with stakeholders. A final report will be prepared for December 2000.

Community Involvement: Eliciting Local Theories Of Change

The original invitation to bid for HAZ status stated that HAZs would involve community groups and the voluntary sector in their work. They would 'harness the dynamism of local people and organisations by creating alliances to achieve change', empower people and give them the tools to take greater responsibility for their own health. In addition, they would achieve sustainable capacity by building on existing strengths in the local community. They would also enlist 'public support for change and involvement in the work of the HAZ, developing strategy and appropriate structures for involving the public on a continuing basis in partnerships for improving health and monitoring services.'

Public involvement and public empowerment have thus been seen from the start to be central to the achievement of HAZ objectives. But the range of objectives implied by these exhortations to include both community and voluntary organisations within the work of HAZs also indicate the need for clarity about the different ways in which groups and individuals might play their part in HAZs, and what different objectives might be achieved as a result. Suggested objectives relate to the achievement of (at least) the following:

- More sensitive and person-centred health services
- Greater individual responsibility and control over health status
- Capacity building within communities
- More accountable systems of decision-making
- More cohesive communities
- The reduction of social exclusion
- The reduction of health inequalities

The original proposal for this element of the evaluation was based on the following principles:

1. That the evaluation should explore both the impact of community involvement on the achievement of HAZ objectives and the impact of HAZ on the development of community involvement.
2. That there is a need to distinguish both the different types and purposes of community involvement and to develop a framework within which to understand the wide range of action contained under this heading.
3. That it would be necessary to work with local HAZ participants and/or evaluators in order to develop an appropriately participative method of working to undertake this element of the evaluation.

Our initial experience during the first six months of the evaluation confirms the basis of this approach and has clarified how this might best be put into practice. We can thus expand on the three principles outlined above.

Public participation and community involvement are not new ideas. They have appeared in different guises in strategies for social change initiated from within statutory organisations as well as constituting both the means and ends of groups who have felt themselves excluded from decision making and who have sought to have their voices heard within systems of policy making and service delivery (Craig and Mayo, 1995). The history of social action amongst community groups and action from within official agencies seeking to involve

service users, community organisations or the 'public' more generally has demonstrated the different and sometimes conflicting objectives that participants in such action may seek to achieve. It has also demonstrated the contested nature of concepts such as 'empowerment', 'community', 'partnership' and other concepts underpinning the HAZ initiatives as well as other contemporary policy initiatives (such as SRB, New Deal for Communities, and Community Safety Strategies) which prioritise the active engagement of community groups as a means of achieving policy objectives. In some instances people who have experienced themselves as excluded have developed alternative strategies seeing little benefit in taking part in practices which have developed without reference to their analyses of their own needs and problems. Groups which have sought to engage with officials to achieve influence within policy making processes have experienced tensions as their different priorities and values have been compromised by working within official systems (e.g. Barnes et al, 1999: Jordan, 1998: Sullivan, 1997).

Community involvement is increasingly being seen by the Government as fundamental to the delivery of public policy objectives. This is the case not only in the context of health, but also of, for example, local economic development, community safety and education. Thus HAZs provide a context in which it is possible to explore how action from central and local government agencies might increase the capacity of communities to become active participants in policy making and implementation across a spectrum of policy areas. There is also growing commitment to the value of community involvement amongst local policy makers and service deliverers.

However, there is also considerable uncertainty about how to proceed and concern about the multiplicity of initiatives which call for community involvement. There is concern that communities will be 'over consulted' and become cynical about frequent consultation if this does not lead to positive outcomes. In this context it is important to focus on whether top-down initiatives such as HAZ can create a context in which community involvement is experienced as genuinely empowering, as well as to consider whether such involvement does in fact contribute to the achievement of policy objectives, in this instance the achievement of health improvement and the reduction of health inequalities.

