Health Action Zones:

A new form of partnership for tackling health inequalities?

A comparative case study of four local areas in England

1999-2002

PhD Thesis April 2003

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UMI Number: U183092

UMI

Dissertation Publishing

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8193

Abstract

This study investigated the process of policy development and delivery in relation to the complex problem of health inequalities. The study examined whether Health Action Zones represented a new form of partnership that provided an effective mechanism for policy delivery.

A schema of mechanisms for 'collaborative policy delivery' was constructed to provide the theoretical framework for evaluating the policy processes. It was contended that Health Action Zones could represent a practical demonstration and test of network management.

The empirical investigation involved a comparative case study analysis of two HAZ and two non-HAZ areas in England. It relied on semi-structured interviews conducted over a period of three years and documentary evidence from all the sites. The development and changes in the health partnerships in the four areas were tracked between 1999 and 2002. Impact was assessed in terms of 'intermediate process outcomes' ie organisational changes and action that took forward strategies addressing health inequalities.

The findings suggest that HAZ status helped accelerate growth in capacity for partnership working and the adoption of a more strategic approach to tackling health inequalities. HAZ case studies demonstrated distinct features of partnership working in comparison with the two non-HAZ case studies. HAZs systematically built leadership, management and institutional capabilities around the pursuit of health inequalities that involved organisational learning and development. Strategic progress and changes were more likely if the network building was an integral part of the mainstream processes through which players managed their inter-organisational relationships.

<u>The implications for network theory</u> were considered. While network management has an important contribution to make to the policy process and policy delivery, it does not operate in isolation and has to be fostered and resourced. Network theory appears limited in dealing with contextual issues, particularly in coping with the political dynamics of the policy process. The importance of investment in developing the capacity of the network of players to engage in interagency working is not fully recognised. It is contended that more attention needs to be given to context, and to creating the conditions that promote network management and delivery of integrative strategies.

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Acknowledgements

I would like to thank my supervisor, Professor Howard Glennerster, for his guidance, wealth of expertise and encouragement.

I would also like to thank all those who participated in the study in the four areas, and gave their time and insights about their experiences.

I am also very grateful to the Health Development Agency as my sponsor of this thesis.

Introduction

Aim

The overall aim of the study was to investigate how the concept of Health Action Zones (HAZs) was translated into practice to tackle inequalities in health. It aimed specifically to examine whether HAZs represented a new form of partnership that provided an effective mechanism for policy delivery in relation to this complex problem.

Social policy has shown a renewed interest in the process of determining policy goals and the ways in which they are translated locally. There is a history of policy goals being determined centrally but mediated locally. There has been a lot of policy failure arising from a misunderstanding of government's power to achieve policy goals that lies in failure to appreciate the importance of the 'policy process' and of local interagency capacity (Newman 2002; Schofield 2001). This is perhaps no where more true than in the field of public health. This thesis is concerned with the policy process and delivery. It is not concerned with evaluation of health outcomes.

Public health and health action zones

Reducing health inequalities has been a feature of the present Government's new public health strategy for England expressed in a series of policy documents and initiatives. This contrasts with a period of inaction following the Black Report (1980). HAZs have been viewed as one mechanism for delivery of this policy goal. *Saving Lives: Our Healthier Nation*, set out the aims of improving the health of the population as a whole, and the health of the worst off in society to narrow the health gap (Department Health, 2000). The strategy is based on a 'socio-economic' model of health that acknowledges the wider social, economic and environmental determinants of

health (Dahlgren and Whitehead 1991). The evidence of the relationship between poverty and ill health, documented in the *Acheson Inquiry into Inequalities in Health* (1998) was accepted by the Labour Government, as was the need for a multi-faceted coordinated and collaborative policy response (Department Health 1998).

> *Connected problems require joined up solutions. This means tackling inequality, which stems from poverty, poor housing, pollution, low educational standards, joblessness and low pay. Tackling inequalities generally is the best means of tackling health inequalities in particular.* (Our Healthier Nation,1998.)

The main government responsibility was viewed as 'tackling the root causes of ill health'. This broader commitment to tackling deprivation and social exclusion has been a theme within many government policies. It has been expressed especially by the series of area-based initiatives targeting areas of multiple deprivation (Social Exclusion Unit 1998). HAZs was one of these area-based initiatives.

The national public health strategy was to be taken forward locally as part of the major reform programme for public services; which has been progressed through a successive series of White Papers and legislation. Quasi-markets have been replaced by an approach based on 'partnership' working. Health Improvement Programmes (HImPs) were to be the key local mechanism for securing improvements in health and reducing health inequalities. Essentially HAZs were intended to give a kick-start to action in areas that have the worst health record. However critics pointed out that HAZs could also be seen as a tokenistic response that demonstrated that the government was doing something, but at minimal cost.

The concept of HAZs was announced by the Secretary of State for Health in June 1997 only a month after the general election that brought Labour to

power. It predated all the other health initiatives mentioned above and therefore presents a rather interesting policy development. The purpose of HAZs was 'to bring together all those contributing to the health of the local population to develop and implement a locally agreed strategy for improving the health of local people' (*Health Action Zones-Invitation to Bid* 1997). Local consortia of organisations, set up by health authorities, would take forward joint health action programmes to 'reduce health inequalities, improve services and secure better value from the total resources available'. Such programmes would comprise public health measures and plans for reconfiguring health services covering a five to seven year timescale.

Eleven first wave HAZs were established in April 1998 involving a competitive bidding process, followed by a further fifteen HAZs in April 1999 (Department Health 1998). In total, the twenty six zones cover a population of some 13.4m.

Towards more holistic government

The new Labour Government's broad programme of policy reforms could be viewed as what Kingdon defines as a 'policy window' (Kingdon 1995). A new administration with a new approach at the beginning of its term of office had the opportunity to move the policy agenda forward. There was potential for rapid change and shifting evolved patterns of policy and institutional development in new directions. Poverty and social exclusion were 'cross-cutting' issues that the new Government now sought to tackle.

Commentators have variously defined this desire to achieve more integrated responses to complex problems as a move towards a more 'holistic' government (Mulgan 1998; Wilkinson and Applebee 1999). Perri 6 refers to the need for 'holistic, preventive, culture-changing, outcome-focused public policy'(6 Perri1997). The whole public policy system needs redesign to be outcome-orientated and based on a new relationship between the different

levels of government (Richards et al 1999). On the other hand, the public sector, and NHS in particular, has had almost two decades of major policy initiatives and change and may be 'innovation weary'. Outcome-based policy and joint working were intentions espoused by the 1974-79 Labour Government, and the subject of aspects of the later Conservative Government's reforms. Would these changes be any different? This study sought to understand HAZs within this context of transition in the public policy system.

Core assumptions

This study was also guided by recent thinking about appropriate approaches to the evaluation of complex social programmes, and specifically Pawson and Tilley's ideas of *Realistic Evaluation* (Pawson and Tilley 1997). This approach is concerned with explaining 'why programmes work, for whom, in what circumstances'. Evaluation, they argue, is a process of continuously unpacking the assumptions that underpin the choices of key stakeholders involved in the design and implementation of programmes. The concept of HAZ in principle created a new mechanism of partnership working that would enable local agencies to transform the way they operated to improve the health and wellbeing of communities. Close reading of the policy guidance on HAZs, suggested that from the perspective of policy makers, the policy rested on three core assumptions.

- *Improving health means tackling inequalities and demands action far beyond the NHS*

    Inequalities in health can and must be addressed if an inclusive society is to be achieved. Public health outcomes can be best secured through linking different policies and initiatives, nationally and locally (horizontally and vertically), designed to tackle social exclusion. HAZs, as one of

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number of area-based initiatives, provide a practical mechanism for achieving this integration. Furthermore problems of deprivation require local solutions based on engaging communities to 'harness local energies.....and build sustainable capacity'(Department Health 1997).

- *Public health must now move centre stage*

Public health should be mainstream rather than peripheral to the agendas of health agencies and local government. HAZs can act as the link between *Our Healthier Nation* and the reform programme in both health and local government. It is possible to reconcile and advance simultaneously the goals of improving the health of the least well off and modernising health services-'a massive double challenge' (Department Health 1997). This will ensure maximum value from total public expenditure.

- *New partnership mechanisms are required*

Formal strategic partnerships and collaboration are the best way of engaging all key stakeholders, including communities, in agreeing joint objectives and taking action to secure public health outcomes. Policy needs to be developed through local implementation; opportunities are required 'to create bespoke approaches' (Department Health 1997). New freedoms and incentives will help remove barriers to effective interagency working. This is within the framework of clear national goals and standards, and accountability mechanisms both to the centre and the public.

Interviews conducted as part of this thesis, showed that local stakeholders shared these assumptions.

Yet past experience and social science research discussed in chapters one and two suggest that:

- It is very difficult to bring about the complex changes required. Reducing health inequalities is dependent on a combination of fundamental social structural change, institutional collaboration, as well as individual opportunities and behaviour changes that are governed primarily by social and economic factors.

- Area-based approaches have limited capacity to achieve major change. The early establishment of Health Action Zones might indeed be no more than a publicity gesture or 'a quick political fix', with an inadequate budget for the task. Furthermore there is a deeper debate about the appropriateness of area-based approaches to effectively address issues of deprivation.

- The main NHS actors have never taken public health seriously.

- Formal strategic partnerships between agencies have tended only to achieve superficial change, and at the margins.

Would HAZs be any more successful? Would HAZs provide new ideas about how to tackle poor health outcomes in poor areas, where in the past efforts have been unsatisfactory. In particular, there is evidence that national programmes of health improvement tend to effect the middle class most readily and hence can contribute to widening inequalities (Macintyre 2000; Macintyre and Petticrew 2000).

This thesis concentrated on the effectiveness of partnership working methods. What was the new partnership approach being tested and did it work?

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Objective of this thesis

The limited objective of the thesis was therefore to answer the following questions:

- What theoretical models of partnership were being used as the intellectual framework behind the HAZ initiative and were evidenced in practice? (means)

- What was the success of these partnerships in addressing inequalities in health? (intermediate process outcomes)

This was a study of the policy process. The key logic was that policy required joint working. A necessary but not sufficient condition of success was that this form of interactive governance was achieved. This study is not concerned with whether health outcomes were achieved. The answer to this question would be a different more costly and long-term study.

Part I: Health inequalities and policy delivery

The first part of this thesis positions health action zones within the historical and current social policy context.

Chapter 1 defines why tackling health inequalities represent a 'wicked problem' for government, and identifies enduring and fundamental difficulties. Interpretations of the problem and policy responses from 19th century to 1997 are discussed.

Chapter 2 considers the Labour Government's approach. It argues that while the context for addressing health inequalities has become more positive, many factors remain that serve to marginalise public health. Consequently the potential of health action zones to bring about collaborative action in pursuit of health equity might or might not be realised.

Chapter 3 presents the theoretical framework for analysis of health action zones as a mechanism for collaborative policy delivery. This framework was used to generate and refine the research questions.

Chapter 4 sets out the research plan for addressing the research questions. How the research was conducted is described.

Chapter 1: Tackling health inequalities: a wicked problem

This chapter positions Health Action Zones within the context of long standing attempts by governments to address health inequalities. It discusses why health inequalities represent a wicked problem for government. It argues that governments' failure to deal with this complex problem relates to three enduring and fundamental difficulties.

Firstly the position of public health as a policy goal and as a profession has been variable or weak. The review of past trends in public health policy demonstrates that for much of the 20th century public health has failed to count. Public health policy has been narrowly conceived and marginalised within the framework of health <u>service</u> policy. The public health profession has itself been consistently marginalised.

Secondly political ideologies and values of different governments have influenced how the problem of health inequalities has been conceived, and hindered the development and legitimisation of a robust policy framework. In particular the role of the state and public sector investment has been a central feature of the health inequalities debate.

Thirdly the intrinsic approach to governance of Britain as a unitary state did not provide the necessary mechanisms for effective policy development and delivery. The culture and mechanisms necessary for a cross-sectoral and cross-government response to health inequalities have been lacking.

The changing fortunes of public health as a political issue

The 19th and early 20th centuries have been termed by commentators as the hay day of public health. The public health movement was based on the obvious link between social, economic and environmental conditions

associated with urbanisation and population expansion and poor health. The main and inter-related public health issues were sanitation, housing, infection, nutrition and the poor health and excess mortality of the population. The public health movement was characterised by examples of public health leadership, the support of public opinion, effective interventions and massive achievements. Chadwick, Farr, Simon and others acted as powerful advocates, and positioned public health as a central function and as a priority on the political agenda (Hamlin and Sheard 1998). For example, Chadwick's report on the *Sanitary Conditions of the Labouring Classes* (1842) mobilised public opinion in favour of reform (Holland and Stewart 1998). The report described...:

> *The appallying living conditions of the poor and the association between poverty and ill health. Inadequate drainage, sewerage brought the inevitable consequences of disease, high rates of mortality and limited life expectancy.* (Holland & Stewart 1998).

The public health legislation of the 19th century established the state as guarantor of standards of health and environmental quality, despite the dominance of laissez faire thinking that dictated minimum state intervention. Early public health acts facilitated the building of sanitary systems but also established local and central units of government that would take responsibility for health. Locally this focused on the appointment of local Medical Officers of Health. The 1885 Public Act served to consolidate much of the previous legislation. Furthermore, health reform was seen as 'an umbrella for other social questions'. Public health legislation became 'a filter for wider social reforms' given that this was the only way of tackling them (Lewis 1986). 'State protection of public health positively flourished' through wide ranging legislative measures (Lambert 1963). Over the last half of the 19th century and early 20th century there were radical improvements in terms of reduced mortality and morbidity rates for all ages, particularly as the toll of infectious diseases was brought under control. However infant mortality remained high (Whitehead 2000).

At the beginning of the 20th century public health remained strong. Locally MOHs were effective in bringing about many local improvements. The establishment of the Ministry of Health in 1919 indicated that health and particularly public health was on the political agenda (Holland and Stewart 1998). However the focus now started to shift from the environmental and social model of public health to concern with individual health status, and personal health services. The idea of what public health was about and what public health as a function was legitimately mandated to do was considerably narrowed (Lewis 1986). Scientific advances in bacteriology appeared to show a more tenuous link between ill health and social issues and attention focused on personal hygiene and health education. Holland and Stewart noted that the emergence of effective therapeutic agents for acute treatment of disease began to overshadow disease reduction through public health efforts. The link between poverty and health became more complicated and more difficult to discern.

This fundamental tension between health services and population health is captured in Brockington's comment (quoted by Holland and Stewart 1998).

> *Public health is an abstract idea; it has not the glamour or drama of disease. The newspapers can fill a column with an account of saving of life by an eminent surgeon or physician called as a last resort to the bedside of their child, or with a description of some novel operation on the heart or brain. In contrast there is little news value in the activities of public health; what is there to say about an epidemic of typhoid fever that never occurred.* (Fraser Brockington, 1949)

This tension has endured. The structuring of the argument as a trade off between health services and public health has consistently served to marginalise public health in the political agenda.

Public health was being positioned within a narrower medical model of health. It could be argued that this tension was actually reinforced with the creation of the National Health Service. Specifically the creation of a national health service was assumed to be the way of improving the health status of the population. Promotion of public health was equated with health care and equity with removing the price barrier to care. Beveridge's vision was of 'a health service which will diminish disease by prevention and cure' (Webster 1998; Holland and Stewart 1998). It was therefore expected that expenditure would level off or even decline, as people became healthier. A key role for the NHS was prevention.

Conversely, the creation of a national health service, with its strong value-base of social justice, could have provided a strong platform for pursuing equitable health care provision and promoting wider public health. But medical politics, including the low status of public health doctors within the medical profession, proved to be the dominant factor determining the configuration of the NHS and marginalisation of public health (Honigsbaum 1979). The new tripartite structure had the effect of reducing the power and influence of the public health function from the start. MOHs remained within local authorities with reduced responsibilities covering preventive and community health services and environmental health. Holland and Stewart point out that public health, not for the first time or the last, did not grasp the political reality. 'It expected reason to prevail and grossly underestimated the power of concentrated lobbying by bodies such as the British Medical Association, the Royal Colleges and the voluntary hospitals' (Holland and Stewart 1998).

The weak position of the public health function continued to hinder the public health voice in the debate about health priorities. The 1974 reorganisation brought public health doctors together with community services into the 'unified' NHS. The former MOHs, newly named community health physicians

were positioned within consensus management boards. The public health voice was expected to produce more rational allocation of resources based on the assessed health care needs of communities. In practice, however, community medicine became 'deeply embedded within the NHS managerial philosophy' and failed to provide any real advance of public health 'by way of approach to health problems or as a model for delivery of health services' (Lewis 1986; Webster 1998; Holland and Stewart 1998).

Concerns about geographical disparities in access to health services had their origins in the 1940s, and the establishment of the NHS was intended to address these disparities. However by the 1960 frustrations were expressed with the apparent failure of the NHS to deal with this issue. Tudor-Hart in 1971 pointed to the operation of 'the inverse care law' ie 'the availability of good medical care tends to vary inversely with the need of the population served' (Tudor-Hart 1971). The early 1970s saw an increasing number of studies (such as Cooper and Culyer's work) that demonstrated geographical and social class disparities in access the health services and personal social services (Webster 2003). It was not until the 1970s that significant financial pressures however led to the first genuine government attempts to establish a more systematic approach to rational planning and resource allocation (RAWP formulae) in pursuit of both efficiency and equity. Glennerster and colleagues' analysis showed that both RAWP and its successors did succeed in 'pulling health-service resources nearer to what experts, at least, think are those areas' relative needs' (Glennerster et al 2000). They also pointed out that the long term support for resource allocation based on relative needs had in fact transcended political differences and been based on 'a moral predisposition' and 'a general societal belief in fairness' (equal need receiving equal resources).

However the goal of reducing inequalities in health outcomes is clearly a much broader issue than equity of access to health care. The problem has

been subject to ongoing political debate and conflict and struggled to achieve policy recognition. As far as NHS policy, increased emphasis had been continually placed on prevention, which in essence meant encouraging the public to adopt a healthier lifestyle. Webster comments that this lifestyle approach served to give 'license for the state to withdraw from its obligations' to tackle broader issues as well as produced unrealistic expectations of efficiency savings (Webster 1998). However such concerns were being expressed more broadly with the effectiveness of Welfare State policies in dealing with inequalities. A 'campaign' by Titmuss and colleagues articulated this 'rediscovery of poverty' (Webster 2003). Their work provided the basis for renewed policy debate.

The health inequalities debate and concepts of welfare

The recognition and interpretation of the problem of health inequalities and the policy response has been strongly influenced by political ideologies and values. Governments' concept of welfare has been central to the debate. Different models of welfare have underpinned the direction of policy on health inequalities ie whether 'ill health' was viewed as a 'burden' or an asset to be realised.

This influence of political values was very evident in the 1980s. Certain Labour politicians were aware and concerned with the growing evidence about social as well as spatial differentials in heath and their causes. Consequently the Labour Government commissioned the *Black Report* (DHSS 1980). This proved crucial to advancing the debate about the need for a broader national health policy. It was the first attempt authorised by a government to explain trends in equalities in health and to relate these to the policies intended to promote health. It showed that disparities in health were real and had widened continuously among adults since 1951. Much of the problem lay outside the scope of the NHS itself. Economic and social factors

such as income, work and unemployment, environment, housing, education, transport and diet all influence health and are better handled by the more affluent members of society. National health policy did not, <u>but should</u>, involve itself in these factors. Recommendations centred on a comprehensive antipoverty programme. It also called for national health targets to be set and the establishment of a national inter-departmental committee to achieve greater co-ordination of health-related policies between government departments and local counterparts. However the new incoming Conservative Government was unwilling to accept explanations that called for more government expenditure and more government intervention. Indeed it attempted to limit its impact by stifling its publication. Despite this rejection, the *Black Report* and subsequent *Health Divide* (Health Education Council 1987) were successful in stimulating public awareness, debate and research.

In particular, Black stimulated much research and debate about the possible explanations of the social variations in health. Black pointed to four main possibilities: an artefact of measurement error; arising from social selection; caused by individuals' behaviour; and results of individuals' material and social circumstances. Critics argued (eg Illsley 1986) that there were a number of reasons why differences in mortality by social class were an artefact of the way the statistics were derived. These included numerator/denominator bias and the unstable meaning of social class over time. However further reviews indicated that, although such statistical problems were numerous, other measures of socioeconomic status had demonstrated similar patterns (eg Blane 1985; Macintyre 1986). Illsley (1955) identified the phenomenon of social selection ie social variations in health can arise from social mobility. However later work (eg Fox et al 1990; Whitehead 1992) found that although social mobility may be health related, it was only likely to account for a small proportion of the mortality differential between social groups. The behavioural explanation has been well supported by evidence. People in disadvantaged circumstances are more likely to engage

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in health-damaging behaviour. However studies also showed that, having controlled for behaviour, social gradients in health still existed (eg Whitehall Study, Marmot et al 1984). Furthermore numerous studies built an evidence-base demonstrating the association between poor material and physical environments and high levels of mortality and morbidity (review by Whitehead 1992). Studies have also demonstrated that the individual's psychosocial environment is an important determinant of health.

Interpretation of the causes of social inequalities has been critical to establishing the conceptual framework and basis for a policy response for addressing health inequalities. Black and others (including Acheson 1998) in reviewing public health approaches necessary to impact on the problem, have endorsed the need for income redistribution and increasing public expenditure. However the incoming Conservative Government of 1979 was fundamentally opposed to such measures. Reducing public expenditure was regarded as vital to improving economic performance, and any increase in even the NHS was unacceptable, as indicated by Patrick Jenkin's comment in his memoir on the Conservative's response to the Black Report (Secretary of State for Social Services 1980):

> *The Conservative Government had come into office in May 1979 committed to establish a firm control on the public finances, to reduce public expenditure and to make room for progressive cuts in the burden of taxation......What was clear, however, beyond a peradventure was that I could not look to the Treasury for any significant increases in NHS spending beyond the growth agreed by the Cabinet.* (Patrick Jenkins 2003).

Political ideologies and values reflected Titmuss's 'public burden model of welfare'.

> *In general terms this sees public welfare expenditure, and particularly expenditure which is redistributive in intent, as a burden; that is, an impediment to growth and economic development. Consequently spending on the welfare state needs to be reduced.* (Titmuss 1967).

The Conservative Government's policies aimed to constrain public sector resources but also secure the support of 'middle income voters'. The solution was a programme of public sector reforms that was designed to respond to consumer demands (Glennerster and LeGrand 1995).

> *The new watchwords for the public sector become competitiveness, efficiency, consumer choice and value for money, while other values embedded in the history of the welfare state-access, equity, need and universalism-were ideologically discredited.* (Taylor-Gooby 1991).

Furthermore, the New Right ideology meant that the government could not be perceived as 'nannying'; and choice meant freedom to choose to adopt healthy lifestyles with the state providing the necessary information through campaigns as well as primary health care. Emphasis was given to improving delivery of health care services and the voters wanted this. The policy context therefore presented rather unpromising prospects for any advance of a broader public health approach.

Irrespective of academic debate, and lack of national leadership in the 1980s, locally some health authorities and local authorities embraced the wider health inequalities agenda. This was given momentum by the World Health Organisation's strategy for *Health for All by the Year 2000* and associated Healthy Cities projects (Townsend, Davidson and Whitehead 1992).

The national health strategy: centralism versus localism

It is therefore surprising that the Conservative Government launched England's first national health strategy (*Health of Nation* Green Paper DH 1991). But there are a number of reasons that help explain this development. Health ministers saw the creation of the NHS internal market and the purchasers-provider split as the opportunity for health authorities to develop a more strategic role and manage provider driven demand. *Health of the Nation*

(*HOTN*) was viewed as filling the policy vacuum-'the key to shifting the focus from NHS institutions and service inputs to people and health' (Mawinney and Nichol 1993). Furthermore, newly named Directors of Public Health were given a key role in helping shape local health strategies (DH 1988). The government had also become concerned about England's poor health record internationally. The strategy may have been an acknowledgement of the influence of the public health movement internationally. It could be seen as a response to 'peer pressure' driven by an international climate of values. Canada, the US and a number of European countries already had national health strategies, and the WHO's Healthy City programme had growing local support in the UK (Allsop 1995).

HOTN aimed to secure 'continuing improvement in general health of the population by adding years to life and adding life to years'. Five key areas with associated objectives and national targets were defined to focus efforts. The NHS was given the central role in leading implementation. *HOTN* was a key strategic goal for the NHS and included in successive *NHS Priorities and Planning Guidance*. 'Healthy alliances' across sectors at both national and local level were viewed as central. No additional resources were made available.

There was both support and criticism of the document. Many welcomed *HOTN* as it was the first national health strategy and represented some shift in health policy from health care to population health. However it was criticised for its narrow disease focus on individual lifestyles. Health inequalities caused by poverty were absent. For example the Faculty of Public Health Medicine proposed that it should 'focus on the factors that led to ill health-smoking, poverty, inadequate housing for example rather than on the disease and conditions that resulted'. Belatedly the CMO's report *Variations in Health* in 1995 set out the role of the DH and NHS in addressing 'health inequalities' (DH 1995). Although acknowledging the document as

worthwhile, Wilkinson viewed it as a further lost opportunity for genuinely addressing health inequalities, and that inaction would prove costly in the long term (Wilkinson 1995). The King's Fund report *Tackling Inequalities in Health* reiterated the differential health experiences amongst social groups, drew attention to the detrimental health consequences of growing income disparities, and echoed calls for wide ranging changes in social and economic policies as well as more significant efforts by the NHS (Benzeval M et al 1995).

A series of reviews showed variable progress towards *HOTN* targets. Attention was drawn to the fact that changes could not necessarily be attributed to the national strategy (eg National Audit Office 1996). The most comprehensive and recent process evaluation of *Health of the Nation* stated:

> *The HOTN failed over its five year lifespan to realise its full potential and was handicapped from the outset by numerous flaws of both a conceptual and process type nature. Its impact on policy document peaked as early as 1993 and by 1997 its impact on local policy making was negligible. It wasn't seen to count while other priorities, for example waiting lists and balancing the books, took precedence.*
> *(The Health of the Nation-A Policy Assessed DH 1998.)*

HOTN was regarded as a DH initiative, which lacked cross-departmental commitment and ownership. At local level it was seen principally as a health service document and lacked local government ownership. Within the NHS the strategy had little impact on the dialogue between purchasers and providers and did not cause a major readjustment in investment priorities by health authorities. Little impact was made through the contracting process. It did not have serious impact on primary care practitioners either as commissioners or providers. Community trusts were mostly involved through community development activities and health promotion programmes. Acute trusts were untouched. Local authorities in general perceived the *HOTN* to be dominated by a disease-based approach and heavily medically led. This was

a cause for concern among those local authorities, which believed that they contributed more to a health agenda, in its broadest sense, than health authorities. There was criticism of the targets on technical grounds. The performance management process was heavily geared to short-term outputs, largely driven by the Efficiency Index/Patient's Charter/financial management agenda. There were no performance management incentives to develop strategies to promote health as opposed to health services.

Overall *HOTN* demanded inter-sectoral partnership working. However it failed to provide the necessary framework and incentives for either cross-departmental working or engagement of key players locally. It was perhaps rather ambitious or naïve to expect genuine cross government working and commitment given the traditional 'Whitehall' centralist mode of operation and 'silo' mentality (Heclo and Wildavsky 1974). Local authorities had difficulty reconciling rhetoric about 'healthy alliances' with the allocation of lead responsibility to the DH and the NHS (Moran1996). The result was that HOTN was 'ghettoised within public health departments' (DH 1998).

In summary, this review of why health inequalities has proved to be an intractable problem has highlighted its marginal and compartmentalised position within health policy. Political ideologies and values have significantly influenced governments' willingness and commitment to take action. Furthermore the centralist and compartmentalised mode of governance failed to provide the necessary mechanisms and incentives for broader inter-departmental and multi-sectoral policy development and delivery of health strategies.

Chapter 2: The Labour Government's promise

This chapter considers whether the Labour government's approach, since 1997, has represented a distinct response to tackling health inequalities. It is suggested that the three main factors that made health inequalities a wicked problem (discussed in the previous chapter), have been challenged.

Firstly a more robust policy framework has emerged that reflected the growing academic understanding of the multi-factorial nature of the problem. Health inequalities are viewed as a 'cross cutting' issue that is integral to wider policies aimed at reducing social exclusion and deprivation. Secondly this definition of the problem and response is aligned with Labour's political ideology and values. Welfare reform is viewed as central to Labour's proclaimed 'third way', which regards that pursuit of social justice and economic prosperity as not mutually exclusive (Deacon 2002). Thirdly Labour appears committed to addressing issues of governance and silo mentalities, through 'joined up government' and partnership working.

Furthermore the emphasis has been on implementation or at least 'seen to be doing something'. This was exemplified by the launch in 1998 of Health Action Zones as a new form of partnership and mechanism for policy delivery on health inequalities. This chapter assesses the rational for Health Action Zones in the context of:

- the long history of less than successful area-based approaches to poverty and deprivation, and,
- the series of rapid policy developments under New Labour that have influenced local partnerships working.

Two schools of thought on the possible impact of HAZs are identified based on this assessment.

Tackling health inequalities: taking forward the Black agenda

It could be argued that the election of Labour to power and size of the majority created the political conditions for a significantly different approach to tackling health inequalities, than under the Conservative Government. Indeed the large majority gave a mandate for change. New Labour's policies, with respect to health, in fact demonstrated a great deal of continuity with past old Labour values (with some additional features). The agenda that had been started in 1979 with the Black Report, but rejected by the Conservative Government, could now be taken forward.

Although there was much discussion and argument about a 'third way', health inequalities and Health Action Zones were more a kin to the traditionalist approach of old Labour. The academic evidence about the nature of the problem, and what needed to be done, was in line with traditional values and ideology. As outlined in the introduction of this thesis, the *Acheson Inquiry into Inequalities in Health, Saving Lives: Our health nation* and Health Action Zones were early signals of a radically different national policy framework for improving health and tackling health inequalities from the Thatcherist era. The Acheson Inquiry set out the evidence explaining the social variations in health that led Ministers to declare:

> *The whole Government, led from the top by the Prime Minister, is committed to the greatest ever reduction in health inequalities....Poverty is a principal source of ill health. Poor people are ill more often and die sooner....*(Frank Dobson, DH Press release November 1998.)

Some aspects of social policies (such as welfare reform) however did show shifts from the Labour past. Certain features were defined as a new approach. The 'authorised version' of the 'third way' of Blair and Giddens emphasised the need to adapt the traditional values of the centre left to contemporary social and economic conditions. There was not a contradiction

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between the creation of wealth and the pursuit of social justice. It was possible to both promote enterprise and to attack poverty and discrimination (Giddens 1998). Furthermore welfare reform was viewed as a centerpiece of third way politics. Investment in public services was not a burden. The emphasis on active citizenship and 'rights and responsibilities' (a shift from Titmuss' model of 'old Labour') had its roots in communitarism.

With respect to economic policy however the Labour Government maintained the conservative public expenditure plans for the first two years. The early HAZ initiative could therefore be questioned as more about political expediency, demonstrating that something was being done at minimum cost. However subsequent Spending Reviews of 2000 and 2002 did increase investment in public services, particularly in health and education (Treasury 2000, 2002). It was therefore possible to invest in some of the wider measures required to improve public health, such as a strategy to reduce child poverty. The political preconditions for advancing the Black agenda therefore existed, although initially constrained by limited additional resources. Targeting through Health Action Zones was in fact in line with Titmuss' advocacy of priority allocations (positive discrimination) within a universal framework of provision (Titmuss 1967).

Furthermore, institutional evidence indicates government's intention to address weaknesses of governance for policy development and delivery, as highlighted in White Paper: *Modernising Government* (1999). This was expressed in 1997 with the launch of the Health Action Zones and most recently by the Treasury's *cross-cutting review of health inequality* (Treasury 2002) and forthcoming government-wide delivery plan. There are attempts at least to integrate the goal of reducing health inequalities within a cross government response to tackling deprivation and poverty. (Analysis of how health inequalities have been reflected in wider policies since 1997 is

discussed later in this chapter.) The Treasury's cross-cutting review of health inequalities:

> *was set up to assess our progress ...sets out our long-term strategy to reduce health inequalities...will form the basis of our cross-Government delivery plan...It puts health inequalities at the heart of every key public service, harnessing the power of billions of pounds of extra Government funding*
>
> *......Health Action Zones have done a great deal of innovative work in deprived areas, and ..this should be mainstreamed to other parts of the NHS. (Treasury Spending Review: Tackling the causes of health inequalities.* November 2002.)

This study examines whether this positive claim about health action zones was justified. The next sections assess the rationale for Health Action Zones and prospects for success, based on previous evidence of such approaches.

A history of area-based approaches

There has been a long tradition of area-based social programmes. Trends in area-based policy development have been underpinned by debate about whether area-based approaches are appropriate for dealing with the problems of poverty and deprivation and reducing inequalities. This debate is highly relevant to assessing the rationale for HAZs and the potential success of HAZ partnerships as a policy delivery mechanism.

In the 1970s Townsend led the challenge against over-reliance on area-based schemes, stating in the Barnet-Shine Memorial lecture that such policy initiatives were unlikely to succeed on their own (Townsend 1979). His national study of poverty at the end of the 1960s demonstrated that problems of deprivation related to structural factors, and also showed that many of the worst urban problems also occurred in more affluent areas, though smaller percentages of the population were affected. This led him to recommend

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'giving priority to national, not area-based policies, though the latter clearly had an important supplementary role' (Townsend 1991). He noted that:

> *'the tendency of those in administration, the professions, politics, and the media was to misrepresent national problems as area problems, with the effect of minimising their extent, and scape goating whole communities. Another effect was to divert attention from central political, market and institutional responsibilities for social ills to the vagaries and lesser importance of local administration and local social relationships. Indeed, the term 'inner city' has to be qualified and deployed as just one concept among a set of structural concepts that have to be used in explaining a national disorder, or it will end up reinforcing the self-same tendency.'* (Townsend 1991.)

The need for both area-based and national responses

Academic understanding and debate subsequently moved on. Over the past decade in particular new evidence has demonstrated increasing levels of inequalities, and most recently increasing polarisation between areas as measured by available indicators of deprivation and affluence (Hills 1996,1998; Green 1996; Noble and Smith 1996). This is recognised as an international phenomenon (OECD 1998). New theories relating to the causes of growth of distressed areas, and the processes of neighbourhood decline and change serve to demonstrate the complexity of the relationship between economic, social and spatial factors. The argument of 'area versus national' is much too simplistic.

Glennerster and colleagues draw attention to new economic theory and work showing that structural causes of the increasing concentration of deprivation have a distinct 'area effect' (Glennerster et al. 1998). Culter and Glaser's US study demonstrates that concentration of low income households produce 'negative spillover effects' beyond those to be expected from the additive effects of many poor people living together- 'segregation leads to adverse

outcomes not that adverse outcomes result in more segregation'(Culter and Glaeser 1997). Reasons relate to how reinforcing labour market, housing market and educational factors operate. For example Jargowsky's work (1997) distinguishes between the effects of macro structural explanations of neighbourhood poverty and local reinforcing factors. Poor work opportunities lead to poor school performance, poor human capital leads to low productivity and low income for example. While larger metropolitan wide changes can explain four fifths of the higher poverty of these areas, a fifth must be associated with 'neighbourhood effects'. This implies that macro economic policy geared to full employment are not likely to succeed unless economic and education and training policies are targeted on deprived areas to ensure socially excluded groups can be brought into the labour market. Similarly with respect to the operation of the housing market, the more unattractive the housing and the area facilities the more segregated the population the lower the social and human capital content and the less capable are the individuals and the area to attract jobs (Power 1997). Research on education performance and later earnings shows that, even when poverty and family background and initial abilities are taken into account, being in a class with many other poor children has an additional effect. Such children's school performance is worse and their later earnings are lower (Robertson and Symons 1996).

Furthermore the ESRC research programme on *Health Variations* has demonstrated that place makes a contribution to health inequalities (Graham 2000). While individual factors are the primary cause of spatial inequalities in health, areas also have an effect. Poorer people may have poor health in part because they have to live in places which are health damaging (Macintyre 1997). Material and psychosocial pathways have been suggested to explain how place damages health. People are more likely to be exposed to hazards such as environmental pollution, traffic volume and rates of road accidents, and have poorer access to public services. The way community relationships

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operate have been investigated, to understand the social dimensions of areas and impact on health (Graham 2000). The idea of social capital has gained particular currency and is discussed further below.

This evidence of an area effect shows that success in addressing inequalities is likely to be dependent on the extent to which national policies concerned with structural causes of deprivation are translated through local initiatives into opportunities for socially excluded groups.

> *'Macro and micro anti-deprivation policies are interdependent'* (Glennerster et al 1998.)

Community regeneration and health

The academic debate has begun to explore the link between area-based community dynamics and the potential for improving health as well as social and economic outcomes. The level of community 'cohesion' can be an important factor militating against neighbourhood decline. Some poor areas are stable because a high degree of 'collective efficiency'-a predisposition to be active in both family and community life (Morenoff and Tienda 1997). Community participation and 'bottom-up' community initiatives have become increasingly regarded as central to the success of regeneration programmes.

