

King's Fund

Policy
PAPER



Authors

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FINDING OUT WHAT WORKS

Understanding complex, community-based initiatives

Finding Out What Works

BUILDING KNOWLEDGE ABOUT COMPLEX, COMMUNITY-BASED INITIATIVES

ANNA COOTE, JESSICA ALLEN AND DAVID WOODHEAD

The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through grants. We are a major resource to people working in health, offering leadership and education courses; seminars and workshops; publications; information and library services; and conference and meeting facilities.

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Forewords

The King's Fund has a long-standing commitment to promoting better health and reducing health inequalities. We recognise the importance of individuals taking responsibility for their own health, but know that opportunities to choose healthy lifestyles are not evenly distributed between different social groups. Those who are disadvantaged in society often find it much harder to give up smoking, eat well, take enough exercise and avoid other risks to their health. This may be because of poor levels of education and 'health literacy' or because of poverty and hopelessness associated with unemployment and social isolation. In addition there are many health risks that are largely beyond individual control, such as those inherent in poor-quality air, water and food, and in unsafe roads and heavy traffic. Disadvantaged communities are disproportionately vulnerable to these risks.

Efforts to influence individual behaviour will founder if they do not also address the reasons why people have unequal capacity to choose to behave in ways that are good for their health. That is why this paper addresses the Government's wider social policy agenda – its efforts to tackle social exclusion and to regenerate communities, through major social programmes such as Sure Start and New Deal for Communities.

We need to know whether, how and why such efforts make an impact on people's health. But finding out 'what works' is a considerable challenge. How should we seek out the best possible evidence about community-based initiatives that address complex problems with multiple causes? How should we deal with uncertainties when the evidence is inconclusive? How can we build knowledge over time and use it effectively to improve policy and practice?

This paper is intended to shed light on these questions. It contributes to the King's Fund's Putting Health First programme, which explores ways of developing a health system capable of improving health for all.

It has been greatly enriched by the international seminar series organised by the King's Fund, the Rockefeller Foundation and the Aspen Institute between 2001 and 2004. Our US colleagues have encountered similar challenges in relation to supporting and evaluating community change initiatives, and it has proved immensely useful to exchange ideas and information with them.

Niall Dickson
Chief Executive
King's Fund

The Rockefeller Foundation is a knowledge-based global foundation with a commitment to enriching and sustaining the lives and livelihoods of poor and excluded people throughout the world. We provide grants to help eradicate poverty and hunger, minimise the burden of disease, improve employment opportunities, increase the availability and quality of housing and schools, and stimulate creativity and cultural expression. While we do not – and cannot – have a presence everywhere, we work intensively in eastern and southern Africa, South-East Asia and North America.

In the United States, the growth in the number of poor urban neighbourhoods and the increase of persistent poverty has been a vexing problem on the national agenda. The economic expansion of the 1990s and national policies like the earned income tax credits for people on low wages reduced the overall number of poor people. But neither a strong economy nor a number of other philanthropic initiatives made a major difference in helping communities tackle more complex problems, such as how to get better schools, affordable housing or improved health outcomes. These challenges proved to be resistant to national policies and highly dependent on local conditions, local priorities, and local capacity to deliver services.

Starting in the mid-1980s, the foundation launched several community initiatives. By 2000, there were dozens of philanthropic initiatives to develop solutions, attract resources, and implement programmes that would improve the lives and livelihoods of families living in poor urban neighborhoods. Despite two decades of experience and a plethora of documents touting the value of locally driven initiatives, the lack of overall progress is troubling.

In 2001 we began a series of dialogues with the King's Fund and the Aspen Institute's Roundtable on Comprehensive Community Initiatives (CCIs) to share what we knew. We went beyond evaluation questions of what worked to exploring what we actually knew about the more complex questions of where, how and for whom. The transatlantic nature of these meetings allowed us to transcend our national biases and to compare and contrast the differences as well as the similarities.

After a series of meetings, we have a greater sense of the emerging nature of this field. Despite decades of trying, we still struggle to implement effective community interventions that bring together notions of participation, resident empowerment, and real partnerships between government agencies and community organisations. We have developed a better understanding of the narrowness of research and evaluation methods that describe or measure outputs and outcomes, but do not provide robust insights into the tensions, challenges and practices of actually implementing CCIs. We have also gained useful insights into the fragmentary nature of philanthropic efforts in the United States. These efforts have contributed to the current state of knowledge but have not advanced the agenda very far in 20 years.

This document and its companion from the Aspen Institute, *Building Knowledge about Community Change*, do not purport to have answers. But they are a record of our attempt to ask ourselves the difficult question of why we have not seen more progress, what else we need to know if we are to make a difference in this endeavour, and how else we might proceed. Our hope is that from this pause for reflection, we can come together to create a more informed agenda for action.

Julia I Lopez
Senior Vice-President
The Rockefeller Foundation

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Anna Coote
Jessica Allen
David Woodhead

Summary

Since 1997, there has been a growing interest in the United Kingdom in reducing health inequalities, regenerating disadvantaged neighbourhoods and ending cycles of social exclusion. The Government has invested unprecedented sums of public money in large and ambitious social programmes. Most of these are centrally determined, but designed to be implemented in partnership with local communities. All this is taking place within a political framework that strongly endorses an 'evidence-based' approach.

This policy paper asks to what extent these new social programmes are really evidence based, what is being done to find out whether they 'work', and how far their evaluations are helping to build knowledge to inform policy and practice in the future.

The King's Fund's interest in these questions arises from our long-standing commitment to improving the health of disadvantaged communities. Most of the social programmes that the Government has introduced since 1997 are highly relevant to this, because they have been designed to address many of the underlying determinants of health at community level. Therefore, it is important to know as much as possible about their impact and how to build on that knowledge and put it to use.

This paper contributes to the King's Fund's Putting Health First programme, which aims to develop an effective health system that gives priority to preventing illness and reducing health inequalities, not just providing health services. Understanding how knowledge is built and how evidence is gathered, interpreted and deployed is crucial to understanding the changes that would be needed to create such a system.

Our research partners

Our main partners in this project have been the Rockefeller Foundation and the Aspen Institute in the US, and the Cabinet Office and Health Development Agency in the UK, which – as major grant-giving, development and policy-making bodies – are all interested in these issues.

Initially, we intended to produce one publication from this work, but we found the UK and the US policy contexts were sufficiently different to merit two publications. The US report, *Building Knowledge about Community Change*, is summarised in Appendix 3 of this paper.

The research

The discussion set out in this paper is informed by a transatlantic seminar series, a programme of interviews with commissioners, policy leads, academic evaluators and paid workers (practitioners) in five major social programmes in the UK, an examination of case studies and a literature review.

Complex community-based initiatives

The programmes chosen for field research were:

- **Health Action Zones (HAZs)**, which aim to improve health in deprived areas
- **New Deal for Communities (NDC)** and the **National Strategy for Neighbourhood Renewal (NSNR)**, which seek to end social exclusion by improving health, education, employment, housing and community safety in disadvantaged neighbourhoods
- **Sure Start**, which aims to improve the health and well-being of very young children and their families
- **Local Strategic Partnerships**, which are the main vehicle for co-ordinating interventions in deprived localities.

HAZs were nationally evaluated between 1999 and 2003. The other programmes are still being evaluated. Two of the evaluations – of NDCs and Sure Start – are among the biggest ever undertaken, costing £16 million and £20 million respectively.

Case studies

Six case studies, from the UK and the US, were examined in the course of the seminar series. These help to shed light on key points about evidence, evaluation and learning.

The UK case studies are: **Healthy Communities Collaboratives**, which involve local people in evidence-based efforts to cut falls among the elderly; the **Employment Retention and Advancement Demonstration Project**, which measures the effects of offering specialised support to job seekers and low-wage workers; and the **Social Action Research Project**, which seeks to deepen understanding about community capacity building.

The US case studies are: **Plain Talk**, which replicates good practice in communicating with young people about sexual risks; **California Works for Better Health**, which seeks to trace pathways to better health through community-building and employment; and the **East Tennessee Foundation Peer to Peer Learning Project**, a programme of structured learning for community-based organisations and funding bodies.

Messages from the UK field research and case studies

Our interviews aimed to find out to what extent major UK social programmes were based on evidence, how they were being evaluated, and what barriers and opportunities existed to learning from the evaluations. Consistent messages emerged that were reflected by discussion of the case studies in the seminar series and were borne out in our literature reviews.

Evidence

Despite the claims made in official publications, the social programmes discussed in this paper are not strongly evidence based. There is a gap between the rhetoric of evidence-based policy and what happens on the ground, which is a great deal more complicated.

Interviews with those in central government make it clear that they have been designed, by and large, on the basis of informed guesswork and expert hunches, enriched by some evidence and driven by political and other imperatives. This is not surprising and will not, necessarily, lead to less effective interventions.

The research that forms the evidence base is the result of haphazard and unrelated decisions by funders and researchers, so acting only on what has been shown to work could greatly reduce the scope for activity, and inhibit creativity and risk-taking.

At local level, where practitioners are under pressure to deliver tangible results, there are few opportunities to reflect on this gap, to have their own experience recognised or to contribute to the evidence base themselves. This can generate confusion, exasperation and cynicism.

There can be serious tensions between two of the Government's stated objectives: evidence-based policy and practice, and local empowerment. When local people gain control of local decision-making, they may choose to be guided by 'common sense' and experience rather than the formal 'evidence base'. Our interviews show that practitioners are often faced with a lack of appropriate evidence and, even when it is available, they may lack the capacity, organisational support and resources to make 'evidence-based' decisions.

