National evaluation of Health Action Zones

Health Action Zones:

Learning to make a difference

EXECUTIVE SUMMARY

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Health Action Zones (HAZs) are a central part of the new health policy being forged in Britain in the late 1990s. HAZs are expected to be 'trailblazers'; pioneering innovative approaches to reducing health inequalities, and developing services that are more responsive to patients and users.

A great deal is expected of health action zones. The initiatives they promote will offer many opportunities for learning. Evaluation, therefore, is essential. However, the complex and changing contexts of HAZs and the evolving nature of their own efforts create genuine difficulties for evaluation. Firstly, 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. 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 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.

Our report has two main purposes, which are to:

- Report findings from a scoping exercise conducted during the first part of 1999, which consisted of initial monitoring and mapping activities designed to begin to assess the extent of HAZ development.
- Contribute to the process of making decisions about a focus and format that should be adopted for the national evaluation of health action zones.

This report 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. Your views are essential.

Background

Three sets of background information provide a context for the evaluation of HAZs:

- The national policy context
- The characteristics of the 26 Health Action Zones.
- The approach of the national evaluation.

The National Policy Context

In October 1997, health authorities were invited in conjunction with local authorities and other agencies to submit bids to become Health Action Zones. 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.

Forty-one bids for Health Action Zone status were received by the Department of Health. From these, Health Action Zone status was granted to 11 areas from April 1998. 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.

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 (with approximately £306 million to be spent on the HAZ initiative between 1998 and 2002), and announced a number of new monies for them, such as the HAZ innovations fund and funds to develop smoking cessation services. Thirdly, a *Development and Performance Management Framework* has been established. Finally, the Government advertised and commissioned a national evaluation.

Haz Characteristics

The 26 HAZs are located across England and vary significantly in their local characteristics. In total, HAZs include 34 health authorities and 73 local authorities. However, they range in complexity from those which comprise multiple HAs and multiple LAs and have the largest population (such as Merseyside and Tyne and Wear) to those based on unitary local authorities but only part of the associated health authorities (such as Luton and Plymouth).

The communities within HAZs do however face the common problem of ill health and disadvantage. HAZs represent some of the most deprived areas of the country with some of the poorest levels of health. By using publicly available data to rank health authorities by two deprivation indices, it is evident that HAZ health authorities account for 15 out of the 25 most deprived health authorities on the Jarman Under Priviledged Area index and 16 out of 25 according to the 1991 Level of Local Conditions. In addition, between 21 and 29 of the 34 HAZ health authorities have illness or mortality rates greater than the national average based on indicators from the most recent Health Survey of England and ONS vital statistics.

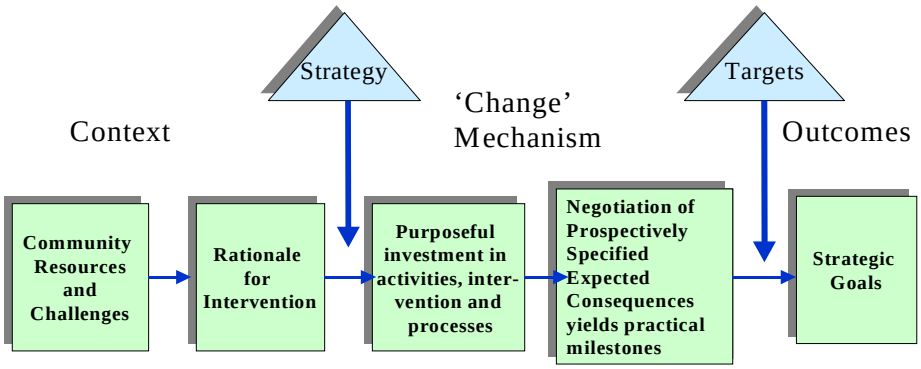
An Approach to the National Evaluation

HAZs are intended to be learning organisations with a 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.