Various strands of work shed light on what social cohesion means and how it might be enhanced. In particular the concept of social capital has been proposed as a framework to help understand the dynamics of social cohesion and its economic and social benefits and more recently the potential health benefits (Putnam 1993; Gillies 1997,1998). Putnam's work defines social capital in terms of four characteristics: community networks; civic identity ('sense of belonging'); norms of cooperation and reciprocity and trust; and civic engagement. Social capital has been related to good governance, economic performance and some measures of health status such as infant

mortality and life expectation in regions of Italy (Putnum 1993). It has been suggested that social capital may act as a mediator between deprivation and health (Wilkinson 1996; Kawachi et al. 1997).

Health promotion programmes aimed at communities are not new but greater emphasis has traditionally focused on changing health-related behaviours of individuals. Increasingly social capital is being viewed as a potential framework for providing a new theoretical base for health promotion policies and the design and evaluation of community-based programmes geared to creating 'enabling environments' (Campbell et al. 1999). This means investing in community involvement and capacity building as prerequisites for successful health programmes (Kreuter et al. 1997). The greater the level of community involvement in setting agendas for action and in sharing power the greater the potential health gain. Volunteer work, peer programmes and civic activities ensure maximum benefit from community approaches. In addition durable structures that facilitate planning and decision making at local level, such as social action committees, are key factors in successful partnerships for community development (Gillies 1998). The US 'Comprehensive Community Initiatives' is an example of how programmes, based on the principle of community building, are now being developed and evaluated (Apsen Institute 1997; Connell et al. 1995).

In short both US and UK evidence suggests there are good grounds for taking an area-based approach as part of a national strategy for tackling health inequalities.

The area-based approach is now central to the Labour Government's national strategy for tackling inequalities and social exclusion. This could be seen as policy learning, and HAZs are part of this process. The evidence seemed to support a policy of combining national policies with geographically targeted initiatives that were strategically coordinated and integrated through local

multi-sectoral partnerships. Theoretical arguments, increasingly supported through empirical findings, suggested the importance of spatial targeting and local differentiation of policy in addressing social exclusion. This at least was how New Labour policy entrepreneurs saw it in 1997.

New Labour's health policy agenda: health action zones to neighbourhood renewal

As set out earlier in this chapter, the new policy context has become more conducive to the promotion of public health and reducing health inequalities in comparison to the previous Conservative environment. There has in effect been a convergence of policy streams; the alignment of health inequalities with the broader cross government commitment to tackling deprivation and social exclusion. The Acheson *Inquiry into Inqualities in Health* secured the more robust conceptual framework required for tackling health inequalities. Despite this convergence at a conceptual level, the mechanism for integrated policy delivery remained a major challenge for the Labour Government. Health Action Zones were viewed as 'trailblazers', pioneering new ways of partnership working to secure implementation locally and provide a source of learning nationally.

However Health Action Zones cannot be considered in isolation. Over the study period HAZs have operated within a complex and turbulent wider policy context. HAZs have been part of a rapidly evolving programme of public sector reforms.

More specifically, the table below sets out the chronology some of the key policy developments that have influenced changes in local partnership arrangements and the positioning of the health inequalities agenda. It is important to recognise that not all these developments were conducive to promoting action to tackle health inequalities, but overall a more positive

policy climate was created. Stewart and colleagues' evaluation of collaboration in the field of regeneration and inequalities, defined in effect two 'generations' of policy ('or more accurately mechanisms and machinery for policy delivery') over this comparatively short period (Stewart et al. 2002). The first reflected the long-standing emphasis on small area approaches including the creation of a large number of zones. The second phase placed emphasis on mainstream programmes and strategic partnerships. Specific mechanisms for delivery of health improvement and reducing health inequalities were integral to these developments. Two 'generations' of policy are evident and are highlighted in the table.

Chronology of some key national policy developments influencing changes in local partnership arrangements and positioning of the health inequalities agenda since 1997	
Phase one	*The New NHS* White Paper: Primary Care Groups established for devolution of health resources and decision making for service development and delivery.
	26 Health Action Zones established: first wave April 1998, second wave April 1999.
Legitimisation and positioning of health improvement and health inequalities on the joint strategic agenda Proliferation of initiatives addressing social exclusion and inequalities.	Acheson *Inquiry into Inequalities in Health* *Saving Lives: Our Healthier Nation* White Paper sets out national health targets Health Act 1999: Health agencies have duty of partnership Health Improvement/Health Partnership Board structures established; replacing Joint Health Consultative Committee mechanisms. First Health Improvement Programmes 1999/2000. Pooling of budgets for health & social care. Social Exclusion Unit established. Series of initiatives targeting issues of social exclusion. Area-based initiatives launched by a number of government departments, including Sure Start, Healthy Living Centres, Education Action Zones, New Deal for Communities, Single Regeneration Budgets etc *Modern Local government* White Paper and Local Government Act: Local authorities duty to promote economic, social and environmental wellbeing of communities. Requirement for new local government political management structures; cabinet model. Best Value plans. *Reaching Out: The Role of Central Government at Regional and Local Level* (Feb 2000). Regional Coordination Unit set up; review of area-based initiatives, including Health Action Zones. *2000 Spending Review:* GIDA (government initiatives in deprived areas) targets, including health, basis for Performance Service Agreements across government.

Phase two	NHS Plan and national targets: Chapter 13 defines NHS commitment to addressing health inequalities; reference to PCTs linking with neighbourhood renewal, 2000.
Locally devolution and integration of health partnerships and health within a whole system approach to promoting wellbeing and reducing inequalities	Shifting the balance: Next Steps: Primary Care Trusts (approx 300) set up, 28 Strategic Health Authorities, replacing health authorities, reconfiguration of public health function (April 2002). Public health function becomes part of integrated government offices at regional level, transferred from NHS Executive regional offices (April 2002). Health and Modernisation Programmes to be produced by new PCTs.
	Select Health Committee Report on Public Health: March 2001. Review of public health strategy and public health function.
Focus on community engagement and cohesion	Local Government White Paper (Strong Local Leadership-Quality Public Services) Dec 2001. Local Public Service Agreements: freedoms and resourcing linked to performance against national targets. Strengthening of local participatory democratic processes.
	National Strategy for Neighbourhood Renewal: Action Plan (SEU;2001) Local Strategic Partnerships established & accredited. Community strategies April 2002. Neighbourhood Renewal strategies & floor targets; Neighbourhood Renewal Funds, Neighbourhood management. Community Empowerment Fund to set up Community Networks.
	White Paper on regional government: options of new forms of regional governance including elected regional assemblies and changes in local government structures.
	National health inequalities targets set for reducing infant mortality and improving life expectancy. DH consultation on delivery plan for tackling health inequalities (2001) and response (July 2002).
	Wanless Report: Securing our future health: taking a long-term view Treasury April 2002. HM Treasury 2002 Spending review, July 2002. Including cross-cutting spending review on tackling health inequalities (Summary report Nov 2002) Cross-government 'delivery plan' for tackling health inequalities forthcoming.
	Improvement, expansion and reform: the next 3 years priorities and planning framework 2003-6, including objectives for NHS contributions to reducing health inequalities. DH Oct 2002.

Initially, The New NHS and Modern Local Government White Papers set out a future vision for local 'health' systems based on partnership working around quality and long-term outcomes. New mechanisms and levers (Health Improvement Programmes, Primary Care Groups (PCGs), new NHS performance management framework, new duties of partnership on health bodies and local authorities, resource allocation processes) were all designed

to bring this about. Local government's public health role was promoted through its new explicit duty for improving the social, economic and environmental well being of communities. Within this context a range 'area-based ' initiatives were launched by different government departments aimed at targeting deprived areas and groups to test innovative forms of service delivery through partnership working. Overall this first phase of developments served to legitimise and position health inequalities on the strategic agenda and also stimulate innovation and experimentation in tackling various forms of inequalities and social exclusion through the proliferation of initiatives.

There is evidence that the government sought to learn about challenges to effective policy delivery. In particular, the Cabinet Office's report *Reaching Out* (2000) examined the role of central government at regional and local level. It was important in highlighting the difficulties of effective implementation, particularly through the range of initiatives.

> *There were two many government initiatives, causing confusion; not enough coordination; and too much time spent on negotiating the system, rather than delivering. (Reaching Out: The Role of Government at Central and Local Level*, Cabinet Office Feb 2000)

Furthermore it had been difficult to exploit local synergies between mainstream and area-based programmes.

The second phase of Labour policies has been characterised by further attempts at 'joined up government'; moves to strengthen the strategic approach to addressing issues of deprivation and social exclusion nationally and locally. Emphasis was increasingly placed on ensuring mainstream strategies and resources address deprivation. Ways of integrating, rationalising and mainstreaming initiatives were an important concern.

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The *2000 Spending Review* was significant in setting out the Government's aim:

> *to narrow the gap between the most deprived neighbourhoods and the rest of the country, so that within 10-20 years no one should be seriously disadvantaged by where they live.*

For the first time government departments' performance was to be assessed according to impact on the worst rather than the average. The task of tackling health inequalities has been increasing aligned with government's efforts to tackle neighbourhood renewal.

The NHS Plan became the NHS strategic framework for delivery of improvements in health care. It set out targets in areas such as coronary heart disease, cancers and well as service access (DH 2000). In principle it also reinforced the NHS' commitment to tackling health inequalities. But this study investigation revealed that the *NHS Plan* in fact was perceived locally as downgrading health inequalities as a priority and was interpreted locally as a shift in Ministerial commitment (discussed in detail in later chapters). It was waiting lists that mattered.

Shifting the Balance of Power brought about rapid and radical NHS restructuring (DH 2001). This led to the creation of approximately 300 new Primary Care Trusts (covering populations of approx 150,000-200,000). PCTs were given the remit of improving health and tackling health inequalities (as well as health care) although their commitment and capacity to take forward this role was questionable. 28 new Strategic Health Authorities replaced health authorities. Furthermore *Shifting the Balance of Power* involved radical restructuring of the public health function. In particular this would involve the devolvement of public health staff to Primary Care Trusts. The creation of 'public health networks' (to operate across PCTs) were proposed as the way

for ensuring this specialist public health resource could effectively support PCTs deliver their agenda.

The *National Strategy for Neighbourhood Renewal* was seen as a key vehicle for targeting efforts locally as well as directing mainstream government department spending and commitments (Social Exclusion Unit 2000). It set out the action plan for achieving the Public Service Agreement 'floor' targets, which included health targets. Additional Neighbourhood Renewal funding was made available to the 88 local authorities that experience the highest levels of deprivation. New Local Strategic Partnerships, led by local authorities, were expected to provide the overarching strategic vision locally, through community strategies, based on collaborative efforts across public, private and community sectors. LSPs were required to prepare local neighbourhood renewal strategies to achieve floor targets. Such strategies were expected to integrate and coordinate the range of regeneration and other initiatives as well as influence mainstream services.

There was some coverage and commitment to health inequalities (Chapter 13) in *The NHS Plan*, although many perceived this as inadequate. However the health inequalities agenda subsequently received increased policy attention and impetus following the setting of national health inequalities targets (for the first time ever). This apparent revived central government commitment appears to reflect economic concerns as well as political ideology.

The *Wanless* report *Securing our Future Health: Tacking a Long-Term View* (Treasury April 2002) was commissioned by the Chancellor, and modeled scenarios of future health care costs in relation to demands. The 'fully engaged scenario' was recommended. It estimated that a potential £30b could be saved in resource needs by 2022 through greater investment in public health measures that maximised the population's healthy life

expectancy. It concluded that additional resources should be directed to public health, targeted at those interventions where the long term impact on poor health would be greatest. The Treasury's subsequent cross-cutting spending review on health inequalities (undertaken as part of the preparation of the 2002 spending review) considered the contribution that public services could make to:

narrowing the health gap, in childhood and throughout life, between socio-economic groups and between the most deprived areas and the rest of the country.

Furthermore the review recognised the need for the reduction of the social gradient of health differentials to be an integral component of population wide strategies as well as the focus of targeting of resources and efforts.

It recommended:

a comprehensive approach to tackling inequality in health outcomes through improved focus of programmes and resources-in particular education, health and housing-as well as increased efforts on smoking cessation, better nutrition and exercise, and other preventive health care services.

The NHS Priorities and Planning Framework for the next three years (2003-2006) reiterated reduction of health inequalities as a priority, and specified objectives and targets to be met (DH 2002). The NHS, as the lead agency on health inequalities, was expected to work with local authorities and other partners to agree local priorities that address the wider determinants of health. Regeneration and neighbourhood renewal programmes were expected to make a major contribution.

The above chronology of policy developments, indicates a significant shift in the policy landscape. The goal of reducing health inequalities was increasingly integrated within broader cross government commitment, goals

and delivery mechanisms. The key issue would indeed appear to be one of effective policy 'delivery'.

Marginalisation versus integration of public health locally

This thesis examined the nature and impact of this national policy context on local partnership working and efforts to tackle health inequalities through Health Action Zones and Health Improvement Programmes. Overall, in principle this policy context provided conditions more conducive to joint efforts to reduce health inequalities. Potentially Health Action Zones could test out new forms of partnerships for policy delivery. HAZs could be a source of learning for the development of the local system, particularly how health could be integrated within community and neighbourhood renewal strategies. However, the history of public health suggests this optimism needs to be qualified. Although many of the 'conceptual and process flaws' that characterised previous Conservative efforts to improve health, appear to have been addressed, the forces that can marginalise public health remain strong.

- The knowledge base remains comparatively weak. The precise nature of what constitutes effective strategies and programmes for tackling health inequalities ('what works') is unclear.

- The power of professions, and medical profession specifically, remains an influential force in public health policy in maintaining the focus on acute hospital services.

- Experience suggests that the leadership and capacity of the public health function required to bring about the changes in priorities and resources allocation across the system is questionable (Alderslade 1998). Furthermore *Shifting the Balance* is bringing about radical reconfiguration of the public health function (DH 2001). While a more multi-disciplinary

and multi-agency approach is recognised as central to support the delivery of strategies that address health inequalities, the future nature and capacity of the public health function is uncertain.

- In the NHS, the creation of PCTs devolves further decision-making and resources, and shifts the power dynamics away from the acute sector. In priniciple the more localised focus is vital for addressing inequalities. However evidence suggests that PCTs' wider public health role cannot be guaranteed (Marks and Hunter 1998; Public Health Alliance 1998; Killoran et al 1999). The commitment and capacity of these new organisations to become an effective public health force is questionable.

- The capacity of the health sector to lead the process of inter-agency health strategy development and implementation is under-developed. Experience indicates that this is highly problematic, although there are many examples of heroic Healthy Cities initiatives.

- Furthermore, the energy and capacity for managing change may not be sustainable. There is still a real danger of 'innovation overload' associated with the Government's desire for change on many fronts. The massive structural changes can only divert efforts and undermine peoples' sense of security.

- Despite experimentation with new forms of partnership working and 'new partnership duties', local government remains essentially distinct and separate from the NHS as ever; with separate funding, local political agendas, recruitment and training of qualified staff etc.

- Consumer expectation, and demand for public services by the 'middle income voters' will be difficult to reconcile with the needs of the least well off; those least able to exercise consumer choice or exert their rights.

Sustained investment in building the capacity of deprived communities will always compete with more immediate political and managerial imperatives (waiting lists being one of many).

In summary it is possible to identify two schools of thought on the outcomes of HAZs. The positive one is that Health Action Zones test a new form of partnership working that could impact on health inequalities. HAZs could provide an important source of policy learning to inform developments locally and nationally. Alternatively, the forces acting against public health could prevail. Health Action Zones would be a marginal initiative and fail to provide a strategic and sustainable approach to tackling health inequalities. At the extreme, cynics could view HAZs as a tokenistic gesture by the government to show that something was being done. This thesis tested these two views. How this was done is explained in the next two chapters.

Chapter 3: Theoretical framework for analysis of 'partnerships'

This chapter examines the 'assumptive world' of policy makers involved in the design of Health Action Zones as 'partnerships' for policy delivery, and the coherence of the intellectual framework underpinning this design (Young K 1977).

Changes in the public policy system and forms of public management are considered; the move towards a more 'holistic' form of government (6 1997; Wilkinson and Applebee 1999). A typology of policy processes is set out, drawing on theoretical and empirical work, as a framework for analysing past and present approaches to dealing with cross cutting issues within the fundamentally centralist and compartmentalised machinery of government. The framework is used to define the nature of HAZ partnerships and assess their appropriateness for dealing with the distinct challenges posed by the task of tackling health inequalities.

From the perspective of policy makers, the proposition is that HAZ was an experiment in a new form of partnership that provided a robust model for development and implementation of public health policy. HAZs represented a new form of partnership that was about government, and locally public sector bodies, learning to steer networks of organisations in different policy spheres. Such partnership working was about governing through networks; the task of 'network management'. From the perspective of critics HAZ was an ill thought out act of tokenism, based on little prior discussion.

Changes in public management: the 'partnership approach'

In the next section it is argued that it is at least possible to see HAZs as the logical outcome of past policy failure in public health implementation, and a process of 'policy learning' (Heclo 1978).

The context of changes in the public policy system and forms of public management needs to be understood in order to assess whether HAZs did represent something new and applied learning about previous lack of progress in tackling health inequalities.

Literature on governance is particularly relevant. This stresses concepts of partnership, interagency action, joined up government and management through networks (Rhodes 2000; Newman 2001; Lowndes and Skelcher 1998). Rhodes' work on the theory of the state in particular provides a valuable perspective on changes in the policy system and a reference point for the study (Rhodes 1997). Rhodes' work helps to position HAZ partnerships within a historical sequence of changes in the policy system. Rhodes argues that the traditional top-down and centralist 'Whitehall' model can only provide a partial understanding of how Britain is governed. The Conservative Government of the 1980s and 1990s transformed the way government operates. The creation of next steps agencies, the bypassing of local government, competitive tendering, purchaser-provider split and quasi-markets resulted in more functionally differentiated and fragmented networks of players in the different policy spheres. Such networks did not respond well to the command or bureaucratic approach and slippage in implementation resulted (Marsh and Rhodes 1992;Stewart 1996). Rhodes uses the term 'governance' to describe the new process of governing.

Governance refers to:

> *'Self organising, inter-organisational networks characterised by interdependence, resource exchange, rules of the game and significant autonomy from the state'. 'Although the state does not occupy a sovereign position, it can indirectly and imperfectly steer networks.'*

Governance is both multi-level, embracing actors from sub-national, national and supranational levels of government, and multi-sectoral, comprising actors drawn from the public and private sector. Rhodes defines the shift from a system of direct management, or hierarchy, towards managerialism and quasi-markets and subsequent rise of networks and partnerships as the way of dealing with complexity and fragmentation in such strategic areas as economic development, environmental protection and crime prevention.

This shift of emphasis is also evident in the area of health. It is depicted by trends in the 'new public management' movement (eg Ferlie et al. 1996). The translation and application of private sector concepts and approaches has been a key feature of new public management involving progressive decentralisation and diverse organisational forms. Overall, health policies, under Thatcher, were characterised by devolution of budgets within a tight framework of accountability against performance expressed through league tables. Incentives and rewards were linked to 'market competitiveness'. Under Labour, although the trend of devolution with strong centralist tendencies has continued, this dynamic is set within the longer-term strategic approach to public services governed by the three year Spending Reviews and Public Service Agreements. There was at least a strong rhetorical commitment to cross-government and local partnerships as a strategic way of working (6 Perri 1999). The need to find new ways of promoting 'joined-up thinking' to problems that require 'joined-up solutions' is advocated. But this thinking about 'holistic government' has increasingly been practically expressed through institutional changes. Joint working has been seen as the way

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forward, for example through the eg creation of Social Exclusion Unit, and strengthened role of the Cabinet Office. Furthermore, local government is expected to provide a stronger local focus for strategy and collaborative efforts (through Local Strategic Partnerships) as well as the mechanism for strengthening local democracy.

Government therefore appears to acknowledge that its control capacity is limited in addressing complex problems, such as public health, involving a multitude of players. More 'steering than rowing' is required. The challenge is to define the steering mechanisms that enable government and public sector agencies locally to establish partnerships that effectively harness the interdependencies of players towards public health goals. HAZ partnerships could be viewed as one such experiment.

Initially at least HAZs could have been an expression of what Richards and colleagues define as the move to a public policy system (a paradigm shift) that is more outcome-orientated and governed by a 'tight-loose' relationship between the center and local public sector agencies (Richards et al.1999). While the concept of partnership is clearly not new, (particularly in areas of community care, education, housing, criminal justice, urban development and public health) their variable record can be attributed in part to the flawed design of the public policy system geared to operating through command and control (Richards et al 1999).

HAZ partnerships: fit for purpose?

Those involved at the centre in formulating policy had to acknowledge that previous attempts at achieving public health goals and strategies had clearly failed (DH 1998). Furthermore failure was partly due to the government policy process that had not been able to moblise interagency commentment and action. Civil servants could have viewed HAZs as offering a potential solution.

A typology of policy processes is set out in the table to provide a framework for assessing the nature of HAZ partnerships and their appropriateness for dealing with the distinct challenges of tackling health inequalities ie whether HAZ partnerships are 'fit for purpose'.

These are structural and long standing challenges that have defeated previous attempts to deal with the problem. These challenges are:

- The need to forge a common purpose and commitment to tackling health inequalities between a diverse range of players based on an acknowledgement of interdependence ie an understanding that they will be unable to achieve their own organisational objectives without the contribution of other organisations.

- The multiple priorities of organisations which compete and potentially relegate and/or undermine contributions to public health.

- The lack of evidence about what strategies and programmes are likely to be most effective in reducing health inequalities and therefore uncertainty about what the specific contribution of organisations should be, and what balance between national and local actions will achieve the greatest impact.

- The difficulties of genuinely engaging communities and the most deprived groups in finding solutions that are based on principles of empowerment and building social cohesion.

- The lack of professional public health leadership, and the low status and priority afforded to public health and tackling health inequalities within the NHS in comparison with the urgency and pressing needs of

hospital services, particularly waiting lists. There have been comparatively few champions of the cause with the necessary political or organisational clout.

- The difficulty of defining appropriate measures to monitor progress and demonstrate success given the long timescales involved in bringing about population based health improvements.

- The multiple and potentially conflicting accountabilities: to the partnership and individual organisations; and to the centre, elected representatives, and communities.

The assumptive world of policy makers acknowledged that previous policy delivery mechanisms had failed. Policy makers drew on both previous experience as well as actual modes of working. The table sets out the series of preferred policy delivery mechanisms (assumed good practice), and how they were interpreted in relation to public health policy and achievement of public health goals.

The types of approach in the table are drawn from theory and applied to public health, supported by empirical evidence. A selective approach was taken to analysis of relevant theories, and focused on theories concerned with the policy process and delivery at a macro level and also those concerned with inter-organisational relationships.

Social scientists have analysed why organisations should work together; and also why organisations do or don't work together in practice. Each 'type' of approach to partnership highlights particular dimensions of partnership working. Academics have tended to regard these approaches independently. Each approach may have a certain validity and legitimacy in its own right. The emphasis has changed through time. For example after the second world war

the centralist approach of the state system appeared to have merit. Other insights have been provided by the different perspectives. However the key question is relevance to achieving public health outcomes and dealing with the challenges set out above.

Partnership model	Behaviour of parties	Implications for public health mechanisms
Rational/centralist Strategic coordinator	Central committees Command & control Authoritative Centrally defined targets & priorities and standards	Health of the Nation-healthy alliances Saving Lives:Our Healthier Nation HIMPs, SAFF & Performance Assessment Framework National Service Frameworks NHS Plan-Modernisation Boards
Incrementalism Muddling through	Decentralised coordination via partisan interaction & mutual adjustment Use of incentives & compulsion for collaboration on common goals Centrally driven experimentation based on partnership	Joint finance Tradition of area-based social deprivation initiatives Single Regeneration Budget But minimal impact on mainstream policy & resources Health only recently part of experience HAZ?
Economics & public choice	Perceived costs & benefits; selection of option yielding greatest benefit at least cost Collective action problem ie free riders Dominance of individual incentives and rewards Set of rules required as framework for collaboration	Health benefits are a public good; reduced inequalities cannot be attributable to single organisation Design of satisfactory joint performance management framework complex, including specific incentives Must transcend dept boundaries
Policy networks Resource dependency model	Politics & power Roles & powers of actors based on distribution & type of resources 'Closed' system with winners & losers	Public health weak player-marginal in NHS & wider policy Empowerment of poor requires redistributive income policies Community involvement builds social capital with health gains
Network management	Involves: - Network structuring - Game management Use of range of mechanisms & incentives Trust & diplomacy	Integration of health within wider government policies for social & economic development HAZ? Local Strategic Partnerships Neighbourhood Renewal

Strategic coordinator model

The traditional thinking and logical approach to policy formulation and delivery has adopted procedures based on coordination through central committees. The cabinet committee clearly exemplifies this approach. There is a long history of committees and units set up to strengthen coordination and integrated action, such as the JASP in the1970s, and the introduction of corporate governance in local authorities (Blackstone and Plowden 1988; Challis et al., 1988). Under New Labour this trend has continued through the strengthening of the role of the Cabinet Office and the establishment of a number of units concerned with policy development and delivery including the Social Exclusion Unit, Number 10 Delivery Unit and Regional Coordination Unit.

Later critics, including Lindbolm, labelled this approach as the 'strategic coordinator model'. Lindbolm and colleagues placed mechanisms for achieving coordination between parties on a continuum with the 'strategic coordinator' model at one end of the continuum (Lindbolm 1965; Lindbolm and Woodhouse 1993). This essentially defines the natural and logical way of addressing a problem that demands the commitment and action of many players. However it does assume that certain conditions are met. Importantly it assumes that all activities that need to be coordinated come under or can be placed under a single higher authority. Furthermore it assumes that 'synoptic' decision making is possible ie that the rational actor can undertake comprehensive analysis based on full information to formulate policy which is then implemented by the players involved. Although these assumptions can be rarely met in full this model has tended to be the dominant model applied widely in government to take forward policy. The national direction and targets are determined and set centrally and local mechanisms are established to achieve coordinated implementation. This model has fitted with the political context of the UK as a unitary state. It is assumed that local

players will respond to central directives. This command and control style in some cases has proved appropriate but with respect to public health and reducing health inequalities this model does present major difficulties. In particular public health has had no central political power base. Many disparate players have different mindsets and different interests and motivations for engagement.

The Conservative Government's health strategy *Health of the Nation* was the first attempt to provide a national framework and direction for improving health. It demonstrated a failed attempt at the 'strategic coordinator' model. Healthy alliances were encouraged to implement the policy but without specification of how they would operate, and incentives were flawed and weakly applied. No resources were made available. Consequently bargaining between the 'local partisans' achieved very variable progress. Public health was not systematically aligned to the mainstream management and accountability mechanisms of health and local governments. The narrow disease-led framework alienated local authorities-a key local player. In the main local authorities only participated substantively where there was an opportunity to take forward Healthy City initiatives and broader strategies such as Agenda 21 and anti-poverty strategies. Where progress was made, for example linked to Healthy City initiatives, it was largely achieved through local sustained commitment and efforts to address public health issues. There was therefore concern for local health outcomes that could be tapped.

The Labour Government's successor national health strategy *Saving Lives: Our Healthier Nation* adopted a not dissimilar top down approach, while addressing some of the previous flaws (DH 1998). The introduction of local Health Improvement Programmes required for the first time that mainstream local strategies covered improvements in health and reducing health inequalities, as well as health care, and specifically how national targets set out in *Saving Lives: Our Healthier Nation* were being addressed. National

Service Frameworks for CHD, Mental Health, Cancer and older people specified the standards that should be met locally, and growth monies were allocated to support implementation in particular areas. Although health improvement was an integral requirement of mainstream planning and management, evidence of the early experience of the HIMP process indicated the primary concern within the NHS remained the modernisation of health care. This was given further momentum by the NHS Plan and centralist driven implementation (DH 2000). Public health and tackling health inequalities does not sit comfortably within the largely health care agenda.

Within the context of a centralist approach, different models have been applied as a way of dealing with the 'implementation gap'. The solution has been to incentivise agencies as an extension of the strategic coordinator model.

Incrementalism

In practice the ideal conditions necessary for a centralist approach cannot be met and Lindbolm and others, determined that the key to effective joint working is some form of 'decentralised coordination via partisan interaction and mutual adjustment'. Partisans working for their own private and organisational gain, and their own vision of the public interest, will interact in ways that 'often converge toward fairly sensible outcomes' (Lindbolm and Woodhouse 1993). Left to their own devices the result could be a conservative process of incrementalism that serves to maintain status quo. However incentives or compulsion can be exerted to direct efforts of local players, making collaboration and exploration of new approaches in their interests. Sustained local action responding to locally perceived expediencies can over time achieve significant change.

Public health and health inequalities have a history of failed attempts to engender the commitment of many players. The lack of clarity and immediacy of the problem and lack of understanding about the contribution of different players have hindered joint working. However the use of direct financial incentives has been characteristically absent.

Although the application this model to public health has been lacking, its use of for policy delivery in related areas has been well established. Joint finance was a classic example of how ring fenced allocation were used to simulate joint working between health and local authorities with respect to service delivery.

The long tradition of use of area-based schemes to tackle social deprivation illustrate differing degrees of central versus more devolved approaches to policy implementation-hybrids of centrally defined purpose with decentralised local inter-agency working to find solutions. Funding and bidding for resources was used to incentivise joint efforts, and partnerships became the preferred delivery mechanism.

The experience of the 1990s showed an increasingly positive trend towards a broader and more strategic approach to use of this model for stimulating collaboration. The Single Regeneration Budget exemplified this (Geddes 1997; Brennan et al. 1998). It was distinct from previous programmes in that aggregated budgets were allocated to the new integrated Government Regional Offices, and agencies were required to compete for funds through a bidding process that required demonstration of a track record of partnership working. The national evaluation suggested that this approach, although competitive, was effective in allocating resources according to needs (Brennan et al 1998). It showed that outputs were being generated across the whole range of standard output indicators relating to the labour market, enterprise development, housing, crime and safety, physical regeneration and

community development. It was estimated that 50-60% of the gross outputs would not have occurred without SRB. The health sector was a comparatively late participant in the urban policy network. Despite the successes demonstrated by certain evaluations, the health dimension and participation of the health sector in partnerships has in the main been marginal (eg Talyor et al., 2002).

Nevertheless, this model has proved an important source of learning that has been subsequently been applied to Health Action Zones and Neighbourhood Renewal. The proliferation of area-based initiatives, including Health Action Zones by the Labour Government demonstrates how incentives ('freedoms' and resources) are being used to encourage collaboration amongst local players to deliver on national goals of social exclusion and poverty. Evaluations however have highlighted concerns and limitations. A national review of a cross section of these area-based initiatives revealed a lack of strategic context and little impact in bringing about mainstream change (Stewart et al. 2001). It showed clearly that:

> *There is little which provides a common agenda to the various ABIs, little to encourage the sharing of a common agenda across them at either national, regional or level....area-based initiatives do not, therefore, conform to any strategic framework, nor collectively do they provide it locally.* (Stewart et al. 2001.)

This would suggest a somewhat 'muddling through' approach. Important concerns have been highlighted by the recent report of the House of Commons *ODPM: Housing, Planning, Local Government and the Regions Committee* on *The Effectiveness of Government Regeneration Initiatives* (2003). It noted that there has long been a tendency in central government to launch a new ABI in response to a problem. This approach can cause confusion and resentment in local government, with witnesses stating:

I do not think we have any need for the number of disparate initiatives we have faced as local government from government.

I have kind of described it as rabbits in the field, which is that the Government lets out these rabbits and we all run after them.

The Committee's following comment perhaps serves to summarise the role and limitations of this partnership model as a mechanism for policy delivery:

Individual government departments want to select and control their own response to a problem. But we have heard from both academics and practitioners that changes in government priorities and single-issue initiatives can be detrimental to the long-term regeneration of an area. It is important that any new initiatives galvanise ongoing and sustainable activities and contribute to the long-term vision for an area. This is not always the case. New, high-profile initiatives may actually distract from the coherence of initiatives already in operation on the ground. Such initiatives may also die out when the initial funding disappears. It is vital that government changes in policy do not distract from long-term targets and priorities of regeneration programmes.

Economics and public choice

The most pessimistic interpretation of Lindbolm's theory is represented by public choice theory. This model is the about the economics of bureaucracies and stresses the importance of individuals' motivations and incentives in influencing behaviours of players. Public choice assumes that the individual is intrinsically rational, and will select those options that will yield the greatest benefit for them at least cost. Also political behaviour is assumed to be an aggregation of individual behaviours. Consequently public actors are viewed as pursuing self-interests on the basis of perceived costs and benefits. This self-interest is demonstrated in the 'bureau shaping' behaviour identified by Dunleavy ie organisational shape and structure not only budget maximisation were important incentives (Dunleavy 1992).

For example those who control large budgets in the NHS, the clinicians and service providers, have traditionally dominated decision making and sought to increase their budgets as a source of power, or advance their interests through structural changes. Although the power balances might have shifted with the creation of Primary Care Trusts, clinicians and service providers, still command disproportionate power through their resources. In contrast public health as a function and policy goal has no large discrete budget, and has always tended to loose out in priority setting and resource allocation, despite the strength of research evidence on the 'burden of preventable disease' and avoidable costs.

The important implication of public choice theory for pursuit of public health goals is to highlight issues of accountability, performance management and incentive and reward mechanisms. This is within a national context of increasing emphasis on Public Service Agreements, targets, results, and regulation and auditing of performance. Performance management frameworks can counter or reinforce personal or professional incentives and sanctions.

It is clear that the pursuit of improvements in public health and health equity significantly challenge public sector performance management frameworks. Long term health and social benefits and outcomes are a public good and reduction of inequalities cannot be attributable to a single organisation. The links between cause and effects are complex and unclear and demand multi-dimensional strategies and involve long timescales. The precise impact and outcome of particular interventions and contributions are very difficult to determine. Other 'confounding' factors can be significant eg the state of the national economy. Defining appropriate long term indicators, (and sensitive and robust interim milestones) to hold managers and organisations to account is an extremely difficult task.

Consequently there are major challenges for designing a performance management framework that effectively aligns organisational targets across the whole system with long-term equity goals, and also secures public accountability for progress.

Lovell and colleagues highlight the dilemmas and the need for expanding the notion of organisational performance measurement to support joined-up government (Lovell at 1999). They are pessimistic about how the contradictions, ambiguity (and hypocrisy) can be resolved. Public sector managers are exalted to tackle the difficult issues by reflecting upon causes and effects and developing strategies, alliances, partnerships and networks that address the former. However at the same time they are required to achieve performance targets that emphasise and strengthen the definitions of their localized and immediate organisational boundaries-'wide angled policies but tunneled-vision accounting'.

Furthermore the regulation regimes associated with the rise of regulatory bodies (such as the Commission for Health Improvement, NICE, Audit Commission, Ofsted) raise further complexity. Regulatory agencies, particularly inspectorate bodies are functionally organised, while 'regulation' of action on health inequalities demands collaborative regulation to assess the collaborative performance of local government and health agencies in particular. Cope and Goodship (1999) are again pessimistic about how cross cutting issues such as public health can be pursued through the bureaucracy of government.

Moves towards joined-up government, including joined up regulation, are likely to be hindered by the way in which the state is functionally organised and the entrenched interests of politicians, bureaucrats and professionals that have sustained such an organisational and functional carve-up of the state. Consequently progress towards joined-up government, if the past is anything to go by, is likely to be slow and possibly more aspirational than real. (Cope and Goodship 1999.)

The implications of public choice theory with respect to health inequalities are that those players with responsibilities for health inequalities and for reducing health inequalities need to be rewarded. However the complexity of causal links and the lack of clarity about how particular agencies can reduce health inequalities and by how much present significant challenges to the design of an appropriate performance management framework.

Policy networks

One of the policy lessons from public choice theory has been the recognition of 'policy networks'. The concept of policy networks, developed by Heclo, Jordon, Benson, Rhodes and others, draws on the notion of power and dependency to explain the way organisations will manage their relationships in pursuit of their objectives. The idea of networks also provides the context in which interactions take place. The Rhodes model postulates that organisations depend on each other for resources (money, authority, information, expertise) and therefore enter exchange relationships (Rhodes 1986). The distribution and type of resources within a network explains the relative power of actors (individuals and organisations). It builds on the resource dependency model central to much interorganisational theory (eg early work by Levine and White 1961).

Networks are important for six reasons (Marsh and Rhodes 1992):
- They limit participation in the policy process
- They define the role of actors.

- They define which issues will be included and excluded from the policy agenda.
- They privilege certain interests, not only by according them access but also by favouring their preferred policy outcomes.
- They substitute private government for public accountability.

Traditionally policy networks have been viewed as 'closed', and resulted in 'winners and losers'. There are established power bases that are resistant to change. Application of the policy network model to public health serves to highlight the political and power dimensions of inter-agency relationships involved in pursuit of health equity.

The evolution of interagency partnership working in the areas of urban deprivation and public health demonstrates that distinct policy networks have operated in these two policy spheres. Each of these policy networks has their own set of players, rules of the games, and shifting power dynamics. The separate operation of these networks and the changing power structures ensured that public health remained marginal to mainstream agencies and concerns of players.