From the case studies it is clear that a rigorous approach to evidence can be combined with community development and capacity-building but only where highly specific and relatively straightforward health risks are concerned. There are other, generally more complex, health risks for which there is far less – or no – evidence of 'what works'. And in order to replicate 'what works' in different settings, a considered, systematic approach is important.

Evaluation

Complex, community-based initiatives are hard to evaluate because of their size and the speed with which they are being rolled out, and because they are trying to address multiple problems within shifting political environments.

Just as different stakeholders want different things from evidence, they want different things from the evaluation process. For example, politicians favour quick wins, while senior civil servants seek clear results that satisfy ministers. Researchers, meanwhile, prefer to pursue academic credibility and profile, and practitioners in the field want to secure funding and get help with improving local practice.

There is no shared, theoretical framework for evaluation across government departments or among evaluators. Experimental models such as randomised controlled trials (which are used, for example, in clinical research) may be difficult to apply or inappropriate for evaluating complex, community-based initiatives.

Multi-method evaluations are increasingly popular among social researchers, including the approach known as Theory of Change, which engages local participants in identifying goals and pathways for achieving them. However, there is not, as yet, any consensus about which methods are most suitable for which purposes.

Practical difficulties for evaluators include collecting and analysing reliable local data, and dealing with huge volumes of information. In many cases, national and local evaluations are running alongside each other, but do not always have integrated or even compatible aims or methods.

Local practitioners are less interested in the competing claims of different research methods, but many feel they lack the necessary skills and resources to evaluate local practice and that their own learning and skills are not being captured.

The case studies suggest that, if a project is to be subject to a randomised controlled trial, this must be made central to its design and purpose. Other methods are needed to show why things happen, how they can be replicated and whether they are worthwhile. The Theory of Change approach to evaluation can be useful in planning local projects, although it can be difficult to encourage communities to buy into the process and follow it through. Evaluators who contribute to community development and provide technical assistance can find it hard to remain objective, while communities may be confused about the evaluators' role.

Learning

Ideally, research findings and evaluations are part of a continuing process in which all involved are building knowledge over time that improves policy and practice. However, our interviewees in central government admitted that the Government has yet to develop a 'learning culture' and that some departments are reluctant to invest in disseminating and learning from findings.

Political imperatives, such as the need to demonstrate success within tight timeframes, also tend to inhibit rather than encourage learning. Local practitioners often say that they are too busy 'getting things done' to reflect and learn, and that they lack opportunities to learn from policy-makers, researchers or other experts, or from their own peers.

Overall, it seems helpful to focus on knowledge-building, rather than merely on promoting evidence-based policy and practice. However, this will require a synthesis of radically different cultures and philosophies about how people and organisations learn and change.

The case studies confirm that local practitioners and community residents must be able to contribute to the evidence base. They suggest that it is helpful to focus on releasing assets inherent in communities and developing the capacity of public sector organisations to enable them to engage with local people. Elements of successful peer learning are likely to include: sensitivity to individuals' learning needs; a rigorous and structured programme; a focus on action and results; and the development of strong networks.

Opportunities

There are significant opportunities for making better use of evidence and evaluation to improve policy and practice. There is a strong political will to intervene for social change, a chance to learn from a series of very large social experiments, and unprecedented levels of investment in evaluation to do so.

Government departments are committing new resources to public health research and developing evidence resources, while the Cabinet Office is making concerted efforts to develop shared standards for evaluation and to promote multi-method approaches. More government officials, as well as researchers, are coming around to the view that evaluation should seek to understand processes and systems and to facilitate learning, as well as to track progress towards targets.

Recommendations

All of these opportunities can be built upon and we make the following suggestions for increasing knowledge more effectively in future:

Evidence

- ✓ There should be continued investment in building the evidence base, but this should be in the context of broad-based, critical appraisal.
- ✓ There should be much more open discussion at all levels of the complex and varied roles that different kinds of evidence can play in helping to plan and implement social programmes.
- ✓ Evidence should be disseminated more widely in accessible forms, but the risks of oversimplifying should be more openly acknowledged.
- ✓ There should be more investment in helping people at all levels to acquire skills and techniques for using the evidence base effectively.

Evaluation

- ✓ There should be sustained investment in developing a wider range of evaluation techniques and working out the best ways of effectively combining multiple methods.
- ✓ More open and extensive dialogue is needed about the challenges of evaluating complex, community-based initiatives, the different functions of evaluation and the range of methods need to fulfil them.
- ✓ The value of involving practitioners in evaluation and learning from their experience should be more widely recognised – and skills and techniques must be developed to enable this to happen.

Learning

- ✓ The need for a stronger learning culture within government should be more openly acknowledged and addressed.
- ✓ There should be more widespread discussion about conflicting interests and competing philosophies, and how these influence the knowledge-building process.
- ✓ More efforts should be made to promote shared learning and organisational change at national and local levels.
- ✓ Sustained investment is needed to develop ways of facilitating peer-to-peer and organisational learning, and to bring them into the mainstream.

Conclusion

Above all, four broad changes are required:

- ✓ We need to acknowledge the tensions and problems and bring the debate out into the open – and we hope that this policy paper will stimulate reflection and debate among policy-makers, evaluators and practitioners.
- ✓ We need to develop a learning culture in government, among evaluators and practitioners in the field.
- ✓ We need to integrate the experience of practitioners and local residents with research findings.
- ✓ Most of all, we need to develop a more explicit understanding of the trade-offs required by the political context of the day.

Introduction

Since 1997, there has been a growing interest in the United Kingdom in reducing health inequalities between social groups, regenerating disadvantaged neighbourhoods and ending cycles of social exclusion.

To this end, the Government has invested unprecedented sums of public money in large and ambitious social programmes.¹ Most of these are centrally determined, but designed to be implemented in partnership with local communities. All this is taking place within a political framework that strongly endorses an 'evidence-based' approach;² or, to paraphrase the Prime Minister, Tony Blair, a commitment to doing 'what works'.³

This policy paper examines the role of evidence, evaluation and learning in contemporary UK social policy. It asks to what extent the major social programmes of the current Government are really evidence-based and what is being done to find out if they 'work'. It also considers how far the major evaluations of these programmes are helping to inform learning and build knowledge to improve policy-making and practice in the future.

The idea of exploring these issues arose from conversations between the Rockefeller Foundation in the United States and the King's Fund in the United Kingdom. The argument presented here is informed by a transatlantic seminar series, field research in the United Kingdom, an examination of case studies and a literature review. These reveal considerable discrepancies between political rhetoric and practical experience, as well as important but unresolved tensions between different objectives and interest groups.

This paper is intended mainly for policy-makers and practitioners interested in tackling the underlying causes of illness and health inequalities through community-based initiatives, many of which are likely to be at the sharp end of these tensions. Although we do not attempt to present a definitive analysis, we hope to stimulate reflection and debate, and to help develop a better understanding of what is required to build knowledge effectively.

The paper first addresses the context in which these questions arise. It briefly reviews the UK policy environment and how the key terms 'evidence', 'evaluation' and 'knowledge-building' are used in this discussion. It then sets out our study of the experience of those involved at different levels in complex, community-based initiatives – policy-makers, evaluators and local practitioners – before examining a selection of case studies that offer insights into evidence, evaluation and learning.

Finally, it considers the challenges arising from the discussion for those who shape policy and practice in the United Kingdom, and suggests some ways in which these challenges might be addressed.

In the course of the paper, we suggest the need for a more open and inclusive discussion about the unresolved tensions and dilemmas identified by our study. We make the case for developing a learning culture that gives priority to building knowledge, rather than just to promoting evidence-based policy and practice.

And we argue that knowledge should be built by integrating the experience of practitioners and local residents with research findings and with a more explicit understanding of the imperatives that shape policy-making in the United Kingdom.

1

Evidence, evaluation and learning

This section sets out the background to the study, explains who was involved and briefly describes the methodology. It examines the policy environment in which complex, community-based programmes operate. It considers the Government's commitment to basing policy on the evidence of 'what works' and its significant investment in evaluating social programmes that aim to tackle social exclusion, ill-health and health inequalities. The section ends by defining key terms: evidence, evaluation and knowledge.

Background

The idea for the study arose from a series of conversations in 2000–01 between the Rockefeller Foundation in the United States and the King's Fund in the United Kingdom, about the difficulties both organisations were encountering in finding out whether and how community-based initiatives were effective in tackling entrenched patterns of social deprivation and ill health.

The Rockefeller Foundation is a leading philanthropic grant-giver, which supports social change by funding innovative local projects and influencing public policy. The King's Fund's interest arises from its long-standing commitment to improving the health of disadvantaged communities. This requires action well beyond the provision of health services: it involves tackling the underlying social, economic and environmental factors that affect individuals' capacity to make healthy choices and their chances of living long and healthy lives.

Public health in its broadest sense embraces a wide range of policies and practices that influence the quality of day-to-day experience, especially for poor, vulnerable and socially excluded groups. Most of the Government's social programmes introduced since 1997 are highly relevant to public health and almost all have been designed to change what happens at community level. Therefore it is important to know as much as possible about their impact and worth, and about how to put that knowledge to use. As we shall see, this presents considerable challenges for policy-makers, for researchers and for practitioners at local level.

The study forms part of the King's Fund's Putting Health First programme, which is seeking to develop an effective health system – one that gives priority to preventing illness and reducing health inequalities, not just to providing health services. A key part of the programme is to examine how and why changes occur, or fail to occur. Understanding how knowledge is built and how evidence is gathered, interpreted and deployed is crucial to understanding change within the health system.⁴

Other organisations made important contributions to the study, including in particular the Aspen Institute in the United States, which had already carried out ground-breaking work on evaluating community-based initiatives, and the UK Cabinet Office, which has responsibility for improving standards of government-funded research. We also worked closely with

'You can only
review evidence
about things
you've got
evidence about.'