Evaluation has a dual role to play in helping HAZs to communicate these results, both in terms of assessing processes and outcomes and assisting stakeholders to structure their own activities in a way which promotes investment in learning.

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. Our approach blends two theoretical frameworks which have been developed to adapt to the challenges of evaluating complex community initiatives such as HAZs. The first is *realistic evaluation*, which can be summarised in a formula which links the context of an initiative with the mechanism chosen to achieve change and the outcomes which emerge over time. A successful evaluation will identify Context-Mechanism-Outcome (CMO) configurations, and identify those which do and do not work, in order to refine policy development in the future. The second approach has been developed over a number of years through the work of the Aspen Institute in the USA. This *theories of change* approach to evaluation 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 together with the medium and longer-term outcomes intended.

Realistic Evaluation and Theories of Change



Community Health Improvement Process

The Figure above 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. Within this approach, evaluators work with local stakeholders to promote learning across the entirety of the community health improvement process.

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. We believe that this approach should be operationalised in *future* research as a central part of the national evaluation, a point we return to at the end of this report.

Findings From The Scoping Exercise

The primary focus for the first six months of the national evaluation of Health Action Zones was a scoping exercise. This 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. Findings are presented in four sections:

- From Visionary Goals to Logical Targets; an analysis of material in the implementation plans relating to strategic objectives, activities and outcomes
- Programmes of Action; which outlines HAZ programmes and activities
- Findings from First Wave Interviews
- Resources and Freedoms; which presents baseline data in relation to the use of HAZ finances and requested freedoms and flexibilities.

From Visionary Goals to Logical Targets

The aims and objectives of Health Action Zones are described in their implementation plans. These descriptions provide a valuable insight into how individual HAZs are approaching the community health improvement process. It also illustrates the extent to which there is a lack of clarity regarding what HAZs aim to achieve, how they are planning to achieve their aims and how they will measure progress along the way. In order to inform our analysis of HAZ programmes and activities outlined in the next section, we reviewed the varied statements of visions, strategic objectives, outcomes and targets in the first and second wave plans.

Visions and Strategic Objectives

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. 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.

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, such as focussing on children and young people.

Outcomes

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.

At Level 1, the statement in the plan clearly sets out all of the information required to ascertain if the outcome change is successfully achieved. At 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. At Level 3, it is very unclear how the achievement of the outcome will be identified, assessed or measured. An example of how our categorisation relates to one key goal - reducing health inequalities, is shown in the Box below:

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.

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

Targets

Health Action Zones are required to produce explicit targets. But there has been quite a lot of confusion about what constitutes an appropriate target. While to varying degrees all of the implementation plans are strong on identifying problems, articulating long-term objectives and specifying routinely available indicators for monitoring progress, they are much less good at filling the gap between problems and

goals. Only in very rare cases is it possible to identify a clear and logical pathway which links problems, strategies for intervention, milestones or targets with associated time-scales and longer-term outcomes. 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

In recent months there is evidence that the process of target setting is improving, both in revisions to the first wave implementation plans and a number of strong second wave plans. We highlight two good examples of attempts to develop clear and logical approaches (Walsall and Wakefield) in the main report. Despite these examples 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.

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. A detailed analysis of the implementation plans of both 1st and 2nd wave health action zones was undertaken to obtain information about HAZ programmes and activities. The methods we employed to do this and some caveats about the quality of the information are described in detail in the report. Here we simply present some key preliminary findings.

Programmes
A total of 214 programmes were identified across 1st and 2nd wave Zones, which fall into seven broad categories. There are approximately 25 – 30 programmes across the HAZs focusing on each on the following areas: population groups, health problems, health and social care, community empowerment, and internal processes. About double that number -61- are concentrating on addressing the 'root causes of ill health', including changing people's lifestyles. Finally, a small number of programmes covered a range of different foci.