Our interviews have indicated that community involvement is as yet underdeveloped in most HAZs, but that there are both intentions and aspirations to commit time and resources to achieve a range of goals relating to community involvement. We can learn more from an analysis of implementation plans about the nature of intended action and goals to be achieved. Our initial analysis of first wave implementation plans identified five types/purposes of community involvement:

1. Community participation in the HAZ development and implementation process, i.e. community participation in partnerships, governance and accountability arrangements. Plans indicate a range of proposed mechanisms including community representation within partnership structures, 'parallel' mechanisms such as reference groups which will meet separately from the main partnership groups and feed into them, and mechanisms for engaging user and community groups at different levels within the decision making and implementation process.

2. Community development as a method of working to deliver HAZ objectives relating to health improvement. There are many examples of actual and proposed work in this area. They include: training older people to become health advocates, child to child health promotion, and community based rapid appraisals as a basis for developing local health strategies. There are proposals to appoint community development workers in a number of HAZs and to link community development for health with other community regeneration and employment initiatives.

3. User involvement in decision making about service, practice and policy development, and in personal service provision. Action focusing on the development of policies and services for disabled people, people with mental health problems, women who have experienced domestic violence, young people and other areas of service provision is planned to include the direct users of such services in planning and implementing service developments.

4. Communication and other strategies to keep the public informed and develop public support for the HAZ. This is a smaller category, but at least four of the first wave HAZs have specific plans to engage the interest and support of the public as a whole in the work of the HAZ. Such plans involve contact with local media and/or Arts organisations. In one case a citizen's jury is mentioned as a means of accessing citizens' views about broader information strategies.

5. Community and user involvement in generating evidence and knowledge – often expressed in terms of the need to involve users, citizens and communities in assessing the effectiveness of action within the HAZ. The experiential knowledge of those living with health problems or impairments, and of those with direct experience of poverty or ageing is seen as an important resource in developing ideas for action, as well as for assessing the impact of the HAZ.

The methods proposed to involve user and community groups and citizens generally reflect not only the different purposes to be sought, but also the different groups to be engaged and the existing level of community organisation. Thus in areas where there are established community organisations representatives of such groups are already being included within partnership structures. Elsewhere, there is reference to the need for capacity building before direct representation may be possible. Often the level at which community involvement is considered to be most effective is at neighbourhood, user or identity group level: young people are to be engaged through youth forums, users of mental health services through stakeholder conferences, and locality groups through community based health partnership forums, for example. Our initial analysis suggests that it is more helpful to consider community involvement strategies by reference to the different purposes or objectives to be secured than by reference to the specific methods of involvement adopted. Thus the framework we will apply to this element of the evaluation will be based on an analysis of community involvement strategies for:

- Improving public accountability
- Improving health

- Improving service responsiveness
- Increasing public knowledge and support
- Accessing lay and experiential knowledge

Each of these purposes can be considered to both require and contribute to the empowerment of individuals and groups. Each may contribute to the achievement of greater social cohesion and sustainable community development. But the achievement of such outcomes is also likely to be mediated by the nature of the processes developed. The process of involvement will need to be empowering in itself if participants are to become empowered. Public support and social cohesion will be at risk if participants feel unable to influence the way in which their involvement is negotiated. Thus the evaluation will need to reflect on the experiences of participants as well as on the nature of outcomes achieved.

It is also clear from interviews as well as informal contacts that, whilst community involvement constitutes a significant element within HAZ programmes few players have a clear idea about strategy and objectives to be achieved through community involvement. In this context (as in other aspects of the evaluation) an approach based on the theories of change model drawing on the above framework, has the potential not only to provide a useful approach to evaluation, but can also contribute to the development of focused local strategies and cross HAZ learning. It can be used as a way of enabling HAZ participants to think through the range of purposes and objectives for community involvement and to articulate their hypotheses about why particular forms of action are being proposed. Comparison of local theories of change and the effectiveness of action based on these in the context of a common framework should enable the building of explanatory models across sites which can provide a more powerful source of learning about what works and why than is possible from single site studies.