Government researcher

representatives of the Health Development Agency, the Neighbourhood Renewal Unit and the Treasury in the United Kingdom, as well as the US-based consultancy MDRC, and leading academic and government experts from both sides of the Atlantic.

Methods

Our report is intended to provoke a wider debate about the relationships between evidence, evaluation and learning and their implications for improving policy and practice. We draw our material from the following sources, which are described more fully in Appendix 1:

- a scoping study, including three workshops and 12 one-to-one interviews with policy-makers and practitioners working in community-based initiatives
- a transatlantic seminar series to exchange ideas and experience about evaluation, evidence, policy and practice between 2001 and 2004
- case studies commissioned and examined in the course of the seminar series, illustrating particular approaches to evidence-based practice, evaluation and learning
- field research in the UK from 2003 to 2004, providing a snapshot study of the experiences of government commissioners and policy leads, evaluators and practitioners involved in major social programmes
- an extensive review of literature relating to the seminar discussions, the case studies and the field research.

Transatlantic contrasts

We originally intended to produce one report, based on the seminar series. However, we found in the course of our transatlantic dialogue that the UK and US contexts were sufficiently different to merit two reports.⁵ There were three main differences:

- Most of the UK initiatives with which we were concerned were funded by the Government, while most of the US programmes that featured in our discussions were funded by independent grant-giving foundations.
- Because they were government-led, UK initiatives were happening on a much larger scale and developing at a much faster pace than those in the United States.
- Although most of the UK initiatives placed considerable importance on community empowerment and local action, the Government's involvement meant value was attached to meeting nationally defined goals and timetables, while most of the US initiatives gave more emphasis to local determination.

In spite of and partly because of these differences, our conversations with colleagues in North America were invaluable in understanding the issues involved, and in framing our analysis and interpretation of UK research findings.

The US paper, *Building Knowledge about Community Change*, by Patricia Auspos and Anne Kubisch, is summarised briefly in Appendix 3. Although it covers different ground and is written

'Evidence-based policy and cutting-edge innovation seemed to me rather a contradiction in terms.'

Senior government official

primarily for a US audience, it contains much that is highly relevant and useful for those in the United Kingdom and elsewhere who are interested in understanding the processes of community change.

The UK policy environment

Several related developments have helped to put the issues discussed in this paper on the map for organisations, such as the King's Fund, that are committed to social justice, equal opportunities and better health for all. These include a new interest on the part of the Government in bringing evidence and policy together; a substantial investment in new kinds of policy intervention for social change; a new commitment to building an evidence base; and new approaches to evaluation and learning.

Bringing evidence and policy together

In the past decade, evidence has taken on an increasingly prominent role in the process of policy-making in the United Kingdom.⁶ This is partly because post-war ideologies have become less prominent. Decisions are now seldom justified in terms of overarching philosophical goals, such as 'rolling back the state' and freeing the market, or 'increasing common ownership of the means of production'. Instead, decisions are justified in pragmatic terms, as seeking to achieve specified, practical results by whatever means seem most effective.⁷

Although this interest in basing policy-making on evidence can be traced back to earlier developments,⁸ it has intensified under New Labour.⁹ The Prime Minister, Tony Blair, famously declared that his was 'a party of ideas and ideals but not of outdated ideology. What counts is what works.'¹⁰

The implicit claim that ideology can be detached from evidence is debatable; it may be more useful to regard the commitment to 'evidence-based policy' as an ideology in itself.¹¹ But the important point for this discussion is that if the Government wants to do 'what works' it has to find out 'what works' and relate it in some meaningful way to its political priorities and decision-making processes.

In the field of health care, there has been a growing commitment to 'evidence-based medicine'.¹² In theory at least, this involves integrating clinical judgement, experience and expertise with the best available evidence from systematic research.¹³ The Cochrane Collaboration, founded in 1993, and dedicated to systematic reviews of international research findings on clinical interventions, helped to set new standards in what counts as evidence and how this might be integrated into clinical practice and health policy.¹⁴

The shift towards 'evidence-based medicine' that occurred throughout the 1990s was part of a wider shift in thinking about how clinical decisions should be justified, from autonomy based on professional status to shared knowledge based on clinical trials.¹⁵ The less the public trusted the 'men in white coats or grey suits' to look after their interests, the more important it became to show that professional judgements were based on documented findings from verifiable studies. Strengthening the role of evidence in decision-making was one way – for many, the most important way – to improve the quality of decision-making and restore public confidence.

The idea of 'evidence-based medicine' directly inspired the idea of 'evidence-based policy', but Labour's second-term commitment to 'delivery' raised the stakes again. As Davies and Nutley put it: 'Evidence about what to do, how to do it and how to ensure it happens became a focus for much activity in many parts of the public sector.'¹⁶

By 2002, those responsible for implementing policy at local level wanted, and in many cases were obliged, to base their investment decisions on evidence, as far as that was possible.¹⁷ The development of biennial spending reviews by the Treasury further increased the importance of ensuring that policies, programmes and projects funded by the public purse were able to demonstrate their effectiveness and efficiency.¹⁸

More broadly, a climate had been created that influenced funders outside government. Charitable foundations and other grant-giving bodies became increasingly keen – as did their US counterparts – to make 'evidence-based' decisions about how to spend their money and invest in evaluating their grant-aided projects.¹⁹

New kinds of intervention for social change

For 18 years, Conservative administrations favoured 'less government' in economic and (some) social affairs. The idea that government should actively intervene to address social problems returned to prominence in the United Kingdom with the election of the first Blair administration in 1997.

The current Labour Government has claimed to be committed to ending child poverty, eliminating social exclusion and, through these and other means, preventing illness and reducing health inequalities.²⁰ This has meant that it has had to address problems with multiple and interrelated causes: poverty, employment, family background, education, neighbourhood, opportunity, lifestyle and self-esteem among them.²¹

Since 1997, unprecedented amounts of public money have been invested in new programmes to reduce the number of families dependent on welfare benefits, to raise levels of employment, to improve public services, to breathe new life into disadvantaged and derelict neighbourhoods and to reduce health inequalities.²² Concerted action has been required from health organisations and local government, schools, local charities and community groups, families and individuals, to influence the range of factors that might, or might not, bring about desired change.²³

'What you do is dictated by politics and by what local people want. Then you find the evidence to back it up – and above all – avoid doing harm.'

Local practitioner

Some measures, such as changes in taxation and in school curricula, came directly from the centre in the conventional style of the post-war welfare state. Others are part of a new style of intervention that lays claim – whatever the reality in practice – to several distinct characteristics:

- **Innovation** There has been a premium on ideas and approaches that are, or appear to be, fresh.²⁴
- **'Steering, not rowing'** These interventions have been driven by the centre, usually with precisely articulated goals and timetables, but their implementation has ostensibly relied upon local initiative, energy and action.²⁵
- **'Joined-up' government** These interventions require a range of statutory and non-statutory organisations to work together in partnership.²⁶

- **A neighbourhood or locality focus** These interventions depend on a range of local activities.²⁷
- **Involving local people** These interventions are, allegedly, shaped and implemented through a process of community engagement, generating a sense of local ownership and control.²⁸
- **Experimental** This new style of intervention is usually part of a programme that is time-limited and meant either to stop or to become part of the mainstream activities of its partner organisations.²⁹

A new commitment to building an evidence base

A 1999 Cabinet Office paper remarked: 'Given how much experience there is of delivering policy, it is surprising how little systematic knowledge there is about what works... One reason is that more ideologically driven governments were not eager to rigorously assess delivery lessons. Another is that governments have only relatively recently invested substantial resources in evaluation...'³⁰

A sure sign of the Government's commitment to finding out 'what works' was the amount it invested in evaluating its programmes. In 2001, for example, it commissioned an evaluation of the New Deal for Communities (NDC), a programme aimed at tackling social exclusion at neighbourhood level. The programme itself covers 39 'pathfinder' partnerships and cost nearly £2 billion.³¹ The evaluation was to be conducted by a consortium of 17 organisations, headed by Sheffield Hallam University, and would cost approximately £16 million over four years.