Activities
First Wave HAZs
We conducted a very simple analysis of 1st wave plans and identified 750 activities which fell into four broad groups. Just over a third of activities are attempting to improve health and social care services, in particular primary and community services. Just under a third of activities are concerned with changing internal process, for example, developing the capacity of the partnership or establishing new strategies across a range of services and client groups. One-fifth of the activities are trying to change some of the root causes of ill health by promoting access to healthy lifestyles, improving education, creating employment opportunities and developing the local

neighbourhood. The final and smallest group of activities, about 10 per cent, are aimed at promoting community involvement and empowerment

Second wave HAZs
Building on the experience of our analysis of 1st wave plans, we adopted a more detailed approach to the analysis of 2nd wave activities by asking the following four questions:

- *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?*

This generated a wealth of information, on 1036 2nd wave activities, which it is only possible to give a flavour of here. For example, only twenty per cent of activities are concerned with a specific health problem, and these mainly reflected Health of the Nation priorities – mental health, sexual health and accidents. Most of the activities are focused on the whole population; however, a significant minority do concentrate on children and young people – about 20 per cent - and older people – nearly 10 per cent.

Second wave HAZs are trying to change a broad spectrum of issues in order to achieve their long term goals. They are putting a similar degree of effort into: tackling the determinants of heath; promoting healthy lifestyles; reshaping health and social care; empowering the community; and, developing and improving internal processes.

To achieve these changes, 2nd wave HAZs are engaged in a range of different tasks. About one third of their efforts focus on providing goods and services. Nearly half of their activities are focused on developing systems and mechanisms to achieve change be it organisational development; strategy development or learning. Finally, the smallest group of activities are aimed at engaging with local people through forums, user groups, conferences and community development.

It is important to bear in mind that the HAZ plans themselves are continually changing and it is right that they should do so. What we have tried to do is to convey, in a relatively simple way, something of the diversity of HAZ activities. The most important implication of the wide range of programmes that HAZs are developing is that careful choices have to be made about where to focus scarce research resources.

Findings from First Wave Interviews

While the implementation plans begin to reflect some of the complexity which HAZs represent, more in-depth knowledge of the key issues facing HAZs could only be gained from individuals working within the Zones themselves. The national evaluation team carried out over 90 semi-structured interviews with key stakeholders in each first wave HAZ between March and April 1999. The interviews addressed a range of themes:

- Goals, Strategies and Targets
- Partnerships
- Critical Next Steps and Challenges

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 included 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. 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.

Questions about the strategic approaches being adopted in pursuit of high-level goals did not elicit clear or convincing responses. Well-developed strategies linking problems and goals 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.

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.

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 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. These difficulties are perhaps most 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. Improved communication between partners and within organisations was a related priority for stakeholders. 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. 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

As part of the initial scoping exercise, the national evaluation also 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. 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.

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. Finance information was collected from each first wave HAZ by means of a postal questionnaire. Only nine responses were received from the eleven first wave HAZs by the closing date, therefore analysis was carried out on these responses.

Information was obtained regarding the total financial allocations for 1998/99 and 1999/00 for each HAZ. Where data was provided on actual expenditures and variances from planned allocations, it was clear that underspends were substantial.

Project and Programme funding
HAZ budget reports and expenditure plans comprised diverse categories of expenditure. Comparisons between HAZ programmes is impossible without detailed discussions with HAZ officers responsible for financial management; this is due to the absence of a common accounting framework. The diversity of programmes and their multiple sources of funding means that achieving an accurate picture of comparative HAZ spending on particular programmes will always be a complex task.

Additional sources of funding
Despite the early stage of development, some early trends were discernible concerning plans for the generation of additional income, including: efforts focusing on specific NHS and other public sector sources of funding; potential partnerships with the private sector; and, in the case of Northumberland, the intention to appoint a funding facilitator to investigate European sources of funding.

Management and additional costs
Most HAZs identify the £100,000 sums allocated to ‘development support’ as management costs, however, these are only what are referred to as ‘direct’ costs; most

of the HAZs point out that there have been other categories of additional management costs. It was also evident that HAZs have found it difficult to provide precise quantitative estimates of additional costs, however this work seems to have been important to them as evidenced by the fact that many have chosen to explain this work in some detail. Any serious attempt at measuring these additional costs will probably require a bottom-up approach to costing, possibly through the use of time-diaries or similar instruments.