Participative approaches are not only consistent with the philosophy of community involvement, they are the only effective way of accessing the theories implicit in decisions about local action, of enabling appropriate data to be collected and of contributing to developmental learning to improve chances of success. But such methods are labour and resource intensive and it is unrealistic to expect national evaluators to be able to build close local contacts in all HAZs in order to carry through the detailed work involved. Thus we propose a way of working which would involve first training and then working with local participants (either local evaluators or local players with particular responsibilities for community involvement). The remainder of this section outlines how we propose to proceed on this basis.

Marian Barnes will be attending the meeting of the Community Involvement Network in July. She will be describing the analytical framework and seeking support for a co-operative mode of working on the evaluation of community involvement. We propose that we invite HAZs to nominate one or two players who will take responsibility for local action on this. Such an approach has to proceed on the basis of consent and thus we do not consider it would be productive to require all HAZs to take part. However, in view of the interest in this aspect of the initiative we anticipate that a sufficient number of HAZs would want to be involved to enable useful learning to take place across sites.

Nominees, who will become co-researchers, will be asked to do the following:

1. Use the analytical framework to start to describe their local situation, including any initial definitions of objectives for community involvement, e.g. to distinguish objectives relating to partnership development and accountability mechanisms, from those concerned with health improvement and service improvement, and those concerned with community capacity building.

2. Attend two initial one day training workshops. The first would introduce them to the theories of change approach and start to consider how this might be applied to local situations. This workshop would also start to identify both shared and different theories of change across HAZs. The second workshop would focus on data collection methods to be used at a local level to generate data to answer the research questions posed. These research questions would be framed in a way which will enable comparative analysis across sites, even though the detailed application might require the collection of different data. For example, one shared hypothesis may be that direct community participation within HAZ partnership mechanisms will result not only in greater commitment to the HAZ strategy by community organisations, but also wider public knowledge and awareness. The mechanisms by which involvement in partnerships will be secured will vary across HAZs and thus the precise data to be collected is likely to vary, whilst the question to be answered remains the same.

    A variety of data collection methods are likely to be required and data will include both quantitative (e.g. the number of community organisations actively involved in HAZ initiatives and the frequency of attendance at partnership meetings), and qualitative (e.g. participants' experiences of being able to influence rather than respond to agendas).

3. The co-researchers would then have the responsibility for implementing the information gathering process at a local level. They would have access to advice and, if necessary, trouble shooting support (see below for staffing for this) to assist them.

4. Progress/learning would be shared at meetings of the Community Involvement Network.

5. Initial results from local data gathering will be brought together for a meta-analysis to be carried out by the National Evaluation Team at the end of the contracted two year period. The results of this will be discussed amongst the co-researchers and the evaluation team before final presentation.

6. If this model is successful, it should be possible to continue the evaluation process at a local level beyond the two year contracted period. Any further drawing together of results would require additional funding for a central evaluation capacity.

Some additional resource will be necessary to implement this proposed approach during the remaining 18 months contract period. We are seeking a change in contract with the Department of Health in order to secure this.

Tackling inequalities in health: mapping & monitoring local strategies

Tackling inequalities in health is seen as a central role of Heath Action Zones. At the same time, HAZs are central to the Government's strategy to reduce health inequalities. The strong emphasis on health inequalities in HAZ's remit has been articulated in a number of Ministerial statements and is reflected in The *Development and Performance Framework* (NHSE, 1999), as highlighted below. Understanding the different ways that individual Health Action Zones take up this challenge, and their overall contribution to the Government's achievements in reducing health inequalities is, therefore, a key element of the national evaluation.