The evaluation had three objectives: to provide evidence of 'what works and why' in neighbourhood regeneration; to assess the value for money and cost-effectiveness of the NDC programme; and to support the partnerships and programme in achieving high standards of performance.³²

In a parallel move, £20 million was invested in the evaluation of the Government's Sure Start programme, which aims to provide child care, early education and parenting support for children aged 0–3.³³

In the field of health policy, several initiatives underlined the new interest in an 'evidence-based' approach. In February 2000, the Public Health Observatories were launched, one for every English region, with a view to achieving 'a clearer national picture of health and health inequality' in order to 'track changes over time'.³⁴

Two months later, the Health Development Agency launched its HDA Evidence Base website and on-line database, which aim 'to provide access to the best available health improvement and health inequalities evidence and to enable and encourage evidence based practice'.³⁵

These developments coincided with the formal launch, in February 2000, of the Campbell Collaboration, an international network for preparing and maintaining systematic reviews of trial-based research evidence 'to meet the needs of those with a strong interest in high quality evidence on "what works"'.³⁶ While its older sister, the Cochrane Collaboration, was devoted to health care evidence, Campbell focused on the effects of policies in education, crime and justice and social welfare, many of which were likely to influence health and health inequalities.³⁷

New approaches to gathering evidence

Standards of evidence in the clinical field strongly favour randomised controlled trials (RCTs) and systematic reviews of controlled evaluations. As Sanderson comments, 'The "gold standard" for evaluation is seen as the experimental (or quasi-experimental) design';³⁸ however, these methods do not lend themselves easily to finding out 'what works' in complex, community-based initiatives. This view was echoed by a Cabinet Office paper in 1999: 'Even when there are serious evaluations, the range of factors that can impact on results makes it hard to draw definitive conclusions.'³⁹

Between 1997 and 2003, it was gradually acknowledged in official circles that a more flexible and creative approach to evaluation was required.⁴⁰ The NDC evaluation tender, for example, called for a pluralistic approach, including quantitative and qualitative research, 'theory of change' and cost-benefit analyses, but not for any kind of controlled trial.⁴¹

It was becoming clear that what mattered above all was the quality of research and getting an appropriate match between the research method, the nature of the intervention and the purpose of the evaluation.⁴² By 2004, the Chief Social Researcher's Office in the Cabinet Office had endorsed this view and was making concerted efforts to improve standards. Through its web-based *Magenta Book*, it was providing guidance notes on social research methods for policy evaluation and analysis.⁴³

Defining terms: evidence, evaluation and knowledge

The terms evidence, evaluation and knowledge are open to many different and contested interpretations.⁴⁴ Evaluation can generate many kinds of knowledge, yet not all knowledge is routinely defined as evidence.⁴⁵ Evidence can contribute to the building of knowledge, yet so do many other things, from many other sources.⁴⁶ Knowledge may be valued for its own sake, but in this context it is only as useful as the capacity of individuals and organisations to learn and change.⁴⁷

There are also profound differences between those who give priority to measuring and attributing the impact of any given input, in order to inform programme planning and performance management, and those who espouse complexity theory and evolutionary, holistic approaches to change.⁴⁸

We do not intend to stray into these debates, but to help define the terms used in this paper, we briefly address the following questions:

- How is evidence defined?
- For which aspects of community-based initiatives may evidence be sought?
- What methods can be used to gather and process evidence?
- What other factors influence decisions?
- What are the implications for knowledge-building?

How is evidence defined?

The HDA suggests that evidence can have a narrow or a broad definition. Narrowly, it is the product of scientific investigation. Broadly, it is information about a problem, its causes and solutions, from a variety of viewpoints and sources, including scientific investigation, research studies, expert opinion, evaluations, reports and reviews, good-practice examples, professional views, pilot projects and case studies.⁴⁹ It can be useful to distinguish between

'We haven't yet established a proper learning culture here. It's absent in government generally I think.'

Central government official

evidence generated by scientific investigation or other research methods, and knowledge drawn from the views and experience of professionals and lay people.^{50, 51}

It is not unusual for evidence from different sources to give contradictory or ambiguous messages, raising questions about how evidence is – or should be – gathered and interpreted, about the reliability of sources and about the uses to which evidence is put. For this discussion, we are not trying to reach definitive answers to these questions, but trying to understand the context in which they arise and set them within a broader framework.

What aspects of community-based initiatives can be studied?

Perhaps more important than defining 'evidence' is deciding what are the appropriate questions to ask when trying to understand whether an intervention 'works'. One obvious research question is: has anything changed, over a given period of time and, if so, what? Closely linked to this is: has the change been more beneficial than doing nothing or doing something else would have been and, if so, beneficial to whom? If there is a benefit, is it short-term or sustainable, and what makes it lasting or otherwise?

A further question is: if change has occurred, can it be attributed to the initiative? Questions about causation are usually the hardest to answer, especially in complex situations where initiatives are multifaceted and take place alongside other developments that may also effect change.⁵² How such questions are addressed – if, indeed, they are considered relevant – will vary according to whether one takes a linear or complex view of how change occurs.⁵³

It may be just as important to understand how an intervention has been implemented, and whether it has achieved interim objectives in terms of processes and outputs. And it will be important to know whether the intervention has been cost-effective and how it has been received by local residents. Cost-effectiveness can be calculated in different ways, taking a short-, medium- or long-term view, as well as a broad or narrow view, of how costs and benefits accrue.⁵⁴ What is well received may not be cost-effective. However, the value of a positive reception may need to be factored into the cost-benefit calculation.

There is often a desire to know whether a particular intervention can be repeated in another setting, or whether a small local project can be expanded to a larger scale. This raises questions about the specificity of an intervention: not just 'did it work?' but 'for whom and in what circumstances and why?' and 'how could it be replicated elsewhere?'⁵⁵

Finally, it may be necessary to weigh the impact of one initiative against that of others. Such a judgement about relative merits may have political or ethical dimensions, or involve a range of other considerations (see below).

What methods can be used to gather and process evidence?

Research and evaluation methods are set out in many other documents.⁵⁶ They include controlled and randomised controlled trials (see box overleaf), quantitative and qualitative research and analysis, observational and ethnographic studies, participatory appraisal and document analysis. Evidence gathered by these and other methods may be considered in different categories. These include systematic reviews, which, at their best, search, critically appraise and rigorously analyse literature-based research findings according to explicit criteria. Other categories include single studies, case studies and pilots, which employ a range of

RANDOMISED CONTROLLED TRIALS

Randomised controlled trials (RCTs) is a technique used in some evaluations (for example the Employment Retention and Advancement Demonstration Project), which involves randomly assigning a pool of individuals, with the same or similar characteristics, to either an experimental group that is eligible for the policy, programme, or project under investigation, or to a control group, which is not. As a result, any differences between the two groups on specific outcomes identified by the evaluators may be attributed to the effects of the intervention being studied.

research methods, and expert opinion, which may come from professional experts such as doctors or academics, or from lay experts such as local residents or individuals with personal knowledge of how to manage a chronic illness.

Each of these methods and categories has countless variations and researchers routinely engage in argument about their relative merits and relevance.⁵⁷ There are two main points to bear in mind for this discussion. First, different methods lend themselves to finding out different things, so their usefulness depends on the purpose to which they are put.⁵⁸ Second, no one method alone is likely to be sufficient to establish whether a complex, community-based initiative has 'worked'.⁵⁹

However, ways of collecting evidence have traditionally been ordered by researchers and others into a 'hierarchy' that is supposed to indicate which are more reliable.⁶⁰ There has been a tendency to put systematic reviews of RCTs at the top, followed by single RCTs, quantitative analysis, qualitative research, expert opinion, with lay people's views at the bottom.

This value-laden hierarchy has been challenged for many years as it has become more widely accepted that a 'multi-method' approach is required, especially where complex, community-based initiatives are concerned.⁶¹ As a senior researcher in the UK Cabinet Office told the Campbell Collaboration in February 2004: 'Privileging any one type of research evidence or research methodology is generally inappropriate for evidence-based government. The guiding principle for types of evidence that are appropriate for policy-making and implementation is: "what is the question?".'⁶²

'There are different stakeholders in different circumstances in different positions of power with differing criteria and expectations about what they want from any given policy.'

Senior government researcher

Theory of change

'Theory of Change' (ToC) is an approach to evaluation (see box opposite) that is relatively new to the United Kingdom.⁶³ It has not featured in the hierarchy and some dispute whether it is an evaluation method or chiefly a developmental tool.⁶⁴ It is important to this discussion because it was designed to address many of the difficulties of evaluating complex, community-based initiatives. It featured strongly in the seminar series on which this work is based, where we discussed some of the strengths and weaknesses of ToC, and ways in which this approach might be adapted in the future.⁶⁵

What other factors influence decisions?

Those involved in planning, commissioning and implementing social programmes may decide on a course of action for a range of reasons unrelated to evidence.⁶⁶ These may include the need to win over particular voters, the amount of money that is available and its sources,

THEORY OF CHANGE

Theory of Change (ToC) is an approach to designing, implementing and evaluating complex, community interventions. It tries to cope with their inherent complexity by establishing and elucidating all the interventions and outcomes required to bring about long-term goals. All partners and stakeholders involved in or affected by the intervention will work together to establish what is required at specific times to enable the desired changes to happen. These are then mapped graphically, providing a representation of the 'pathway for change'.

ToC is an adaptation of theory-based evaluation, first described by Carol Weiss in a 1995 Aspen Institute publication in the United States. It now has widespread application in the United Kingdom, and has been used in evaluations of Health Action Zones, New Deal for Communities and Local Strategic Partnerships among others. However, there are critics of the approach.

Critics say it implies that change happens in an ordered, linear way and that this is a rigid view. Moreover, because ToC strives to capture the complexity of an initiative, it can be cumbersome in practice, requiring inordinate time and skilled facilitation, and resulting in a product that is more complicated than practical. Finally, ToC does not resolve causality problems although its advocates claim that it can be combined with other methods to try to 'make a case' for causal attribution.

pressure from lobby groups, media exposure, internal power relations, personal preferences, political and ethical values, a desire to innovate and change course, and a need to produce measurable 'results' within a certain time. Any or all of these may prompt a decision to act with little or no regard to evidence.⁶⁷

Such decisions may not be bad ones. Some of the most successful public health policies (such as outlawing child labour and building sewers) have been based on good hunches, some knowledge and little or even contradictory scientific evidence.⁶⁸

Conversely, evidence that a health measure works may not justify its introduction. For example, compulsory contraceptive injections for particular groups of girls would reduce teenage pregnancy rates, but the dangerous implications for race relations, social cohesion and civil liberties would outweigh the potential health benefits. What is known to be effective may not be appropriate or ethical.⁶⁹ Other factors help to put evidence into perspective and may provide a more useful guide to decision-making in some circumstances.