Health inequalities was narrowly defined and handled in a way that reflected the capacities of the network rather than restructuring the network in a way (ie linking regeneration and public health) that could understand and respond to the complex and multi-dimensional nature of the problem. Furthermore each of these policy networks has traditionally been dominated by forces that favoured other priorities and/or promoted ineffectual and partial solutions. The medical model, medical profession and hospital health care have traditionally dominated health policy. While more devolved models of decision making (such as fundholding and the current rise of Primary Care Trusts) and moves to more equity based resource allocation have served to shift the power

dynamics away from the hospital sector, public health as a professional voice, a function and case for investment has remained weak.

The marginal position of deprived communities and groups that suffer the worst health and the challenges to genuine partnership working are clearly exposed by the policy network model. Such groups are subject to high costs of entry to these 'closed' networks. Public involvement and consumer responsiveness have become an established part of policy discourse for new public management, but the evidence suggests that complex concerns are raised about who is to participate, at what level and on whose terms.

With respect to community care, Barnes and colleagues found professionals and managers viewed user groups as one of many interest groups with an important contribution to make, but also commented that groups could be unrepresentative either of users or of the general public (Barnes et al. 1997). Officials therefore held user groups to be legitimate and illegitimate simultaneously. Furthermore professionals referred to playing the 'user card' as a resource to be employed in attempts to secure their own ends and source of legitimacy for the official managerial role. Geddes' review of the effectiveness of the role of urban regeneration partnerships in tackling social exclusion shows that voluntary and community organisations where not equal partners in partnership bodies (Geddes 1998). Often both public and private organisations were unable or unwilling to let go of the necessary degree of power and control. They often had limited awareness of what community involvement really meant and had few policies to support it. Brennen and colleagues' evaluation of the SRB programme shows similar findings (Brennen et al. 1998).

The concept of community governance became central to the Labour government agenda for the modernisation of local government. Ross and Osborne (1998) note that it has the potential to offer a genuine new vision of

the governance of local communities-'active communities' participating vigorously in bottom up policy process. It has its roots in the communitarian movement of the US, which emphasizes the plural distribution of power within local communities. Deacon (2002) asserts that communitarism has significantly influenced ideas of the New Labour's 'Third Way', and specifically the principle of 'rights and responsibilities' (Deacon 2002). Policy learning is apparent in that the Labour government is taking note of Putnam's ideas of social capital and evidence that community engagement can have economic, social and health benefits in its own right. Health and community regeneration are dependent on communities being involved in identifying problems and finding solutions. However this movement beyond consumerist and client-based models of participation raises difficult political questions (Ross and Osborne 1998). There are tensions to be addressed-between direct community involvement, representative bodies (voluntary and community groups) and elected members.

This new 'assumptive world' or model of policy networks became influential in DH and other departments' thinking about joint working, and particularly in relation to regeneration and health inequalities. It could be further argued that the political climate became receptive to the notion of network management. Tackling health inequalities is fundamentally concerned with the empowerment of the worst off in society. The model of network management described below could be the way to restructure and 'manage' these policy networks and engage disadvantaged communities and groups. However Rhodes states that network management places too much emphasis on managerialism and fails to deal adequately with political aspects of networks. Rhodes emphasises the need to seek ways of 'democratising functional domains' and exploring new forms of representative democracy. However, in practice those groups and communities that experience poor health tend to be poorly represented through the normal democratic mechanisms. Therefore

this 'democratisation' would indeed be a significant challenge for network management.

Network management

Network management builds on the thinking about policy networks discussed above. It draws on systems thinking, of the management and organisational literatures, with its roots in cybernetics and ecology. Systems thinking has been applied to change management in the NHS (eg Iles and Sutherland 2001; Dawson 1996). Less attention has been given to its application to the complex 'public health' governmental and multi-sectoral environment. In the policy context, network management builds on systems ideas and has been proposed by Kickert and colleagues as an opportunity to improve management and governance of public policy processes (Kickert et al 1997).

It can be viewed as:

> *Promoting the mutual adjustment of the behaviour of actors with diverse objectives and ambitions with regard to tackling problems within a given framework of interorganisational relationships.*

It is essentially concerned with using processes and creating conditions for joint problem-solving, goal searching and exploring solutions of joint interest. Finding a common purpose is one to the main tasks of network management. It is a process:

> *Whereby opportunities for creating win-win situations by means of integrative strategies are explored and pursued ie mutually beneficial solutions can be found.*

According to Kickert and colleagues it takes two forms: managing interactions within the network, or 'game management' and building or changing the institutional arrangements that make up the network-'network structuring'.

This involves use of a range of processes and mechanisms to manage relationships and behaviours and actors. These are shown in the table below (P53, Kickert et al.1997)

Strategies for network management	
Game management	Network management Arranging Brokerage Facilitating Mediation Arbitation
Network structuring	Influencing formal policy Influencing interrelationships Influencing values, norms, perceptions Mobilisation of new coalitions Management by chaos

The types of network management strategies are defined in very broad terms, however suggest use of system-wide change management and organisational development techniques. There appears to be an acknowledgement of the complex, open and dynamic nature of the public policy system, and the challenges government, organisations and managers face in pursuing their objectives, or indeed shared objectives, when direct control is inappropriate. But it is perhaps surprising that 'innovation and learning' are not explicitly highlighted as a network strategy, given that the notion of 'the learning organisation' (Senge 1990) is well embedded within change management literature (eg Davies and Nutley 2000) .

Shared values and norms are the glue which holds the complex set of relationships together; trust is essential for cooperative behaviour and therefore, the existence of the network. Diplomacy is the way to get things done; 'the emphasis lies not in imposing one's objectives on another but on finding out about the other'.

Kickert asserts that the nature of leadership by public organisations and individuals is critical to the success of network management:

> *The results of network management are determined by the capacity of actors to demonstrate leadership in interactions by devising new options, speaking out for them to their organisation and … Network management however rarely directs itself to organisations as a whole. Interactions take place between representatives of 'corporate organisations'…..In network management it is important not only to create consensus between the representatives of organisations regarding a joint course of action, but also to establish support for these ideas within the organisation.*

The role of the manager is that of mediator, process manager and network builder.

The concept of network management is consistent with Pratt and colleagues definition of 'co-evolving partnerships and their associated pre-conditions (Pratt et al 1998). It is also consistent with the idea of ~~competitive~~ collaborative advantage and rise of strategic alliances within the management literature (eg Kanter 1994), and most recently applied to the inter-organisation collaboration in the public sector by Huxham amongst others.

> *Collaborative advantage will be achieved when something unusually creative is produced-perhaps an objective is met-that the organisation could not have produced on its own, and when each organisation, through the collaboration, is able to achieve its own objectives better than it could alone.* (Huxham 1993.)

The opportunity for creating synergies is a necessary requirement for collaboration. Huxham uses the term 'meta-strategy' to define the development of a shared common inter-organisational strategy that simultaneously allows pursuit of individual organisational objectives.

Ferlie and Pettigrew provide one of the few empirical investigations of network theory in a public sector context (Ferlie and Pettigrew 1996). While there are moves towards network-based organisations in the NHS, mixed modes of management may be emerging. Furthermore they point out that it is

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'unclear whether centrally-sponsored initiatives consistent with network-based approaches will be sustained or whether networking will be no more than a faddish phase'.

The concept of network management appears to provide a useful bridge between theory and what HAZ 'steering' might mean from a managerial perspective. In particular it differs from the strategic coordinator and increamental models, in that it recognises the importance of structuring the context (redesigning or adjusting the wider policy system) in a way that supports partnership working ie integration of health within wider government policies and processes for social and economic development. It tests the extent to which such areas as regeneration and public health policy spheres are joined up; and the vertical silos of policy development and implementation are no longer dominate. There are criticisms that the managerial perspective cannot cope with the political and power dimensions of the policy process (Rhodes 1997; Newman 2001). However it is argued that the 'assumptive world' of policy makers at least now recognises the network management approach and that this has informed the design of HAZs as a mechanism for policy delivery.

The optimistic view is therefore that HAZ partnerships are an experiment in this new form of partnership. The concept of network management starts to define what collaborative governance could involve for securing joint commitment and action across agencies in pursuit of health equity. It could provide a prototype for Local Strategic Partnerships. But The model might only provide a 'managerial fix'. The model might not be robust enough to deal with the more fundamental political dynamics that underpin how a unitary state works. The most pessimistic view is that HAZs are 'more of the same': one more central initiative that is a tokenistic response by the government to be 'seen to be doing something', and at best could only achieve some change at the margins.

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Fitness for purpose?

The different models of partnership working are likely to operate simultaneously in delivery of policy for reducing health inequalities. Each can by used as a lense through which to analysis the responsibilities and behaviours of participants, and provide evidence and insights into the problems and challenges to addressing health inequalities.

The diagram below attempts to summarise the position of the models on the two dimensions of centralisation/devolution and marginalisation/mainstream. The literature on network management theory does not define how this model might be operationalised or how the theory fits into to the wider literature concerned with inter-organisational relationships and policy processes. The schema below is an attempt to position network management within this framework.

Network management might be viewed as linked to each of the quadrants, and exploiting the potential of the different policy forces for joint working.

Schema of 'collaborative' policy delivery mechanisms

Centralisation

Centrally driven
experimentation

Strategic
coordinator

Marginalisation — | Network management | — **Mainstream**

Locally driven
'political' priorities
(policy networks)

Local strategic
Integration

Devolution
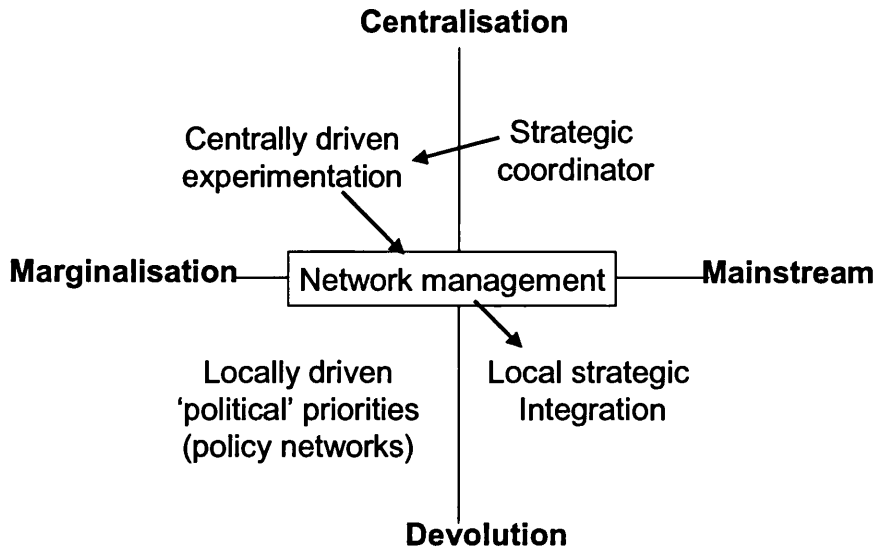
The proposition is that 'network management' is potentially a model of partnership working that could change the pattern of interaction between the key local players in the collaborative pursuit of greater health equity. The strategy espoused by government in the HAZ guidance, (and subsequent policies) involves a shift from the traditional centralist 'strategic coordinator', 'command and control' model of policy delivery, with its emphasis on priorities, guidance and targets. Reductions in health inequalities would be strongly legitimised by the centre and but the local actors would be able to develop their own means of networking. 'Network management' also implies a more strategic approach to collaboration that involves change across the system to reduce health inequalities. Health inequalities would be integral to joint strategies. It goes beyond the incrementalism driven by incentivised initiatives that tends to achieve only marginal impact. Trust and reciprocity would underpin behaviours. Performance management and accountability mechanisms would prioritise health-related goals across organisations and provide the necessary incentives for individuals to collaborate. Traditional established networks which have guarded the status quo would be

restructured, and 'managed' according to new 'rules of the game', and redistribute power to those worst off. (The arrows indicate the shift of emphasis between the policy forces.) Network management would essentially provide for an effective mix of models to stimulate collaboration between the local players and enable delivery of integrative strategies that impact on health inequalities.

Investigation of the evidence of the different partnership models, and use as collaborative policy delivery mechanisms, is the subject of this thesis. In particular, assessment of the extent to which there is a shift towards a network management approach and its impact is a central element of the thesis.

Research questions

The foregoing analysis served to define the fundamental research questions as:

- What theoretical models of partnership were being used intellectually and in practice by stakeholders to address health inequalities? (means)

  To what extent did health action zones represent a distinctive model of partnership working for policy delivery, in term of intellectual framework and resources? Was this a network management model?

- What was the success of these partnerships in effectively engaging stakeholders in addressing inequalities in health as a 'win-win' endeavour; or did the dominant self-interests' of the different stakeholders undermine success? (intermediate process outcomes)

  To what extent did health action zones make a difference? How did the model of network management add value to the policy process and delivery?

These research questions focus the study on defining the policy processes and their success in delivery in tackling health inequalities. In short how important was network theory relevant to pursuit of public health goals in comparison to other approaches?

A set of supplementary questions were also generated by the different models:

Centralist

- How effective have HImP partnerships been in taking forward strategies for tackling health inequalities?
- What are the implications of the *NHS Plan*, driven by the centre, for addressing health inequalities?

Incrementalism

- To what extent is HAZ 'just' another area-based initiative with collaboration around a stream of money, that has limited impact on mainstream and longer term strategies and resource allocation, making only a marginal contribution to tackling health inequalities?
- How does HAZ add value to the health improvement process?

- What is the potential for integrating action on health inequalities within the remit of Local Strategic Partnerships?

Incentives, rewards and accountability

- How are health inequalities reflected in performance management regimes?
- Are the incentives right to direct politicians, managers and others to focus joint efforts on health inequalities?
- How will they be rewarded/or sanctioned for progress?

Power and politics

- Are the critical players included in the network?
- Are the power relationships right? Who holds the balance of power?
- Are deprived communities empowered to participate in the partnership decision making processes as well as specific initiatives that respond to their needs and problems?

Networking

- To what extent do national policies provide the context and conditions for HAZ partnership working for health equity? How do they help or hinder?
- How far has a focus on health inequalities been absorbed locally into mindsets and priorities?
- What is the nature of leadership and how does this benefit or not pursuit of health inequalities?
- To what extent is a culture of trust and diplomacy evident and how does this benefit or not pursuit of health equity?

- To what extent is the experience of HAZ partnerships providing an example and/or prototype for Local Strategic Partnerships?

Networking presented the most innovative framework that potentially could address many of the challenges facing delivery of policies that impact on health inequalities. The thesis gave particular attention to this approach and evidence of its impact.

Chapter 4: Research plan

Purpose of the study

The government acknowledges that promoting public health and reducing health inequalities is part of the wider challenge of tackling deprivation and social exclusion. Consequently the public health goals can only be achieved through multi-sectoral responses at both national and local levels. HAZs were viewed as a key delivery mechanism, within the context of moves towards more 'joined up' government.

Chapter three set out a schema of 'collaborative policy delivery' to provide the theoretical framework for evaluating the policy processes. The appropriateness of the different models for delivery of public health goals (particularly reducing health inequalities) was assessed based on relevant literatures and evidence of past experience.

The proposition is that HAZs test a new model of partnership that involves government, and locally, public sector agencies, *steering networks of organisations* in pursuit of public health goals. This 'network management' is more likely to be effective in enabling local integrated responses to the complex problem of health inequalities than the traditional model of 'strategic coordination'. This study aimed to define the new partnership processes established, and examine how and why they proved effective or not in bringing about inter-organisational development and action.

The study addressed the <u>principle research questions set out in chapter three.</u>

The study approach

The research questions focused on defining the <u>processes of policy delivery</u> and their success in bringing about changes and action that could impact on health inequalities. It is a study of institutional and organisational processes and relationships, their development and impact. It was <u>not</u> a study of health outcomes. Such population based impact evaluation would have involved significant investment of resources over a number of years, and beyond the practical scope of this study.

The study employed an approach and methods that are well established in the investigation of the research questions (Bryman and Burgess 1994; Yin 1994). A comparative case study design was judged to be the most appropriate and feasible approach, using qualitative methods, given the research resource (researcher time) available. Case study areas were selected, and field investigation involved face-to-face semi-structured interviews of a sample of the main stakeholders engaged in partnerships aimed at tackling health inequalities. Case studies could all have been HAZ areas, however, this would not allowed counter factorial assessment. Therefore the comparative case study approach based on two HAZ and two non-HAZ areas was viewed to be the most appropriate way forward.

Comparative case studies

The comparative case study analysis of two HAZs and two 'shadow' non-HAZ areas would allow assessment of the extent to which *distinctive* HAZ partnership mechanisms (new multi-organisational governing processes) were established; and in-depth examination of how and why HAZ partnership mechanisms were successful or not in advancing strategies that tackled health inequalities in differing contexts.

The approach involved:

- Comparison of the HAZ case study partnership mechanisms and their organisational consequences over time.

- Parallel study of 'shadow' non-HAZ areas. This enabled some assessment of whether the 'new' collaborative governing processes were HAZ-specific rather than a national phenomenon, and also how processes relating to Health Improvement Programmes and associated joint planning arrangements in these non-HAZ areas were developing and advancing public health goals.

The HAZ case studies were selected to represent different 'types' of HAZs with scale and complexity used as the primary contextual variable. The shadow non-HAZ areas were selected as far as possible to be comparable in terms of level of deprivation and scale and complexity. However it was difficult to match case studies in terms of history of partnership working. Selection bias was difficult to avoid given that one of the criteria for awarding of HAZ status was agencies' record of good partnership working. It is also important to note that the non-HAZ areas were not intended to represent formal 'quasi-experimental controls' but provided an important opportunity for comparative analysis and gaining deeper insights into partnership mechanisms.

Process evaluation and measures of effectiveness

This was a process evaluation. Conceptually, there is a relationship between the processes of partnership working and intermediate outcomes (such as changes in services, community engagement and improved social, economic and environmental circumstances) and longer-term improvements in health (National HAZ Evaluation Team 1998). However, the robust empirical

evidence defining and linking partnership working to such outcomes is lacking. The research base on the effectiveness of large complex partnerships in securing improvements in public health in particular is largely under-developed. Studies have been predominantly concerned with evaluating the process of partnership working with effectiveness judged in terms of reported achievements and perceptions of different stakeholders. Few studies have attempted to link partnership working with measurement of actual outputs and outcomes.

Nevertheless, the empirical evidence does show that partnerships have a range of benefits for attaining integrated responses to complex social problems (eg Geddes 1997; Brennan et al; 1998; Gillies 1998). In particular, they can bring together the expertise and resources of agencies and communities to develop and implement strategies and initiatives. Economies can result from joint operations and programming. Partnerships can also lever new resources, create synergies through 'bending' mainstream programmes, and integrate fragmented efforts to achieve longer term health and social outcomes. Such benefits could be viewed as 'partnership process outcomes'. The evidence also indicates the particular characteristics and factors that are likely to influence the effectiveness of partnerships in achieving such process and longer-term outcomes.

This study sought to define the partnership models operating and associated characteristics, and the factors, including external national and local contextual factors, that influenced progress in achieving early 'partnership outcomes'.

Realistic evaluation of complex social programmes

The study approach was underpinned by recent thinking on what constitute appropriate approaches for the evaluation of complex social programmes. In

particular, Pawson and Tilley's approach of *Realistic Evaluation* is highly relevant to the evaluation of HAZs (Pawson and Tilley 1997). This approach acknowledges social programmes as complex open systems. They comprise 'the interplay of individual and institutions, of agency and structure, and of micro and macro social processes'. Pawson and Tilley argue that approaches that draw on the traditional pure experimental design of the medical sciences in an over-simplistic way (e.g. quasi-experimental evaluation) are inappropriate for the evaluation of social programmes. Experimental design, involving matched intervention and control groups, emphasise internal validity based on the 'controlled' conditions, that are not possible in open systems (i.e. contamination). The focus is whether the programme works. The potential for explaining how or why the programme works is weak. It tends to overlook contextual factors in explaining different sorts of outcomes. Such limitations are evidenced by the findings of evaluation trials of community-wide programme (eg Tudor-Smith et al; 1998). As discussed above the non-HAZ case studies were not intended to be formal 'quasi-experimental controls', because it is not possible to control for all variables. However they would offer a further opportunity to gain deeper insights and understanding of different partnerships mechanisms.

Realistic evaluation is concerned with understanding why a programme works, for whom and in what circumstances. This approach centres on following relationship:

Context (C)+mechanism (M)=outcome (O)

A programme is defined as 'its personnel, its place, its past and it prospects'. A programme activates mechanisms for change by influencing key stakeholders' choices (reasoning) and capacities (resources). However the nature of outcomes will be contingent on contextual conditions (spatial, geographical, location, social rules, norms, values and interrelationships).

Emphasis needs to given to defining what contexts enable or disable the mechanisms from achieving intended outcomes. The evaluation is about identifying CMO configurations relating to the successes and failures of the programme to inform future policy development.

> *'Programmes work (have successful outcomes) only insofar as they introduce appropriate ideas and opportunities (mechanisms) to groups in appropriate social and cultural conditions (contexts)-it is not programmes (per se) which work but people cooperating and choosing to make them work.'* (Pawson and Tilley p36.)

> *'Outcomes are explained by the action of particular mechanisms in particular contexts'* (p59).

The evaluation process involves defining the different programme context-mechanism-outcome (CMO) configurations that are possible to generate hypotheses about theories of change that can be tested empirically.

In policy terms, the HAZ initiative introduced a number of new opportunities which could be viewed as partnership 'mechanisms' (new processes). This was based on the hypothesis that they would foster more effective partnership working and thereby secure the development and implementation of strategies and long term health improvement.

The comparative case study design tested this hypothesis as shown in the diagram below. It was clearly not possible to evaluate the impact of strategies and programmes on actual health outcomes, given the timescale and resources of the study. The impact of HAZs were evaluated in terms of intermediate process indicators defined on page 83.

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Context + Partnership
Mechanisms
⟶ 'New'
governing
processes
⟶ Organisational
development &
action
= Health
Outcomes

No 'new'
governing
processes

No
organisational
development &
action
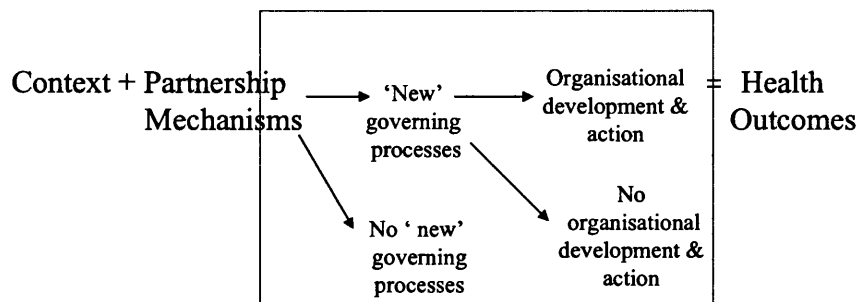
Method

Case study selection

The HAZ case studies were selected based on their scale, complexity, and location (north/south) with associated socio-economic circumstances.

The table below shows the scale and complexity of HAZs according to the organisational configuration (number of health authorities and local authorities) and size of population served. Four categorises of HAZ organisational complexity can be identified.

Scale and Complexity of Health Action Zones		
Organisational configuration	Range of population served	Health Action Zones
Multi-HA/Multi-LA	770,000-1.1m	Tyne & Wyre (3 HAs, 5 LAs), Manchester, Salford & Trafford (2HAs, 3 LAs), South Yorkshire Coalfields (3 HAs, 3 LAs)
Single HA/Multi-LA	310,000-730,000	Northumberland (HA, 7 LAs), North Cumbria (HA, 5 LAs) City & East London (HA, 4 LAs) **Lambeth, Southwark & Lewisham (HA, 3 LAs)**
Coterminous HA and LA	300,000-486,000	Sandwell (HA, LA), **Bradford (HA, LA)**
City (sub HA, corresponding to a single PCG) and unitary LA	181,400-260,000	Luton (part HA, LA), Plymouth (part HA, LA)

A 'single HA/multi-LA HAZ' (Lambeth, Southwark and Lewisham) and a coterminous HA/LA HAZ (Bradford) were selected. Shadow non-HAZ areas were selected to be comparable as far as possible in terms of level of deprivation as well as scale, complexity and north/south location. Based on DH analysis of a range of health and socio-economic indicators of deprivation, forty-five HA areas were initially judged to be eligible for HAZ status. Given twenty-six areas were successful in gaining HAZ status, the remaining nineteen areas although experiencing comparable levels of deprivation did not have HAZ status. Of these areas Kensington, Chelsea & Westminster acted as a shadow to Lambeth, Southwark and Lewisham. Bradford was shadowed by Birmingham. (See table below). Both the boroughs of Kensington and Chelsea, and Westminster suffer severe deprivation, (as well as high levels of affluence).

Ideally, the study would have included HAZs from each category. However given the research time available this was not feasible. Also it was not possible to take full account of the history and quality of partnership working in areas, although this factor would clearly be important in case study

investigation. In fact one of the criteria for awarding of HAZ status was agencies' record of good partnership working. Therefore this represented a selection bias that was different to avoid.

Organisational configuration	HAZ	Shadow Non-HAZ
Coterminous HA/LA	Bradford	Birmingham
Single HA and multiple LAs	Lambeth, Southwark & Lewisham	Kensington & Chelsea and Westminster

Case study investigation and analysis

The case study investigation involved three main stages.

Stage One: Profiling of health partnership mechanisms within context (1999)

This stage was primarily a descriptive mapping of the baseline position in each case study area in terms of local context, partnership mechanisms and health strategies. It aimed to define the distinctive partnership features of HAZ case study areas. This baseline enabled tracking of changes and developments overtime. The fieldwork was conducted in late summer and early autumn 1999.

The profile used two sources of data collection and analysis:

- <u>Documentary analysis</u>. Documents included the original HAZ proposals, HAZ implementation plans (1999/2002), Health Improvement Programmes, Public Health Reports, previous health strategies and commissioning plans, Local Authority strategies including Community Plans, Regeneration (SRB), proposals and plans relating to other Zone and related initiatives such as New Deal for Communities. Papers relating to joint health partnership arrangements and policies were also considered.

- Semi-structured face-to-face interviews were conducted with four to seven stakeholders in each case study. The individuals interviewed were the HAZ directors, Chairs of HAZ Boards, Public Health Directors, Local Authority Directors (Health/Social Care/Housing).

The interview schedules are provided in appendix two. The schedules covered:
- key local contextual features,
- public health priorities, and how these were demonstrated in health improvement programmes and HAZ plans and degree of consensus between partners
- partnership processes for developing and implementing these strategies, including their relationship to wider agendas and processes
- views on early intended outcomes in terms of organizational development and service delivery, and the factors likely to influence progress
- differences between the old and new systems.

The data was analysed according to the above themes. The four draft profile reports were discussed and validated by individual case study areas (by the end of 1999).

This stage allowed the further development of the study hypothesis. This is set out in terms of Context-Mechanism-Outcomes in the box below. This baseline stage allowed identification of process measures that could be used to test the operational validity of health partnership mechanisms and their consequences. Stakeholders were asked what would constitute success in the short and medium term ie intended outcomes.

Respondents were clear that changes at a population level would be a long term outcome.

HAZs as a new form of partnership for tackling health inequalities		
Context	**HAZ partnership mechanisms**	**Desired process outcomes**

• Major geographical areas with the worst health record in the country
 	
• Multiple deprivation & social exclusion with health consequences
 	
• Variations in scale & complexity of multi-organisational partnerships
 	
• Variation in history and maturity of partnership relationships; and commitment & action to improve health & tackle inequalities
 	
• Cross government commitment, policies and machinery for tackling inequalities & social exclusion
	• HAZ strategy & 3 year Implementation Plan promotes systematic approach to joint action, engaging communities, targeting efforts & resources
	
	• Partnership/governance arrangements create conditions for 'co-evolving' partnership & secure accountability
	
	• Additional HAZ resources increase joint action & lever funds from other sources
	
	• New freedoms remove traditional barriers to partnership working
	
	• Processes for linking HAZ to mainstream strategies & other national initiatives (e.g. regeneration, Zones, New Deal) secure wider impact & sustainability
	
	• DH operating as 'partner' creates conditions for effective local partnership working
		• Commitment & contribution secured from full range of players
		
		• Creation of a partnership culture
		
		• Nurturing of a core network of champions
		
		• Effective positioning of HIMPs/HAZs to wider Community Planning: including
		  o Linkage of partnerships
		  o Alignment of strategies and targets
		
		• Partners modify own strategies & ways of working in line with partnership objectives
		
		• Robust inter-agency partnership working at locality level: devolvement and linkage of local authority and health planning and management of services
		
		• Effective involvement of deprived communities & socially excluded groups
		
		• Value added through linkage & integration with other national area-based initiatives
		
		• Development of corporate strategic role of local authorities in improving health and tackling health inequalities
		
		• Focus on deprived communities and socially excluded groups: piloting and mainstreaming new ways of working based on community development principles
		
		• Effective and efficient shared organisational infrastructure supporting partnership working
		
		• Overall resources available to tackle health inequalities enhanced

Stage 2: In-depth study of health partnerships (2001)

In-depth investigation of the health partnerships was conducted to assess how the partnership processes were operating in practice and extent to which they were building multi-organisational capabilities that could take forward health strategies and programmes that tackled health inequalities. Again contextual factors were examined.

The data was collected through semi-structured interviews. The interview schedule is provided in appendix two.

In the two HAZ areas stakeholders were interviewed face to face and were selected to provide distinct perspectives. These perspectives represented a diagonal slice through the local system. (The precise numbers were dependent on the organizational structures and complexity.)

- Approximately eight individuals involved in strategic management of the health improvement programmes and HAZs. These included HA Chief Executive/Deputy CEs, local authorities Directors (Health/Social Care/Housing), Primary Care Group/Trust CEs, Directors of HAZs, local HAZ researchers, senior managers (eg Regeneration, public health specialists), wider agency representatives (eg Chambers of Commerce; Universities, community and voluntary sector representatives).

- Approximately two or three individuals involved in specific schemes and initiatives addressing the needs of deprived neighbourhoods and socially excluded groups. These were frontline staff (eg DNs, HAZ community coordinators, Neighbourhood Renewal officers) and community workers

In the non-HAZ case studies changes in the development and operation of Health Improvement Programmes were *monitored* and not investigated in as much depth as the HAZ areas. As well as documentary analysis, monitoring involved semi-structured interviews (face-to-face or telephone) with approximately five stakeholders. Some attempt was made to follow up interviews with original respondents at stage one, but this was not possible in many cases. Individuals included Directors of Public Health, PCT Chief Executive, Local Authority Deputy Chief Executive/Directors of regeneration/ or health /social care, Policy/Planning Officers, Councilor with Health Portfolio).

The fieldwork was conducted in autumn 2001. All face-to-face interviews were taped and transcribed for subsequent analysis.

Observation was undertaken through attendance at national HAZ case study meetings and events. Ongoing documentary data collection and analysis was also undertaken, including case study progress reports, minutes of Board and Executive meetings, local evaluation activities.

Main analysis

An initial analysis of fieldwork data was undertaken following the stage two fieldwork ie at the end of 2001 and spring 2002. 'Context-Mechanism-Outcomes' was used as the overall framework for analysis of the data. Within this framework, the data from the transcripts and documents, for each case study, was initially analysed in relation to the major themes of:

- context and specifically respondents perceived influence of national policies, partnership working and efforts to address health inequalities,
- definition and development of partnership processes and structures for partnership working, strategy development and implementation,

- 'impact' in terms of changes in nature and processes of interaction between stakeholders, and evidence of practical progress in addressing health inequalities,
- 'impact' in terms of nature and degree of engagement with communities and deprived groups.

Within each of these themes a number of emergent issues were identified, the interrelationship between issues were examined, and also HAZ and non-HAZ comparisons were made. This initial analysis highlighted the focus of 'integration' and 'mainstreaming' health inequalities as a key challenge and outcome within a context of rapid policy activity and structural changes.

Stage 3: Follow up investigation of integration and mainstreaming with Neighbourbourhood Renewal (late summer/autumn 2002)

This stage involved interviews with two or three selected stakeholders (a combination of face-to-face and telephone) in all case studies, to assess the integration of health partnerships within community planning and neighbourhood renewal processes and strategies and impact. It particularly focused on the legacy of HAZ ie stakeholders' views on the extent to which HAZ learning had/was being 'mainstreamed'. Those interviewed included Directors of Public Health, HAZ Directors, PCT Chief Executives, Voluntary organization representative, those involved in Local Strategic Partnerships or Neighbourhood Renewal.

Only the face-to-face interviews were be taped and transcribed for subsequent analysis. The data was analysed in relation to the issues that had been previously identified.

Empirical investigation of policy processes to test theory

In summary, the research plan had a number of features that provided a sound basis for evaluation of health partnerships as a policy delivery mechanism.

- An aprori framework presented as a 'schema for collaborative policy mechanims' based on synthesis relevant theories concerned with the policy process and inter-organisational relationships.

- The approach of realistic evaluation informed the research plan. Realistic evaluation is increasingly being recognised as particularly relevant to the evaluation of social programmes and therefore of policy delivery. It has formed the evaluation framework of the national evaluation of both Health Action Zones and more recently Local Strategic Partnerships.

- The case study design and use of qualitative methods are well established in the study of policy processes.

- The match comparison of two HAZ and two non-HAZ areas was a strong feature of the study. It proved valuable in determining whether HAZs were different and distinctive forms of partnership working, and their added value for policy delivery. (However it was recognised that given the nature of HAZ status, the sample was bias in terms of areas 'organisational readiness' to take forward the health inequalities agenda.)

Part II: The findings

The following chapters present the study findings and evidence of the operation of the different partnership models. Each chapter considers experience and evidence of tackling health inequalities through partnership working to address the research questions:

- What theoretical models of partnership were being used intellectually and in practice by stakeholders to address health inequalities? (means)

  To what extent did health action zones represent a distinctive model of partnership working for policy delivery, in term of intellectual framework and resources? Was this a network management model?

- What was the success of these partnerships in effectively engaging stakeholders in addressing inequalities in health as a 'win-win' endeavour; or did the dominant self-interests' of the different stakeholders undermine success? (intermediate process outcomes)

  To what extent did health action zones make a difference? How did the model of network management add value to the policy process and delivery?

Chapter five assesses evidence of whether national policy provided a context conducive or not to tackling health inequalities locally through partnership working. The extent to which the different theoretical partnership models ('collaborative policy delivery mechanisms') were evident was explored.

Chapter six documents what partnership mechanisms for tackling health inequalities were developed over the study period. The relationship of

HIMP/HAZ partnerships to wider partnerships is considered. The extent to which HAZs present <u>distinctive partnership mechanisms</u> is assessed. Again the theoretical framework was applied.

Chapter seven assesses evidence of the <u>impact</u> of these partnerships in terms of partners' commitment, priorities and ways of working at an organisational and individual level. Differences between HAZ areas and non-HAZ areas were explored.

Chapter eight considers evidence of the <u>impact</u> of partnerships in terms of engaging deprived communities and groups, and addressing their needs. Differences between HAZ areas and non-HAZ areas were considered.

Chapter nine reiterates the thesis' overall approach as a study of 'collaborative policy delivery mechanisms' addressing the key research questions. The empirical findings are summarised. The contribution of the study to network theory is then discussed. The implications for the future role of Health Action Zones and research are considered.

Chapter 5: The impact of national policy on local mindsets

This section considers the influence of the national policy context on the nature of partnership working for tackling health inequalities as perceived by respondents. Evidence of the influence of the different theoretical models, particularly network management, is explored.

Shared understanding and ownership of the problem

Across all the different organisations respondents widely acknowledged the evolution of a more supportive policy context for tackling health inequalities, particularly when compared with the previous Conservative agenda. It was clear that Government's policy messages relating to the 'socio-economic' model of health and health inequalities, based on the *Acheson* report, were understood and absorbed to some extent across the system in all case studies. Therefore, such awareness could not be attributed solely to the Health Action Zone initiative. However the understanding of HAZ respondents appeared more developed, particularly at the early stage of the study. Senior officers including Chief Executives in health and local authorities, involved in HAZs were motivated to take on the role of advocates for reducing health inequalities, and became particularly articulate in talking about health inequalities and the potential for action. Health inequalities were no longer the sole remit of public health directors and specialists.

The government's commitment to a comprehensive agenda for addressing social exclusion and poverty was regarded as an essential backdrop and stimulus to local efforts. *Saving Lives: Our Healthier Nation* was viewed as providing an important new framework that went 'beyond healthcare' and provided a whole systems perspective:

what's important is the focus on health and moving away from the notion of healthcare and competition and the biggest benefit is that organisations can sit together and work out what is best use of money for health...in health economic terms its looking what's the most effective way to spend the public money in respect of all public agencies rather than just in the health proportion of the budget...that's a big shift'. (Local Authority officer-HAZ area*)*

The majority of respondents were able to define the interconnections between health inequalities and wider social and economic factors, and the lesser role of health services. For example many respondents referred to the important link between income and poverty, and government policies relating to work and benefit system.