Ministerial statements

Health Action Zones are a key part of the Government's drive to target areas with particularly high levels of ill health...and so improve the health of the worst off at a faster rate than the general population. This is the first time a British Government has set itself such a task. (Dobson, DH 98/329)

Health Action Zones are in the vanguard of our new approach to tackling health inequalities and promoting new ways of working together locally between health and social services. (Denham, 1999/0034)

Health Action Zones are in the frontline of the Government war on health inequalities. They have both the opportunity and the responsibility to pioneer new ways of driving up local standards of health... (Jowell, 1999/0038)

Development and Performance Framework, NHSE (1999)

Core objective 1. Improving health and reducing health inequalities

1a. Are there clear, measurable and challenging strategic targets (with milestones) by specific conditions, care groups and/or communities for improving the health of the HAZ population and to reduce local inequalities between areas and groups in determinants of health, health status, access to health and social care and access to other health supporting services?

1b. What is the evidence of progress and achievement?

In this module of the national evaluation (i.e. months 9-24), a number of essential building blocks will be developed that will facilitate long term learning about the contribution of HAZs to reducing health inequalities. Two broad questions will be addressed. To what extent have individual HAZs achieved the goals they set for themselves in relation to health inequalities? How effective has the HAZ initiative been overall as a mechanism for reducing health inequalities nationally?

The underlying theoretical approach to this module of the evaluation will be based on our blending of *theories of change* and *realistic evaluation* methodologies, which is described in more detail in Section I above. Broadly speaking, we will identify the similarities and differences between HAZs in the strategic pathways they develop to reduce health inequalities. We will focus on: the problems they are trying to address within their own context; the interventions they introduce to tackle them; the expected consequences of their activities; and, how they believe these will lead to their outcome 'targets' and long term aspirational goals. In doing this, it will be particularly important to draw out the key milestones that HAZs set themselves within these pathways in order to monitor and evaluate their progress towards long term goals.

In order to develop an understanding of their pathways to reduce health inequalities, a number of specific research questions need to be addressed. These include:

What do Health Action Zones mean by health inequalities?

What particular dimensions of inequalities are HAZs focusing on?

What goals are HAZs setting themselves?

What kinds of problems do HAZs believe they need to tackle in order to reduce health inequalities?

What general strategies have HAZs adopted to tackle health inequalities?

What particular services or initiatives have been introduced to reduce health inequalities?

What beliefs about the causal processes that underlie health inequalities have informed policy makers' selection of strategies to tackle them?

What evidence base has been drawn on to inform the choice of particular service changes or new initiatives to reduce health inequalities?

What beliefs do HAZs have about the length of time it will take to achieve changes in inequalities in health outcomes?

What intermediate milestones/goals do HAZs believe they should be able to achieve within their lifetime?

Is there a logical pathway between problems, interventions, expected consequences, outcome 'targets' and long term goals?

To what extent does the socio-economic and political environment external to the HAZ areas inhibit or promote HAZs' ability to tackle health inequalities?

Building Blocks

This part of the national evaluation will have two aims:
- to develop a map of what HAZs mean by health inequalities, the goals they have set themselves in relation to health inequalities and the strategies they have employed to tackle them;
- to unpack the implicit theories of change behind local strategy development to better understand the underlying causal models and evidence base, and to identify specific milestones that can be monitored in the longer term to assess progress.

In addition to the analysis of information gathered as part of the core data collection and the review of the NHSE performance management framework, described above, two main research methods will be employed:
- a map of each HAZ's overall approach to tackling health inequalities will be developed from their implementation plans;
- A small number of HAZs will be approached to work with the research team to draw out more explicitly the theories of change that underlie their strategies. These will be used to develop a range on intermediate milestones that can be employed to monitor HAZ progress in tackling health inequalities over the longer term.

Preliminary exploration of the implementation plans shows that a number of different clusters of HAZs can be identified in relation to some of the initial research questions. For example, approaches to defining health inequalities range along a spectrum. At one end are those HAZs with uniformly high deprivation and SMRs, whose goals focus on reducing

inequalities between their Zone and an external reference point. At the other extreme are those Zones whose SMR and deprivation scores are nearer to the national average who have focused almost entirely on reducing inequalities within their Zone.