Efficiency savings
Some efficiency savings are expected but it is still too soon to estimate their size. The only HAZ specific about such savings was Tyne and Wear.

Financial management and accountability
The inter-agency partnership working upon which the HAZ approach is based involves new lines of management and accountability. In most HAZs 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.

Freedoms and Flexibilities

In their plans the HAZs requested a wide range of freedoms in order to operate more flexibly. These freedoms fall into five main groups.

- *New budgetary freedoms.* These include the ability to pool budgets between agencies and freedom to move between budget headings including capital and revenue budgets, and perhaps the ability to move savings from one agency to another.
- *Joint working.* Many HAZs are keen to test the flexibilities of *Partnership in Action* in order to improve joint working across health and social care boundaries. Common requests from HAZs include harmonisation of planning between LA and NHS planning cycles and freedoms to develop common monitoring mechanisms across government initiatives.
- *Sharing information.* Some HAZs request changes in information systems rules in order to develop common inter-agency records and systems. This includes flexibility to develop new confidentiality protocols between agencies.
- *Primary Care.* A number of the freedoms requested around primary care relate to the development of primary care premises. HAZs also request relaxation of GMS regulations to allow extra reimbursement to GPs for delivering services, and other financial incentives for primary care staff. Other flexibilities requested include the extension of prescribing responsibilities. HAZs also request some freedoms in relation to the emerging Primary Care Groups.
- *Housing.* Freedoms related to housing include the ability to use capital receipts for housing repairs, in some cases on non-council owned property. Other HAZs requested to develop equity release scheme for housing improvement and freedom from building regulations.

New and augmented finances, freedoms and flexbilities are the principal means available to HAZs to support innovative ways of responding to the health needs of their communities. It was evident both from the plans and the interviews that how these will be used to best effect remains uncertain. Future evaluation efforts, in conjunction with the new performance management framework, will have an important role to play in monitoring developments and assessing their implications.

Future Research Plans

Findings from our scoping exercise illustrate the extent to which HAZs are complex partnership entities with huge ambitions that are seeking to achieve significant social change. Evaluating the HAZ initiative therefore poses significant challenges. Scarce evaluation resources have to be focussed in a purposeful way. The main aim of this final section of our report is to make recommendations and suggestions about what the priorities should be.

This final section of the report outlines:

- A conceptual framework for thinking about health action zones
- A series of key research questions based on this framework
- Critical assumptions that underpin our thinking about future evaluation efforts
- Phase one of the national evaluation, which outlines research plans for the remainder of our current contract period
- Setting the strategic direction; a series of key questions which we pose to help shape the future of the national evaluation

Conceptual Framework and Key Research Questions

Based on findings from our initial research and our early opportunities to work with stakeholders in the health action zones, we have constructed a conceptual framework of HAZs which can be found on page 89 of the main report. It illustrates the complex relationship between different components of the HAZ. These are:

- The National Policy Context in which HAZs are being developed
- The Means: including the resources, freedoms and support available to HAZs, which come with associated obligations such as performance management
- The Local Framework, including the partnerships HAZs create and the strategies and priorities they develop to achieve their goals
- Intermediate Outcomes of HAZs, which encompass the three main themes of new ways of delivering health and social care, community empowerment and tackling the root causes of ill-health
- Final Outcomes of HAZs, which are to achieve improvements in population health and well-being.

Each of these components within the conceptual framework is linked, and each is underpinned by particular local conditions or context and the capacity of local communities to become learning organisations both through evaluation efforts and other means.

We have formulated a series of key research questions around the components of this conceptual framework. This reflects the fact that the evaluation approach we have argues is necessary requires more than a simple measurement of outcomes. Evaluation questions need to ask not only whether HAZ objectives are achieved, but how and why. The range of questions cannot be listed in this summary. Readers should refer to pages 90-94 of the full report. We provide four examples here:

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?