'Health inequalities are the same issues as rich and poor..the government needs to give people more money...and self esteem....' (PCG CE-HAZ area.)

'The NHS Plan priorities do not deal with the nature of the problems in LSL...the starkness between poverty and health'. (Local Authority Community Manager-HAZ area.)

Respondents were also aware of the need for action at both national and local levels. As well as income levels, certain other issues such as housing and transport did need national and regional intervention. But there was much that could be tackled locally through the links of health inequalities to the agenda for economic growth, regeneration and neighbourhood renewal:

'Fundamental health experience relates to broader inclusion. Life chances relate to good education, crime free neighbourhoods, real employment opportunities linked to better education to break the cycle of poverty.' (LA Director-HAZ area)

The macro level, what is happening economically to this city in terms of its regeneration is going to be more important in the long term about what happens to heart disease and strokes and cancers and what we say in service delivery terms needs to be achieved in be achieved in best practice and standards of health care and I think everybody knows that.' (HA Director of PH-non HAZ area)

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While previous evidence suggests local players might be unwilling to take on responsibilities, in the absence of government commitment, this was not the situation. Indeed there was a sense of urgency and acknowledgement that previous efforts had failed, and that the notion of partnership working was fundamental and the logical way forward. The majority of those interviewed were well able to define the broad role of their organisations and others, and showed a willingness to take forward their responsibilities through partnership working. Health/HIMP Partnership Boards were cited as having helped achieve this understanding. Not surprisingly, commitment appeared particularly strong in the HAZ areas in relation to the HAZ objectives at the early stages of the study.

Despite certain exceptions, there was widespread acknowledgement of local authorities' significant role in community leadership in influencing inequalities:

'It was not a matter for debate'. (LA Director, HAZ area).

The Conservative council members' political stance in KCW (non-HAZ area) was the exception. The councilors were reported to be dismissive of the Government's policy on health inequalities as having anything to do with local authorities. In both non-HAZ areas, local authority thinking appeared less well developed. One respondent in a non-HAZ area expressed the view that the City Council did not view the disease targets as 'particularly their business' or could easily define their contribution. There was a lack of understanding about how the organisation or specific functions could have a practical impact. However by the end of the study period the responses indicated that local authorities in all case studies areas had increased their level of understanding and commitment.

Health authorities' potential for impacting on health inequalities was viewed as 'modest at best', but the health authority role was important in providing 'wisdom'-some direction and leadership. The role of new PCGs/Ts was generally viewed as potentially important for establishing a neighbourhood approach to service development and resource allocation. They would be able to link closely with regeneration initiatives as well as ensure primary care services were 'sensitive' to needs of deprived groups and communities. But the lack of policy incentives to engage acute trusts in the health inequalities agenda was recognised as an important weakness, and viewed as a 'missed opportunity'.

Overall, respondents acknowledged the emergence and evolution of a policy framework that endeavored to link health inequalities with other policies across government especially those addressing social exclusion. Such alignment would be evidence of government's attempt to 'steer' the system-a feature of 'network management'. However observations made in 1999 first phase of the study relating to the lack of policy coherence were restated in the later follow up phase of interviews at the end of 2001. Aspects of the policy agenda were regarded as supportive to tackling health inequalities but still lacked coherence:

> *Marrying different strategies, marrying different plans and indeed initiatives, is getting more difficult by the day.... initiativitis'*
> (Local Authority Social Services Director-non HAZ)

> *'the government is genuinely trying at 'joined up ness' but largely failing'.* (HA Director-HAZ)

Fundamental tensions remained and created difficulties for joint working. In particular three issues served to undermined progress.

Health care versus health inequalities?

Within the context of moves towards cross government policy coordination, dominance of the centralist approach to management of the NHS and its influence on efforts to ~~health~~ address inequalities were clearly evident. The NHS Plan was perceived by respondents as raising uncertainty about the role of the NHS in tackling health inequalities and its relative priority. The majority of respondents viewed that the NHS Plan had failed to signal sufficient commitment to the wider health agenda. It was perceived as superseding *Saving Lives: Our Healthier Nation* as the framework determining NHS priorities, and 'downgrading health improvement' vis modernisation of health services. Disappointment was expressed at the lack of reference to Health Improvement Programmes as the key mechanism for the NHS to develop joint health strategies:

> *'There is a tension between the political priority of implementation of the NHS Plan and commitment to health improvement in the poorest communities' (LA Director, non-HAZ area).*

The highly prescriptive nature of the *NHS Plan*, along with National Service Frameworks, and 'hypothecated' resources, were felt to limit capacity to respond to local health priorities. This emphasis was described by one respondent as:

> *'a centralist Stalinist approach where you are instructed exactly how to drill the holes….'* (HA Director, HAZ area)

The HAZs were not immune from central messages and ambiguity about the relative priority of health inequalities. Both HAZ Directors indicated that some adjustment of HAZ priorities had been necessary.

This experience demonstrated that the traditional tension around the role of NHS and population health was deepened. The public (electorate) concern

for delivery of health care, heightened and fueled by high media visibility, clearly intensified political pressure to deliver. The political pressure to adopt a highly centralised approach to secure implementation was high and was in Ministers' self interest. It was the power of the 'voters' and medics that were driving the political priorities. Conversely the public generally is not so attuned to broader public health issues; the public health agenda rarely commands or drives electorate pressures.

> *If hospital care gets worse or doesn't improve then people will want to focus less on broader inequalities............this is a bit of a caricature but we know that the hospital issue is partly about getting things right according to a clinical model and as things in hospital worsen there will be a greater emphasis on central specifications to get things right and that will go against the grain of the health inequalities work...*
> (Regional government officer)

However, while the centralist approach to delivery might be appropriate to forge change within the health services, it may be the wrong vehicle for addressing health inequalities.

Mainstream versus initiatives?

There was evidence of use of a full range of policy instruments to incentivise collaboration; both longer-term strategic partnership, but also opportunistic collaboration between local players. Changes in legislation relating the statutory duty of partnership had given impetus to the establishment of local Health Partnership Boards. The ability to pool budgets had allowed early progress towards more integrated mainstream approaches to health and social care, compared to some other areas of housing and education.

However the proliferation of initiatives, with money attached, had clearly given impetus to collaborative projects addressing the needs of deprived communities, whether or not this was part of a mainstream strategic approach

or based on genuine partnerships. This was a view that was shared by many respondents in both HAZ and non-HAZ areas.

The continued requirement to work in partnership as a criteria for access to resources was highlighted as influential in prompting SRB managers to approach health staff to input into a major initiative:

> 'the (SRB managers) had to get us involved because they (the Treasury and DETR) truly don't see it as sexy unless you do everything in partnership and it is this reason why things happen….people say do you want to get involved not because they want to work in partnership but they know that they have got to do it that way to get the money. So this focus by the Government on joint partnerships has meant that health has got a focus in regeneration that it has never had before' (PCG CE, HAZ area).

A number of respondents expressed concern that initiatives could only at best achieve marginal impact and served to distract attraction from the more fundamental 'long haul territory', and the need to influence changes in mainstream services. For example a regional government officer stated with respect to the riots in Bradford:

> The riots took people by surprise, given the range of initiatives in Bradford…. Such initiatives fail to prevent civil unrest-but can even fuel the underlying sense of alienation between communities…….It highlighted the need to get policies to work together …the Neighbourhood Renewal agenda should bring about a shift in focus from targeted initiatives to addressing mainstream programmes…But Neighbourhood Renewal is still about single funding rather range than mainstream in the first year. (Regional government officer)

The potential negative impact of the proliferation of initiatives as a source of tension within and between communities was also highlighted by a number of local respondents. It generated perceptions of winners and losers.

> It creates stark differences between those who have and those who don't so it exacerbates inequalities in many ways and if you've got

people on one side of the street getting a service and the others not and its visibly evident in whether your front door's been painted, in whether you've got new central heating or new windows and whether you haven't its not good for a community, not healthy…(Director local voluntary organization-HAZ area)

Despite the potential negative aspects of initiatives respondents were clear that initiatives represented an important source of additional resources for making at least some progress and offered a focus for collaborative work in areas that would not attract mainstream resources. In a non-HAZ area the comment was made that such initiatives 'were the only game in town', given the lack of clarity of commitment to health inequalities centrally and locally.

Change versus continuity?

A major tension was evident between the longer term changes in how the system might be structured to promote and benefit partnership working, and the significant ongoing change and organisational disruption, which served to undermine this potential. In particular, networks are based on people interacting and learning to do so over long periods of time. This is essential to building trust that is vital to collaboration. The importance of relationships is reflected in the following comment:

People want to see planning structures that are quite neat, and the structures going to be quite neat but to make it work, you've got to have a lot of fuzziness, and all that networking and knitting….

…..you can't go through the radical changes we do without giving some space to building new relationships and new understanding….
(Joint planning officer, HAZ area).

The following comments conveyed the sense of continual turmoil experienced by many respondents. The system was in transition but would there ever be sufficient stability and continuity required for organisations to understand and develop their public health roles?

The system is in a state of chaos.' (HA Director, HAZ area,1999)

The system is melting and a new system is being invented....Primary Care Trusts are to lead the NHS role and PCGs need to be recast as new organizations to take on this role ..... The scale and pace of change makes a nonsense of policy. (HA Director, HAZ area, 2001)

The organizational map is patchy....fragmented...unstable, lacking coherence. (Local authority deputy chief executive)

Furthermore continuity of individual relationships, that is fundamental to the notion of 'network management', was being undermined. Many respondents highlighted the difficulty of maintaining relationships, given the context of job insecurity and organisational change.

While HAZs could point to some success in influencing mainstream agendas, service development and systems (discussed later) the organisational changes involved in implementing *Shifting the Balance of Power* presented significant difficulties to dissemination of HAZ learning. One respondent emphasised this point:

not only have we had changes in personnel within the schemes themselves, but everybody that you knew in the partnership organisations is either in a different organisation, in a different building or doing a different job-if they're there at all-so that makes it difficult. (LA officer, HAZ area)

There was some acknowledgement that in the long term the restructured system could promote partnership working on health strategies. One respondent noted that there were new opportunities for sharing agendas as all the main players in the system (local authorities, health and police) were being required to rethink their roles, relationships and the way forward. In particular the creation of a focus of coterminosity around future Primary Care Trusts and local authorities was regarded as critical to the more effective engagement of key players around local priorities. Primary Care Groups and

subsequently Trusts were expected to be the key health agency leading public health. However most respondents indicated that new PCTs were unlikely to be able to give early attention to public health.

> *They are obsessed with internal organisational development...and struggling to cope with everything else.* (Policy officer, non HAZ area)

> *I think the PCTs have got business to do in their own organizations. They've got to get that done and then lift their head up to the bigger agenda again, and its whether they can do that in time that will make the difference. (LA Director, HAZ area)*

In summary, the above analysis suggests that the different models of partnership working (set out in the theoretical schema in the previous chapter) were operating simultaneously. The influence of national policy on the case studies suggests aspects of a 'network management' approach. Government was perceived as evolving more supportive conditions for tackling health inequalities locally through partnership working. However, while there was recognition that the government was making attempts to 'structure the network' to support local collaborative action, there were still major difficulties.

The highly centralist and prescriptive command and control model was clearly the dominant model being adopted to implement the *NHS Plan*. Public choice theory can be viewed as driving or reinforcing this centralist approach. Some centralism was clearly being driven by political expediency. Ministerial reputations and self-interests were at stake.

> *I'm not convinced that the NHS because of political priorities is committed. Understandably it is still driven by the media....it's very difficult for the NHS to take a step back when the political imperative is waiting lists and all the rest of it and in that sense the more preventative bigger picture approach that addressing health inequalities requires doesn't fit within a very tight clinical perspective....floor targets are quite puny mechanisms when faced with the bigger juggernaut...the trolley waiting lists agenda.*
> (local authority deputy chief executive-non-HAZ area).

Centralism may be appropriate to ensure progress on reducing waiting times and fulfilling electoral pledges, but it undermines the building of networks locally. This does raise serious questions about whether the NHS can now be expected to lead the wider health inequalities agenda.

The perceived government preoccupation with central initiatives including Health Action Zones was viewed as a means of achieving some collaborative action at the margins (ie incrementalism), but was questioned as an effective way of impacting on the more fundamental structural issues that required sustained mainstream efforts based on a more locally integrated strategic approach. Furthermore targeting central funding could have a divisive effect within communities and foster tensions based on perceptions of winners and losers.

By stage two of the study there were high expectations about Local Strategic Partnerships as the mechanism for devolution and enabling a more integrated strategic approach locally. At this stage therefore the influence of the central driver of the local government modernisation programme and neighbourhood renewal funding was evident. LSPs could provide a local vision and strategic framework for integrating health within the domains of the non-health care sectors. Indeed, LSPs were was viewed by the majority of respondents as a natural next step to Health Boards and HAZs. However this assumed strong leadership to forge a joined up agenda and commitment between the different players. It also assumed the organisational capacity of players to engage effectively in the process, at a time of massive organisational changes, involved in implementing *Shifting the Balance*. The optimism was therefore qualified:

> *Current partnerships have their own silos and there's a need to look at connections and how the LSP would add value. But reconfiguration of*

the big picture might be no better than rearranging the deckchairs on the titanic. (Local Authority Policy Manager)

The following chapters examine in more detail the experience of respondents in tackling health inequalities locally through these different partnership models. The above analysis suggests that there are some tensions between the models that were influencing progress on policy delivery.

Chapter 6. Partnerships for reducing health inequalities

This chapter reports the development and changes in health partnerships in each of the four case study areas over the study period (autumn 1999 to autumn 2002). These were the inter-organisational structures and systems for the development and implementation of strategies that addressed health improvement and health inequalities. In particular the role and relationship of HAZs to the mainstream partnership and systems of the Health Improvement Programme and community strategy were examined.

This chapter also starts to examine the what type of theoretical models as the mechanism for policy delivery, as defined in the schema set out in chapter three; and to what extent HAZ represented a distinct model with features of network management.

This chapter is primarily descriptive. It documents stakeholders' views of how the partnerships should operate in principle. Subsequent chapters present analysis of stakeholders' experiences of whether or not partnerships were successful in enabling actions that would contribute to reducing health inequalities.

Case study partnerships for improving health and tackling health inequalities

The study provided a snap shot of partnership arrangements in each of the four case studies at two points in time: autumn 1999, and autumn 2002.

The partnership arrangements across the four case studies showed great diversity reflecting their own distinct histories, strategies and contexts. In particular scale and organisational complexity of the arrangements and the strength of existing collaborative working were important factors, and were reflected in the selection of the case studies. Clearly the strong tradition of

joint working in Bradford and LSL was an important factor in achieving HAZ status. Furthermore individuals' roles and relationships including informal relationships were regarded by respondents as a critical dimension of partnership working.

The strategic priorities and partnership arrangements, prefaced by a brief reference to context, are described for each of the four case studies below.

Bradford: HAZ area

Bradford displayed a combination of features that in principle provided an ideal test bed for the HAZ initiative. Bradford covers a population of 486,000. Marked health inequalities mirror the pattern of deprivation within the district, with multiple deprivation concentrated in the inner city and a number of other estates. Collaborative working was well established between the health authority and coterminous Labour City Council, providing a sound platform for HAZ. The total public sector budget amounted to almost £1 billion. Bradford HAZ received a three year grant of approximately £9m (excluding earmarked HAZ-related monies).

Public health priorities and HImP/HAZ

The HAZ preceded the HIMP process and considerable attention had continually been given locally to understanding and reviewing the relationship between the HAZ and HImP-their priorities, strategies, processes and alignment. The HImP and HAZ shared the overall common priority of reducing health inequalities and improving well being. The first HImP (1999) document defined the major priority as:

> 'to shape programmes of action that reduce health inequalities without reducing standards-between Bradford and England as a whole and between communities within the District'.

The relationship between the HImP and HAZ was stated (in the 1999 HImP document) as follows:

'The HImP provides an overall strategy for health improvements in the district (what needs to be done) and the HAZ provides the practical methods and solutions for achieving mutual aims (how it can be done).

Those people interviewed commented that the HImP should now be the

'central bible..' ...'the real centre of our attention'. (HA Director)

The HAZ was explicitly viewed as 'adding value' through its emphasis on partnership working, ability to test new freedoms, and opportunity to focus on the underlying causes of ill health.

'What the HAZ does is accelerate the HImP and focus very strongly on inequalities issues.' (Local Authority Director)

The specific priorities and 'programmes of action' identified in the HIMP 1999, HImP 2000-3 and HAZ documents are showed in the table.

Bradford Priorities in the HImP and HAZ			
Priorities	1999/2000 HImP	2000/3 HImP	HAZ Implementation Plan
Disease /Conditions	coronary heart disease, cancer, diabetes	coronary heart disease, cancer, diabetes	diabetes CHD (physical activity, nutrition, HLCs)
Health & social care	mental health, rehabilitation & recuperation	mental health, learning disabilities, older people, promoting independence	mental health rehabilitation & recuperation people with disabilities
Population group		children & young people	children & young people
Health in deprived areas	deprived areas accidents	primary care, black & ethnic minority health, accidents, sexual health, drugs & alcohol abuse, housing & regeneration, socially excluded groups, smoking cessation	primary care health & regeneration accidents
Building communities		community involvement	community involvement
Organisational Development			evaluation LA infrastructure/ Best Value communication information & technology
Health services	waiting lists, waiting times, emergency admissions	waiting lists & times emergency & winter pressures vaccination & immunisation	
Other		regulation	

The priority areas selected were seen as representing the integration of national and local priorities. They reflected previously identified priorities, particularly issues highlighted in the series of Annual Public Health Reports. They also built on the wide ranging current programmes of work. They also reflected the model of health that had been developed by the health authority and the Council in 1994. This model (included in the HImP document) recognised the full range of health determinants (including poverty, housing, work) and the need for multi-agency contributions. At the time of the HAZ bid, the emerging draft HImP was seen as providing the rationale for the HAZ priorities, but HAZ priorities were also the outcome of debate amongst

stakeholders and reflected the need to provide some 'early wins' and some degree of pragmatism.

It was felt that the consultative and negotiation processes involved in developing the HImP and HAZ plans had achieved consensus about the overall aims and priorities, at least at a high level. However it was acknowledged that the process had been 'top down' rather than 'bottom up'.

Those interviewed acknowledged that the programmes and projects were at very different stages of development. Programmes varied in their focus and the type and timing of outcomes that could be expected. In the first HImP and HAZ, for most priority areas, there was limited specification of long term health goals/targets/outcomes or activities/milestones and definition of responsibilities, (with the exception of HAZ funded schemes).

HAZ programmes and activities encompassed both 'mainstream' and HAZ funded work. They covered:

- 'Early wins' through implementation of already well developed programmes: for diabetes, improvements in primary care in inner city areas, and early improvements in rehabilitation and recuperation. Implementation through HAZ would ensure a whole systems perspective. It was felt that these areas would achieve measurable improvements in the short term.

- Strategy development for the integration of health and social care to achieve joint commissioning, joint provision and delivery of services (covering people with learning disabilities, mental health of children and adults, rehabilitation and recuperation). Over a 2-3 year period improvements in services were felt to be achievable.

- A number of disease focused programmes and initiatives (CHD, Cancer) spanning health service provision and community based opportunities for healthy living; including Health Living Centre bids, promotion of physical activity.

- Investment in building the organisational infrastructure and processes for partnership working. This included investment in developing an evaluation capability and culture with the support of Bradford University; strengthening the local authority's commitment and capacity to contribute to HAZ; development of a communications strategy to encourage involvement of communities and front line staff.

- Investment in building the infrastructure and capabilities for community involvement as a critical foundation for long term community health and regeneration.

- 'Long-haul territory'-action that addressed the root causes of ill health through the integration of health within regeneration and other Council strategies.

All of those interviewed stressed that both the HImP and HAZ were about mobilising the total resources of the public sector, and others, to tackle health inequalities and improve the quality of life of people in Bradford. HAZ monies were viewed as helpful but a minor element. 75% of the three year £9m HAZ budget was allocated to four priorities: Local HAZ schemes (27%), improvements in primary care in the deprived areas, including diabetes services (25%), rehabilitation and recuperation (13.4%) and 'HImP' priorities relating the disease prevention and community health promotion initiatives: CHD, Cancer (9.7%). 3.6% was being used to strengthen the community infrastructure.

At the time of undertaking the profiling exercise, priorities were being reassessed to determine how the HAZ could best make a real difference to tackling health inequalities. Regeneration was now being regarded as the key focus for action.

Partnership arrangements including the health action zone at stage one

The partnership arrangements in Bradford were comparatively well developed. There was a history of strong joint working between the health authority and local authority, especially in areas of health and social care and health promotion. Bradford partnership system represented a comparatively mature and favourable context for HAZ to add value. Bradford adopted a highly 'integrated' approach to HAZ. HAZ was viewed primarily as a mechanism for pump priming developing and implementing of mainstream health improvement priorities as well as focusing on the underlying causes of ill health.

At stage one the main features of the system were:

- *The Bradford Congress*: a large interagency body of senior figures in public, private and independent organizations, that oversaw the development of the District's strategy (Bradford 2020 Vision).
- *HIMP/HAZ Partnership Board and Steering Group.* Board membership was primarily chairs/members and chief officers from the HA, City Council, PCGs, CHCs, Bradford University, Police, TEC, Chambers of Commerce, Voluntary sector, regional TUC and MPs. HIMP/HAZ officer steering group had the remit of developing and implementing the Health Improvement Programme. The development and implementation of specific strategies for HIMP priority areas was the remit of district-wide interagency strategy groups (including coronary heart disease, cancer, diabetes, health and regeneration). HAZ

priorities and projects were integrated within these district-wide strategies. A HAZ evaluation board oversaw and supported the evaluation of all HAZ activities.

- *Local health improvement/HAZ groups based on the four Primary Care Groups.* Each PCG was allocated upto £300,000 HAZ monies a year for three years to address health inequalities. These local groups were intended to link with the existing community development infrastructure and consultative mechanisms of the local authority (the five constituency area committees and neighbourhood panels). This was supported by the HAZ funded Community Involvement team. The groups linked with other related government initiatives including Sure Start, New Deal for Communities and SRB activity in their areas.

The establishment of the HAZ and Health Improvement Programme was regarded by respondents as giving significant impetus to the integration of a strong health improvement and health inequalities focus to the district's community planning processes, and locally within the emergence of primary care groups.

Health was incorporated within the various themes of Bradford Vision. The HIMP and HAZ were regarded as providing the health dimension to this district strategy. The integration of health within the district strategy was viewed as a crucial high level endorsement of the link between health and the wider agenda for tackling health inequalities. The HAZ in particular had a critical interface with the new regeneration strategy. At this stage it was acknowledged that the system was 'top down'.

HAZ funding provided for important investment in development of organisational capacity for interagency working. The HAZ project director was a full time designated post. Other key appointments were designed to strengthen organisational infrastructure, including management of communications, a community involvement coordination team and

strengthening the local authority Health Coordination Team. Furthermore the allocation of HAZ monies to the four Primary Care Groups required these emerging new organisations to address health inequalities as well as helping them develop the necessary capacity, particularly more effective relationships with their communities.

Partnership arrangements at stage 2

Implementation of *Shifting the Balance* involved the abolition of Bradford health authority and establishment of four Primary Care Trusts (based on the PCGs). Riots in Bradford in the summer of 2001 gave impetus and urgency to the creation of the Local Strategic Partnership-Bradford Vision. The Neighbourhood Renewal Strategy became the focus for establishing a more neighbourhood based approach to inter agency working that was intended to influence mainstream planning and budgeting processes. The HAZ approach and its learning were viewed by respondents as a platform for the Neighbourhood Renewal Strategy.

The main elements of the new partnership arrangements were:

- *Local Strategic Partnership-Bradford Vision Board (reconstituted Bradford Congress), Executive and Assembly.* This had the aim of overseeing the development, implementation and review of the district's community strategy-*Bradford 2020 Vision*. This strategy was to be revised on an annual basis, and address local Public Service Agreement targets. The Board comprised twenty-one members and was constituted as a Limited Company. The Executive supported the Board with responsibility for implementing the strategy. The Assembly was intended to enable representation of all constituencies. The Community Network, established through the Community Empowerment Fund was to provide the facilitative/secretariat role for

the Assembly. Six new community members of Bradford Vision were recruited through open advert.

- *District Health Improvement Board and Steering Group* had responsibility for the Health Improvement and Modernisation strategy. The four PCTs now had the lead responsibility for the development and delivery of the HIMP, with the abolition of the health authority.

- *Area-based planning and delivery*; was to be based on PCT primary care investment plans and area priority plans for the five parliamentary constituencies. Five Annual area conferences in each constituency and one covering 'communities of interest' would enable neighbourhoods to identify common needs and priorities, emerging from neighbourhood action plans. This would inform the mainstream planning and budgetary processes, as well as informing use of the Neighbourhood Renewal Fund ie district-wide strategy groups would seek to respond to the Area Priority Plans.

- *Neighbourhood Action Planning.* Local partnerships would produce Neighbourhood Action plans with aims that linked to local Public Service Agreement targets. Plans would identify funding sources: neighbourhood, mainstream public services, external funding (including Neighbourhood Renewal Funds and other area-based initiatives). Neighbourhood Management would be piloted through this process.

- *Health coordination function for Health Improvement.* The network of people and organisational capacities concerned with the health improvement and health inequalities agenda, including the HAZ team and organizational development resource, would form a 'virtual' health coordination team/function. This team would enable the integration of the LSP, local authority and PCT efforts and plans to improvement health and reduce health inequalities.

In comparison with the three other case studies, the nature and evolution of partnership working to reduce tackling health inequalities in Bradford was the most 'advanced'. It is suggested that the Bradford experience was distinct and illustrated aspects of a network management model of partnership working. In principle the approach involved exploiting the centre's agenda, including the incentives provided by HAZ status, to advance the local commitment to tackling health inequalities. The HAZ represented central permission for health inequalities to be defined as a common strategic priority and linked to both the modernisation of health services, but also regeneration. The HAZ status and resources were used to develop the strategic commitment and capacity of partners to work together on tackling health inequalities. By stage 2 the HAZ experience of joint working on inequalities, and the organsational resource (HAZ director and team) were providing a platform for developing Bradford's approach to Neighbourhood Renewal. Whether and how the Bradford approach actually changed organisational culture and ways of working and benefited communities will be explored further in the following chapters.

Bradford Partnerships (1)

National:
HAZ Development Unit,
gov depts/Cabinet Office
MPs

Regional
offices

Regional
Assembly
RDA

Bradford 2020 Vision
District Strategy

Health Improvement
Programme

Bradford Congress

HAZ Board

Chief Officer
Group

Health
Strategy
Group

City Council
Committees
Best Value

HAZ
Steering
Group

HImP
Steering Group

HAZ Evaluation
Board

Partnership in
Action Group

Priority Leads and Interagency Strategic Fora
(district-wide strategic frameworks for priority areas)

Four Local Health Improvement Groups
based on PCGs, linking with Trusts/ Council Area Committees/
neighbourhood panels, etc

Bradford Partnerships (2)

National:
gov depts/Cabinet Office,
MPs

Regional
offices

Regional
Assembly
RDA

Bradford 2020 Vision
Neighbourhood Renewal Strategy
Public Service Agreements/Floor Targets

Health Improvement
Programme/HAZ

Executive

Bradford Vision
(Local Strategic
Partnership)

Health
Coordination
Function

Assembly

District Inter-
agency strategy
groups

Health Improvement
Board &
Steering Gps

Community
Network

Area-planning & delivery:
Four PCTs/ Area constituencies panels
Annual Area Conferences

Neighbourhood Action Planning/Communities of Interest
(linking with area-based initiatives incl HAZ projects)

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Birmingham: non-HAZ area

Birmingham is characterised by its scale and complexity, both in terms of the public health agenda and the management task of health improvement. Birmingham's population of one million people is one of the most deprived in the country. Marked health inequalities are displayed across the district, linked to the pattern of poverty and deprivation. Birmingham health authority was coterminous with the Labour City Council, which was moving towards cabinet government and strengthening its local democratic structures. Twelve Primary Care Groups had been established. The history of joint working between the HA and Council had been variable. The total public sector resource amounted to about £2.9 billion.

Public health priorities and the HImP

The overall aim of the HImP (as defined in the HIMP document-1999) was to improve health and modernise health services, particularly for people suffering the worst health. The first HImP identified five overarching priority areas (CHD and stroke, infant and child health, promoting independence, modernising health and social care, and creating healthy, supportive environments); with each priority covering a number specific health issues. These are set out in the table below. Action plans were set out for each of these health issues. The Programme did not quantified long term health outcome goals.

Birmingham HImP priorities	
Priority areas	**Health issues**
Coronary Heart Disease and stroke	
Infant and child health	All children Children with disabilities Child & Adolescent Mental Health Services Children Looked After and Other Vulnerable Children
Promoting independence	Mental Health Substance Misuse Learning Disabilities People with Physical and Sensory Disability
Modernising health and social care	Achieving Waiting List Targets Providing Efficient & Effective Emergency Care Improving Primary Care Effective prescribing Community Pharmacy Development Implementing Birmingham's Health Care Future Black & Minority Ethnic Communities Oral Health
Creating healthy, supportive environments, including partnerships for regeneration and tackling social exclusion	Housing & health Transport & health Regeneration & health Tobacco Control

All the people interviewed stressed the significance of inequalities and deprivation as the key determinants of the health priorities and the action that should be taken. The local pattern of health and priorities were the product of

> *that combination of uniqueness around (our) cultural diversity together with the economic problems that the city has suffered. (Director of public health)*

Infant mortality and child health issues and the health of black and ethnic minorities were particularly highlighted. Issues of access and facilities in primary care, especially with respect to the needs of ethnic minorities, were regarded as a crucial area for action by the health sector. However real impact on health inequalities would be dependent on regeneration efforts and particularly social regeneration.

While it was felt that the HImP captured these priorities to varying degrees, it was acknowledged that the HImP needed to be 'bounded', and a critical issue would be making links to other strategies particularly regeneration.

There was felt to be some agreement about the HImP priorities amongst partners, at least in terms of endorsement of the document. However there uncertainty was expressed amongst respondents about the commitment and ability of all partners to take action forward. There was consensus across council members about the need to modernise health and social care; due to 'the immediacy of what their constituents bring to them'. There was also a consensus in the Council that it had the lead role in improving health through improving the environment but there was felt to be a lack of understanding about how the organisation or specific functions could have a practical impact. Furthermore there was the potential for other 'perceived' organisational priorities to deflect attention from the health agenda. As yet the link between the HImP and the wider local government agenda appeared unclear and confusing. PCGs had in the main embraced the HImP, and some had been enthusiastic in identifying specific health targets to action. However the HImP was felt not to have influenced mainstream budgeting processes.

Partnership arrangements at stage one

The history of joint working between the health authority and Council was regarded as variable and influenced by controversy and problems relating to hospital services. This issue had dominated a great deal of both political and public debate and hindered constructive dialogue on the public health agenda. The relationship of the HIMP process to the wider agenda and partnership processes was acknowledged as a central issue. Progress on reducing health inequalities in Birmingham was regarded as fundamentally dependent on sustained economic growth and success of regeneration efforts.

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The main elements of the partnership approach were:

- *City Pride Group and Futures initiative;* had the remit of developing Birmingham's City Vision and Plan, including a set of Quality of Life indicators. This was expected to provide the overarching framework, supported by other key strategic partnerships including the HIMP, regeneration and community safety.

- *Health partnership group;* a small group of executive officers from the HA, City Council and Voluntary Services Council and Primary Care Groups, with the remit of agreeing city-wide priorities, strategic frameworks and targets for the HIMP.

- *Health policy panel:* a member level Health Policy Panel that coordinated the Council's activities for health and social care, prior to the Cabinet arrangements.

- *Twelve PCGs* were required to include HIMP targets within PCG Locality Action Plans. PCGs were expected to link with the Council's democratic structures in their areas: Local Involvement Local Action (LILA) and 39 Ward subcommittees, supported by Ward Advisory Groups. Ward subcommittees had the remit of producing Ward Development Plans. It was intended that the locality level should increasingly drive the HIMP process.

- *Interagency planning forums.* Previous client based joint planning groups would no longer function as standing committees but were expected to take on time-limited tasks such as setting local standards or overseeing implementation of the NSFs for mental health and older people.

Partnership arrangements at stage two

At this stage the potential for developing strategies that would impact on health inequalities was viewed by respondents as dependent on the integration of the health dimension within the agenda of the new Local Strategic Partnership, neighbourhood renewal and regeneration and the processes of democratic renewal. *Shifting the Balance* had major implications for the reconfiguration of health services in Birmingham. It involved the abolition of the HA and creation of four new Primary Care Trusts (through PCG mergers). Birmingham City Council was also undergoing further major changes in its political management structures with the aim of significantly strengthening participatory democracy, and devolving management of certain services.

The main components of the emerging partnership arrangements were:

- *Local Strategic Partnership* with responsibility for overseeing the development and implementation of the community strategy. The new community strategy built on previous work on the City Plan and identified a range of strategic themes which included health.

- *Local authority cabinet committee health portfolio and health scrutiny committee.*

- *Health partnership group* with the remit of ensuring the development of a Birmingham-wide health strategic framework and the integration of health within key Birmingham wide partnerships and strategies. Membership comprised council members and chairs of PCTs.

- *Primary care trust/ parliamentary constituency interface.* The four Primary care trusts each had the remit of developing and implementing a Health and Modernisation Programme. The eleven parliamentary constituencies were planned to become the focus of management control of a range of devolved council services.

- *Ward level joint planning and management, based on 39 new Ward Strategic Partnerships.* These would build on the council's ward level infrastructure for involving communities: ward sub-committees and ward advisory groups, and Local Involvement Local Action (LILA mechanisms of neighbourhood forums and initiatives). Ward Strategic Partnerships would have the remit for developing Ward Development Plans, and other activities including management of selected devolved services. PCTs planned to establish effective links between the ward infrastructure and the PCT planning activity at this locality level.
- *The creation of a public health network function* supporting the PCTs and the City Council. This included the creation of a joint director of public health post between the council and one of the primary care trusts.

With respect to the theoretical schema of collaborative policy delivery mechanisms, the strategic coordinator model combined with use of initiatives and incentives were evident. The policy network involving established players was strong. The power of established power bases including the acute sector, and councilors were strong. At stage one, local health politics remained a major feature of partnership relationships. Acute hospital services and major problems about bed blocking dominated political debate on health and partnership relationships. Chief Executive leadership that might have promoted more collaborative working at a strategic level was regarded as lacking. However the introduction of the Health Improvement Programme provided a local framework for raising the priority of health inequalities. However health inequalities, and the role of the Health Partnership Group remained marginal. This contrasted with the impetus and focus created by HAZ status in the two HAZ case studies. Nevertheless, regeneration and other initiatives (for example Single Regeneration Budget schemes) were used opportunistically and tactically for joint working in areas where there was common ground, such as the Family Support Strategy. Leadership and action

appeared dependent on a small number of committed 'product champions' working across organisations on specific areas.

By stage 2 of the study a much stronger joint commitment to health inequalities was evident. In particular the role of Birmingham City Council in tackling health inequalities was starting to be articulated by Council officers and also Councilors.

> *At a strategic level the council owns and understands the issues of health inequalities. Health is about how we live our everyday lives. The City Council touches people in every aspect of life and can influence health.....80,000 properties is a huge investment that influences the environment and health ..* (Birmingham City Councilor)

The impetus and incentives for this increased collaboration were more to do with the Government's programme of local government modernisation, (including local Public Service Agreements) and the need to lead the delivery of regeneration of communities and neighbourhood renewal. Decentralisation of management and consultation processes in both the local authority and health were regarded by respondents as a positive step to local action on inequalities and shifting balances of power and resources towards communities.

Birmingham Partnerships (1)

Central government
Regional offices
RDA/Regional Assembly

City Vision

Health Improvement Programme

Council
LA Service Committees
Policy Panels
Best Value
Performance Plan

Multi-agency
Steering Groups:
incl City Pride
Community Safety

Health
Partnership
Group

Health Authority
Performance Review

Area-based initiatives incl
Sure Start,
New Deal, SRB etc

Task Groups

39 Ward Area
Subcommittees:
LILA

12 Primary Care
Groups

Birmingham Partnerships (2)

Central government
Regional offices
RDA/ Regional assembly

Community strategy
Quality of Life Indicators
Local Public Service Agreements

Strategic
Health
Authority

Health Improvement &
Modernisation Programmes

Local Strategic
Partnership

Cabinet
Health
Portfolio

Health
Scrutiny
Committee

Birmingham wide
Interagency strategies
incl Community Safety

Health Partnership
Group

4 Primary Care Trusts
11 parliamentary constituency management teams
Coordiantion & initiation of area-based initiatives

39 Ward Strategic Partnerships (incl councillors, PCT reps,
LA services, Police, Fire, neighbourhood forum reps etc)

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Lambeth, Southwark and Lewisham: HAZ area

Lambeth, Southwark and Lewisham was characterised by complexity with respect to the health inequalities agenda and organisational configuration within the district. LSL covered a population of 736,000, one of the most deprived in the country. Marked health inequalities and patterns of social exclusion existed across the district. The health authority corresponded to the three Labour-held boroughs of Lambeth, Southwark and Lewisham that were moving towards cabinet government. Six PCGs had been established and rapid transition to Trust status was anticipated, potentially resulting in coterminosity with the boroughs. The history of partnership working was regarded as a sound platform for the HAZ, particularly at the interface of health and social care.