What are the implications for building knowledge?

In our view it is helpful to understand evidence and evaluation as two components among others in a process of continuous knowledge-building.

There are, of course, many theories and debates about how knowledge is constructed.⁷⁰ We use the term 'knowledge-building' to convey a creative process of understanding, learning and changing that helps to create the conditions in which evidence can be gathered effectively and used appropriately to improve policy and practice. As such, it involves:

- gathering evidence and insights about programmes and projects through evaluation and other forms of appraisal

- drawing on practice and experience as well as on research
- critically appraising different kinds of evidence and insights, as well as other factors influencing decision-making and change
- taking account of how evidence and other factors interact with each other, and of how they are shaped by context and time
- understanding how individuals and organisations learn
- disseminating evidence and wider knowledge to facilitate learning
- engaging critically with developing ideas about the complex ways in which change occurs.

It is beyond the scope of this paper to examine all these dimensions in depth. We focus primarily on the contribution of evidence and evaluation, and on links with organisational learning. Next we turn to the practical experiences of those involved in commissioning, evaluating and implementing complex, community-based initiatives.

2

Voices from UK social programmes

This section examines five major UK social programmes designed to improve the health and well-being of poor and disadvantaged communities. It considers how far they were based on evidence; how they were being evaluated; and to what extent knowledge gained from evidence and evaluation was being used to improve policy and practice. It draws on interviews with senior civil servants, academic evaluators, and practitioners working with those communities.

To help shed light on the role of evidence and evaluation in building knowledge about what works, we conducted interviews with people involved in five major UK social programmes. These were: Health Action Zones (HAZs), the New Deal for Communities (NDC), the National Strategy for Neighbourhood Renewal (NSNR), Sure Start, and Local Strategic Partnerships (LSPs) (*see box overleaf*). All are expected to influence, in various ways, the health and well-being of poor and disadvantaged communities.

The first four programmes share a number of characteristics:

- They are intended to tackle intractable social and economic problems.
- They have ear-marked budgets.
- They are led from the centre and implemented locally.
- They are based on cross-sectoral, locally based partnerships.
- They aim to involve local communities in planning and delivery.
- They are intended ultimately to influence core public services.

Local Strategic Partnerships are central to the implementation of all four of these programmes. Further details are set out in Appendix 2.

Each of these programmes has been planned and commissioned within central government by senior civil servants. These are policy leads, responsible for developing and realising policies based on ministerial decisions. They usually work closely with senior research staff, whose job is to ensure, as far as possible, that the programmes are based on evidence and properly evaluated.⁷¹ Both groups are accountable to government ministers.

Evaluation has been contracted out to independent academic consortia, led by a senior professor and including teams from several universities. Their job is to evaluate the programmes according to the terms of the contract. Most evaluations were still under way at the time of writing.

Out in the field, the programmes are being implemented at local level by many thousands of paid workers, variously equipped with skills in health promotion, community nursing, community development, regeneration, housing, child care and education. As far as it is possible to generalise about such a diverse group, their time is spent planning and managing local delivery systems, recruiting and developing staff, negotiating with residents and other stakeholders, pitching for funds, handling budgets and coping with crises.⁷²

'The politicians want to say "yes this policy works" – a "no argument" type of answer. A more likely result is "these aspects work with these populations under these conditions" – and some might not work at all.'

Evaluator

FIVE COMPLEX COMMUNITY INTERVENTIONS

Health Action Zones (HAZs)

Health Action Zones were launched in 1998 to tackle inequalities in health by concentrating on some of the most deprived areas in the United Kingdom. They were partnerships between the NHS, local authorities, the voluntary and private sectors and community groups, and were co-ordinated locally by a partnership board and had two main roles – to improve health outcomes and reduce inequalities, and to act as 'trailblazers', developing new ways of working to tackle health inequalities.

HAZs were rolled out in two waves. There were eventually 26 of them, covering 13 million people. They were originally intended to run for seven years, but since 2002/03, most HAZ functions have been incorporated into primary care trusts (PCTs). HAZs were allocated a total of £320 million for their first three years, about one per cent of the overall NHS budget. A national evaluation of HAZs ran from 1999 to 2003, funded with £1 million from the Department of Health.

New Deal for Communities (NDC)

The New Deal for Communities began in 1999 and was one of the first programmes in the government's strategy to tackle the multiple causes of deprivation in the most disadvantaged areas of the country. The NDC is centrally funded but delivered through locally based programmes, with partnerships that are meant to involve community organisations. Each programme must focus on five key policy areas: health, education, worklessness, housing and the physical environment, and crime.

NDC is now a pathfinder programme for the National Strategy for Neighbourhood Renewal (NSNR) and operates from the Neighbourhood Renewal Unit, which is part of the Office of the Deputy Prime Minister. There are currently 39 partnerships, funded for 10 years. The total funding is £1.9 billion – around £50 million for each programme. A large-scale evaluation of the NDC programme, costing £16 million, began in 2001.

Neighbourhood Renewal

Neighbourhood Renewal is based on *A New Commitment to Neighbourhood Renewal: A national strategy action plan*, which sets out the Government's vision for narrowing the gap between deprived neighbourhoods and the rest of the country, so that 'within 10 to 20 years, no one should be seriously disadvantaged by where they live'.⁷³

It is also the Government's major programme for tackling areas of severe deprivation in 88 authorities in England. The aim is to deliver economic prosperity, safe communities, high-quality education, decent housing and better health to the poorest parts of the country. The authorities in the programme work with Local Strategic Partnerships (see overleaf). The Government has directed funds to them through the Neighbourhood Renewal Fund (NRF).

The NRF provided £900 million from 2001/02 to 2003/04. The Comprehensive Spending Review 2002 made available an additional £975 million in 2004/05 and 2005/06 and the Comprehensive Spending Review of 2004 a further £525 million, although, at the time of writing, this had not been allocated.

Other programmes within Neighbourhood Renewal include NDCs, the Neighbourhood and Warden Management Team, the Deprived Urban Post Office Fund and, from April 2004, the Single Community Programme. In addition, the £21.6 million Skills and Knowledge Programme is a learning and development strategy for all involved with neighbourhood renewal (see p 14). Currently, evaluations are under way for NDCs, the Neighbourhood Management Pathfinder Programme, and the Skills and Knowledge Programme. The initial Neighbourhood Wardens Programme evaluation was completed in 2003.

Sure Start

Sure Start is a part of the Government's drive to tackle child poverty and social exclusion. It aims to improve the health and well-being of children and their families before birth and from birth to age 4. The Sure Start Unit is jointly based in the Department for Education and Skills and the Department for Work and Pensions. The first local programmes were set up in 1999 and there are now 524, covering up to 400,000 children in disadvantaged areas.

Sure Start local programmes aim to bring together providers of early education, child care, health and family support. They also aim to increase the availability of child care, improve health, education and emotional development for young children, and support parents and help develop their employment opportunities.

Sure Start's budget has risen from £800 million in 2002/03 to more than £1.5 billion in 2005/06. A large-scale evaluation of the local programmes is under way and will finish in 2007. It will cost £20 million: £18 million for the national evaluation and £2 million for support for local evaluations.

Local Strategic Partnerships (LSPs)

LSPs were introduced in 2000 to help tackle social exclusion and enable renewal of deprived neighbourhoods. They are non-statutory, non-executive organisations, aligned with local authority boundaries. They are meant to bring together public, private, voluntary and community sectors into a single partnership to work together to reduce levels of deprivation and ensure that different initiatives and services support each other.

There is currently no requirement for local authorities to have an LSP, unless they are one of the 88 areas in receipt of neighbourhood renewal funds (see p 14). If they are in receipt of such funds, the LSP must prepare and implement a community strategy for the area, develop a local public service agreement, and deliver a local neighbourhood renewal strategy. A national evaluation of LSPs, costing £1 million, began in 2002 and will probably run until 2007.

The programmes are intended to benefit, and often directly involve, many hundreds of thousands of local residents, with a vast and varied range of experience, knowledge needs, skills and opinions. Many local residents work alongside the paid staff as volunteers.

We interviewed senior civil servants and academic evaluators for each of the programmes, while at a local level we interviewed paid workers, who are described here as 'practitioners'. We interviewed paid workers rather than local residents because they are more likely to have

direct responsibility for basing decisions on evidence and contributing to evaluations. Our limited resources obliged us to choose between the two.

Interviews were recorded and transcribed. Passages quoted in this paper were checked and approved by the interviewees. As far as possible, their observations were cross-checked and corroborated by other interview material and supporting documentation.

We were not seeking to find out whether the programmes themselves 'worked'. Our interviews focused on three main lines of inquiry:

- **Evidence** How far were the programmes in which the interviewees were involved based on evidence?
- **Evaluation** How were the programmes being evaluated?
- **Learning** What were the barriers to, and opportunities for, learning and changing?

This was a small, snapshot study. But the quotations represent consistent messages, emerging from a range of interviewees. The discussion points echo those raised by many participants in the seminar series and are borne out in much of the literature we have reviewed.

How far were the programmes evidence-based?

Claims were made for the 'evidence-based' nature of all the programmes in this study, although there were different interpretations of what counted as 'evidence' and what amounted to an 'evidence-based approach'. Most of our interviewees at the centre agreed that: there was little appropriate evidence on which to base the planning and commissioning of programmes; different kinds of evidence could provide conflicting messages; evidence was used selectively; and other factors were often more influential in making key decisions. Local practitioners expressed similar views, although their experience of working with, or without, evidence was inevitably different from that of civil servants or academics.