Promoting Community Involvement

- Can HAZs create the conditions within which community involvement becomes genuinely empowering?

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?

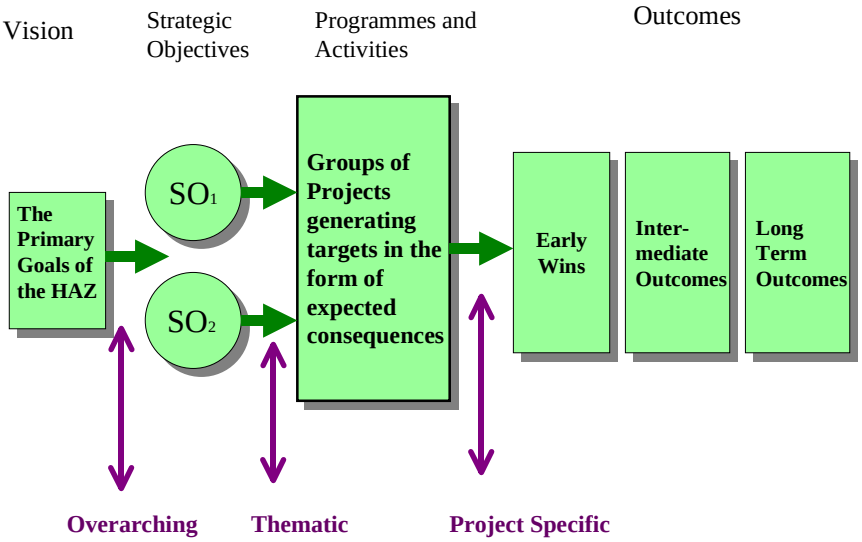
Critical Assumptions

We believe that the research questions we have identified could be approached in a variety of ways. Indeed, multiple research methods will be required to address many of them. However, it currently seems premature to set out detailed research protocols. 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 which the full report outlines. These are:

- 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.
- 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.
- 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.
- 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.

The Figure below illustrates our proposed approach to the longer-term development of the national evaluation. It links our analysis of the HAZ community health improvement process with the need to proceed by focussing on specific areas for research.

From Vision to Outcomes: Eliciting Theories of Change



Theories of Change

In conjunction with the logical pathway that underpins the existing HAZ planning process (from initial goals, to strategies, activities and targets, and then to short and longer-term outcomes) we see three particular opportunities for future research:

- Firstly, a project specific approach is required to work in particular HAZs. We propose that the best opportunity for this collaborative research may be with projects selected under the HAZ innovations fund
- Secondly, a thematic approach is proposed. 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.
- Thirdly, 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. 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.

To address at least some of the key research questions that we have identified, and especially to do so with adequate development, unifying and dissemination functions, will require more research resources than are currently invested in the national evaluation. 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.

Phase One of the National Evaluation

The existing research team was commissioned to conduct the first phase of the national evaluation 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 the report. 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.

Our current approach to monitoring and mapping health action zones will consist of two main elements. The first is the continued development of a 'core data' collection. This will aim to provide an economical overview of how all Zones are progressing. Our initial proposals for how this work will be structured will need to be agreed. For the moment, we suggest that this core collection be developed by:

- conducting interviews with a selection of key actors at regular intervals;
- 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;
- obtaining and analysing performance management reports and statistical returns, as well as compiling and monitoring a series of baseline statistical data;
- seeking to participate in as many developmental and learning group activities as time permits.

The second element of phase one of the national evaluation consists of three research modules relating to themes that are particularly central to HAZs, including:

- Developing effective partnerships
- Promoting community involvement
- Tacking inequalities in health

Details of how these three modules could be developed are outlined in some detail on pages 103-112 of the full report.

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 our findings and proposals. We are particularly keen to encourage responses to a series of questions posed on the final page of the full report.

We urge you to respond in some way if you can to the contents of the 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.