Public health priorities-HImP and HAZ

The first HImP identified the overall aim as 'to improve the health and well-being of people who live in the London Boroughs of Lambeth, Southwark and Lewisham', through effective local partnerships. The HImP process had primarily been an agenda setting exercise, identifying priorities, while a subsequent phase of inter-agency planning would determine specific contributions and action plans. Four priorities were identified for 1999/2000: CHD and stroke, mental health, children and young people and inequalities. HAZ was the key vehicle for advancing the priority of children and young people.

The four priorities shown in the table below were identified for 1999/2000 based on a comprehensive assessment of the evidence of population health needs and potential for taking effective action, and wide consultation. In addition 'other national and local objectives' were also highlighted as areas for action.

Lambeth, Southwark and Lewisham 1999/2000 HImP	
HImP priority topics for 1999/2000	Other national and local objectives
- Prevention and treatment of coronary heart disease and stroke - Reducing mental ill health - Improving the health of children and young people - Reducing inequalities	- Waiting list targets - Emergencies - Cancer services - Accident prevention and public safety - Community safety, crime reduction and youth offending teams - Regeneration - Quality Protects - Sure Start - Better Services for Vulnerable People/Joint Investment Plans - Protection of public health - Information strategy - Improved performance - Human resources - Best Value

Those interviewed felt that there was an overall consensus amongst the partners about the HIMP priorities, at least in terms of areas that needed to be addressed. From a local authority perspective, the HImP was perceived as a very HA-led process and plan. Tackling inequalities was viewed as fundamental. The role of local authorities in providing community leadership and engaging communities was regarded as a crucial contribution to health improvement, although this was necessarily fully recognised. Acute trusts were not adequately engaged and their contribution remained uncertain at this early stage.

The HImP process was felt to contrast with that of the earlier HAZ. The HAZ process had been a coming together of all agencies with the mutual commitment to improve the health of children and young people, and built on established consensus.

The roles and functions of the HImP and HAZ were evolving. The HImP process was now recognised as the HA's mainstream core function. The HImP had to shift from priority setting to implementation.

'The HImP will become a general management process and any documents and plans will be the very essence, the centre of the health authority's work-linking to primary care groups, trusts, local authorities, voluntary, community sectors, private sectors and education sector'.
(HA director)

The overall aim of the HAZ was to improve the health of children and young people and reduce inequalities, and also to bring about system-wide changes. The HAZ had nine specific priority objectives with associated programmes, which covered parenting skills, teenage pregnancies and sexual health, tacking social exclusion, youth crime and improving training and employment opportunities, and developing healthy communities. For each priority area long term health and social outcomes were defined, with associated 'HAZ programme targets' –key interim process/service indicators. The prime intention was to test new models of multi-agency working, and influence mainstream policies, ways of working and service delivery. In addition four cross-cutting workstreams were developing the capacity to engage communities more effectively and the organisational infrastructure for partnership working.

The nine specific HAZ priority objectives with associated programmes are shown in the table below.

Lambeth, Southwark and Lewisham HAZ priorities	
Priority objectives & programmes	Developing healthy communities
	Improving parenting skills
	Increasing opportunities for disabled children and young people with special needs
	Working with excluded children and young people to bring them back into the mainstream
	Reducing unwanted young pregnancy and improving sexual health
	Reducing youth crime
	Reducing substance misuse
	Increasing training and employment opportunities and health through work
	Smoking cessation
Cross setting workstreams	Community development
	Communications
	Information
	Evaluation and Learning

The HAZ recurring annual allocation was approximately £5.8 m (over three years 1999/2003). In 1999/2000 42.2% of this HAZ budget was committed to three programme areas: parenting (15.4%), disabled children with special needs (11.2%), reducing exclusions (15.8%).

The programme to develop healthy communities and community development workstream were particularly distinct. 18.3% of the HAZ budget was funding these areas. These areas were focusing on the broader social exclusion agenda and 'upstream' health determinants in support of HAZ objectives for children and young people as well as the HImP priority of tackling inequalities locally. The development of healthy communities included a range of housing, nutrition and education initiatives and geographically focused projects. The community development workstream included a £540,000 Community Chest Budget (annually) to support diverse local community group projects and was managed by a community group. It was also funding of three community development workers to foster community development approaches locally.

HAZ was viewed as potentially an 'integrative force' for securing improvements in health and social inclusion for children and young people across LSL. It was developing a coordinating function with respect to all the new social inclusion initiatives impacting on children and young people locally (HAZ, Education Action Zones, Sure Start, Quality Protects, Employment Zone, New Deal for Communities, youth justice pilots, Single Regeneration Budget).

Partnership arrangements including the health action zone at stage one

Borough-based planning, centred on new Partnership Boards, was viewed as the key focus for addressing health inequalities, and replaced borough-based Joint Consultative Committee structures. The HAZ had a narrower focus of improving the health of children and young people and reducing inequalities.

For the first two years HAZ adopted a 'project-based' approach. HAZ was managed separately from mainstream and commissioned projects using HAZ monies. The HAZ was viewed as a key opportunity for 'experimentation and innovation', and for challenging existing models of service provision.

The main features of the partnership arrangements were:

- *Three borough-based Partnership Boards and Sub-Boards.* Each borough operated a similar model. The Partnership Boards had responsibility for developing a shared vision for health and well being, formulating joint strategic objectives, priorities and programmes and managing performance. Membership comprised elected members, non-executives, chairs and officers of the health authority, local authority, PCGs and voluntary and community groups. Sub-groups covered client groups and 'health' promotion groups eg Southwark Health Alliance.

- *Six PCGs* (two in each borough) were required to develop health improvement plans as part of their annual plans. It was intended that PCGs would take forward specific HImP priorities. PCGs linked with wider locality based schemes and plans, including HAZ initiatives.

- *HAZ Partnership Board and Executive Group.* The Partnership Board had the responsibility to direct, manage and monitor the work of the HAZ. It comprised senior officers from the health authority, the three local authorities, three voluntary sector bodies (one for each borough), three PCGs (one for each borough) and three NHS Trusts. Its remit included linking with the existing and evolving joint working mechanisms, and ensuring that HAZ plans fit with other agency strategies and plans.The Board was supported by an Executive Group, which consisted of the lead officers of the nine Programmes, with key link people from local authorities, PCGs and other key sectors.

- *Interagency programme and workstream groups.* with a designated 'lead' drawn from different agencies. Each programme group had the responsibility for commissioning a set of innovative projects that would contribute to overall HAZ objectives and targets. Projects had to meet certain criteria and a multi-agency Project Appraisal Group ensured the fit with mainstream agencies' commissioning strategies.
- *Organisational development and infrastructure for partnership working.* A core HAZ team comprised: HAZ Director, Development Manager, Research and Evaluation Manager, Communications Manager, and temporary Commissioning Manager.

Partnership arrangement at stage two

Shifting the Balance, involved abolition of LSL HA and the creation of the larger South London Strategic Health Authority; and the establishment of three Primary Care Trusts (merging of PCGs) which were coterminous with the three boroughs. LSPs were established in each borough to oversee the development and implementation of community plans.

The changes in the HAZ partnership arrangements demonstrated firstly a clear response to learning and review of its impact, and secondly the need for HAZ to be integral to these wider changes in partnerships arrangements. The initial 'project-based' phase of HAZ was recognised as not effective in linking with and impacting on the mainstream.

The local HAZ review indicated that the various Programme Groups had developed autonomously. Some had continued to meet and work well while others had stopped and comprised one or two people. They had suffered from a range of difficulties including lack of central HAZ guidance and, lack of clear lines of accountability. They were viewed as excluding various groups (voluntary sector and black and minority ethnic) and often in need of

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facilitation due to competing interests. Skills needed to run groups had been limited (chairing, leadership, conflict resolution). Their project commissioning role was judged to be no longer relevant.

HAZ launched (July 2001) phase two, to shift from the 'project based approach' to 'mainstreaming and transformation'. Its role would be to function as an organisational develop resource supporting strategic systems change. This phase involved:

- Devolving the commissioning of 'projects'/service developments to boroughs —each of the HIMP Boards or LSPs, and the PCTs.
- The selection of a new set of priorities through wide consultation and linked to the development of Health Improvement and Modernisation Plans by the HIMP Boards.
- The focus of the HAZ team/infrastructure on 'whole systems change'- in support of HIMP Boards, and involving the development and use of change management techniques.
- Creation of 'transformation teams'-practitioners working with the HAZ team to determine new service models in priority areas and using HAZ monies to pump prime change.
- Creation of learning networks to share learning across the three boroughs in priority areas.

These functions were established by the end of the study period. The HAZ team was practically hosted within one Primary Care Trust, although it remained a function that served the three boroughs.

The LSL case study and management of the HAZ initiative illustrates well the partnership model based on use of incentives by the centre to promote experimentation around tackling health inequalities. HAZ was concerned with:

'Trying out new approaches that is supporting the development of wider partnerships, stronger partnership, different models of partnership, different models of governance and linking the health improvement agenda into the service modernisation agenda.'

In particular HAZ could test 'system-level opportunities'; the 'modelling' and demonstration of how whole system resources could be used in different ways. It was seen as 'the leading, dynamic edge of the HImP'.

However by stage 2 there was widespread recognition that the initial 'project-based' phase of HAZ was not effective in linking with and impacting on mainstream strategies of key players. Almost all respondents were clear that the HAZ projects could only have a marginal (although positive) impact.
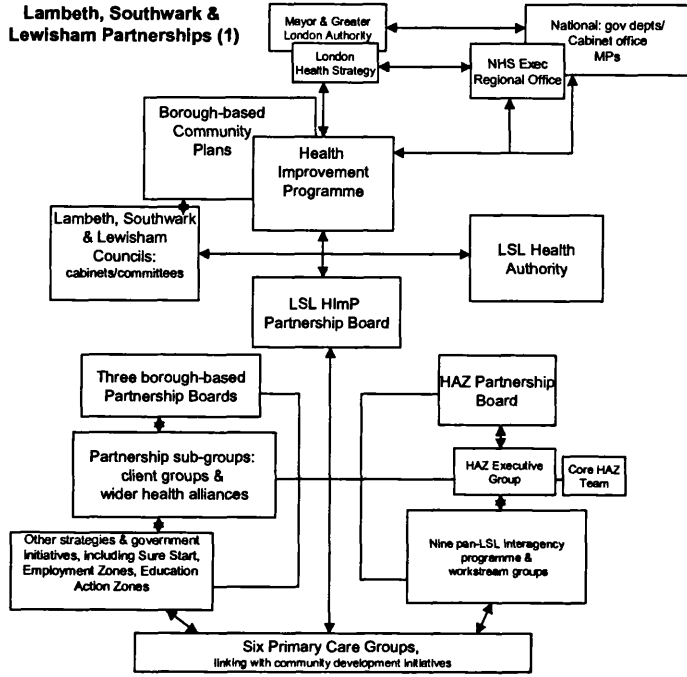
'A hundred projects does not achieve much...they are useful but not the answer'. (HA director)

Even at the initial stage, in 1999, respondents had expressed different views and uncertainty about how and when HAZ should be 'mainstreamed'.

'HAZ cannot float off on its own, it does have to fit into a broader strategic picture and I think there is a problem with the HAZ. It feels ..so collaborative and so cooperative ...It is kind of orbital and maybe it needs to be orbital for this year because what they are doing is different but I think at some point it does have to be brought back into the mainstream.' (LA regeneration officer)

A different approach based on 'mainstreaming and transformation' was being adopted by stage 2 of the study. The features of this 'mainstreaming' approach demonstrates features of a network management model of partnership working.

Lambeth, Southwark & Lewisham Partnerships (1)

Mayor & Greater London Authority

London Health Strategy

National: gov depts/ Cabinet office MPs

NHS Exec Regional Office

Borough-based Community Plans

Health Improvement Programme

Lambeth, Southwark & Lewisham Councils: cabinets/committees

LSL Health Authority

LSL HImP Partnership Board

Three borough-based Partnership Boards

HAZ Partnership Board

Partnership sub-groups: client groups & wider health alliances

HAZ Executive Group

Core HAZ Team

Other strategies & government initiatives, including Sure Start, Employment Zones, Education Action Zones

Nine pan-LSL interagency programme & workstream groups

Six Primary Care Groups, linking with community development initiatives

Southwark Partnerships (2)

Community strategy Neighbourhood Renewal Strategy

Health improvement & Modernisation programme

Southwark Borough Council

Lambeth partnership system

Lewisham partnership system

Local Strategic Partnership

Southwark Primary Care Trust (hosting HAZ Team)

Other strategic Partnerships incl Crime, etc

Health Partnership Board HAZ priorities, commissioning, mainstreaming

Sub-Boards Client group & Healthy Alliance

HAZ team

Area and neighbourhood planning

Kensington, Chelsea and Westminster: non-HAZ area

The district faces a highly complex set of public health issues. It covers a population of approximately 390,000, which is growing, highly mobile and ethnically extremely diverse. Marked health inequalities are evident and the gap between the wards with worst and best health record is growing. A history of good partnership working in the area of health and social care was reported. A number of initiatives had extended collaboration to other local authority departments. Both councils had mounted joint health strategy initiatives. Health promotion activities focused on certain diseases and a range of community development work targeted vulnerable groups. The two Councils were traditionally strongly Conservative. Although relationships had been productive at officer level, sustained involvement of elected members in the joint wider health agenda had proved difficult. The health authority suffered financial constraints (nationally furthest below its target resources allocation). Its trusts had structural financial problems.

Public health priorities and HImP

The key challenge was defined as 'reversing the trend of increasing difference between death rates in wards' in KCW. This meant improving the health of everyone and the health of the worst off in particular. Partnership working to address health inequalities was based on the notion of identifying 'coincidence of interest' –'clarifying common areas of interest and identifying how we can help each other achieve our strategic objectives and address social exclusion'. This notion served to highlight areas central to both health and local government and also those areas led by local authorities (including education, housing, and crime) with health implications.

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Specific strategies

The HImP 2000-3 document integrated the Service and Financial Framework, and set out 'areas for health improvement'. These areas varied in their focus and are shown in the table below.

Kensington and Chelsea and Westminster draft HImP 2000-3 priorities	
Focus/Type of programme	**Health improvement areas**
Disease/Condition	Cancer, Coronary heart disease & stroke
Health-related behaviour	Sexual health, Smoking, Substance misuse, Oral health
Population Group	Children's welfare, Older people
Health services	Acute and community services, including primary care development
Health & social care	Learning disabilities, Mental health, Physical disability, Palliative care
Wider health determinants-root causes of ill health	Education, Youth Offending Teams, Housing, Crime, Unemployment, employment & health, Accidents
Community development	
Other	Clinical governance, Tackling racism

It was starting to set out action programmes to meet specified targets, including collaborative working that addressed wider health determinants and needs of socially excluded groups. For each area the relevant national and/or local targets were defined (long term health and social outcomes or interim process measures). Reference was made to the current position and evidence/guidance. Progress on 1999/2000 and proposed developments (action) were specified. A programme of community development had the key aim of helping reduce the health gap between wards. This included the work of the new Community Health Development Team, and work centred on SRB and Healthy Living Centre bids. Areas of housing and homelessness, crime, unemployment and education in particular included proposals for further strategy development, through existing or new partnership mechanisms, as well as specific initiatives addressing vulnerable groups. All three PCG Investment Plans highlighted reducing health inequalities as a key theme and developments included joint working on a range of community-based

initiatives, as well as improvements in primary care based disease prevention and health promotion programmes.

The ability to assess impact of plans and progress was regarded as dependent on the development of a more comprehensive set of long term outcome measures and interim process measures, supported by more robust information systems. Defining the pace of reduction in health inequalities within the district as measured by SMRs was being considered as a way of assessing progress over the longer term.

The majority of those interviewed highlighted addressing health inequalities as the key challenge. In some cases this was expressed specifically in terms of equity of access and quality of services to meet the needs of ethnic minorities and other socially excluded groups. Children were highlighted as an area for particular attention as this was an area that offered the greatest potential for long term health improvements. The evidence of stark inequalities on all key health indicators meant 'tackling inequalities was an inescapable framework'.

Furthermore the point was made that the complexity of the issues facing the district meant that it was difficult to limit priorities: 'tackling inequalities demanded multiple strategies and therefore multiple priorities'. The aim had been in preparing the HImP, to integrate national and local priorities. The intention was to build on established areas of work and initiatives and add momentum, and increasingly integrate health inequalities within all programmes of work.

The distinction was made between the role of the HImP as a document and as a process. As a document 'it was just another opportunity to make bold statements and get partners signed up to acknowledging the problem and thinking what they can do about it'. What was more important was the

process: engaging and extending the scope of partnership working particularly across the local authorities, and with others, through effective partnership structures and processes.

It was felt that there was consensus amongst the partners about the priorities, at least with 'those round the table'. Elected members found the language of 'health inequalities' difficult. The linkage between health inequalities and deprivation and social inequalities produced some sense that the health authority was 'intruding' into central and local government remits.

There was a sense that the first HImP round had not been ideal; an 'okay start'...'a practice run'. Disappointment was expressed, by council officers, with the process as a 'collation of existing documents' and failed to provide any clear overall strategy for tackling health inequalities.

Partnership arrangements at stage one

New local authority-based partnership arrangements were established to respond to the new duties of the Health Act and Local Government Act, and to replace the existing joint planning/JCC structures. These arrangements were regarded as the main focus for future partnership working on health.

The main features in Royal Borough of Kensington & Chelsea were:

- *A member-based Partnership Board* with representation from across the council's functions, as well as HA, Trust and PCG membership. It had the remit for developing the overall strategic vision for joint working between the NHS and the RBKCW. It would agree the Health Improvement Programme, act as an umbrella for the wide range of strategic and operational alliances and partnerships across the

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borough, and provide the framework for joint commissioning and budgeting.

- A *senior officer group* supported the Board, again with broad-based Council representation.

From the Council perspective's, these arrangements offered the potential for securing greater corporate Council understanding of and commitment to the wider health agenda. The arrangements also built on some well established groups. In particular the Healthy Alliance Group had proved a valuable focus for the development of the borough's joint health strategy- 'Partners for Good Health'.

The main features in Westminster City Council were:

- A *Health Partnership Committee* with elected member representation from across the Council, the health authority, trusts and PCGs. Its remit was 'to develop a shared vision and strategy for the development of health and social care and improved health and well-being' for Westminster.
- A *Health Partnership Board* of senior officers supported the Committee with responsibility for developing an annual workplan and performance monitoring.
- *Partnership Groups and Project Groups* were intended to provide inter-agency planning fora for client groups and topics relating to the 'new wider health agenda'.

These arrangements were intended to build on the Council's increasing commitment to partnership working for health and its corporate contribution.
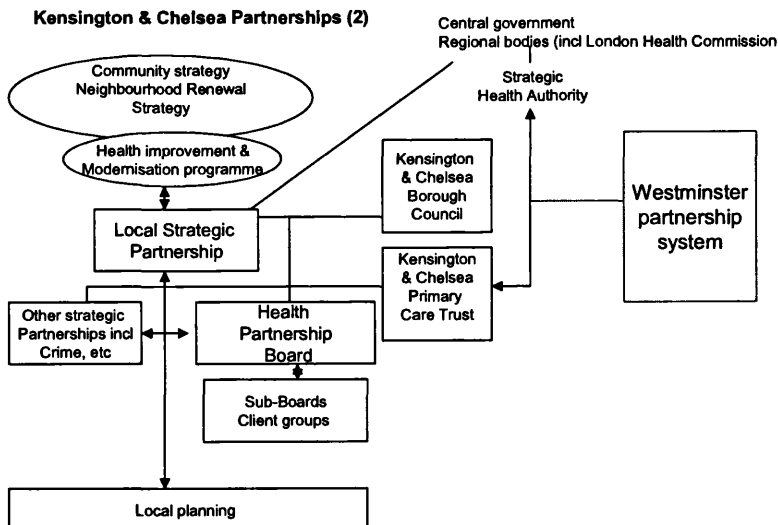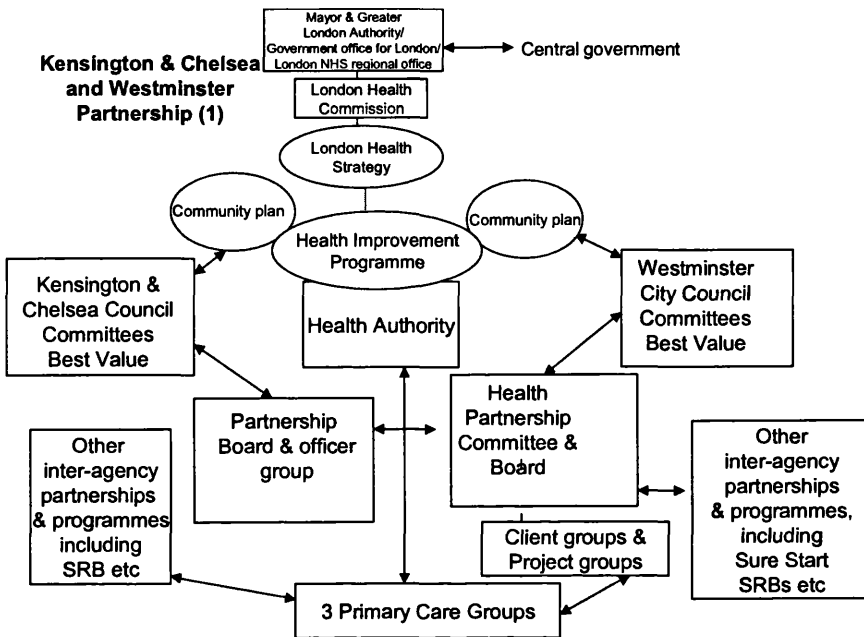
The three PCGs were required to include HImP priorities within their initial Primary Care Investment Plans. The health authority's Community Health

Development Team was intended to have an important role to play in taking forward the objective of reducing health inequalities and sustained investment in this function was planned. In particular, the team would work with PCGs, the local authority, and voluntary and community organisations to strengthen the infrastructure for community development.

Partnership arrangements at stage two

The implications of *Shifting the Balance* in Kensington & Chelsea and Westminster were significant. London region was covered by five new Strategic Health Authorities. One of these covered Kensington & Chelsea and Westminster. The previous KCW health authority was abolished. Two new Primary Care Trusts were established. Each PCT was coterminous with the respective boroughs of Kensington & Chelsea, and Westminster. At stage two there was uncertainty about the future planning arrangements. However the key features in each area were:

- Local Strategic Partnership with responsibility for overseeing the development and implementation of the community strategy. The new community strategy identified a range of strategic themes which included health.
- *Local authority cabinet committee health portfolio and health scrutiny committee.*
- *Health partnership board,* building on the previous arrangements, but with the Primary Care Trust now as the lead health agency. Membership comprised council members and chairs of PCTs.
- *Primary care trust/ parliamentary constituency interface.* The Primary care trusts each had the remit of developing and implementing a Health and Modernisation Programme.
- The creation of a public health network function supporting the PCTs.

Kensington & Chelsea and Westminster Partnership (1)

Mayor & Greater London Authority/ Government office for London/ London NHS regional office

Central government

London Health Commission

London Health Strategy

Community plan

Community plan

Health Improvement Programme

Kensington & Chelsea Council Committees Best Value

Health Authority

Westminster City Council Committees Best Value

Other inter-agency partnerships & programmes including SRB etc

Partnership Board & officer group

Health Partnership Committee & Board

Other inter-agency partnerships & programmes, including Sure Start SRBs etc

Client groups & Project groups

3 Primary Care Groups

Kensington & Chelsea Partnerships (2)

Central government
Regional bodies (incl London Health Commission

Strategic Health Authority

Community strategy Neighbourhood Renewal Strategy

Health improvement & Modernisation programme

Local Strategic Partnership

Kensington & Chelsea Borough Council

Westminster partnership system

Kensington & Chelsea Primary Care Trust

Other strategic Partnerships incl Crime, etc

Health Partnership Board

Sub-Boards Client groups

Local planning

Application of the schema of 'collaborative policy delivery mechanisms' highlights the relevance of the policy network model. This model is concerned with politics and distribution of power and resources. Guarding of the status quo by the main established players was evident. The Tory councils in the two boroughs resisted the Labour Government's policies and particularly the notion of health inequalities. In Kensington & Chelsea particularly, local councilors resisted designating health inequalities as a strategic priority, and questioned its relevance to the role of the local authority.

It appeared that centrally funded initiatives, such as Healthy Living Centres, Sure Start and Education Action Zones, were used tactically and opportunistically by officers to respond to the needs of vulnerable groups, despite the lack of robust strategic framework. However the difficulties of 'mainstreaming' this work were acknowledged by a number of respondents. This was expressed for example by the comments of a director of social services and health. Health input to Westminster's Education Action Zone would be vital.

> *Partnership working with health is absolutely fundamental to improvements in the quality of education experience with a population like ours, where we have got a very high turnover of children and we have go over a hundred first languages spoken in schools. We have got tremendously difficult social exclusion experiences for children to handle within the education environment and the schools performance at secondary level is poor. So there is everything to play for and health makes a difference.*

Meeting the housing needs of transient refugee populations also meant meeting their health care needs. Such work would be undertaken despite the HImP, but the HImP potentially would enable pilot schemes and initiatives to be mainstreamed.

> *We are used to trying initiatives and projects to test out ideas. The trick is then to mainstream what we learn to get away from projectitus.*

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At stage two, again the local government modernisation programme was the main central driver that served to increase the councils' role in joint planning. The requirement for local authorities to establish Local Strategic Partnerships to access Neighbourdhood Renewal Funding appeared critical to the integration of efforts to tackle health inequalities within the broader agenda.

What partnerships existed to develop health strategies and tackle health inequalities?

Overall, the above analysis of each case study shows that the local systems experienced massive changes over the study period. There were clearly features of partnership working that were common to all four case studies. The case studies illustrated the local translation of national policies as well as the local evolution and dynamics of inter-organisation relationships and learning.

The above analysis of case studies started to apply the theoretical schema of collaborative policy delivery mechanisms set out in chapter three. Overall centrally-driven directives and initiatives were a dominant influence on how health inequalities were addressed locally. As highlighted in the previous chapter, the central policies were perceived as having both positive and negative implications for health inequalities. At stage 1 of the study there was a strong reliance on centrally driven initiatives (not only health action zones) within the context of Health Partnership Boards and Health Improvement Programmes. At stage two of study the emphasis focused on Local Strategic Partnerships and mainstream programmes as the means of tackling health inequalities as part of the wider agenda of neighbourhood renewal and deprivation. The case studies demonstrate what Stewart and colleagues defined as two 'generations' of policy (Stewart et al.2002). The first placed

emphasis on small-area approaches, involving the creation of a large number of 'zones' (including HAZs); the second generation placed emphasis on mainstream programmes and strategic partnerships.

Stage one showed legitimisation and positioning of health improvement and health inequalities on the joint strategic agenda and area-based experimentation. Health (HIMP) Partnership Board structures were established to replace Joint Consultative Committee structures and manage the development and implementation of the Health Improvement Programme and other areas of common concern. These Boards were viewed as supporting the local authorities' new statutory duty for promoting the economic, social and environmental wellbeing of their communities. For the first time health improvement and health inequalities were legitimised as integral to the joint strategic agenda. Relationships were no longer soley dominated by the interface of health and social care.

More specifically common core functions and features partnership working were evident across all the four case studies:

- *Health policy and strategy development:*
Health partnership boards, supported by some form of executive group, with the remit of setting strategic goals and priorities and overseeing the development of programmes of action and their performance management; seeking to secure involvement of members (non-executives and elected members); engaging partners beyond health and local government; ensuring links and alignment with wider strategies and mainstream organisational processes.

- *Strategy development and programming for specific priority areas for health improvement and reducing health inequalities:*

Inter-agency groups (and sub boards) with the aim to provide strategic and resource frameworks (action plans with milestones/outcomes) for implementation; providing the mechanism for developing approaches to joint commissioning and provision, using new freedoms and flexibilities. These built on existing joint planning forums.

- *Locality planning and management:*

PCGs were expected to lead the development of local health programmes/initiatives within strategic frameworks, linking with local government arrangements and new democratic processes for consultation and community planning. It involved linking with other area-based initiatives (such as SRBs, New Deal for Communities). It was also a focus for developing community development approaches.

Stage two showed devolution and integration of health partnerships and health inequalities within a whole system approach to promoting wellbeing and inequalities. This shift was evident in all four case studies, although this integration was more advanced within HAZ areas. Local Health Improvement Programmes, via Health Partnership structures and processes were being integrated within the remit of Local Strategic Partnerships and Community Strategies. Local authorities, in non-HAZ as well as HAZ areas showed greater understanding of their role in tackling health inequalities. Links were being made between health inequalities and emerging Neighbourhood Renewal Strategies. The local authorities were at different stages in establishing more devolved planning and consultative structures (area and neighbourhood panels). Primary Care Trusts were the 'lead' health agency, with the abolition of health authorities, providing in principle a devolved and localised health perspective. Ways of linking health improvement and health inequalities to the wider new and emerging local mechanisms, including neighbourhood action planning, were starting to be explored. In principle there would be greater potential for strategic alignment of efforts to improve

health and tackle health inequalities to broader community strategies concerned with employment, education, housing, leisure and recreation and transport.

To what extent did health action zones represent distinct forms of partnerships?

Despite the big changes experienced in all the four case studies, additional and distinctive features were identified in the two HAZ areas.

Furthermore, the distinct HAZs features in both Bradford and Lambeth, Southwark and Lewisham were consistent with a <u>network management model.</u> The study design of matched comparisons proved important in demonstrating that these HAZ features were additional to the health improvement programme processes, and were not systematically being developed in the non-HAZ case studies.

- *HAZ Partnership boards and executive groups* for planning and implementation of HAZ strategies, established in advance of the creation of Health Partnership Boards; engaging senior representation of key players around the strategic focus of health inequalities.

- *Infrastructure for partnership working on a range of programme areas* aimed at tackling health inequalities, and project management; including interagency commissioning of new approaches to service development and delivery in priority areas beyond health and social care (with additional HAZ monies).

- *Mechanisms for learning and evaluation;* systematic investment in research and evaluation of projects and approaches to sharing learning, particularly to inform mainstream ways of working.

- *Designated support team:* funded posts within health and local authorities with experience and expertise in project management, information management, communications and organisation development/change management.

- *Community involvement.* Community involvement strategies. Funding of community engagement at strategic and project levels.

Essentially HAZ partnerships engaged leaders' commitment to the health inequalities agenda, and established a joint resource base of people and money that aimed to develop the capacity for partnership working at strategic and local levels in a systematic way.

However the two HAZs also demonstrated different approaches to managing the HAZ, in terms of how these features related to wider partnerships structures and systems. This influenced the scale of impact ie whether HAZs made a difference at both strategic levels and the micro level of projects.

- *Bradford HAZ: mainstreaming health inequalities*

The Bradford HAZ was integrated into the mainstream Health Improvement Programme partnership arrangements at stage one. Interagency strategies for priority areas were developed by inter-agency groups. HAZ was positioned to pump prime and accelerate the development and implementation of these priority programmes. HAZ was also used to pump prime the development of PCGs partnership working for addressing health inequalities, including community involvement. The

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HAZ team became the resource and expertise for strategic change management ie developing the Neighbourhood Renewal strategy and the infrastrustructure for neighbourhood action planning.

- *LSL HAZ: a project-based and topic specific approach to tackling health inequalities (children and young people) at the initial stage ; followed by a subsequent mainstreaming stage with HAZ providing a change management capability*

The HAZ partnership arrangements engaged agencies across the three boroughs and managed a set of inter-agency programmes concerned with improving the health of children and young people, that were intended to link with borough-based/PCG strategies and processes. The initial project-based approach involved the commissioning of HAZ funded projects by HAZ interagency programme groups. However concerns that this focus on projects was not effective in bringing about sustainable mainstream changes led to a radical shift in approach. This was based on devolving the HAZ budget to the borough based HIMP partnerships (practically to the new PCTs) to commit on locally defined priorities for tackling health inequalities. The HAZ team and expertise was used to support the interagency planning (using change management techniques eg whole systems events) and delivery of service reconfiguration in these priority areas.

In summary the analysis of each case study in this chapter has started to apply the schema of collaborative policy delivery mechanisms.

The Bradford approach to managing the HAZ, as an integral element of mainstream planning and management processes, could be viewed as a network management model of partnership working. The later approach adopted by LSL to managing the HAZ emphasised 'mainstreaming and

systems change' and also illustrated some of the features of network management. Essentially HAZ partnerships created a joint strategic focus on health inequalities and engaged a network of leaders in championing the agenda. HAZs also provided a designated resource (people and money) that supported an infrastructure for joint working, learning and organisational development. The HAZ resource developed the capacity of the different players to engage in partnership working and take action to reduce health inequalities.

In the non-HAZ case studies the centrally-driven models of partnership working were more evident. Health Partnership Boards and Health Improvement Programmes put health inequalities on the strategic agenda. However HImPs were perceived by local authority respondents as primarily health documents and an assemblage of existing plans and strategies, rather than a joint strategic endeavour, and failed to gain the full commitment of the different players. Established local politics and power bases created difficulties to taking the agenda forward in a strategic way. There appeared to be a stronger reliance on centrally driven initiatives such as Education Action Zones and Single Regeneration Budget schemes that helped existing individual 'product champions' within the system to make progress in an opportunistic way on certain aspects of the health inequalities agenda (initiatives in particular communities, issues, population groups).

By stage two the requirement to implement the Local Government Act and White Paper was a strong central driver to the further local collaboration on tackling health inequalities and deprivation in all the four areas studied. This included the appointment of councilors with a health portfolio and the establishment of health scrutiny committees as part of the new cabinet arrangements. Specifically the requirement placed on local authorities to set up Local Strategic Partnerships to access to Neighbourhood Renewal Funding gave impetus to collaboration and recognition of health inequalities

as a strategic priority within early draft community and neighbourhood renewal strategies.

However these developments were simultaneous with implementation of *Shifting the Balance* involving abolition of health authorities and the creation of strategic health authorities and primary care trusts. Some of the potential for collaboration on addressing health inequalities was undermined by the health agencies' focus on the NHS Plan and lack of organisational capacity:

> *I think there is an issue about how PCTs are buying into LSP structures and how much help there is on board, given the pressure on them to deliver the NHS agenda.*
> (Local authority director-non HAZ area)

The abolition of health authorities was clearly impacting on partnership working.

> *The role the health authority has played in creativity around the wider determinants of health agenda in the district has been absolutely crucial...They've been absolutely crucial and I'm not convinced that there's a strong strategic view of all that from the PCTs at the minute, which I think is entirely understandable and that's not a criticism of them.* (Neighbourhood Renewal director-HAZ area)

There appeared therefore to be a tension between the moves towards a more locally integrated strategic approach and the centralist modes of governance.

Subsequent chapters present analysis of stakeholders' experiences of whether or not the different theoretical partnerships models were successful in enabling actions that would contribute to reducing health inequalities.

Chapter 7: Systems and processes

This chapter examines the changes in the ways organisations and individuals addressed health inequalities. It considers whether the partnerships for health improvement programmes and HAZs led to widespread changes in the system in the four case studies in pursuit of health equity. Evidence of a shift towards a 'network management' approach to partnership working was considered. In particular, the extent to which HAZs added value to the collaborative efforts was explored.

Network management, as a model of partnership working, implies the effective engagement of all key players that have a role in influencing health inequalities. The dominant culture that governs the nature of the relationship between the players is reciprocity. This derives from an understanding and acceptance that achievement of their own organisational objectives are dependent on the contribution of others. Trust and diplomacy are central. Direct control is not possible or appropriate. Network management provides structured opportunities for exploring the potential for 'collaborative advantage' and development of 'integrative' strategies. Were HImPs and HAZs able to foster this way of working? It was not possible to isolate fully the impact of HImPs and HAZ on joint working, given the full range of policy drivers discussed in chapters two and five. However the case study design did allow the distinct contribution of HAZs to be examined. It allowed the distinct HAZ features and their impact to be explored in more depth.

Shared agendas and logic of partnerships

There was widespread acknowledgement amongst respondents that the new requirement for HImPs, and the introduction of HAZs had made a major difference. Health improvement and health inequalities had been legitimised and positioned on the mainstream agendas of health and local government.

The new Labour Government's signaling of health inequalities as an important priority was viewed as a radical change, in comparison with the Conservative policies. Previously 'you couldn't talk about inequalities'. Government health policy now recognised the wider social and economic determinants of health. Respondents felt that the importance of local government's public health role was much more explicit and appreciated within both health and local authorities. Health partnerships were no longer regarded as 'an underground activity'. Public health specialists were 'no longer fighting guerilla warfare'. The comment was made that HIMPs and HAZs had introduced for the first time a systematic and disciplined approach to health improvement and tackling health inequalities through partnership working, within an accountability process. Previously marginal and fragmented activities and initiatives were now being positioned within a strategic framework that went beyond health care and the health/social care interface.