Claims of an 'evidence base'

The official literature for all the programmes with which we were concerned claimed they were based on evidence. For example, the documents introducing HAZs declared that 'one of seven underpinning principles' of the programme was 'taking an evidence-based approach'.⁷⁴ The HAZs were also described by one of our interviewees, who contributed to their evaluation, as 'part of the general thrust towards policy being more informed' in that they represented an attempt 'to learn from both the good and the bad' of earlier area-based initiatives and to 'recognise their limitations and opportunities'.

The National Strategy for Neighbourhood Renewal (NSNR)⁷⁵ is on record as having been 'developed in response to evidence about the extent, nature and causes of neighbourhood deprivation, and analysis of how government and other public sector interventions could be improved'.⁷⁶ It draws on reports by 18 Policy Action Teams (PATs),⁷⁷ which were charged with 'reviewing the evidence across a range of different areas relevant to neighbourhood renewal' and bringing it together with 'informed opinion', as well as ensuring that 'lessons were learned through drawing on evidence of approaches that had worked in deprived neighbourhoods in England and abroad'.⁷⁸

The NDC has 'a huge evidence base about area-based initiatives in cities over the past 20 years', which was 'thoroughly reviewed by the Social Exclusion Unit', according to a senior member of the evaluation team. He argued: 'In that sense, the policy was evidence-based and NDCs were intended to redress past failures by really engaging the community, by really making

public services join together in relatively small areas, and by aspiring towards long-term mainstreaming of programmes which would last and be stable.'

Likewise, the recommendation to form LSPs was based on '20 years of evidence that many of the main organisations in Whitehall and locally had failed to integrate programmes, to pool budgets and share resources, so they didn't get a strategic view'.

Sure Start is reportedly based on extensive evidence about the impact of pre-school experience on achievements in later life,⁷⁹ including the 1998 Comprehensive Spending Review,⁸⁰ the EPPE study⁸¹ and the longitudinal evaluation of the US Head Start programme. Prime Minister Tony Blair asserted that the latter evaluation of these showed that 'for every \$1 invested in early years, \$7 is saved in better educational outcomes, better jobs, and reduced crime'.⁸²

National perspectives

Our interviews suggested that these official claims were too sanguine.⁸³ One official in the Office of the Deputy Prime Minister told us there had not been 'a lot of longitudinal work looking at outcome change in health, education, crime, housing and other things, and the connections between them'. It was this kind of evidence, he said, that would indicate whether the initiatives they were setting in train for neighbourhood renewal were likely to work – and it was the kind of evidence in which the Treasury was most interested. What they had instead, he told us, was informed advice 'in the sense that people published a report saying this is what you should do'. Accordingly, much of the Neighbourhood Renewal Strategy was based on 'assumptions and expert hunches'.

This view was echoed by a research specialist in the same department. He pointed out: 'You can only review evidence about things you've got evidence about.' One weakness in addressing social exclusion was 'the lack of sufficient evidence on preventive measures'.⁸⁴ His own view was that preventive measures were 'much more worthwhile in terms of value for money and sustainability than short-term reactive measures', although he wryly remarked that he could not claim to have evidence to back up his hunch.

An interviewee involved in evaluating the HAZs commented: 'If you ask if there was an explicit awareness of evidence as the basis of HAZs, I would say "not really".'

Selective use of evidence

A strong theme emerging from our interviews was that evidence was used selectively.⁸⁵ People chose to deploy it for certain purposes and not for others, and cherry-picked from the 'evidence base' whatever best suited their argument.

A member of the Sure Start evaluation team told us that Sure Start and Head Start were 'very different'. The evidence from the US programme was 'used to get the idea adopted and then largely ignored in the design of the programme'. Another team member agreed: 'We had the evidence that one thing worked and then the programme was designed in a different way. They [the programme designers] had a different agenda.'

A senior Whitehall figure involved in the same programme was unapologetic about a selective approach: 'You pick up an idea from here, there and everywhere and it's interesting and it answers some questions and raises others and you throw it in the pot... so you use evidence you want to hear.'

But a government research director struck a more critical note. Selecting parts of the evidence base and ignoring others could undermine a programme's effectiveness, she suggested. In the

case of the NRS, she was 'not sure evidence was used, except in a very headline way'. The strategy drew on evidence that area-based work did not become 'embedded and sustainable in local areas' without community involvement, but 'what that actually meant was not looked into in enough detail'.

It was easy, she said, to acknowledge that communities needed to be 'on board'. But there was a strong temptation to ignore the full implications of the evidence, which meant 'setting up specific community-led programmes and projects and ensuring effective community participation' – a far more challenging task.

Other factors influencing decisions

Many of our interviewees felt that political values played a greater part than evidence in developing programmes.⁸⁶ A leading member of the HAZ evaluation team was unequivocal: 'Overall, the HAZ initiative was value-driven, not evidence-based.' Frank Dobson, the Health Secretary who launched it, 'was very keen to get new money into disadvantaged areas... he was determined to seize the moment, to demonstrate that New Labour could do something'.

Similarly, one of the Sure Start evaluators said the programme was 'politically driven and value driven'; it happened 'because [Chancellor Gordon] Brown had the will'. A colleague agreed, saying: 'Research is never the engine for social change – policy is... research can give a push or a nudge in the right direction.'

A senior official confirmed that, while evidence from the US showed that multi-disciplinary interventions were more effective than single-track ones, a more important factor in developing Sure Start was how to get buy-in from different government departments. This was, inevitably, a political matter. 'Ministers wanted one outcome each, so there was a health one, an education one, a social care one, a worklessness one...'

A desire to act swiftly and to innovate often overrode efforts to base decisions on evidence.⁸⁷ A Cabinet Office report on the role of pilots in policy-making in 2003 pointed to 'frequent conflicts between the demands of the policy cycle on the one hand and rigorous evaluation on the other'.⁸⁸ Ministers were reluctant, it said, to let social research run its 'relatively ponderous course' especially when they were 'convinced that the results [would] confirm that the policy [was], after all, on the right track'. Everyone agreed that policy trials should take better account of such conflicts, but 'nobody proposed any straightforward way of resolving them'.⁸⁹

Several interviewees referred to the difficulty of reconciling innovation with an evidence-based approach. 'Evidence-based policy and cutting-edge innovation seemed to me rather a contradiction in terms', a senior Whitehall figure told us.

'As soon as you have local control then you can't tell the people what to do just because that is what the evidence says works!'

Senior government official

Another official noted that the NRS introduced new 'structures and infrastructures', so that even if there was some evidence about the effectiveness of a particular intervention, it was not known whether the institutional changes would 'impact positively or negatively on the intervention'.

Local perspectives

A research specialist in central government suggested there was seldom a comfortable fit between 'bottom-up' and 'top-down' evidence: that is, between the informed opinion of people in particular communities and evidence derived from academic research. 'When the aim is to tackle deprivation, to close the gap, would you come up with the same answer from each end? I suspect probably not,' he mused.⁹⁰

A senior civil servant put it more graphically. 'A key tension in all this evidence-based stuff', she said, is that the evidence strongly suggests that local control works better than control from the centre, yet when local people take control, they might choose to ignore other evidence. 'As soon as you have local control then you can't tell the people what to do just because that is what the evidence says works!'

Our local interviews confirmed much of this. Our interviewees all knew their work was supposed to be 'evidence-based', although they had widely different views of what that meant. Many agreed it was important to have regard for the evidence, but felt there was not enough that was relevant to their needs. They also used what was available selectively, to serve their own immediate purposes and to justify decisions that were mainly influenced by other factors. For practitioners, a major problem was lack of capacity to find, interpret and deploy the evidence base.

Using evidence at local level

Both the HDA and the NRU have websites designed to help practitioners navigate and use the 'evidence base'.⁹¹ However, as the HDA acknowledges, 'Making information available to practitioners does not necessarily or automatically lead to its application to practice.'⁹²

Many of our local interviewees found it impossible to keep up with new research and rarely used evidence as an 'upstream determinant of what you do locally'.⁹³ More often, they used it to justify prior decisions and to help them make the case for political and financial support.

Some said it gave them confidence when they had to defend ideas and projects against local critics and other professionals pitching against them for funds. Others said it provided pointers to how best to proceed locally, once objectives had been set.

The prevailing view was summed up by a public health practitioner: 'What you do is dictated by politics and by what local people want. Then you find the evidence to back it up – and also to get some clues as to how to do it well and, above all, how to avoid doing harm.'

Mostly, practitioners made it clear that they developed insights intuitively, through countless local conversations, observations and encounters. But they also tapped into tacit knowledge through formal and semi-formal engagement with local communities, using consultations, meetings, facilitated dialogue and other mechanisms.⁹⁴

'I am drawing on my own experience rather than any formal evidence base or advice,' said one practitioner in the NDC. 'A lot of it is bloody common sense. It shouldn't take a research study to find out that having to take two buses and over an hour to get to a hospital antenatal service deters women who are already facing disadvantage.'

Overload and frustration, as well as high levels of commitment, were common. It was not unusual to find that frustration directed at those who gave orders from the centre. One interviewee pointed out that his job was to implement national policies that were not themselves evidence-based. 'Yet we're expected to find evidence to support the implementation – I think that's contradictory.'

Insufficient and inappropriate evidence

A public health practitioner said he was trying to work in small neighbourhoods, where the need was greatest but the 'evidence base' at its thinnest. He felt the electronic databases merely exposed the paucity of relevant data and that efforts to distil evidence that was already flimsy or inconclusive could have vacuous results. 'They're combing things so much that they

comb out the nuances... What you're getting is headline statements, which actually I think any one of us could knock up on a Woodbine packet on the bus to work on a Monday morning.'