In relation to different dimensions of health inequalities, again some clusters of foci are apparent. For example, a number of HAZs have a very clear focus on the health problems of Black and Minority Ethnic communities. Others are focusing on particular geographic areas or on specific socio-economically disadvantaged groups, such as people who are unemployed, teenage mothers, looked after children or children excluded from education.

In terms of strategies to tackle health inequalities, again, a number of crude clusters can be identified. Some HAZs have chosen to focus very specifically on reducing inequalities in access to health services, because it is something they feel they can achieve in the short run. Others have very much taken a *Health of the Nation* lifestyle/settings approach, while others have focused on some of the social and economic determinants of health such as unemployment, low incomes, social isolation and poor neighbourhood infrastructures.

There has been insufficient time to date to explore in detail the logic of the strategic pathways HAZs are developing to reduce inequalities in health. However, some clear inconsistencies are already apparent. For example, a number of HAZs have set themselves long term goals that focus on reducing health inequalities WITHIN their Zone, but set outcome 'targets' which only assess changes in AVERAGE health outcomes. Much more work is required to review HAZ strategies to develop a better understanding of what HAZs are trying to achieve in relation to health inequalities and how they plan to do so.

In the remainder of 1999 a more systematic investigation of the research questions will be conducted with detailed analysis of the implementation plans. On the basis of the different clusters of HAZs identified as part of this process, a small number will be approached at the beginning of 2000 to work with the research team to explore the implicit theories of change that underlie their strategies. A report will be produced at the end of 2000 drawing on the material from both of these exercises and suggesting a possible way forward in terms of monitoring a HAZ's contribution to tackling health inequalities at the local level.

Setting The Strategic Direction

A consistent theme of this report is that an agreed way has to be found for the national evaluation of health action zones to focus on a relatively small and manageable set of important tasks. In order to do this we are seeking the assistance of colleagues in the HAZ community by asking them to think about and respond to the findings and proposals contained in this report. We are particularly keen to encourage responses to the kinds of questions set out below.

- Is the preliminary map of early HAZ development contained in Section III of the report a plausible one?
- Do the conceptual framework and the associated research questions outlined on pages 89 to 93 capture a sense of the critical issues facing the HAZ initiative? Are any important themes or questions missing?
- We have described our preferred approach to the national evaluation as one that blends together insights from realistic evaluation and theories of change. Does this seem appropriate?
- Do members of the HAZ community recognise and accept the way we have represented the community health improvement process at various in this report?
- Is it sensible and desirable for the national evaluation team to want to combine some participation in developmental activities with HAZs alongside more conventional research tasks?
- Are we correct in our assumption that we should try to work in close conjunction with the performance management process?
- Does the initial priority we have afforded to the themes of developing effective partnerships, promoting community involvement and exploring local strategies to tackle inequalities in health seem appropriate?
- Is there support for the proposition that the existing national evaluation team needs to be expanded if it is to have any chance of meeting the minimum requirements of a reasonably comprehensive overview of health action zones?
- If there is general support for a modest expansion of the national evaluation, should this proceed along the lines suggested on pages 97 to 99, focusing on a mixture of project specific, thematic and strategic studies?
- Given the experience to date, what sort of relationship do local HAZ stakeholders wish to have with the national evaluation team? How could this relationship be made more effective?

We conclude with a word of warning and a final plea. In a number of respects it will be apparent that this report – despite its length - has been compiled in considerable haste to try to ensure that it contributes in a timely way to decisions that have to be made about the future direction of the national evaluation. We genuinely need your assistance to correct errors of fact, failures of interpretation and sins of omission. All of the existing members of the national evaluation team are proud to be associated with the health action zone initiative. But we can only make an effective contribution to its success with your help. We urge you to respond in some way if you can to the contents of this report. It is important that the evaluation of health action zones should be as embedded in the principles of partnership as the overall initiative itself.

We thank you in advance for your help and co-operation.

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