The notion that HIMP and HAZs were a framework for identifying common ground for achieving health and related outcomes, and exploring 'win-win' situations, was widely expressed. For example the task of identifying 'coincidence of interest' amongst the different players was viewed as the basis for tackling health inequalities and was explicitly stated in one HImP document:

> *Clarifying common areas of interest and identifying how we can help each other achieve our strategic objectives and address social exclusion.*

The importance of 'diplomacy' in exploring links between health inequalities and other agencies' objectives was highlighted. For example one HAZ director stated:

We've major issues around employment and New Deal and wider issues about teenage pregnancy of education and sexual health. If you are working in partnership we have to take equally seriously the key driving documents that are the concern of your partners in say education....So therefore you have to address all these policy initiatives otherwise you can never get a partnership going. So for that reason I don't see Saving Lives as more central really than some of the other policy initiatives. (HAZ Director.)

Alignment of the goal of tackling health inequalities with the local authority public health role meant developing a corporate understanding across the local authority of the health impact of the different functions:

Its about incorporating health into the vision and into the practicalities ...how you can express the health agenda through the things that somebody's already got as a priority on their desk.
(Director of Social Services-non HAZ area).

Furthermore, many respondents defined the integration of health inequalities into wider strategies and partnerships as an important outcome to be achieved through partnership working and evidence of win-win solutions.

The term 'evolutionary' was how many respondents described their experience of the culture of partnership working. Progress on agreeing a shared agenda and plans reflected the maturity of relationships between organisations; with HImP partnerships and subgroups at different stages of development. In all case studies, partnership working on health improvement and health inequalities was seen to be involving new players on health (councilors, different local government departments, police, universities and primary care). In particular, respondents felt that the various HImP and HAZ partnerships had led to stronger relationships between health and local authority.

The HIMP partnership board now does foster trust and is about mainstream...There are connections ...trust and understanding and recognition of where each other is coming from, what the potential and barriers within each mainstream service is, allowing people to start moving to innovation and joint delivery. (Local Authority Joint Planning Manager HAZ area.)

However relationships with the community and voluntary sector were much more complex and problematic in all case studies. There was widespread acknowledgement that the dominant culture remained 'top down and bureaucratic...paternalistic and controlling', although the aspirations to bring about much more 'bottom up' approach were widely expressed. (see chapter 8.) Although findings indicate HAZs served to strengthen relationships across the statutory sector, attempts at genuine engagement of the voluntary sector and community groups remained problematic.

Different starting points

Both national and local factors clearly influenced the level of trust and maturity of relationships between local players.

There were clear differences between the HAZ and non-HAZ areas in their 'readiness' to take forward the agenda for tackling health inequalities, even as paper exercise, and commit to action.

In the non-HAZ areas the histories of partnership development on the health agenda had been much more problematic. Important local political tensions had limited the pace of strategic engagement on the health agenda. Local politics and power dynamics between players appeared a more prominent feature of relationships. Some players had resisted health inequalities being put on the agenda. The 'rules of the game' between the players included use of certain terminologies and language. For example in KCW the differences in cultures and policies between the health authority and the two councils with

Tory majorities meant that finding 'coincidence of interest' on the Labour health agenda was a challenging task. The director of social services stated that a number of councilors held firm beliefs that:

> *Health was about individual responsibility and has got nothing to do with us. The national health service is about making sick people better and nothing else.*
>
> *I think there is a minimalist view, in some sense as you'd expect, politically, a minimalist view of the role of the state as expressed by public authorities, whether health authorities or the local authorities, and therefore I think a suspicion of an activist role in health promotion or in health strategy or in linking the work of the NHS to local government at officer level, because it is seen in some way, detracting from the direct control that they exercise, in theory at least, over local authority services.*
> (Local authority Director of Health and Social Services,non-HAZ area.)

These differences in political ideology and culture led to a more 'tentative' use by the health authority and local authorities of the HImP as the mechanism for engagement on the health agenda.

The evidence from interviews and analysis of plans suggested that HAZ partnerships were more able to secure the commitment and sense of ownership of key players, when compared with the early Health Improvement Programmes. The initial HImPs were regarded more as a process of assembling documents and presenting existing strategies. In one non-HAZ area there was a sense that the first HImP round had not been ideal; an 'ok start ...a practice run'. From councils' perspective, disappointment was expressed by a number of respondents, with the HImP process which was viewed as a 'collation of existing documents' that failed to provide any clear overall strategy for tackling health inequalities (as noted in the previous chapter).

Although it could be argued that the HAZs would have made progress regardless of HAZ status, respondents clearly regarded HAZ as an important catalyst. The bidding process had provided added stimulus to the players to produce a joint strategy. For example HAZ was regarded as a 'natural next step' by one health authority director and had acted as a catalyst for a 'step change'. This incentive to collaborate was in advance of the introduction of HIMPs. HAZs were viewed as legitimising both centrally and locally joint efforts to tackling health inequalities. HAZ respondents appeared more willing to acknowledge that previous approaches to health and regeneration had failed.

In both HAZ respondents expressed a sense of urgency about the need to adopt new ways of working to tackle health inequalities. HAZs were viewed as encouraging innovation and risk taking not only in service development, but also to new forms of partnership working around inequalities.

> *HAZs are a test bed at the center of government policy and it enables us to push the boundaries and be legitimised as pushing the boundaries, its almost about saying, yes, you're suppose to rattle the cage.* (HAZ Director.)

As already discussed in chapter 5, this political legitimisation by central government was clearly a strong influence on local players collaborative behaviours. Furthermore the changes in the messages from the centre were a product of political dynamics. The perceived changes in the national priorities, in particular the lack of consistency about the government's commitment to health inequalities influenced local priorities and relationships. The *NHS Plan* was seen as diverting attentions of the NHS from the wider health agenda to the modernisation of health services.

For example one PCT Chief Executive commented that:

> *HImP as it was called has almost gone out of fashion ....the HIMP's almost blurred into this thing called the Modernisation Review, so it's not a title that we use particularly anymore.* (PCT Chief Executive-non HAZ area.)

Similarly:

> *Health improvement has disappeared off the lips of the NHS. It was Health improvement at the beginning of the Labour Government and it was broad in its concept of health, then the Local Modernisation Review led to a narrower NHS role and now emergency capacity plans concentrate solely on acute care and its virtually impossible to get a strategic approach to multi-agency work......its all about waiting lists.* (Director of PH of PCT-non-HAZ area.)

There was a strong sense that the agenda had moved on. By the final phase of the fieldwork, many respondents stated that alignment of health inequalities with the Neighbourhood Renewal agenda and the role of Local Strategic Partnerships was crucial to sustaining efforts to tackle health inequalities.

To some extent HAZ partnerships were felt to provide a 'counterbalance' to the weight of the focus on waiting times. However HAZs were not immune. They too were required to increase the priority of issues linked to modernisation and targets in the *NHS Plan*.

> *When Allan Milburn came with clinical priorities and the acute side of health...we had to re-jig the plan and make it fit into a medical model...but people are creative...for performance management I had to fit projects into the log-frame according to CHD, cancer...*(HAZ Director.)

The impact of *The NHS Plan* on local HAZ priorities nationally was similarly documented by the National HAZ evaluation (Bauld et al. 2001).

Finding win-win solutions?

Bradford HAZ's 'integrated approach' was clearly more effective in influencing wider partnership working and strategies, beyond HAZ projects at an early stage. There was a shift in partnership working:

> *moving from* well I'll turn up in case there's any money', through to that quite sophisticated understanding of 'your targets are my targets and my targets are your targets' and an ownership that the partnership adds value to what we're doing and does deliver for us.....I think there was quite a journey. You can see that people went on that journey and the understanding we've got about health inequalties. I think a lot of that has come out of the HAZ. (Director of Neighbourhood Renewal-HAZ area.)

There was demonstrable integration of health inequalities within the wider strategic framework documented in plans and articulated by respondents:

> *Health wasn't in the housing strategy and it is now, and housing wasn't in the Health strategy and it is now....*(Local Authority Joint Planning Officer-HAZ area.)

The NHS was recognising its role as an employer and in job creation:

> *We have an agreement that the Private Finance Initiative at the Bradford Royal Infirmary will employ 30-34% local construction firms to provide employment for local people...you wouldn't have got that in the previous way of thinking.* (HA Director-HAZ area.)

In contrast, in the non-HAZ areas the relationship between health and wider strategies was less well articulated. For example, a Director of Public Health in a non-HAZ case study stated that the new Community Strategy comprised themes as 'bubbles'. 'Health and social care' was one bubble and health was not integrated across the different themes. In principle the regeneration strategy could achieve important health gains but these were not made explicit.   Doubts were raised over whether new Local Delivery plans (superceding HImPs) could provide a strategic focus for tackling health

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inequalities. The opportunistic and incremental approach linked to central initiatives was viewed by a number of respondents as the only way forward, despite its limitations:

> We have to go with the flow...there's no other game in town. Area-based initiatives can break the mould and lead to possible innovation. The problem is a lot of innovation never gets taken up. Its like water in sand, it disappears.   (Director of PH-non HAZ area.)

Modeling and capacity for whole systems working

The indication of accelerated progress of HAZs appeared partly attributable to the investment in organisational development afforded through HAZ monies. The two HAZ case studies could be viewed as adding value to the process of health improvement and tackling health inequalities through strengthening institutional capacity. HAZs provided a dedicated inter-organisational resource (people, skills and money) that increased the capacity for partnership working and change management. The systems and processes necessary for the engagement of many different players from statutory, private and voluntary sectors were established ie 'whole systems' working. It was possible for the different organisations to explore and agree priorities, develop and implement multi-agency programmes and projects, and systematically invest in evaluation and learning. Such focused and systematic investment in inter-organisational development for addressing health inequalities was not evident in the two non-HAZ case studies. That is not to say all these systems and processes proved effective, but it was clear that HAZ status did create an important process of organisational development and learning. Furthermore, the two HAZ case studies adopted very different approaches to the management of the HAZ. The evidence suggests that this resulted in differences in the pace and scale of impact particularly on the 'mainstream' organisational processes and service development. Despite

such differences the majority of respondents were clear that HAZs had provided significant organisational resource and experience that would help sustain efforts to reduce health inequalities.

The two HAZ case studies illustrate the advantages and disadvantages of an 'integrated' approach versus 'project-based' approach to management of such centrally-funded initiatives.

Bradford, from the start, sought to integrate the HAZ within mainstream joint planning mechanisms and the Health Improvement Programme. HAZ monies were used to establish a dedicated team to coordinate and support the work on health inequalities but the budget was also used to pump prime developments of mainstream organisational processes (particularly within the local authorities, and PCG/Ts). While a large number of HAZ projects were funded these were primarily aimed at supporting the planning and implementation of mainstream programmes including coronary heart disease, inner city primary care, diabetes and regeneration (examples shown in the box below).

Selected examples of Bradford HAZ funded schemes pump priming mainstream programmes Source: Progress report April 2002 (Barriers Broken, health improved.)		
Project aims	Intervention/activities	Outcomes
Diabetes To ensure appropriate treatment of people with diabetes	Reorganisation to provide 21 community based satellite clinics Provision of tiered screening programme to screen for undiagnosed diabetes and complications Training for nursing home staff in management of diabetes.	3000 more cases diagnosed. Satellite clinics double the number of patients receiving specialist care Involvement of service users and carers in reshaping services.
Welfare rights and debt advice development worker To enable access to benefit and debt advice services for people using primary and other health care services across the district	Training for over 150 staff (including community nurses, trainee GPs and occupational therapists) Benefits disc and reference guide distributed to primary care staff Consultation and support for the placing of Welfare Rights provision in over 40 GP practices	More holistic care and more income for patients improving quality of life and reducing stress Opportunities for apprentice advisors (Health Plus Community Support Trainee Scheme) District-wide strategy developed by Community Legal Service Partnership
GP Recruitment and retention To improve the quality standards and availability of primary care services in the inner city	Appointment of 8 salaried doctors working in 16 practices since December 2000	Better access to primary care medical services in some of Bradford's most deprived areas/ A pool of well trained doctors available to take up salaried posts within PMS Scheme being incorporated into mainstream budgets
Food policy worker To address issues of food poverty through improving access to affordable healthy food focusing on areas of disadvantage	Research involving15 focus groups,(300 people); price comparison and random surveys in 6 areas Recruitment and training of local food workers Local food initiatives (10 food coops, local bus service to supermarket	Local sustainable food projects established based on communities' involvement in research Increased access to healthy foods for socio-economically disadvantaged

The model of whole systems working was widely adopted and applied as the mechanism for bringing together a wide range of organisations and individuals from different sectors to explore problems and create action plans. The rolling series of such events were termed 'Powerful Partnerships' events. These meetings brought together both top managers and frontline staff and

proved to be a powerful mechanism for 'sharing understandings and perspectives ..and building trust and understandings'. There was evidence that the term and the model continued to be a central feature of joint working. For example two events had already been held on the neighbourhood renewal agenda. One focused on understanding and learning about neighbourhood action planning.

The comment was made by one respondent that:

> *whole systems events are old hat now*
> (Local authority Regeneration Manager HAZ area.)

to describe how this HAZ initiated approach had become a normal way of partnership working.

The HAZ also allowed for investment in developing the capacity of key players to address health inequalities as part of their mainstream planning processes and service development. For example, HAZ monies were used to apply the principles of the Best Value Initiative in local government more widely within the HAZ partnership, as a way of identifying how the different agencies were contributing to tackling health inequalities and monitoring their performance. This involved establishing an infrastructure within the local authority, and provision of training for all HAZ partners. It engaged elected councilors. It fostered the integration of the non-health partners' contributions into the Health Improvement Programme and Local Modernisation Review, as well helping ensure the health dimension was included in other partners strategies.

Similarly HAZ monies were delegated to the four emerging PCG/Ts to reinforce their roles in tackling health inequalities and support capacity development and learning. Each PCG/T established their own approaches to inter-agency planning to establish local HAZ plans and projects. Local multi-

agency HAZ Boards were set up. HAZ supported interagency projects that addressed priority themes of the Health Improvement Programme, including regeneration. Selected examples of projects are shown in the box below. The experience of local HAZ Boards and programmes were regarded as providing important learning for Neighbourhood Renewal.

Selected examples of HAZ projects of Primary Care Trusts
Source: Progress report April 2002 Barriers broken, health improved

- Resident support worker for drug abusers –YMCA City Centre
- Development of day-care and drop in services for elderly Asian women-Council for Mosques
- Home accident prevention initiative-Bradford Community Environment Project
- Work with Asian and Afro-Caribbean women experiencing domestic violence-Manning Housing Association
- Youth worker training on attitudes and relationships, drugs misuse, diet, exercise and smoking St Johns, Great Horton
- Befriending, support and Day Centre for housebound, isolated older people –Clayton Live at Home Scheme
- Enhancing the literacy skills 7-9 yrs old- Buttershaw Learning and Development Experience
- After school club for 5-11 yrs old addressing crime and behaviour Holmewood Kidzone
- Establishment of Credit Unit in Royds area-Royds Credit Union

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LSL HAZ adopted a 'project based' approach to managing the HAZ, based on commissioning by 'workstream teams' and involving a bidding process. These HAZ workstreams were regarded as demonstrating what 'whole system' working meant in relation to particular priority groups and issues, including youth crime, parenting, teenage pregnancies and school exclusions. Interagency groups learnt how to create a picture of the whole system based on the experience of individuals.

We have brought people into the same room who have never sat down together before to look at changing the system from people's experience, for example to increase employment opportunities for

young people who are likely to be excluded...it is about HAZ trying to be an integrative force. (HAZ Director.)

However these HAZ programmes and projects were managed separately from the mainstream responsibilities of partners. The HAZs own review of the approach showed that key partners such as PCGs did not buy into the process, and the process of commissioning projects failed to effectively engage the voluntary and community sectors. Respondents commented that HAZ had been seen as 'remote..on another planet'. Emerging PCGs had largely 'ignored it and were confused by it and saw it as marginal'. It was perceived as focusing on spending money and primarily concerned with the setting up bureaucratic bidding and project monitoring arrangements, functioning 'like an old JCC'.

Consequently the second phase of the HAZ focused on 'mainstreaming and transformation'. HAZ's remit was broadened from children and young people. A radically different way of managing the HAZ was instituted based on the systematic integration of HAZ into the HIMP Partnership Boards and sub-boards, and the role of emerging Primary Care Trusts, as well as newly created Local Strategic Partnerships in each of the boroughs. (Practically the HAZ budget was devolved to the lead PCT in each borough). The HAZ team undertook widespread consultation involving vigorous promotion of whole systems working. It supported priority setting for tackling health inequalities within the new local HIMP processes and joint planning areas. For example the HAZ was seen to play a vital role in the development of the local Lewisham HIMP, particularly through the sharing HAZ learning at a major conference. The introduction of a new *developmental* commissioning process was a further example of how HAZ learning influenced wider strategic processes. This new developmental commissioning process was intended to effectively engage the voluntary and community groups in the development of new ways of service delivery in the identified priority areas (discussed in more detail in the next chapter).

Many LSL respondents showed awareness of the HAZ's new 'mainstreaming' approach and viewed the shift from the project as essential and highly positive if action to address health inequalities was to be sustained. HAZ was clearly viewed locally as a credible and important contributor to future work and championing of health inequalities within the framework of HIMP partnership Boards, the role of PCTs and the Local Strategic Partnerships. One respondent's comment conveys this perceived role of HAZ:

> HAZ is not the sun but a search light...the lighting conductor for success (but also frustration). Its not the answer but the means to finding the ways through. (HA Director HAZ area.)

Innovative service development

Analysis indicated that in all case studies central initiatives (not just HAZs) were providing opportunities for testing innovative service developments that addressed inequalities in health.

> I think there are models that work, that serve both the key objectives of tackling the root causes of ill-health; namely lower income, lack of qualification, lack of confidence, lack of self-esteem, and career pathways into employment....and specific health gain objectives, such as breastfeeding and community parenting.
> (Director of Public health,non-HAZ area).

It was not possible within the timeframe and resources of this research to fully assess the impact of innovative projects and whether changes in mainstream services resulted. However in both HAZ case studies there was an indication of a systematic approach to testing and evaluating of innovative projects and also assessment of implications for 'mainstreaming'.

Many respondents felt that HAZ had allowed the needs of a range of different vulnerable groups and issues to be recognised that were neglected by

mainstream services. These included diverse ethnic minority groups, young people at risk of social exclusion, domestic violence and self-harm. One respondent commented that projects had gone 'out on a limb' and worked with socially excluded groups, and groups that were hard to access.

Examples of LSL HAZ projects addressing needs of marginal groups		
Promoting inclusion-preventing exclusion To reduce numbers of temporary and permanent primary school pupils	Group work in school, extra curricular activities, family therapy, training in parenting skills, social and practical support to families under stress. Primary care, Education Psychology Service, Voluntary sector, primary schools.	Improved standards for providing safe, supportive local mental health and social care services, including outreach services
Caring for teenage pregnancies To reduce teenage antenatal admissions, STIs, low weight babies. Increased breast-feeding, antenatal education and access to postnatal support.	3 midwives providing health education, group sessions. Drop in and joint working with schools options. Working with primary health care, Education Authority, Teachers and NEWPIN	Provision of comprehensive care for approximately 100 pregnant teenage women under 19 by a team of midwives ad a support worker
Youth employment solutions To improve access to employment opportunities for disadvantaged young people; with associated benefits for health and well being.	Individual assessment of young person, induction, research into placement, placement and support. Sabre Employment Ltd, Health sector employers, Employment Service, Disability Services, Pupil Referral Units, Youth Offending Teams.	Targets being met for securing employment opportunities for young disadvantaged people. But little progress made with NHS partners. Reasons why young people not attracted by NHS as an employer: • Poor perception of disadvantaged young people by the NHS; • No 'street' credibility in NHS working • Poor pay • Lack of career opportunities.

Evaluation of HAZ funded projects was cited by a number of respondents as introducing a disciplined approach to assessment of effectiveness and dissemination of learning. The various local evaluation reports of projects

highlighted examples of a range of outputs and benefits, as well as some less than successful projects.

Both HAZs had established a number of processes to actively assess the learning from projects and ways to mainstream projects and/or learning. In the LSL HAZ emerging findings and implications for mainstreaming were systematically documented and disseminated within the planning processes. The contribution of projects to the NHS Plan targets and Modernisation Review were identified and the HIMP Partnership Boards considered options for mainstreaming of each project.

In Bradford, local evaluation of HAZ funded projects indicated that the most successful projects had good project management, a community-based assessment needs, senior management support and commitment, links into the strategic context, and employed experienced and skilled staff (Henderson et al., 2002). Such projects tended to be 'organic...rooted in communities', but were also relevant to strategic priorities.

The 'integrated approach' adopted by Bradford meant that respondents found it particularly difficult to attribute some service developments directly to the HAZ. This is reflected in the following comments:

> *I think there is clear evidence now of service re-design....I think a lot of the plans for redesigning services are a result of the thinking due to HAZ, so I think HAZ did show them that it is possible to think differently....in diabetes, GP recruitment.....*
>
> *If you go back a couple of years, you'd never have thought that you'd have our local authority social workers being employed by the new care trust would you?* (Local authority Director, HAZ area.)

The point was made that HAZ allowed advanced testing of new models that were subsequently adopted as national standards. For example the HAZ derived model of rehabilitation was now being mainstreamed:

these models were before their time...and are now required as part of the National Service Framework for older people...

Somehow there's been a gradual accumulation of a different way of operating, and that's become implicit rather than explicit. Its like the old things are done in the new way, and are not described as the new way, and its become ordinary practice. (Joint planning officer)

This experience was viewed as a vital building block for the new ways of working demanded by neighbourhood action planning.

The encouragement of frontline staff to do and explore service delivery and change focused on tackling disadvantage and involving communities was modeling behaviours...there are a whole lot of frontline staff who think this is normal and all ready to go onto the next step...(Director of LSP.)

Networking and leadership

In all case studies the importance of sustained development of individual relationships was widely regarded as critical to collaboration on health inequalities.

Partnerships are not just about structures...but relationships and trust and creating opportunities where you can progress from just listening to the problems to trying to resolve the problems together.
(Director of Social Services, non-HAZ area.)

As already described the HAZ partnership arrangements were able to provide a number of distinct incentives and opportunities that strengthened and extended existing networks of relationships. In particular, over the study period, the interviews highlighted the emergence of a strong network of senior people (managers and politicians) in key positions operating across organisational boundaries in HAZs.

*Strong and consistent and sustained leadership in the broadest sense
of the word is important. That is powerful, charismatic and
entrepreneurial individuals working together...it is well integrated roles
and acting trusting partnerships. It's a whole bunch of people across
the district and a range of organisations.*
(Local HAZ researcher)

This is consistent with how Kickert defines the role of leadership in network
management (as discussed in chapter three). Successive interviewing
showed that a number of managers at a senior level became increasingly
articulate and experienced in championing action on inequalities within the
partnership and within their own organisations. HAZ responsibilities in some
cases were part of a radical repositioning of role both strategically and
practically within a 'whole systems' management approach.

*I have shifted from being a Social Services Manager in a Local
Authority who was concerned with better care, to somebody who sees
it in terms of the whole system, impatient with a single agency agenda.
There is no future for social care in any sense separate from the NHS,
and I recognize that social inclusion will achieve health improvement
through partnership with local communities.*
(LA Director and Chair of HAZ Board)

In Bradford senior managers from health, the local authority and voluntary
sector were designated as 'leads' to take forward the different interagency
strategies for priority areas within the HIMP/HAZ, on behalf of the partnership
and as representatives of their organisations. This cut across the established
organisation accountability structures. This approach was based on the notion
of a 'virtual organisation'-key partners working to a common set of objectives,
within a total resource pool and joint performance management framework.

The view that there was 'no one leader' (individually or organisationally) on
health inequalities was widely expressed by HAZ respondents. In contrast, in
non-HAZ areas, leadership tended to more associated with strong Public
Health Directors and/or other key individuals who were long standing
champions.

Furthermore a facilitative leadership style was required:

> *Leadership does not mean control....but letting and making things happen. There is a mature understanding locally....no competition for leadership. It is clear that people in key positions have a well understood commitment to respond to community needs. But there is also acknowledgement this does need to be more practically demonstrated and that does not deliver immediate change on the ground. Building a different culture and approach to deliver change does take time.* (LA Director, HAZ area.)

The more systematic use of whole systems techniques to support interagency working was viewed as:

> *Leadership by facilitation ...Its about changing the way in which we do things to become facilitative, it's a leadership process, its leading the process rather than determining the outcome. What we have always tried to do in the past is to say, you know here's a problem and this is actually what we are going to do, this is the solution rather then getting the solution from other people'.* (HAZ Director.)

The HAZ focus of innovation and learning underpinned much networking and collaborative activity around issues of inequalities. Neighbourhood action planning was an example of an approach being applied in Bradford, building on the HAZ work. It highlights how the notion of networking must include <u>networking with communities</u> in order to build social capital and social cohesion within deprived communities:

> *In pockets of disadvantage ..you need to hook people together around common solidarity around dealing with crime or whatever it is. That way you begin to address the things that might help people stay, rather than force them to leave. What you try to do is create some solidarity. ....It's the idea of having this as a kind of web of connectivity between people. We need it on several different levels-between people in neighbourhoods and also between neighbourhoods-which is why we built the action learning into the process.* (Neighbourhood Renewal Director-HAZ area).

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HAZ respondents stated that they felt more empowered to be creative in responding to the needs of deprived groups and communities.

> *The best thing that HAZ has done is to give us all a confidence to be a bit more cocky about each others agencies not necessarily in a critical way, but in a way that we feel as though we have go a right of entrance...we are being a bit challenging in order to join up.*
> (Local authority regeneration officer-HAZ area.)

> *It (HAZ) has moved the climate more to people who feel freer to say what does work and what doesn't work and there isn't the same level of fear anymore that if you say 'well actually this isn't working' you get shouted at or taken away to a dark room or anything like that, so that's I think helped.* (HAZ Director.)

In contrast one respondent in a non-HAZ area commented on the difficulties relating to the development of mainstream services in the 'bureaucratic culture' of the local authority.

> *The first response is to say no.* (Local authority client group manager-non-HAZ area.)

However even within HAZ case studies, there was evidence that some individuals' contributions were not necessarily acknowledged, rewarded or well supported by their own organisations. Partnership working was still viewed as an add-on to the day job. For example, in LSL, participation in HAZ workstreams had clearly developed new understanding and relationships across organisations, but also raised questions about how such tasks should be incorporated within mainstream work programmes and performance appraisal mechanisms.

> *One of the outcomes of braking down boundaries is that you can actually feel removed from your own organization...There will be a sense in which people that work in HAZ related areas will feel less wedded to their own organisation and more wedded to the notion of working for a group. I already feel like that. But I feel as though I have as much corporate loyalty to the health authority as I do to the local*

authority and that is through the HAZ which is developing me in a way to think not only from a local authority, but from a health authority perspective and I think that is wholly positive for the HAZ process...but it does raise other issues in terms of performance management and organisational management. (LA regeneration officer-HAZ area.)

Incentives and performance management

Public choice theorists stress the importance of incentives and rewards in directing individual managers' behaviour. Individuals' self-interests in terms of how their performance is judged and rewarded will determine behaviours. The extent to which the network management model can provide the necessary incentives for collaborative action on health inequalities is a key issue.

There was much evidence in the interviews to suggest that individuals were personally committed and motivated to reducing health inequalities. HAZs were felt to give permission to act on basic public sector values and concerns for equity: *'its what I'm in the health service for'*. However, while necessary, such personal commitment was unlikely to be sufficient without being reinforced by more formal management incentives and rewards.

This point was clearly made by many respondents in all case study areas, and reflected in the following comment:

> *In the end, as much as I'm committed to this, you know, but <u>I do best the things that I know I have to do</u>, or most of us do best the things that we know that someone's going to haul us up and say, why didn't this happen. And you don't get a sense of that around a lot of the public health agenda.* (Health Authority director,non-HAZ area.)

Respondents acknowledged Government's increasing attempts to move towards a more joint performance management approach to cross cutting issues such as health inequalities: *'it gives it an edge...it feels different'*. But as yet such moves towards a joint performance approach were viewed as

partial and without clear alignment of national targets across sectors a significant barrier to collaboration remained. HIMP and HAZ action plans set out a number of targets and milestones focusing on health inequalities, however, such commitments were not in the main (with a few exceptions) systematically or fully integrated across individual organisations' performance and review processes. The difficulties of trying to reconcile local joint priorities on health inequalities and social exclusion with the multitude of national targets being prescribed by specific policies and different government departments were widely reported.

> *Local authorities are held to account for performance indicators around education standards, efficiency in sweeping the streets and therefore focus on their core business. It's a further step to look at causation of health inequalities and laterally to see the connectivity.*
> (Local authority Deputy Chief Executive, non-HAZ area.)

The 'must dos' of the *NHS Plan* featured prominently in the objectives of those senior NHS managers interviewed. Most interviewees viewed health inequalities as largely absent from the list of must dos. However, a number of respondents felt that the *Plan* did require action on health inequalities (although perhaps implicitly):

> *The government has put health inequalities on the agenda through the NSFs and through the NHS plan. You couldn't have ignored it even if you had got your head in the sand over the last two years...We are all kind of old bureaucrats, we all do what the Government tells us so we all go away and deliver our own NHS plan of must dos...it doesn't really matter if it takes them a bit of time to realise actually what they have been doing is starting to look at health inequalities.* (PCT Chief Executive, HAZ area.)

Given the lack of robust performance criteria, the incentives for acute trusts to engage in the health improvement and health inequalities were weak.

> *....we were talking about how to put the HImP priorities into the actual business plans and institutions and then personal objectives of*

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individuals. The acute sector said well, we never talk about HImP, its simply not part of our thinking.

Political, cultural and financial expectations promote the interests of acute trusts as institutions....Incentives reward selfish bad behaviour ....competitiveness in maximising 'patient' service delivery and the needs of institutions are still paramount.
(Health authority director-HAZ area.)

A number of posts' job descriptions contained reference to partnership working, although not necessarily explicitly health inequalities. However almost all respondents stated that their contributions and efforts to work jointly on tackling health inequalities and social exclusion were absent from their personal performance appraisal. At one extreme the comment was:

I think in some way it is not performance managed at this end because I think we are still feeling our way round what it means to be working in the HAZ partnership ...I think a lot of my most productive work I do with HAZ is done inspite of it. You know if people knew I was doing it they might not necessarily feel very happy about it. (Local authority SRB manager.)

Furthermore, the networking and leadership (highlighted above), did not appear to be supported by formal systems for personal and career development. For example a HAZ researcher observed:

I think leading community level change is an unbelievably complicated process that needs a fantastic range of skills. It is not obvious to me that they have any real ability to train people properly to acquire those skills, to reward them appropriately when they have those skills, and therefore to encourage them to stick to it.

In fact there was a sense that Government was *'still feeling its way'* on performance management. The difficulties of performance managing action on health inequalities, a complex issue that cut across the traditional silos, were highlighted by the following series of comments. Accountability was messy:

There is not single accountability for it in central government-apart from if you were to ask the Prime Minister-there isn't a sense in which an individual is responsible for delivering on those parts of the floor targets including health for which they are responsible. So accountability is divided...

The need for players to contribute to each others' objectives appeared well understood. Therefore the absence of the political legitimisation of national targets and indicators around community involvement was viewed as an important barrier to collaboration.

There is no single national performance indicator for community development or community involvement even though these are really strong elements within the national agenda......if there are so many other national performance indicators that people are having to meet then its very hard to say 'well yours will have to help meet mine' when they don't even exist but there is clearly political commitment locally and nationally to that. (LA Community Unit manager, HAZ area.)

Accountabilities for long-term health outcomes appeared confused, uncertain and questionable:

Reduced teenage conception is one of the floor targets and implies that conception is a health issue, when it shares the same risk factors to youth crime that relate to life opportunities and aspirations.
(Local authority Director: HAZ area.)

A similar comment was made with respect to the role of PCTs and their perceived lack of influence on wider health determinants:

When you talk about the wider determinants of health its seems ironic that the PCTs are going to be performance-measured on targets they can't deliver. I think one of the measures should be the quality of their partnership working because they can't deliver otherwise.
(HA Director, HAZ area.)

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The findings suggest that the <u>central command and control model,</u> with emphasis on performance management <u>remains dominant in influencing local players motivations to collaborate or not on health inequalities.</u> The system is characterised by multiple sources of incentives and accountabilities that are not adequately reflected within the performance management framework. While Government's attempts to align national targets to support local collaboration, the dominance of the centralist model remains a major source of tension and undermines players' incentives and capacity to give priority to shared partnership goals of reducing health inequalities.

Towards local integrated strategies for tackling health inequalities?

Overall, the findings indicated some positive shifts in how local players collaborated on health inequalities and moved towards a more strategic and integrated approach. Although the four case studies were at different stages of 'readiness' to collaborate on health inequalities, all made some progress over the study period. As previously indicated, it was not possible to attribute specific changes solely to Health Improvement Programmes or HAZs, given the context of a much wider modernisation agenda intended to support partnerships and the reduction of inequalities. In particular the centre's legitimisation of health inequalities as a priority was important in influencing local players' response. It was clear that the requirement for Health Improvement Programmes and introduction of HAZs were important in positioning health improvement and health inequalities on joint strategic agendas. Health inequalities became a focus of partnership working between health and local government. This contrasted with its marginal position under the Conservative Government.

The comparative case study design did enable exploration of the nature and impact of HAZ partnerships as a model of network management. The findings suggest that HAZs could provide additional impetus towards a more strategic

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integrated approach to tackling health inequalities. HAZ working helped accelerate organisational changes and actions at both strategic and micro project levels aimed at reducing health inequalities. Certain features of working helped the development and delivery of strategies and initiatives that addressed health inequalities. These features were consistent with the notion of network management. The non-HAZ areas reported contrasting experiences. It was apparent that these features were not being developed in a systematic or strategic way in the non-HAZ areas.

HAZs showed that network management centres on building leadership, management and institutional capacity and learning around the pursuit of health equity. HAZs were important in engaging the involvement and commitment of senior managers in leading and advocating inter-agency action on health inequalities priorities as a shared endeavour. A different approach to 'leadership' was evident. There was no one lead organisation or individual. A core network of champions operated across organsational boundaries, within formal structures as well as at the informal and political levels. HAZs provided a focus for developing an inter-agency organisational resources to support the development of an organisational infrastructure and processes for partnership working at both a strategic and micro level. In effect HAZs provided an organisational development and change management competence and capacity. There was an emphasis on innovation and learning that is consistent with the Senge's notion of 'learning organisations' but operating at a system-wide level (Senge 1990).

The contrasting experiences between the two HAZ case studies demonstrated that a central initiative, in this case HAZ, was more likely to have impact if it was integrated within the existing wider mainstream systems and processes. Bradford's 'integrated' approach was clearly more successful than LSL initial 'project-based' approach. Change management was directed within the whole system to beneficial effect, particularly in terms of influencing

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wider strategic agendas and ways of working. In both HAZ case studies the experience and resources were viewed widely as important building blocks for collaborative action on neighbourhood renewal.

The findings suggest that there are tensions between the different partnership models that potentially undermine policy delivery. It appears that network management cannot operate effectively unless certain contextual conditions are satisfied. In particular, while network management appears able to make an important contribution to local collaborative policy delivery, the model appears somewhat vulnerable. In the absence of consistent political legitimisation of action to reduce health inequalities, coupled with resources and stronger incentives, the sustained commitment of the different players to deliver strategic change must be questioned. The dominant influence of national performance management targets can undermine the more organic and fragile network management approach that rests on personal and organisational relationships of trust and diplomacy. The focus of learning and innovation of much networking is potentially undermined by the pressures to deliver on the national targets, in particularly the *NHS Plan*.

Chapter 8: Engaging and empowering communities

This chapter considers the evidence of whether there was genuine engagement and empowerment of deprived communities through partnership working, as a prerequisite to reducing health inequalities. In particular, as discussed in chapter two, the notion of social capital, and the engagement of communities by public sector bodies as a way of building social capital, has gained considerable currency within government policies. Furthermore, it is supported by a growing evidence-base that suggests that social capital could yield health benefits for disadvantaged communities.

The partnership model of network management implies all players are involved in decision-making and their interests are articulated and taken into account. Network management can bring about the *restructuring* of established policy networks that have traditionally guarded the status quo and maintained power balances. Engagement and empowerment of deprived groups and communities can be viewed as fundamentally changing the 'rules of the game'-devolving influence, decision-making and resources. The extent to which the HAZ experience shifted the balances of power through working with communities and groups was particularly explored.

Mixed policy messages: beyond tokenism?