In general, the practitioners we spoke to said they found that formal evidence tended to reflect researchers' interests, not their own; it was often impenetrable or irrelevant and, when attempts were made to meet practitioners' needs, assumed they should be fed stories of 'good practice' rather than insights into processes or outcomes that might help them to improve delivery.

Many doubted the relevance of material relating to other circumstances and countries.⁹⁵ A public health worker in the north-east said: 'There are things on drug prevention that have worked in American cities with black youths that are just not transferable to the north-east of England because it's a different culture, a different kind of community.'

One interviewee reported his experience of pitching for funds with his commissioning authority. 'I'll say "let's push for elderly people". They say "fine". Then I say "I want half a million pounds for health improvement officers". They say "where's the evidence?" As far as I know there is no evidence, but then we go scrabbling around on the internet and I download some really useful things from the [United] States. You just spend a lot of time making it up ad hoc to fill the gaps.'

Problems of capacity

There were widely differing levels of research and analytical skills among practitioners in the field, which presents a severe challenge for those trying to provide route maps to the 'evidence base'. Many said they also lacked sufficient resources to find the evidence they needed. They had no money to commission others to carry out research. One NDC practitioner told us: 'I know there is some evidence there and I know what it is. But it's not my job [and] I don't think, when there are highly paid people, with endless training lavished on them, [and] there are copious numbers of them... I [should] do my own searches.'

A public health professional in the south-east described her efforts to produce an evidence-based audit of the local links between crime and health, using the unpaid labour of one undergraduate student at the local university.

Her aim was to persuade colleagues in primary care to be more active in working with the police and local council in their community safety partnership. 'We could have made it up. I am sure I could have got everyone to agree just by the force of my personality. But I wouldn't have felt happy as the whole thing was resting on rather scrappy knowledge. Even now it's on thin foundations because all I'm relying on is what one student did. Most of which I haven't examined in detail.'

Evidence: discussion points

- Official claims that major UK social programmes are 'evidence-based' oversimplify the position. They have been informed by some evidence and by views from a range of sources. There has been little or no systematic or critical analysis of the application of evidence and other kinds of knowledge to the planning and commissioning of these programmes.
- There are widely differing views of what 'evidence-based' means and of what constitutes evidence. There is no shared understanding between civil servants, evaluators and local practitioners about what kinds of evidence are reliable and useful.

- There is often a shortage of appropriate evidence on, for example, how to prevent ill health and other problems occurring, and on the effectiveness of community-based interventions in the United Kingdom.
- Serious efforts are being made at national level to build up a body of evidence that is based on rigorous analysis and to make it accessible to lay people as well as to academics and civil servants. However, the electronic databases that have been set up can include only existing findings, so their usefulness depends on the quality and scope of past research. They can also identify gaps in research. But where evidence is thin or inconclusive, distilling it for wider accessibility can rob it of nuance and thereby render it useless.
- Those responsible for designing and implementing programmes often proceed without evidence, or make selective and retrospective use of what evidence they can find, to justify prior decisions taken for a range of other reasons.
- In most cases, political imperatives and a desire to innovate have been more likely to drive decisions than adherence to the evidence base. This is neither surprising nor necessarily less likely to lead to effective interventions. It does, however, conflict with prevailing government rhetoric, which insists that decisions are or should be 'evidence-based'.
- There can be serious tensions between two political objectives: evidence-based policy and practice, and local empowerment. Local people may choose to be guided by 'common sense' and experience rather than by the formal 'evidence base', and this may lead them to different decisions from those that would be made by policy-makers in central government or by academic researchers.
- Some of the issues that local practitioners address do not appear to lend themselves easily to an evidence-based approach, either because there is a shortage of appropriate evidence and/or because the issue is complex and has multiple causes, while the available evidence refers to simpler problems and interventions.
- Even where useful evidence is available, local practitioners often lack sufficient capacity, organisational support and resources to make 'evidence-based' decisions.
- The usefulness of evidence in replicating good practice is open to question. It may depend on the quality and relevance of the evidence, the complexity of the problem that is being addressed, and how the evidence is interpreted and applied.

How were the programmes evaluated?

All the programmes in our study are subject to evaluations of one kind or another. This reflects a strong, government-backed consensus that evaluation is essential where public money is invested in area-based initiatives (ABIs). According to a report presented to parliament by the Deputy Prime Minister, John Prescott, in July 2003, all government departments endorse guidance that says 'any new ABI must have a clear evaluation strategy at the outset' and 'where possible, departments should co-ordinate evaluation for new initiatives with existing arrangements in order to minimise the bureaucratic burden on the front line'.⁹⁶

National perspectives

Officials responsible for commissioning programmes were keen to have them evaluated and wanted to make sure the evaluations were well designed, robust and capable of producing results that would be useful to practitioners in the field as well as to themselves and to their

political masters.⁹⁷ Our interviewees nevertheless identified considerable levels of confusion, disconnection and incoherence both within and between the different evaluations, as well as strong tensions between politics and research.

Purpose of the evaluations

One of the first difficulties brought up in the interviews was that the aims and shape of the programmes themselves were either unclear or in flux, sowing confusion in the planning and design of the evaluation.

The HAZ evaluation, as the earliest of those under consideration here, was probably developed more hurriedly and less strategically than some that came later.⁹⁸ The Department of Health was clear that it wanted the evaluation to focus on process issues: 'whole systems' change, partnership development and community participation'. But beyond that, the evaluation 'was based on a false premise', according to a senior academic, because (as noted earlier) the HAZ investment satisfied a desire to get resources out into disadvantaged communities, come what may.

The aims of the NDC programme were also unclear at the start, according to another interviewee, who said: 'Certainly there was a general hope that changes should be substantial, that they should be ambitious. But no one really knew what those ambitions should be.'

Similarly, the aims of Sure Start became 'nebulous', according to a further interviewee, after it changed dramatically in its initial stage, doubling the number of local programmes and then absorbing children's centres and neighbourhood nurseries, and incorporating additional targets.

A second, related difficulty arose from lack of clarity about the purpose of the evaluations themselves. This was often a direct consequence of confusion about the programme, but could also reflect inadequate planning and tensions between evaluation objectives.

On the face of it, the purpose of the NDC evaluation was clear: 'to provide evidence about "what works and why" in neighbourhood regeneration; to look at the value for money and cost effectiveness of the overall NDC programme; and to support the 39 NDC partnerships and the programme as a whole in achieving high performance standards'.⁹⁹

However, one analyst commented that it was quite difficult to marry up the desire of civil servants to show ministers what an investment of funds had achieved within a fixed period with 'having an ongoing active learning focus' (we return to this theme later).

Timing

Some difficulties arose over issues of timing: when should an evaluation start and how long should it last? The NDC evaluation, although carefully prepared, did not begin until the programme itself was well under way. As a result, the evaluators had no role in planning the early stages of data collection. 'All of the 39 partnerships had already been told to produce baseline information and, although they had been given some guidance, we ended up with 39 different baselines and it has been a major problem,' said a senior member of the evaluation team. 'The logical step would have been to bring the evaluation team in from the start. It would have saved so much time and resources in the long run.'

The Sure Start evaluation got off to an early start in order to obtain early results. A senior Whitehall figure explained: 'We felt if you couldn't measure an effect after two years then you're wasting a lot of public money anyway.'

'I can't imagine an evaluation having more data than we have, but by the time we have contextualised in terms of what's happened in the regions and nationally, I think we'll find very little.'

Evaluator

But how quickly effects could be measured was debatable. In real life, at ground level, things took longer than expected. An evaluator with the NDC told us: 'We originally thought that evaluation teams would get involved in looking at policy and practice in a small number of local partnerships on a particular policy issue and then we'd all learn from what was happening there. But of course it doesn't really work like that. Many of the partnerships have been slow to get things off the ground. And many of the big issues – well, it's not clear that the partnerships can do anything about them.'

The duration of an evaluation was also seen as significant. The NDC evaluation was due to last for ten years; Sure Start evaluators hoped theirs would be extended to at least 20, while that for the HAZs had ended after five years. One academic told us that the period covered by the HAZ evaluation was much shorter than the time needed to evaluate the impact of the programme, and the lifespan of the programme (curtailed after Alan Milburn succeeded Frank Dobson as Health Secretary) had itself been too short to make real changes.

Scale

The scale of the evaluations varied widely, from £20 million for Sure Start to just over £1 million for LSPs. An LSP evaluator spoke of the challenge of having to 'replicate some of the strength of the NDC evaluation with a lot less resources'.

Large-scale evaluations had their own problems. They all required collaboration by several different academic centres, and complex methodologies. One interviewee remarked on the difficulty of managing a 'large cohort of prima donnas' in several universities, in order to conduct a complex and extensive evaluation.

The scale on which the evaluators were working meant they could not easily answer the simple question 'does it work?'. One explained: 'We are answering a mega-evaluation question: "What kinds of interventions work for what kinds of communities, under what circumstances?" It may take time. The longitudinal study will follow children until they are adults.'

Such large-scale evaluations will yield a huge volume of information and some interviewees doubted whether it would even be possible to distil it into useful findings.¹⁰⁰ 'We'll have an absolutely huge amount of data,' said one academic. 'I can't imagine an evaluation having more data than we have, but by the time we have contextualised in terms of what's happened in the regions and nationally, I think we'll find very little. You might find more over ten years, but over two years I don't think we'll find a great deal.'

Another commented that evaluations of large-scale programmes tended to produce 'thousands of overlapping stories rather than definitive findings'.