Respondents were well aware that government policies had increasingly stressed the importance of working closely with communities to address health inequalities and wider issues of social exclusion and regeneration. HAZs were viewed by respondents as one of the earliest signals of this 'new' approach to working with communities. HAZs politically legitimised community development as a relevant investment for tackling health inequalities. The more recent modernisation policies were viewed as important to sustaining the approach: 'a tide sweeping community involvement along'. Within the

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NHS the stress on public and patient involvement was seen as a way of sustaining efforts to work with communities; while the Neighbourhood Renewal Strategy demanded a community focus. Furthermore, during the study period, national responses to local events (including the inner city riots and the requirement for race discrimination policies), gave further impetus to the reappraisal of community relations by statutory bodies. However many respondents reported concerns about the extent to which government policies were coherent and fully supportive to local efforts to work with communities. Some cynicism was expressed with the policy discourse around community involvement, particularly with respect to inconsistencies in use of language:

> *consultation...involvement....community engagement ..social exclusion ... social capital and social cohesion.*

Although government policies were felt to be 'going in the right direction...they do not line up'. A number of clear contradictions and inconsistencies were cited as undermining practical implementation.

Many respondents in all case studies areas highlighted the problems of initiatives based on bidding for earmarked monies. Government departments failed to acknowledge the time required for communities and groups to contribute to plans and service development. The HAZ experience showed that the rapid and compressed timescale for submitting bids and subsequently spending money undermined attempts to gain broad ownership and agreement with the community and voluntary sectors.

> *...its all terribly trendy these days to have community involvement and public involvement in everything...They still don't seem to have got the hang of the fact that we need time to do things properly....This builds up into resentment and cynicism and then the blasted programme changes again in another three years!*
> (Director Voluntary Organisation-HAZ area)

Similarly:

> ...it seems to me that they are trying to have their cake and eat it. They want to take the community seriously but only if they agree quickly to do what ministers themselves or their advisers think they should do. And if they come up with different ideas, different priorities, different ways of doing things, it seems like a fly in the ointment....
> (local HAZ researcher)

Furthermore, perceptions that initiatives were about spending additional monies, such as HAZ monies, could be a significant source of tension and distraction. For example LSL respondents from both the statutory and voluntary sectors cited difficulties. The lack of clarity and uncertainty around the bidding process for allocating the HAZ monies was reported to have led to 'anger and confusion and lasting ill feeling' amongst the voluntary and community groups, and dissatisfaction replaced initial high expectations. Indeed the HAZ Director reported 'we're in serious danger of losing the voluntary sector' two and half years later.

Consultation versus community development?

The baseline fieldwork showed that all case studies aspired to engage communities through a variety of mechanisms and defined this as an early outcome of partnership working. However case studies varied in their articulation of a strategic approach to the development of their relationship with deprived communities and groups.

Clearly the HAZ partnerships were required and expected to forge effective partnerships with communities, and community involvement was integral to projects that sought to respond to the needs of different target groups in innovative ways (discussed in the previous chapter). However the evidence provided through interviews and documentation, suggested that HAZs were more active in pursuing this as a shared partnership objective than non-HAZ

areas. In non-HAZ areas, the range of central initiatives, including SRBs, Sure Start and Healthy Living Centres were viewed by a majority of respondents as important opportunities to develop new approaches to working with communities. However, this focus appeared to lack the overall strategic framework and endorsement afforded through HAZ plans and partnerships. This meant HAZs were confronting many of the strategic and as well as practical difficulties involved.

Bradford viewed HAZ as a process of 'letting go' and mounted a community involvement policy at the very early stage of the HAZ. This included the use of 'the ladder of community involvement' that defined different levels of involvement as a working framework for the development of relationships with communities. Community involvement 'was not bolted on...but used mainstream devices'. There was also some early acknowledgement of the tensions and risks involved:

> *Once people get a voice, they want to be heard and mobilise....Actually good community involvement involves conflict....if it's too smooth it won't have worked properly, but we don't want to say that, do we, we don't want to say anything if it will cause descent or upset.* (LA Director, HAZ area)

Furthermore this emphasis on use of the <u>mainstream processes</u> in health and local government ensured health inequalities was integral to subsequent management and political devolution within health and local government by stage two of the study (discussed further later in this chapter). In contrast LSL HAZ's focused initially on community involvement at a <u>project level</u> and established a strategy for community involvement at a much later stage. There was widespread recognition among LSL respondents that HImP and HAZ Boards had failed to provide a clear strategic approach to community engagement at an early stage. Major difficulties were experienced due to the lack of clarity about the underlying philosophy being adopted and lack of

experience in ways of engaging communities on health issues. Interviews revealed little shared understanding of respective agendas amongst the health authority, PCGs, the local authorities, academics and voluntary groups about community involvement. Much of the early experience of the LSL HAZ demonstrated the great difficulty in finding common ground about how the HAZ should work with communities. Respondents from the voluntary sector expressed dissatisfaction with how the issue was being addressed in the 'community involvement' workstream of the HAZ, including the lack of connection of this work to other HAZ programme areas. There was also disagreement about the allocation of the Community Chest monies. A number of respondents indicated that there was major confusion about the meanings of community consultation and community development, and lack of understanding about the need to invest in building a basic community infrastructure as well as funding community-based projects through HAZ monies.

Unequal partners

Chapter two highlighted that shifts in the power balances in favour of deprived communities and groups was a crucial task for partnerships. Devolution of power is discussed later in this chapter.

With respect to strategic decision-making processes, many respondents acknowledged that voluntary and community sector involvement were perceived to be mainly tokenistic. Both HIMP and HAZ Partnership Boards and forums experienced difficulties. Many stated particularly at stage one of the fieldwork that the dominant culture of partnership working was 'top-down and traditional', although there was a desire to move towards a more inclusive approach.

I am sure we are not very good at engaging voluntary action...I think sometimes they feel a bit left out because its always chief execs, directors and deputy majors sat there talking finance and big stuff because everyone is broke so we have really tricky issues and I think sometimes the service users and those people who represent the service users come last on the list. (PCT Chief Executive, HAZ area.)

This was reinforced from the perspective of voluntary sector representatives:

They're not accepting that your contribution is valuable. They think it's useful and they know they have to hear it and that you come forward with some ideas, but they don't really acknowledge the voluntary and community sector for having made these changes, made these suggestions...whatever it might be.....Its as if we're a permanent thorn in the side... (Director of voluntary organisation, HAZ area.)

Respondents acknowledged that voluntary organizations were perceived as unequal partners as they did not command resources, although their role was widely acknowledged as crucial. There was in fact a degree of sceptism and frustration amongst voluntary sector respondents about their involvement being merely a lever for attracting resources:

We are tired of being used by mainstream groups anytime they want to write a proposal with a race equality dimension....the partnerships are not at all equal. We run the risk of getting swallowed up or that what we say will not be taken on board. They use our name.
(Bital and Hill 2001, Race and Diversity review prepared for HAZ)

Certain voluntary sector representatives viewed their role as acting as advocates for effective community involvement within decision making processes, but felt this task was a major challenge. The following comment related to attempts to achieve open recruitment processes for community representatives to the Partnership board:

I suddenly realized that I was trying to change the whole culture of people who have been working in institutions and local authorities....all the time I'm having to remind people about language and style. There's

masses of process stuff like that, organisational stuff that needs to be done.....

I don't think its anything malicious or intentional.....We've realised that they actually don't know how to do it in a different way and we are teaching them different ways, and of course we're learning too, its not just a one way process, and what a fascinating experience it is. (Director voluntary organization, HAZ area.)

Institutional racism

The lack of experience and capacity of health agencies and local authorities to work effectively with communities was widely cited. For example:

PCGs will need to appreciate the complexity of public involvement and participation and community development ....it's a different way of thinking and some people take time to catch on...we've seen a bit of tension between a community listening approach and entrepreneurial doing approach and somehow those two have to come together. (LA Director, HAZ area.)

The HAZ experience demonstrates in particular some of the fundamental difficulties involved in reaching and engaging the most deprived groups.

The lack of competence of the statutory sector to effective address the needs ethnic minority groups through commissioning processes was clearly illustrated by the LSL HAZ. As described in chapter five the LSL HAZ adopted a project-based approach, which centred primarily on commissioning projects across a range of programme areas. A review was commissioned by the HAZ Task Group on Race and Diversity to evaluate commissioning practice to determine its effectiveness in tackling health inequalities among black and minority ethnic communities (Bitel and Hill 2001). The review concluded that the HAZ commissioning process was:

Institutionally racist as there was little evidence to show that specific consideration was given to minority ethnic issues, even though a significant minority of the population in LSL was from these communities.........The lack of specific consideration runs through the

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process from consultation, representation, commissioning specifications and monitoring of results.

The project-based approach focused on spending money through competitive tendering procedures. This served to disadvantage those organisations that had most to contribute. Short timescales, perceived top down priorities, requirements for evidence and a track record of accountability, disadvantaged smaller voluntary organisations serving black and ethnic minority communities. This Race and Diversity Review appeared to have considerable impact on partners' understanding and commitment to community engagement. The review had initially caused dissatisfaction amongst the parties on the HAZ Board and in other forums:

> *They were really, really unhappy...but then the level of maturity of the discussion was really impressive ...people who felt very sensitive and vulnerable in the original discussion were actually saying 'well, yes, there was something wrong with the way we did things'.* (HAZ Director.)

One respondent from a community perspective commented that:

> *They were brave and honest to subject themselves to that scrutiny.* (Voluntary organization officer.)

Certain senior managers identified the findings of the report as a major source of learning and expressed a commitment to changing both HAZ and mainstream commissioning processes. There was evidence that changes were in the process of being made. By stage two of the study, devolution of HAZ to the borough HImP Partnership boards and the PCTs, involved a commitment to adopt a new 'developmental' approach to commissioning as a way of enabling the contribution of the full range of community sector organisations. It was intended to support smaller groups that were not viable partners on their own and therefore provide a more inclusive model.

Building capacity for community engagement

The four case studies comprised a very diverse mix of communities. All had high proportions of the population who were from ethnic minority groups. Certain groups were highly transitory and mobile. Respondents across the case studies highlighted some common challenges to more effective partnership working with their culturally and socially diverse communities. While there were many community and voluntary groups, the community and voluntary sector was largely fragmented with limited or variable infrastructure to support engagement. Particular groups and communities including black and ethnic minorities, and certain religious groups, were underrepresented in influencing and accessing services. The difficulty of working with such diversity is reflected in the following comment:

> ..the African Caribbean network and communities feel shut out, that they're not accepted or acknowledged anything like as much as the Muslim communities are, so there's a difficulty there....the more people shout inevitably people in the end....there are differences within the Muslim community so we've got factions and differences within differences, which is a bit difficult to cope with. (PCT Development officer-HAZ area)

> ....It is quite clear that there some geographic and some communities of interest who are better supported and developed and resourced than others so we are trying to put extra resources into the ones that need it more. I think people intellectually understand that but its taking the next step. (Voluntary organisation director-HAZ area)

There was also acknowledgement by some community representatives that the voluntary sector and community groups also needed to 'get its act

together'. There had to be a willingness to be held accountable for delivery, and adjust their approaches to recognise some of the constrains of the statutory sector, although this might mean compromise. For example one community worker stated that:

> *Community development does not have a completely open agenda. It is not on PCGs' agenda. They are commissioning to health needs. Community development needs to be framed within top down directives because there isn't the leeway to waste resources and enthusiasm...a different approach is required...Community workers say to me 'its not like the old days'..the emphasis on outcomes takes away the life from the work.* (Community coordinator, HAZ area.)

HAZs clearly provided a focus for learning about how to engage with communities more effectively on the health inequalities agenda. HAZs undertook a range of activities designed to support the development of the infrastructure of the community sector, as well as supporting statutory agencies work with communities.

Bradford's strategic approach to community involvement focused on development of the capacity of both community groups and also the public sector to work together. The role of the HAZ funded community involvement team, that comprised four community development workers, proved central to this. The local evaluation report of the Bradford HAZ community involvement work highlighted evidence of important shifts in attitudes and organisational changes and action, and particularly that:

> *'The values and principles of community involvement are becoming 'embedded' in the PCTs.'* (South and Fawcett 2002.)

All the Primary Care Trusts had established strategies for community involvement and action plans. All had used the self-assessment tool (HAZ derived) to determine how effective they were in engaging communities and to audit their performance over time. Individual practices had been set targets

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for involving communities through the mainstream processes of Personal Medical Services (PMS) contracts and clinical governance. Staff training had helped develop skills. Structures for involvement of communities in planning and decision-making were being put in place. This included the early establishment of local HAZ/HImP Groups with strong community representation. The community involvement team had undertaking a range of activities to develop the capacity of communities for contributing to partnerships and health initiatives (eg training, support to grant applications).

In contrast the non-HAZ areas demonstrated different approaches to building community infrastructures as well as developing capacity of the statutory sector to work with communities. In both non-HAZ areas there were many examples of community-based projects, however these developments were being undertaken as part of centrally funded initiatives, and their impact and potential for roll-out appeared more limited. The approach was more incremental. In Kensington, Chelsea and Westminster, one council was strongly ideologically opposed to the notion of community health development, and central initiatives such as SRBs and Education Action Zones were supported by the council only on the grounds that they potentially improved 'democratic' involvement in public services. These schemes were viewed by council officers as opportunities at least for jointly piloting community development approaches to respond to the needs of different groups. However changing mainstream services would prove difficult. Birmingham's Family Support Strategy was notable in demonstrating that a sustained incremental approach could achieve some important outputs. It was funded through a number of different central initiatives over a number of years to improve community services to families and children living in poor social circumstances. It had been successful in training local people ('community mothers') as a model for working with low income families to improve the health of young children, and had been adopted in a number of disadvantaged estates in the city. However those interviewed who were

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involved in the strategy judged its impact on changing mainstream services to be limited as yet. Nevertheless in Birmingham by stage two of the study, these types of centrally funded projects were being piloted within a context of the council's commitment to strengthening of local democratic processes as well as the development of new PCTs, that were regarded as the main mechanisms for sustaining such work.

Power balances and strengthening local democracy

Overall, within the study period, there appeared to be very limited real shifts in power between the established local players through partnership working. The 'rules of the game' still served to disadvantage those communities and groups that were most deprived.

Respondents when asked directly 'who has the power within the system', gave different interpretations of the nature and position of power, based on their experiences of working in partnerships. The general perception was that power was highly 'dispersed' through the system and tensions existed that influenced the pursuit of equity.

Financial resources were viewed as a major source of power. Central government held the power because it held the 'purse strings', which was administered through national priorities and performance management. The significant budgets held by Primary Care Trusts meant they would be the future powerful health player in health strategies. By stage two of the fieldwork there were high expectations that PCTs would contribute a more localised perspective and provide the mechanism for working with communities at locality and neighbourhood levels. However, many held the view that the power of the acute trusts still remained largely unchallenged as the majority of the PCTs' budgets were tied up in the acute sector and any development monies would be absorbed by cost pressures. Furthermore, it

would appear that trusts' 'non-participation' in the inequalities agenda served to entrench their power.

Although command of resources was viewed as a source of power, the local authorities' <u>democratic mandate</u> was also highlighted as a significant source of power. Over the study period modernisation efforts to decentralise mainstream management of public services and strengthen local democracy were evident, particularly within Birmingham and Bradford, and appeared to be taken seriously by the statutory players:

> *Its about changing the fundamental relationship between the local authority and the people who live in poorer communities....to understand the contribution people in communities themselves to identifying problems and identifying true solutions...however tailored the services are there is something about the skills, capacities, the lives of the people themselves, that needs to evolve a different framework for working...*
> (Local authority Chief Executive-HAZ area)

These moves seemed to represent a modernisation trend that potentially could shift power balances, although the experience and capacity of the different players to genuinely engage the most deprived groups, could still be questioned. The following comment expressed fundamental difficulties in restructuring the established policy networks and changing the distribution of power:

> *Power is political and hierarchical but this is not an issue provided that it is accountable and responsive. No doubt the local authority is seen as top down but it is trying to find ways of taking better and more accountable decisions. But it is difficult for statutory agencies which are performance managed centrally, and therefore partnerships need to operate within the reality of experience of different parts of the system.*
> (Local authority Director, HAZ area.)

Local authorities plans for strengthening local democracy included area and neighbourhood infrastructures. By stage two of the study, local authority

respondents reported that these were increasingly being viewed as an important focus for identifying priorities and development of plans within the context of Cabinets, Local Strategic Partnerships, regeneration strategies and neighbourhood renewal. In all case studies there was increasing recognition that this process of devolution within both health and local government could help secure engagement with deprived communities to address health inequalities and deprivation as part of mainstream planning processes.

This process was most advanced in Bradford (as described in chapter five). The Bradford case study demonstrated the LSP's commitment to strategic devolution through its Neighbourhood Renewal Strategy and the establishment of the neighbourhood action planning. It was widely acknowledged that the health perspective was central to this process, based on the learning and legacy of the HAZ experience. The neighbourhood action planning was intended to fed into and influence the area conferences and committees of the five parliamentary consistencies, and the planning mechanisms of the four Primary Care Trusts, (as well as the various partnership bodies). Neighbourhood action planning was therefore expected to influence decisions about mainstream public sectors in Bradford. The process was viewed as creating:

> ..a politics of partnership –not party politics, people thinking about how they want to live together-that I think can only strengthen representational politics. Where it will be difficult is that I think there will be more people more able to hold the public services and politicians to account and I think they may find that problematic in the first instance.....However the people will be taking responsibility for some of that problem-solving for public services..
> (Neighbourhood Renewal Director).

Application of the theoretical schema, suggests that the <u>genuine</u> <u>empowerment</u> of disadvantaged communities and promoting social cohesion are fundamental challenges. Communities are heterogeneous and community participation has multiple dimensions and a sophisticated understanding and approach is demanded. No one model appeared to make major advances. While all case studies were able to use centrally funded projects as a focus for involvement and innovation (as discussed in the previous chapter), the participation of communities within strategic governance mechanisms was much more problematic, and progress appeared more dependent on the nature of local democratic processes and their linkage to strategy and organisational processes.

The centralist models had an important influence on developments. This was both positive and negative. The legitimisation of community involvement within a range of government policies was a key driver. By stage two of the study the early impact of decentralisation and strengthening of local democratic processes were evident as part of modernisation within health and local government. Local Government White Papers requiring changes in political and management arrangements, and *Shifting the Balance* establishing Primary Care Trusts, were drivers for community engagement and concerns for responding more effectively to deprived communities that involved mainstream changes in organisational processes. While centrally-funded initiatives were perceived by respondents as a significant focus for working with deprived communities and groups, this model (involving bidding, targeting, compressed timescales) also had negative implications. The following comment highlights this tensions centralist models and community empowerment:

> *Although there is now a much more sophisticated understanding in government...The kind of impatience associated with the parliamentary timetable is still there. They know it takes preparation, they know it*

takes time. They still want to deliver for their political masters....(Public health specialist-HAZ area)

HAZs had at least provided an important focus for exploring and demonstrating the many difficulties involved in 'changing the rules of the game' and interactions between players to help empower communities and benefit health. Again Bradford HAZ appeared more advanced in adopting a strategic and 'integrated' approach. HAZ had enabled the development of the capacity of PCT's and the local authority to work more effectively with deprived and marginal groups, as well as building the capacity of the voluntary and community sector. This provided the platform for neighbourhood action planning which was intended to be embedded within the local area parliamentary consistency mechanisms as well as other joint planning management processes. This appeared potentially to provide an example of ~~what~~ networking with communities in a way that shifts power balances and changes the 'rules of the game'. It seemed to offer the prospect for integrating the health dimension within mainstream efforts to build social cohesion and address issues of deprivation and neighbourhood renewal.

Chapter 9: Discussion and conclusion

Policy delivery of wicked problems: reducing health inequalities

The election of a Labour Government in 1997 seemed to introduce a radically different policy context for tackling health inequalities in comparison to the previous Conservative era. The prospects for making progress appeared more favourable. In effect the Black report's agenda for tackling health inequalities could now be taken forward. Ministers were at least sympathetic to the view that health inequalities mattered and the health of the population was intimately connected with economic and social inequalities. Poor health had economic costs and was socially determined at least in part. The desire to do something about health inequalities seemed genuine. However, such enthusiasm was no guarantee of success. Delivery depended on a wide range of actors. Potentially Health Action Zones could test out new forms of partnerships as a mechanism for policy delivery.

This thesis set out to study the potential effectiveness of partnership working as a mechanism for tackling health inequalities. What was this new partnership approach being tested by HAZs and did it work?

The objective of the thesis was to answer the following questions:

- What theoretical models of partnership were being used as the intellectual framework behind HAZs, and were evidenced in practice? (means)

- What was the success of these partnerships in addressing inequalities in health? (intermediate process outcomes)
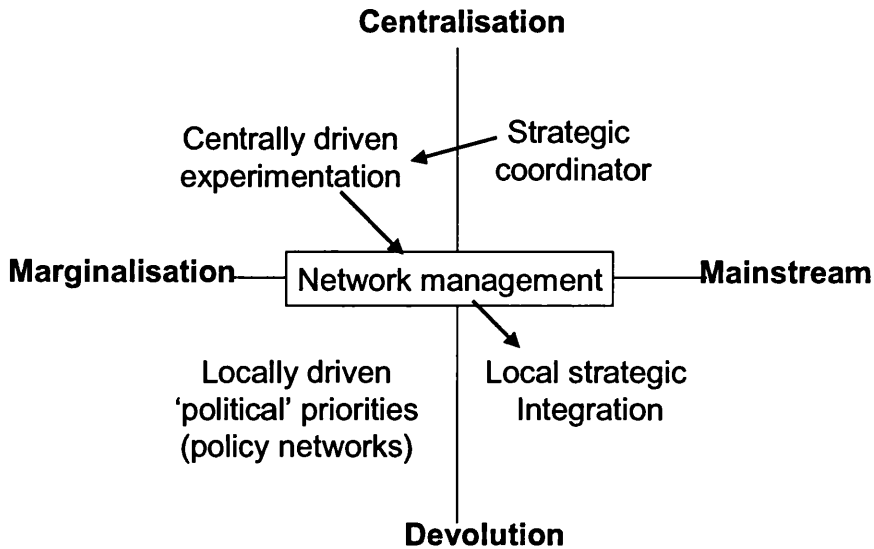
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This thesis demonstrated that network theory in particular had informed the intellectual thinking behind the HAZ initiative. This final chapter summaries the empirical evidence from the study on the operational testing of network theory. The implications of these findings for policy learning and network theory are then examined. To conclude, the future role of health action zones as a mode of governance is discussed.

Theoretical models of partnership

Analysis of selected theories concerned with collaboration and policy delivery provided the framework for evaluating the nature of partnership working and its relevance to public health. The analysis was used to construct the schema of 'collaborative policy delivery mechanisms' shown in the diagram below.

The proposition was that 'network management' was potentially a distinctively new model of partnership working that could change the pattern of interaction between the key organisations in the collaborative pursuit of greater health equity. Health Action Zones were a test of the use of this model in policy delivery.

Schema of 'collaborative' policy delivery mechanisms

Centralisation

Centrally driven experimentation — Strategic coordinator

Marginalisation — | Network management | — Mainstream

Locally driven 'political' priorities (policy networks)

Local strategic Integration

Devolution

The Government's initial strategy as espoused in the HAZ guidance, involved a shift from the traditional centralist 'strategic coordinator', 'command and control' model of policy delivery with its emphasis on prescribed priorities, guidance and targets. Reduction in health inequalities would be strongly legitimated by central government announcements and Ministerial support. There would also be central funding to foster networking but local actors would be left free to invent their own means of networking. 'Network management' would promote lateral relationships across government departments and across organisational boundaries. Network management implied a more strategic approach locally to collaboration that involved change across the system to reduce health inequalities. A culture of trust and diplomacy would allow the different players to explore their roles in tackling health inequalities and the mutual benefits to be gained by taking action. Health inequalities would be accepted as integral to joint strategies. Such change would go beyond the incrementalism driven by incentivised initiatives that tended to achieve only marginal impact. Traditional established networks that had guarded the status quo in the system would be restructured. Health

inequalities would be on the agenda. A more inclusive approach would engage a wider range of stakeholders interests, particularly deprived communities. New 'rules of the game' would operate, and redistribute power to those worst off. <u>Thus there would be some element of strategic coordination from DH, some centrally driven experimentation, some locally driven political priorities permitted and integration with other local strategies. The whole would be made to work by better local network management by key local actors.</u>

Alternatively HAZs could prove to be 'just' another centrally driven area-based initiative with collaboration around a stream of money, that had limited impact on mainstream and longer term strategies and resource allocation, making only a marginal contribution to tackling health inequalities. HAZs could be seen as a tokenistic response by government wanting cheap publicity, to be seen to be doing something. As such, network theory could prove no more effective than all the previous attempts to get separate self-interested local bureaucracies to work together.

The study design provided the framework for testing whether HAZs did represent a new form of partnership, and the extent to which it was effective in bringing about collaborative action by key players in pursuit of health equity. It was based on a comparative case study of two HAZ areas (Bradford; Lambeth, Southwark and Lewisham) and two non-HAZ areas (Birmingham; Kensington & Chelsea and Westminster). The approach was also informed by Pawson and Tilly's notion of 'realistic evaluation' that is concerned with examining *what works for whom in what circumstances.*

The empirical findings

The study documented the development and changes in partnership arrangements in each of the four case study areas over the period autumn

1999 to autumn 2002. Analysis examined the extent to which the different partnership models were operating in each of the four case studies. Analysis also examined the relevance of these different theoretical models in explaining the behaviours of players to tackling health inequalities.

The diagram below attempts to plot the progress of partnerships in terms of the organisational systems changes and actions that addressed health inequalities over the study period.

Schema of 'collaborative' policy delivery mechanisms : Plots of case studies at stage 1 and stage 2 of study
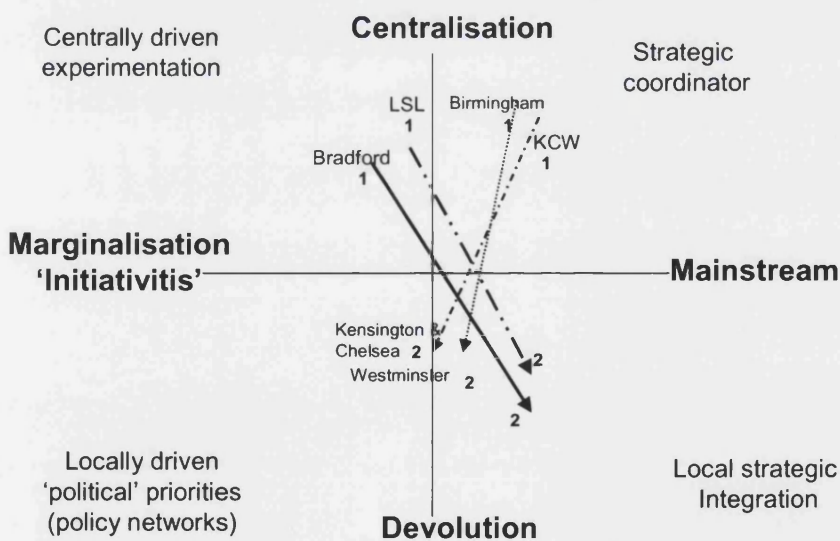
The study has clearly shown that different models of policy delivery operate simultaneously within the system. The dominance of different models changes over time and also with respect to local context. The interaction of the different models is influential on the collaborative behaviours of local players and extent to which they are able to agree and take forward integrative strategies.

The four case studies were at different starting points and made differential progress.

The diagram shows a dominance of the centrally driven approach in the four case studies to tackling health inequalities and deprivation at stage one. The strategic coordinator model influenced the commitment and ability of local stakeholders to tackle health inequalities. In all case studies at stage one Health Partnerships Boards (and associated structures) were established in response to the requirement for Health Improvement Programmes. Health Improvement Programmes, and the HAZ initiative (in the two HAZ case studies) made health improvement and <u>health inequalities legitimate goals on joint agendas</u> alongside other priorities (including acute services), and energised the concerns of local players. It allowed the different players to explore the links between health inequalities and their agencies' objectives, as the basis for commitment to 'integrative strategies'. The two HAZ areas Bradford and Lambeth, Southwark and Lewisham are positioned in the top left quadrant as examples of centrally driven experimentation. Health Action Zones <u>preceded</u> the introduction of Health Improvement Programmes and clearly engaged the energies and commitment amongst the different players in the two HAZ areas, in comparison to the non-HAZ case studies. The HAZ initiative appeared to have a greater impact in Bradford than in LSL as it was integrated within the local mainstream strategic processes. Therefore Bradford is positioned slightly further to the left in this quadrant than LSL. In

LSL the HAZ initiative focused initially more narrowly on tackling health inequalities with respect to children and young people. The position of two non-HAZ case studies in the top right quadrant indicates the influence of the central requirement for health improvement programmes, but absence of the kick start provided by HAZ status. However even in these non-HAZ areas early practical progress on tackling health inequalities was stimulated and somewhat reliant on a number of other central initiatives. Efforts were made to address health inequalities through other area-based experimentation (including SRB, Education Action Zones and Sure Start). These were viewed by respondents as important opportunities for targeting of collaborative efforts to address the needs of the worst off.

Stage two of the study revealed the early impact of *NHS Plan* on local partnership working. It significantly influenced how health improvement was perceived by players, and weakened the status of Health Improvement Programmes. The national evaluation of HAZ also highlighted the impact of the apparent inconsistent central messages diverting local strategies and putting strains on partnership relationships (Bauld et al 2001, 2002). However there was some evidence from this study that locally HAZs helped to maintain a strategic focus on health inequalities, relative to the non-HAZ areas.

By stage two of study, the centre was giving more emphasis to local strategic frameworks as the means of integrating health within broader strategies, and tackling health inequalities. This acted as a counter force to the centralist force of the *NHS Plan*'s emphasis on health services. All case studies were able to move to some degree towards a more local strategic approach to tackling health inequalities (ie bottom right hand quadrant in the diagram). In all case studies the underlying themes of modernisation, and particularly the requirement for Local Strategic Partnerships, served to support efforts to integrate health inequalities within a wider strategic framework. In all cases studies, despite significant structural changes and changes in relationships,

health partnership boards were starting to be clearly positioned within a whole systems approach. Health inequalities were starting to be placed within the remit of Local Strategic Partnerships and neighbourhood renewal, although with strong central encouragement.

Health Action Zones: a shift towards network management?

However the evidence suggested that HAZ status helped accelerate the growth in capacity for partnership working and a more local integrated strategic approach.

There was a long history of partnership working on health in these two HAZ areas that provided a sound basis for progress. Winning HAZ status had meant demonstrating partnership credentials. This was a source of bias in the case study sample that was difficult to avoid, given how HAZ were selected. It could be argued that these areas would have made real progress anyway relative to the non-HAZ areas, regardless of HAZ status. In an attempt to overcome this bias, the interviews and observations sought to identify the distinctive features of HAZ and their added value, although in an admittedly more favourable climate. Respondents claimed that HAZ status had accelerated development and progress in local collaboration. The reasons they gave lay partly in the additional resources that were dedicated to building networks between the partnership authorities and the stimulus to local enthusiasm and initiative that HAZ status had sparked.

HAZ case studies did demonstrate distinct features of partnership working in comparison with the two non-HAZ case studies. The evidence showed that HAZs systematically built leadership, management and institutional capabilities around the pursuit of health inequalities that involved

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organisational learning and development. These distinct features were consistent with the notion of network management. The HAZ idea had helped move health inequalities nearer the centre of the partners' agendas.

- HAZs engaged senior people through Board structures in leading and advocating inter-agency action on health inequalities priorities *as a shared endeavour.* A new approach to 'leadership' was evident; there was no one lead organization. (In the non-HAZ areas the HImP was seen as more a health led activity.) Senior managers and politicians operated as a network of champions across organsational boundaries within both formal partnership structures as well as at informal and political levels.
- HAZs established an inter-agency organisational resource and capacity for managing change. People ('boundary spanners') and money provided the organisational infrastructure and processes for partnership working at both strategic and micro levels. These included:
  - interagency groups on different 'workstreams' and programmes,
  - 'open-space' 'whole-systems' events
  - project management,
  - performance management and reporting,
  - management of investment in evaluation of innovative schemes, with academic centers; with networks and events for systematic learning and reappraising mainstream services.
- Systematic approaches were established to engage community and voluntary sectors in partnership working through partnership membership, designated programmes of work and projects.

The contrasting experiences between the two HAZs showed the importance of integrating initiatives such as HAZ into mainstream and wider systems and

processes. Bradford's 'integrated' approach was clearly more successful than LSL's initial 'project-based' approach, at the early stage of the study. Change management was directed within the whole system to beneficial effect, particularly in terms of influencing wider strategic agendas and ways of working. In both HAZ case studies the experience and resources were viewed widely as important building blocks for collaborative action that ensured health was a clear focus within neighbourhood renewal.

These features of partnership working for tackling health inequalities were not being developed in a systematic way within the two non-HAZ case studies. Local long-standing political tensions had hindered strategic engagement on health inequalities in the non-HAZ areas. The lack of a strong joint strategic commitment appeared to focus the efforts of committed individuals on opportunistic use of central initiatives as a way of achieving some collaboration and practical progress on health inequalities.

Although these distinct features appeared to accelerate progress, in the two HAZ areas studied, one HAZ advanced more than the other. Furthermore, there were tensions between the different policy forces, that limited progress and raised questions about the sustainability of HAZ partnership working and integrative strategies in both areas.

While HAZ had motivated individuals and organisations in a number of ways, the incentives for action on health inequalities provided through formal mainstream performance appraisal remained weak. While there was growing understanding and recognition amongst players that '*your targets are my targets*', this was not necessary reinforced by the national performance management frameworks. Tensions were cited by respondents between existing short-term organisational targets and working towards long term health and social outcomes. This suggests that it may not be possible to design an appropriate accountability and performance framework that is able

to provide the necessary incentives and rewards, when outcomes are so long-term and responsibilities for intervening are unclear. In many cases the incentive to collaborate appeared more based on public sector ethos and individuals' personal commitment to improve the chances of the deprived communities and groups they served, rather than on organisational incentives. This lack of alignment of national performance management framework with health inequalities was a point emphasised by Exworthy and colleagues in their work on how health inequalities were being addressed in the early period of the Labour Government in non-HAZ areas (Exworthy et al, 2002).

Despite concerted efforts by HAZs, genuine community participation remained problematic and there was little real shift in power balances between the players. Emerging findings from the National Evaluation of HAZs indicated the difficult and variable progress HAZs were making in involving communities (Barnes et al., 2001). The findings here showed some efforts towards empowerment of communities, particularly through local projects. HAZs were viewed as signaling a new approach to working closely with communities and politically legitimising community development as a relevant investment for tackling health inequalities. HAZ partnerships pursued a more active and systematic approach to engaging with communities than non-HAZ areas. HAZs appeared to confront many of the strategic and practical difficulties involved. Bradford's more strategic approach appeared more effective. In contrast LSL's learning and progress was problematic.

However voluntary and community sectors were widely acknowledged as unequal partners in strategic decision making processes. Their views and lack of resources failed to command attention. Some voluntary representatives expressed the view that the community contribution mattered to statutory agencies only because it was vital in attracting resources. Perceived inconsistencies in government policies on community involvement

were felt to undermine practical implementation. The rapid and compressed timescale for submitting HAZ bids for example did not allow time for genuine engagement with communities. Furthermore locally the perception that HAZ was more about spending additional monies proved a source of tension particularly with voluntary and community groups, as well as a distraction to establishing a more strategic approach to community engagement.

Lack of experience and capacity of health agencies and local authorities to work effectively with communities was evident across all four case studies. While HAZs had provided a focus and examples of learning about how to work more effectively with communities on the health inequalities agenda the challenges of genuine empowerment remained.

Implications for policy learning

This thesis started with the conjecture that the 'assumptive world' of policy makers was receptive to testing networking theory as a model for tackling health inequalities. Given that policy delivery is now articulated by the *Government Delivery Plan for health inequalities* (forthcoming), Local Strategic Partnerships, Neighbourhood Renewal, and new Local Delivery Plans and 'public health networks' in the NHS, what are the prospects for network management?

The study findings give some basis for comment on the Labour Government's policy for tackling health inequalities as it is developing in early 2003. The empirical evidence suggests that network management has indeed an important contribution to make to the policy process and delivery on such a complex problem. The Labour Government has continued to develop its policy on addressing health inequalities beyond the study fieldwork period. There are signs that policy learning is taking place. Some of the tensions

highlighted by the study that hindered network management and progress on local integrative strategies are potentially being addressed.

The message that health inequalities do matter is being reinforced, signaling renewed political legitimisation for local players to sustain their efforts. There appears to be a more explicit and broader base of legitimisation and leadership for health inequalities across government that goes far beyond the DH. The *2002 Cross Cutting Review on health inequalities* reiterates cross government and Ministerial commitment to health inequalities. The *Spending Review* summary report was launched by Alan Milburn in November 2002. Milburn signaled that:

> *The time has now come to put renewed emphasis on prevention as well as cure so that we develop in our country health services and not just sickness services....*
>
> *Poorer people get sick more often and die earlier...Poor health blights too many communities and holds back too many people....the time has come to recognize that health just like education is a route to economic fulfillment s well as personal fulfillment...The vicious cycle of poverty, social exclusion, educational failure and ill health must now be broken.*
> (Milburn, November 2002)

The forthcoming *Government Delivery Plan for reducing health inequalities* is expected to detail the contributions of all relevant government departments. This progress in the development of cross government collaborative efforts to address health inequalities is documented by the recent study of the impact on policy making of the Acheson Inquiry's recommendations (Exworthy et al., March 2003).

Policies have sought to tackle wider determinants of health and to cover the lifespan.....The Government initially implemented a disparate collection of policies to tackle health inequalities but these are now being brought together in a more systematic and coherent way...... Most government departments have recognized the relevance of their existing and new policies for tackling health inequalities, and the contribution that these policies can make...
(Exworthy et al., 2003)

At a national level, it seems that the <u>incentive and reward mechanisms,</u> required to secure buy in and collaboration amongst the different players to tackling health inequalities, are being put in place. The contributions of different government departments to reducing health inequalities are now incorporated within their national Public Service Agreements, on which their performance will be judged.

Local Strategic Partnerships are viewed as the prime local partnership mechanism for policy delivery. The Neighbourhood Renewal Strategy has received increased funding. The Health Action Zones are being funded for a further three years (£140m: 2003/2006).

Although these developments appear supportive to network management there are also a number of areas for concern. Unless the renewed central legitimisation is translated into clear demands on all the different local players to deliver, (with incentives, rewards and support), network management will remain fragile. Broad and integrated action on health inequalities will be difficult to sustain. The study findings indicate that the traditional tension between population health and health care remains as strong as ever. The positioning of public health within 'health policy' has traditionally marginalised support and efforts to tackle health inequalities. It has been in Ministers' self interest to respond to the expectations of the public and media for quality health services, and public health issues have failed to count as a priority.

Although action to reduce health inequalities now appears increasingly integrated within cross government, locally there appears some uncertainty about leadership and positioning of public health and health inequalities. In particular, the NHS *Local Delivery Plans* have superseded *Health Improvement Programmes* as the key local strategic document. (The *Local Delivery Plan guidance* indicates in its technical annex that locally PCTs have the option of developing health improvement programmes.) The study findings suggest that such lack of clarity and change in use of language signals uncertainty about the relative priority that the government affords to tackling health inequalities. The incentives for prioritisation of health inequalities vis health services appear comparatively weak. As yet health inequalities do not feature in the NHS Chief Executives' (particularly PCT Chief Executives') list of 'must dos'. The pressure to deliver on the plethora of NHS targets make it unlikely that Primary Care Trusts will be able to champion tackling health inequalities within the context of Local Strategic Partnerships.

Furthermore the radical structural change within the NHS has hindered the development of networking. Stability and continuity of relationships between individuals and organisations is fundamental to collaboration. In particular the major reconfiguration of the public health function (involving decentralization to Primary Care Trusts) suggests that it may take some time before PCTs can make a substantive contribution.

It therefore appears important that the role of local government in public health and tackling health inequalities is made more explicit and reinforced, to give impetus to the development of network management as the model that underpins Local Strategic Partnerships. The setting of a national Public Service Agreement for local authorities explicitly for reducing health inequalities could raise the priority and stimulate action by local authorities. Furthermore efforts to reduce health inequalities would be part of the local

democratic processes. Local politicians, particularly those councilors with the health portfolio within the cabinet, could provide a clear focus for championing health equity as part of local government's community leadership role and duty to promote 'well being'. The new cabinet scrutiny committees for health could provide an important opportunity for both the NHS and local government (itself) being held to account for tackling health inequalities.

In principle the 'conditions' that could foster network management would appear to be improved but perhaps still unstable as the basis for sustaining a long-term commitment. The need to understand what these conditions are and how they might be created as part of the policy process is discussed in more detail below.

Implications for network theory

While there is growing literature on network theory there is still limited empirical work that tests its validity, especially within the public sector. Although increasing reference is made to networking as an alternative to managing by hierarchy or markets few studies have sought to define practically what this means or what difference this might make to the delivery of public policy. This study contributes to this area.

In particular, this study has sought to build on Kickert's ideas that network management can be used as a possible mechanism for public sector policy delivery (Kickert et al. 1997). Network management centres on the use of mechanisms that enable different organizations to interact in a way that build consensus and commitment to solving a common problem. A culture of trust and diplomacy is fostered and governs the behaviours and relationships between the players. The different players are motivated to engage in such interactive processes as they recognize the inter-dependence between them - ie that mutual benefits will be gained by tackling the problem together. Kickert

states that organizations recognize the need to shift from 'go it alone strategies' to 'integrative strategies'. It is a process of mutual adjustment; it is likely to involve some compromise and/or adjustment of their individual organisational strategies and ways of working. 'Game management' is how players establish common ground and mutually beneficial solutions. Furthermore 'structuring the network' provides a context that fosters integrative strategies.

There is a strong presumption therefore that network management is relevant as a policy delivery mechanism for tackling health inequalities, that demands collaborative action from multiple diverse players. The study has shown that Health Action Zones have proved to be a useful focus for examining the model in practice. Furthermore the role of network management was assessed along side other theoretical models of policy delivery to help explain whether and how local players collaborate to address the problem.

Indeed, the study reinforces the conclusion of other research that shows different modes of governance operate simultaneously (Lowndes and Skelcher 1998, Lowndes 1999, Ferlie and Pettigrew 1996). The diagram above showed the force of different models changes over time and also with respect to local context. The interaction of the different models is influential on the collaborative behaviours of local players and extent to which they are able to agree and take forward integrative strategies. Therefore it is important to understand the nature of this interaction and whether and how synergy can be achieved. Rhodes suggests that it is the mix of governance modes that will form the new operating system for government (Rhodes 1997). This study indicates that the optimum mix of central driving and local networking will determine the outcome of attempts to reduce health inequalities.

The diagram below presents the study findings in terms of Context-Mechanism-Outcomes, as a basis for examining the contribution of network

theory to policy delivery. As discussed above, HAZs did exhibit aspects of network management (change mechanisms) that appeared to help <u>accelerate</u> organizational changes and actions aimed at impacting on health inequalities. Strategic progress and changes (intermediate process outcomes) were more likely if the network features were an integral part of the mainstream processes through which players managed their interorganisational relationships.

However, network management is not something that just happens and does not operate in isolation. To become a systemic process of policy delivery, network management needs to be stimulated, fostered and resourced. Network theory appears somewhat limited in defining how this might happen. Contextual factors, both national and local, appear critical in influencing how such networking develops and its impact. The sense of trust and mutual advantage that underpins the collaborative relationships is vulnerable. Political factors especially can undermine or enhance networking. Kickert proposed that contextual factors could be 'structured' to foster collaboration. However the study findings suggest that such political factors may be difficult to 'structure' managerially in a way that fosters and sustains interagency action on health inequalities.

There are clear tensions between the political dynamics of policy delivery and the fostering of network management. The political legitimisation of the problem as a priority is subject to electorate expectations and demands, and a powerful media climate. The incentives and rewards available to the key players will determine whether it is in their interests to engage and collaborate, especially whether collaboration will deliver the priorities on which their performance is judged. The power balances between the different players influences whether deprived communities and groups can participate and ultimately benefit. The importance of investment in the infrastructure for

interagency working and the capacity for players to engage, also needs to be fully recognised as a necessary condition for delivery over the longer term.

Network management and contribution to policy delivery		
Context	Change mechanisms	Intermediate process outcomes
Electorate expectations: centrally and locally Media climate supportive to improvement of population health vis focus the NHS acute care Political legitimization of the problem as a priority vis 'expeciencies' (centrally and locally) Incentives and rewards; performance judged by appropriate 'intermediate outcomes' as the path to long term reduction in inequalities History of relationships between players and capacity for joint working (social capital) dependent on some organizational stability and continuity Power balances between players including strength of local democratic processes	Network of strategic leaders and champions Governance structures and systems that effectively engage all key players at strategic, programme and project levels Managed institutional capacity for interagency working and organizational change: including people with mix of skills and experience; and systems for communications, evaluation and learning, training and development Strategic approach to engaging with communities through devolved and democratic processes Additional financial resources pump priming organizational change and service development	Cadre of 'whole systems' leaders and managers Culture of trust and diplomacy that normalizes partnerships as the way of working Inclusive representation and participation of players Agreement and commitment to 'integrative strategies' Resource allocation according to level of need and deprivation Programmes and projects addressing the needs of worst off Community engagement and empowerment

The conditions for effective networking: achieving the optimum mix?

It is contended here that these contextual factors provide the <u>necessary</u> <u>conditions</u> for fostering network management and its potential for delivery of integrative strategies. Furthermore greater attention in the policy process to creating these conditions could bring about a more optimum mix of governance modes; a better balance between central driving and local networking that recognises the politically intrinsic nature of the process of policy delivery.

Ways of creating these conditions for effective networking are elaborated below.

If politicians have any capacity at all for leading change in priority areas it is through changing the climate of public and political debate. <u>Electorate</u> <u>expectations and demands</u> will always be a key driver of priorities. Although there is increased public awareness of certain public health issues (particularly those that generate media scare stories) there is a lack of public understanding and debate about issues of health inequalities. Fuelled by a powerful media, obsessed by hospital services, the public will expect and demand high quality health services. The study demonstrated that the tension between long term improvements in population health and the short-term reduction in waiting times remain. When Ministers' careers and reputations are at stake, in the face of public growing dissatisfaction with the NHS' apparent failures to cope with demands, public health will no longer count.

Given the long-term nature of population health outcomes this tension will always exist, however there seems to be more potential for proactive management of the media and shifting the climate of public opinion. It should be possible for national and local politicians, working with the press and TV media, <u>to create a climate for a more mature public debate on health</u>

inequalities. Indeed this appears vital given increased political recognition that delivery of national targets will demand sustained action over more than one government term.

This climate is necessary for sustained political legitimisation of health equity vis health services and other political expediencies, both centrally and locally. The study findings showed that it was vital to engendering the commitment and efforts of local players to collaborate on health inequalities. At stage one of the study reducing health inequalities was defined as a government priority for the first time. Health inequalities were placed on the strategic agenda of local stakeholders via health improvement programmes. Joint working between local stakeholders to reduce deprivation and health inequalities was incentivised through centrally driven initiatives that offered additional resources to find innovative approaches to local solutions. Health Action Zones were an early national signal and energised players locally to buy into action on health inequalities and social exclusion.

Alternately, the lack of legitimisation influenced the importance local actors attached to the health inequalities agenda. The launch of *The NHS plan* was quickly perceived as a counter signal that downgraded health inequalities.
Current Ministerial messages again signal that health inequalities matter. However the development of effective networks of local champions for tackling health inequalities will be dependent on these messages being consistent and sustained.

There was pressure on the DH to adopt a more centralist mode of working with local NHS action driven by national departmental targets. Public choice theory helps to explain why health inequalities were subject to this variable government commitment. Individual Minister's self interests in part dictated strong central direction and control for early delivery of NHS improvements and shift of concern from health inequalities. This raises the question about

whether the Department of Health can provide the necessary leadership. The long-standing tension between population health and health services means that this volatile political dynamic will continue to operate and impact on local players' collaborative relationships and behaviours. Local authorities could do more to influence the political environment, given their new duty to promote community well-being and scrutiny role for health and health services. Political leadership and advocacy locally could heighten public awareness and debate on health issues, and start to build some understanding and expectation amongst the electorate that health inequalities, and not just health care, demand attention on a sustained basis.

This legitimisation needs to be embedded in the <u>incentives and rewards</u> mechanisms that motivate local players (individuals and organizations) to collaborate. Players' motivation and commitment to health inequalities were strongly influenced by their perceptions of the incentives and rewards available. A range of incentives operated. However whether or not their performance was judged on health inequalities was crucial (and linked to political legitimisation). Although HAZs did create a range of incentives, action on health inequalities remained visibly absent from the list of nationally prescribed NHS 'must dos'. Health Action Zones motivated players in offering resources, profile and kudos, as well as a way of acting on local priorities and long standing concerns about inequalities. The public sector ethos, that values equity, was a strong personal driver for many of the respondents.

Senior people in leadership roles across the partner organisations were engaged and sufficiently motivated to explore how action to reduce health inequalities could also contribute to delivering their own organisation's goals. This understanding amongst the different players of their inter-dependence ie *'your targets are my targets'* was an important outcome. It is clear that other government departments and local government must be made more explicitly accountable for their contribution to achieving health inequalities targets to

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secure and sustain their collaboration and commitment to action. The understanding amongst the players that this inter-independence demanded collaboration was clearly important in fostering a culture of 'diplomacy' and 'trust'. HAZs reinforced the role of strategic leaders in both health and the local authority as champions for health inequalities, and pursuit of this as a shared priority from a whole systems perspective. In effect they operated as senior 'system wide' managers that were able to work to both partnership goals as well as mobilize their own organizations contribution. Alternatively the lack of formalised incentives and rewards mechanisms raises questions about the sustainability of such commitment by senior managers. The development of a cadre of 'system-wide' leaders and managers appears central to networking and policy delivery on such cross cutting issues.

The history and maturity of relationships between individuals and organisations is one of the basic ingredients for networking and collaboration. There were clear variations in this organisational social capital between the four case studies. Investment in institutional capacity for interactive working around a common priority is critical to the development of integrative strategies and their implementation. The experience of the HAZ case studies (that had more organisational social capital than non-HAZ case studies) implies that the capacity for network management nationally is underdeveloped. HAZs provided for this investment in capacity for inter-agency working strategically and operationally. But it was important that existing mainstream processes were used and built on. Existing 'social capital' within the networks should be fully exploited (Ostrom 1990). Furthermore a certain level of capacity may represent a prerequisite for network management and bringing about the necessary strategic engagement of players and change within the system. The focus needs to be on enabling the different players to engage with the problem and explore solutions.

The actual process of network management ie processes for interactions between players had to be serviced and managed by some form of designated management resource, even if this builds on existing processes for joint working. Investment in research, evaluation and sharing learning appears important in fostering a culture of innovation, learning, and review, and a focus for influencing changes in the mainstream services and ways of working.

The issue of *distribution of power between players, and the extent to which locally deprived groups and communities* were genuinely engaged was problematic. The presumption that social capital can yield health (and other social, economic) benefits suggests that the condition of the community itself is the main precondition for involvement (eg Cabinet Office 2002). Network theory postulated that network management could shift power balances to benefit policy objectives. In principle local legitimisation of action on health inequalities could come from communities or their representatives. There are examples from other sectors such as housing of how this can be done. Mechanisms and forums can be established to hear the views of disadvantaged groups. For example, Ann Powers' work on housing in Birmingham showed how the setting up an Independent Housing Commission provided a mechanism for listening to people and making practical recommendations, such as the creation of thirty five community-based housing organisations (Independent Housing Commission report, 2003). But some studies of social capital have indicated the difficulties of trying to involve 'communities' that actually don't exist. For example Chanan (2002) comments:

> ...These neighbourhoods exhibit not only income and material disadvantage but also fractures in the cohesiveness of the community itself...Asking people in such situations to be involved in and as communities is to ask them to help in the management of the crisis in which they are embroiled, to re-embed themselves in a locality which has been cut from under their feet.

Chanan states that a more 'penetrating' approach to community involvement is required that supports more intense community development work. For example studies by the Centre for Analysis of Social Exclusion demonstrated that deprived estates could be 'turned around' through the development of a variety of small-scale community and self help (Richardson L, Mumford K, 2002). Furthermore community involvement in the sense of representation on partnerships would not have been possible without the 'more strenuous, deep-rooted, long-term actions of residents themselves'.

Many of these challenges were reflected in the experiences of the case studies, and real shifts in power on the health inequalities agenda were not yet evident in practice. There were clear tensions between the centralist policy forces and empowerment locally of communities. The simple fact is that poor communities have little clout in local political systems. Little attention is given to their voices unless signs of tensions manifest as problems such as the local election of National Front councilors, or riots.

Local policy networks were a dominant feature of local systems and the 'rules of the game' proved difficult to change in ways that acknowledged the plural and complex nature of community representation and involvement. The findings echo those of other studies, particularly in the field of urban regeneration (eg Taylor 2000). 'Power' was perceived by respondents in this study to be 'dispersed' through the system, and linked primarily to financial resources. Statutory partners were viewed as dominating partnerships. Latterly PCTs were regarded as new powerful players holding large budgets. However in reality the acute sector held the status quo as the bulk of this money was already committed to hospitals. Furthermore, the limited participation of the acute sector in the health inequalities agenda was felt to hinder shifts towards more community orientated patterns of services or developments.

The ways of working of statutory agencies still discriminated against a more inclusive approach. The practical 'rules of the game', as expressed for example through commissioning processes, disadvantaged community participation. Voluntary sector was expected to modify their own values and operations to access resources, a finding highlighted by others (eg Power 1997). Trust was somewhat absent from relationships, with a sense of tokenism and manipulation felt in some cases.

The complex and plural nature of community representation does not fit with a 'management' approach. There was limited 'democratisation' of these policy networks and engagement of deprived communities and groups. HAZs provided opportunities to work with communities in a more systematic way. However community involvement in decision-making, particularly at strategic levels remained problematic, while more effective engagement was evident at project level. Furthermore, the targeting of particular communities reinforced perceptions of winners and losers and intensified tensions within and between communities. Real shifts in power balances appeared dependent on a strategic approach to engaging communities and on wider democratisation and devolution processes with the public sector. The importance of a strong representative democracy as the context for participation is a point emphasized by Lowndes (1995). The participation of deprived communities and groups as genuine partners requires significant changes of culture within institutions. Much more sophisticated thinking and commitment by statutory agencies is required. Local authorities plans to strengthen local democratic processes potentially provide the means for more genuine engagement. Local forums, and consultation processes could be a focus for local interagency partnership working. Such partnerships could provide important building blocks for neighbourhood renewal.

Network management will only be able to have a sustainable impact on tackling health inequalities if it operates within a local system that endeavours to democratise further its relationships with communities through new mechanisms. Network champions need to mobilise local support and community champions. More investment is required to build an infrastructure for networking with and within communities so that those most disempowered groups can actively engage with the agenda. The local authorities' new Cabinet scrutiny committees could be used as a focus for ensuring that both health and local authority agencies actively invest in engaging with deprived groups and are held to account. Network management will need to mean networking with communities in new ways. This will be the real challenge for local delivery of health equity.

Conclusion: health action zones as a new form of governance?

This thesis has examined the process of policy delivery for tackling health inequalities. This conclusion focuses on the future contribution of health action zones to this process.

The construction of the schema of 'collaborative policy delivery mechanisms' provided a valuable framework for defining different models of partnership for policy delivery (modes of governance), and for assessing their impact on local players progress in developing and implementing integrative strategies for reducing health inequalities. Application of the schema, through the empirical investigation, showed that the different models clearly operate simultaneously and the 'mix' changes over time and with local context. It was evident that over the study period there was progress towards the development of local strategies that recognized health inequalities as a strategic priority, despite various tensions and contradictions between the different models. Viewed against this background, health action zones did provide a distinctive model

of partnership working that could be categorised as network management. Furthermore our two health action zones were able to accelerate progress through the range of network management mechanisms that strengthened local players collaborative pursuit of health equity.

The most recent Labour policy developments for tackling health inequalities (discussed above) appear to reflect policy learning and be supportive to promoting network management and the contribution it can make to the process of policy delivery. In particular Health Action Zones are receiving three further years of funding, and are expected to align with Local Strategic Partnerships and Primary Care Trusts, to share learning and ensure their contribution is 'mainstreamed'.

Analysis of the implications of the study for network theory (above) highlighted the need for further attention to be given to understanding and promoting the contextual factors that provide the necessary conditions for network management to operate. Therefore if the learning and role of health action zones is to be mainstreamed these issues need to be addressed. Four specific issues appear central to creating the conditions for network management.

Investment in organisational capacity for collaboration

The HAZ funding was used to develop a focus and infrastructure for inter-organisational working. Funding was used to establish the network management mechanisms set out above. There will need to be investment in the building the organisational infrastructure for collaborative engagement if Local Strategic Partnerships, with Primary Care Trusts, are to act as the strategic focus for tackling health inequalities.

An early report of the national evaluation of Local Strategic Partnerships included findings from a survey of all English LSPs and highlighted the perceived issues and dilemmas LSPs face (Office of Deputy Prime Minister/ Dept of Transport, 2003). These reflected many of the issues that HAZs had experienced:

- Resources and capacity such as staff resources and financial resources for the support of the partnership, funding for joint activities and training and development needs
- Development of effective ways of working: structures, systems, processes and culture
- Developing wider and successful community engagement, and
- Relationship with central government.

There are also concerns that Primary Care Trusts at this stage will find it difficult to engage with the health inequalities agenda, given the scale and weight of health services priorities (Marks and Hunter, 2002). Early findings from a national mapping of emerging 'public health networks' indicates that these networks are at a formative stage of development (Killoran and Abbott, forthcoming). Their current focus is primarily supporting PCT deliver their agenda, and provide professional development support to public health personnel, although many aspire to develop a more multi-agency and disciplinary remit. At this stage tackling health inequalities is not high on the agenda, except for a minority. A small number of health action zones, such as Merseyside, and Manchester, have been linked into the development of public health networks and are starting to contribute to the development of broad based multi-agency capacity to support LSPs and PCTs take forward the public health agenda including the focus on tackling health inequalities.

However further central funding and support is likely to be required to establish robust mechanisms for network management.

Community engagement and democratisation

As discussed above engagement of communities in ways that could benefit health will demand a more sophisticated approach. Reducing health inequalities will be dependent on building of social capital in the most deprived communities and groups. Network management must therefore mean genuine engagement and empowerment of those worst off. Community involvement is by its nature complex and pluralistic, as the communities are themselves highly heterogenous with variable and fragmented infrastructures for engagement, for example through community and voluntary groups. A Local Government Association report indicates the challenge for LSPs. LSPs will need to be viewed as part of a range of new or reformed governance arenas:

> *The nature of involvement....needs to be assessed across the whole LSP 'family of partnerships' (not just) the composition of LSP boards...It is the veracity of the whole LSP circuitry that determines effective involvement-the area fora and town committees, the parish councils and area based partnership panels.... In general voluntary and community sector organizations and rural community councils are not seen to represent well the voice of black and minority ethnic groups.* (Stephens et al. 2002)

Health action zones highlighted the many difficulties and challenges involved in engaging communities and deprived groups in ways that could yield meaningful health benefits. While the study indicated that HAZs had variable and limited (although important) successes in engaging communities, much learning did take place on how health could be integrated into this broader governance approach. A strategic approach to community involvement offers the best prospects, making explicit the different purposes of community involvement and the mechanisms by which they can be achieved. The experience of HAZs shows that this demands investment in both developing the capacity of both the statutory and community sectors for engagement.

This involves review and coordination and harmonisation of the different organisations' community involvement policies and resources.

At one level the role of political representatives needs to be viewed as critical. Locally the role of the local authority cabinet lead on health, and the new health scrutiny committees, could be an important focus for democratic leadership, public debate and accountability on health equity. Local democratic forums could become an integral part of partnership and organisations' mainstream planning processes. However some of the most deprived communities do not have the capacity to participate. More intense and sustained community development approaches are required to work with some of the most socially excluded groups and communities.

Incentives and rewards for network leaders and managers

Health action zones were successful in attracting but also nuturing leaders (politicians, managers, community representatives) who acted as advocates as well as managers for health equity. Network managers understood the inter-dependence of organisations from a whole systems perspective and became adept at seeking 'collaborative advantage', and fostering a culture of trust and partnership working. The performance management framework, as discussed above, is a powerful driver of behaviours that supports or hinders collaboration. Defined contributions and actions for reducing health inequalities as a priority must be incorporated within the performance frameworks of the different organisations. However the way in which individuals' performance is judged is not the only incentive, as the commitment of many respondents was driven by strong personal motives to achieve equity as well as the kudos and development opportunity offered by health action zones. However sustaining such commitment is more fragile. If network management is to be a sustainable mode of policy delivery, the incentives and rewards for network leaders and managers must be

strengthened. In particular, the training opportunities and career pathways that support network management roles and competences will need to be understood and provided.

Study of the policy process

This thesis has contributed to the study of the policy process. Commentators have indicated that this is a neglected field of research and should be a focus for future investigation.

The need to further understand the processes of different modes of governance and their impact appears critical, given the political context that emphases 'joined up government', partnership working and 'new localism' as the mechanisms for achieving long term outcomes such as health equity. It is argued here that greater attention in the policy process needs to given to creating the conditions necessary to bring about a more optimum mix of governance modes; a better balance between central driving and local networking. This should recognise the politically intrinsic nature of the process of policy delivery.

Process evaluation of policy implementation is essential for policy learning. There are however major methodologies challenges, particularly relating to issues of attribution. The approach of realistic evaluation, used in the study, provided a valuable framework for thinking for both empirical investigation and theory development. In particular it provided a framework that allowed the role of context, both national and local, to be fully considered. Understanding how different forms of governance are likely to have differential impact in different contexts is a key research question.

Further research is clearly required for policy learning on how to bring about effective collaboration for action on health inequalities. The national

evaluation of Local Strategic Partnership and Neighbourhood Renewal provide some opportunities. However the certain areas appear to warrant focused investigation.

What is the capacity for network management nationally and how can this developed for effective integration of health inequalties within local strategies and programmes? What role do HAZs and public health networks play?

What are the roles of local politicians and community representatives in tackling health inequalities through partnerships working? What mechanisms are effective in building social capital within deprived communities and engaging people in disadvantaged circumstances in dealing with issues of health inequalities?

What are the backgrounds, experiences and competencies of effective network managers? What incentives are required to develop and reward network managers? What career pathways need to be available for sustained development of network managers?

An important research question is the extent to which network management is evident within central government and what is its contribution to the implementation of the Government's forthcoming *Delivery Plan for Health Inequalities.* One important indicator of progress would include whether the necessary context for effective local collaborative action on health inequalities were promoted.

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Appendix two: Fieldwork

Phase one interview schedule

Could you define how you are involved in the HImP and HAZ?

Public health goals and strategies

In your opinion what are your priorities for improving public health and tackling inequalities?

In your view is there consensus about these priorities amongst other key partners?

How will these priorities be taken forward within the Health Improvement Programme?

How will the HAZ contribute to taking forward these priorities?

What other strategies and initiatives do you view as critical for achieving these priorities? Why?

Partnership arrangements

What are the partnership arrangements for involving the key players?

What are the partnership arrangements for the HAZ? What is the relationship to the Health Improvement process and partnerships?

What is the relationship to other partnerships that you see as relevant?

Planned outcomes

How will the success of the arrangements be judged?

At the end of three years? Could you give an example?

At the end of the first year? Could you give an example?

Wider factors influencing progress

How are national policies helping or hindering progress towards public health goals?

In you view what is the influence of the White Paper *Saving Lives: Our Healthier Nation* on your local efforts to tackle health inequalities?

What are the main opportunities locally or nationally that are helping make progress?

What are the main barriers locally or nationally that are hindering progress?

In your opinion what are the main advantages of the new HImP/ HAZs for tackling health inequalities in comparison with the arrangements pre HImP/HAZs?

In your opinion what are the disadvantages of the new HimP/ HAZs for tackling health inequalities in comparison with the arrangements pre HImp/HAZs?

In your view are the partnership less or more effective in tackling health inequalities? Could you give examples?

Phase two interview schedule

Could you define how you are involved in the HImP and HAZ?

Partnerships

What are the (changes in) partnership arrangements for the Health Improvement Programme?

What are the (changes) in the partnership arrangements for the HAZ? What is the relationship to the Health Improvement process and partnerships?

What is the relationship to other partnerships that you view as relevant?

In your view how effective are these partnerships? Could you give examples? How would you describe the culture of partnership working?

How are deprived communities being involved? Could you give examples? How effective are these arrangements?

Local strategies and health inequalities

How are inequalities in health being addressed through the Health Improvement Programme? Could you give an example/s of what has been achieved?

What progress has been achieved by the Health Action Zone in tackling health? Could you give an example/s of what has been achieved?

What is the key learning from the Health Action Zone? How is learning being used?

How has the Health Action Zone changed ways of working and wider strategies? Could you give examples?

What if the area had not been a Health Action Zone? What would not have been achieved?

How are inequalities in health being tackled through the Community Strategy?

How are inequalities in health being addressed through the Neighbourhood Renewal Strategy?

How has your organizations contributed to addressing health inequalities? Could you give examples?

Where is the leadership for tackling health inequalities locally?

Where is the power for tackling health inequalities locally?

Outcomes and performance

What have been the benefits for deprived groups and communities? Could you give examples?

How are national policies helping or hindering progress towards public health goals?

What are the main opportunities locally or nationally that are helping progress?

What are the main barriers locally or nationally hindering progress?

How is the performance of your organisation in tackling health inequalities being judged?

How is your own performance being judged?

Appendix 3: Summary of case studies' context profiles 1999

(at stage one of the study)

Bradford: HAZ area

Bradford displayed a combination of features that in principle provided an ideal test bed for the HAZ initiative. Indeed the point was made that 'HAZ was made for Bradford'. In particular, well established collaborative relationships between the health authority and local authority, and understanding of health inequalities in the district, provided a state of 'organisational readiness' to take the agenda forward. Important contextual features included:

- Bradford covers a population of 486,000. It is a young growing population with a high proportion of people from black and ethnic minority groups.

- Bradford had a history of a textile and manufacturing economic base that suffered decline with the economic recession. Despite experiencing some economic growth this had been variable and patchy. Bradford had a particularly poor record of educational attainment, producing a poor skill base for future investment.

- There are areas of severe poverty and social exclusion within the district, concentrated particularly in Bradford city, Keighley and certain housing estates. Marked health inequalities mirror this pattern of deprivation, (exemplified by major variations in coronary heart disease, diabetes and mental health across the district).

- It was felt that Bradford had an image of not being dynamic or attractive. There was a sense of low expectation and esteem within some communities and professional working.

- Bradford HA was coterminous with Bradford Metropolitan City Council.

- The Council was strongly Labour. It was planning the implementation of cabinet management arrangements.

- Four Primary Care Groups had been established, serving populations of between 90,000 and 147,000. Primary care services and facilities were judged to be particularly poor in parts of the inner city and Keighley, with a high proportion of single handed practices and difficulties of GP recruitment.

- There was a strong base of joint working between the HA and LA especially in areas of health and social care and health promotion. A number of important joint policy and planning mechanisms and multi-agency forums had been established over the previous four years (Health Strategy Group and Bradford Congress) which had served to deepened relationships particularly at a senior level.

- There were judged to be comparatively strong links with the community through the work of the LA's community development function, and the area committee

structure (based on the 5 parliamentary constituencies) and neighbourhood panels.

- The 3 NHS Trusts were working to clarify roles and areas for future collaboration in the light of the reform agenda. There was felt to be a history of strong competitive behaviour relating to the internal market. The future of the Community Trust and Airedale Trust was viewed as linked to be the future creation of PC Trusts.

- The total NHS and Council mainstream budgets for 1999/2000 were of the order of £306m and £450m respectfully (excluding earmarked allocations/grants). Bradford HA was significantly below target and anticipated receiving recurring growth allocations. Bradford was receiving a HAZ allocation of approximately £9m for the 3 years 1999/2002 (excluding specific HAZ-related allocations).

Birmingham: non-HAZ area

Birmingham was characterised by its scale and complexity, both in terms of the public health agenda and the management task of health improvement. Important contextual features included:

- Birmingham covers a population of about one million people. Approximately 22% of the population are children (0-14). Almost a quarter of the population is from black and ethnic minority groups, with high concentrations in particular parts of the city.

- Parts of Birmingham suffer severe deprivation and poverty. Birmingham ranks 5th in the country on the National Index of Local Deprivation. Infant and child health are worse and healthy life expectancy shorter in Birmingham in comparison with many other cities with similar socio-economic profiles. There are marked health inequalities within the district. For example there is a two-fold variation in death rates in coronary heart disease between areas.

- Birmingham HA was coterminous with Birmingham City Council.

- The Council had traditionally been Labour run. There was a new Council leader, and new political management processes were being established as part of the Modernising Local Government agenda. Locally, the setting up of the scheme of Local Involvement Local Action (LILA) and improved the functioning of Ward Sub Committees (39) were the Council's approach to strengthening local democracy.

- Twelve Primary Care Groups had been established, serving populations of between 62,000-127,000, and based roughly on the constituencies of Birmingham. The 1988 Annual Public Health Report documented marked variations in the level and quality of primary care services across Birmingham and a mismatch in relation to level of need.

- There was a long history of difficulties relating to agreement and implementation of plans for the future configuration of hospital services. This issue had in the past, dominated a great deal of both political and public debate but there was felt

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to be an emerging consensus about the patterns of future developments.

- The history of joint working between the HA and Council had been variable and influenced by controversy and problems relating to hospital services.

- The total NHS budget for 1999/2000 is £784.8 million, an increase of £43.8 million on 1998/1999. £2.4 million was being allocated to PCGs to invest in citywide schemes or support local plans. The City Council budget was £1.977 billion in 1999/2000, an increase of £17m over 1998/1999. The voluntary sector received approximately £14m and £21m a year in grants from the HA and Council respectively.

Lambeth, Southwark and Lewisham: HAZ area

Lambeth, Southwark and Lewisham was experiencing tremendous change and major redesign. It was characterised by complexity with respect to the health inequalities agenda and organisational configuration within the district. Contextual features were:

- LSL covers a population of 736,000 (Lambeth 264,700; Southwark 229,900; Lewisham 229,900). It is a young growing population; 33% of the population is under 25 years. Approximately 25 % of the population is from a diverse mix of black and ethnic minority communities, including large numbers of refugees.

- LSL is the third most deprived district in the country (according to the Jarman Index). It has the highest rate of teenage pregnancies in the country. LSL is characterised by a complex pattern of deprivation and social exclusion, with variations between boroughs, and between and within PCG areas. These inequalities were reflected in the complex range of health problems.

- LSL health authority corresponded with the three boroughs of Lambeth, Southwark and Lewisham.

- The Councils were in the main Labour. They were implementing new political management structures based on a cabinet model.

- Six Primary Care Groups had been established, serving populations of between 138,000 to 150,000. Each borough contained two PCGs. It was anticipated that PCGs would progress rapidly to trust status, involving mergers, and becoming coterminous with the three boroughs.

- The history of partnership working was regarded as a sound platform for the HAZ, particularly at the interface of health and social. There was a strong acceptance of the need to work in integrated and different ways if enduring problems were to be effectively addressed.

- There was judged to be a network of active community groups and organisations, particularly in the field of children and young people. The local authorities had strengthened mechanisms for consulting and engaging communities in service planning and development. However there was as yet no systematic linking of

local authority community strategies with those of the health sector.

- NHS Trusts were undergoing substantial change and reorganisation with the implementation of London-wide hospital plans. Every trust was experiencing major reconfiguration or merger.

- LSL health authority received a revenue allocation of approximately £ 600m (including uplift and modernisation fund allocations). LSL HAZ receives an annual grant of approximately £5.4m over three years (1999/2003).

- LSL contained multiple new initiatives including two Sure Start schemes, Education Action Zones, an Employment Zone, New Deal for Communities, SRB budgets, a New Connexions pilot, Youth Justice pilots and Sports Action Zone.

Kensington & Chelsea and Westminster: non-HAZ area

The district faced a highly complex set of public health issues. Although the agenda was dominated by health inequalities, the local political context presented some challenges to a joint strategic approach to tackling the wider causes of ill health. Important features of the district included:

- KCW covers a population of approximately 390,000. This is a rapidly growing and highly mobile population. A high proportion of the population comes from a diverse range of ethnic minority groups, and includes high numbers of refugees and asylum seekers. Approximately one-fifth of the population is classed as non-white and some wards have particularly high concentrations of ethnic minority groups. Over 95 first languages are spoken in schools.

- Marked health inequalities are evident, associated with the pattern of deprivation, and well documented in Annual Public Health Reports and the Health of Londoners project. The gap between the wards with the worst and best health record was growing. The three worse wards were Westbourne, St Charles and Golborne.

- The health authority corresponded with the Royal Borough of Kensington & Chelsea and Westminster City Council.

- The two Councils were traditionally strongly Conservative. Future changes in council structures towards 'modern local government' were being developed slowly.

- Three Primary Care Groups had been established: Marylebone (104,000 registered population), South KCW (167,000), Westway (152,000). The PCGs were not coterminous with the local authorities, with two PCGs spanning both areas. Health inequalities were present in all PCGs, reflecting the pattern of severe deprivation within particular wards.

- There were two community health care trusts (each covering part of another health authority as well as part of the KCW), a specialist mental health care trust, two acute trusts and a variety of specialist and independent sector providers.

- There was a history of good partnership working in the area of health and social care. Recent initiatives had extended collaboration to other local authority departments. Both councils have mounted joint health strategy initiatives that had advanced areas of joint working in health promotion focused on certain diseases, but also a range of community development work targeting vulnerable groups.

   Although relationships have been productive at officer level, there have been difficulties in achieving effective and sustained involvement of elected members in the joint wider health agenda.

- A large Community Health Development Team within the health authority, was based on the previous health promotion department. It was viewed as considerable resource for promoting community development.

- The HA received growth allocations and was also subject to structural financial problems in its two acute trusts and with respect to funding of mental health and HIV services.

- Other initiatives within the district included an Education Action Zone in Westminster and two major SRB bids. Further bids were planned for Sure Start and Healthy Living Centres.