Research frameworks and methods

Each evaluation had a different methodology. Some had a stronger theoretical framework than others. Most used more than one research method, including quantitative and qualitative analyses, to measure specific results and understand processes and relationships. They attached varying degrees of importance to tracking progress against targets and to facilitating learning at national and neighbourhood levels.

'I do think a framework of targets is important, particularly if they are outcome-based and focus people's attention on breaking down the unachievable into the achievable,' said one official. 'But the value of monitoring targets is only as good as the people who develop them. If they don't understand what it takes to reach the target, then the target won't help.'

Some evaluators made efforts to apply 'theory of change' (ToC) methods, which involve working with local participants to articulate goals and how they hoped to achieve them (*see box, p 11*). This approach has been designed to address some of the methodological challenges posed by complex, community-based initiatives. However, it was regarded by some as difficult to apply to initiatives that were part of a large nationally defined programme.

A senior academic involved in the HAZ evaluation told us: 'We tried to hang on to the "theory of change" perspective. The Department [of Health] were keen. But it rapidly became clear that a proper attempt to carry out a ToC evaluation was unrealistic. HAZs were too big, too scattered, too far removed from the evaluators... in a world where the evidence base is so thin it is unrealistic to expect people to have a linear view of what they are trying to achieve and how.'¹⁰¹

The lack of coherence in the theories and methods used by different evaluations was echoed in a report on research into area-based initiatives published in 2002. 'There is no clear methodology that is capable of identifying, firstly, whether the ABIs themselves contribute to more successful outcomes and, secondly, whether collaboration contributes further added value.'¹⁰²

The same report saw increased interest in 'theory of change' as a sign of progress. 'These approaches recognise the multiplicity of interests represented in many public programmes, and seek to reflect the inevitable variety of such interests and their contrasting views about what works, in what context and for whom.'¹⁰³

Most evaluations had to cope with central government changing the parameters of the programme after the evaluation had begun. 'Every six months, something changes and you have to be flexible,' said one Sure Start evaluator. 'I feel all this has been a good test of our design and it has held up... but it has created a few problems.'

Several interviewees expressed the view that the programmes did not lend themselves to experimental methods of evaluation, or that controlled trials would not produce useful results. A government research specialist said: 'You are just learning about things you have engineered, whereas we are interested in learning about the diversity and richness of what happens. The key thing is: have we learned something useful? Identifying the cause-effect relationship doesn't necessarily guarantee usefulness.'

The HAZ programme was too inclusive to introduce RCTs. 'Ninety-five per cent of disadvantaged areas were included, so controls were a non-starter,' said one evaluator. The same was true of Sure Start. 'The original design had comparator groups, but when they doubled the number of Sure Start programmes there were not enough control areas left to look at.'

In the absence of designated controls, the only possible comparison was between individual programmes that were launched earlier and later. However, this depended on effective baseline information. Gathering reliable and consistent local data was highly problematic, not least because of shifting boundaries for gathering small-area statistics. Sure Start programmes, for example, relied on postcodes rather than on electoral wards – and postcodes changed to suit Post Office requirements.

Efforts were also hampered by the poor quality of data available from central government departments. A Sure Start evaluator told us: 'Ofsted could only match 75 per cent of the postcodes for childminders; 25 per cent had gone missing. It's the same for crime. The indices for multiple deprivation had to miss crime out because the data was so poor.'

As in the case of Sure Start, NDC areas are smaller than ward size. This meant, according to one evaluator, that 'they were almost invariably dealing with surrogate data which didn't actually apply to the NDC area in question'. Sometimes, he told us, 'at partnership level it is impossible to get data to say actually what they are spending their money on'.

Another difficulty, we were told, was finding out how many families in receipt of services from one ABI were also receiving services from other ABIs. Without accurate local data, it was well-nigh impossible to discover whether a particular intervention was having a particular impact. This problem was endemic, as all the programmes in disadvantaged neighbourhoods overlapped to a greater or lesser extent.

Measuring change was all the more challenging when programme objectives were broad and complex.¹⁰⁴ 'Take regeneration as an example,' said a senior government researcher. 'It is not like measuring refuse collection or library books, where there are fairly unambiguous performance indicators. There are different stakeholders in different circumstances in different positions of power with differing criteria and expectations about what they want from any given policy.'

Evaluation or performance management?

We encountered a range of views about the relative merits of using evaluation to describe, explain, assess or manage what is happening on the ground.¹⁰⁵ A senior academic said of one major evaluation: 'We are almost monitors of the programme rather than evaluators.' Demands from central government, he said, were driving them towards performance management. 'We are reviewing the practice and delivery of the programme and we are not asking questions about the changing nature of the neighbourhood: who lives there, who moves in and who moves out? We haven't asked these things yet. And, methodologically, we are asking too many questions about what people think is happening and not enough about what is happening.'

A different view was heard in Whitehall, relating to another evaluation. 'There is actually no point in doing this unless you use it as a management tool... to improve the programme as you go along – not wait until it's all done and say "this is what we've learned" and it'll help someone else set something up.'¹⁰⁶

Political influence

Political influence was a strong theme in most of our interviews about evaluation.¹⁰⁷ A senior government researcher told us that when politicians were involved, especially when there was an election coming up, the clear message to evaluators was: 'Give us some tangible quick wins and a feeling of progress.' What really mattered, in her view, was being able 'to understand the processes and systems between the policy framework and delivering the outcomes... rather than going straight to the quantifiable monitoring to say whether something is working or not working'. However, politicians, she said, generally didn't want to hear about complex problems, such as barriers to progress arising from clashes between local partnerships and statutory bodies, 'and that creates a lot of tension'.

Another government researcher said that evaluators working in the field had to 'carry the can' for these tensions. 'We are managing processes, they are in the field collecting evidence, doing analysis and we are saying "hurry up, hurry up". And then we respond to ad hoc requests from ministers by saying "can you report on x, y, z?".'

Policy leads in government departments need evaluations to produce results that will help secure funding to keep the programme going.¹⁰⁸ As one official said of Sure Start: 'We have two

big problems in terms of the evaluation. One is whether the child outcomes are going to come in time for the next spending review, when the Treasury will be looking for solid evidence. The other is, of course, the next election.'

A senior official in another department said this could distort the way a programme developed. 'It becomes a policy game. You don't put certain targets into a delivery plan if you think the Prime Minister's Delivery Unit are going to come and check up on you. Which means that some of the more challenging and experimental stuff never happens. Because it's not a mutual learning process, it's a monitoring process.'

The same official agreed it was legitimate for the Treasury to want reassurance that the programme was on a trajectory that would lead towards delivery over ten years, and that the right things were being done to achieve this. He was aware of the virtues of being able to deliver good news: 'The more we can say about the impact and benefits our programme is having, the more helpful that will be in resourcing it in future.' But he felt that if there was too much pressure on local practitioners to deliver quick wins, it would 'divert them from putting in place the building blocks for a longer term strategy'.

He also pointed out that feeding the needs of the Treasury would not guarantee continuing government support: 'You've got the faddism of the politicians who might just say "let's lose it now, because it's been going for three whole years and where are your results?"'.¹⁰⁹

Some evaluators were more philosophical than others about the impact of politics on their work. 'You shouldn't be doing this kind of research unless you are aware of these kinds of pressures and to some extent sympathetic to them,' said one. Others were less sanguine; for example, one evaluator said: 'My research falls into a black hole because it doesn't fit with what politicians want.'

Presentation of results

There was clearly a tension between the values of independent, objective research, in which academics had an interest in building reputation through peer-reviewed reports, and the needs of government to receive simpler and more positive messages.¹¹⁰

'It's amusing to see ministers crowing about the success of the programme, but I don't think we have a clue yet,' said one academic. 'The politicians want to say "yes, this policy works" – a "no argument" type of answer. A more likely result is "these aspects work with these populations under these conditions" – and some might not work at all.'

'The more we can say about the impact and benefits our programme is having, the more helpful that will be in resourcing it in future.'

Official, central government

Government officials were acutely aware of the need to produce palatable answers. 'It's not just about short sentences and plain English, although that's important,' said a senior government researcher. 'It's more about making it clear what some of the key messages are for different stakeholders and understanding what their interests are going to be.' Another said: 'It's partly a marketing issue for the Treasury. They won't pore over masses of detail, they just want to feel somehow that this is working or not.'

Another senior official told us she expected to have 'classic rows with the researchers on how we write the summary report. Because that is what the press read – the summary report; and just the way you write it can have a huge influence – is the cup half full or half empty?' She added that learning about failure was as valuable as learning about success, but that press reports about failures in her programme could be very damaging. 'The difficult thing is managing media responses at the same time as using results to reshape and improve the programme.'

Several evaluators complained about officials trying to influence their findings. One said: 'They get the reports, they crawl all over them. They take out all the bad messages and then they publish them. Whether they look at them to improve policy, I don't know. "Give us some good news!" That's what they say.'

All this may be summed up by asking whether evaluators are consultants to government or disinterested outsiders. One interviewee told us: 'I have no illusions in my mind. When you are doing consultancy, as opposed to academic work, you work out what's going on, then go along to the person who is paying you and say "what do you want me to write?", basically. If you are doing academic work, you don't do that. The problem with evaluation, if it is not thought through properly, is that it sits between these two categories.'

A government researcher concluded that the whole area was bedevilled by conflicting interests and a failure to understand and confront such conflicts. He felt that this was primarily a challenge for politicians. 'Ministers are driven to spend money and want to see results. Unless and until they can be persuaded to take a longer view and invest in capacity-building and be more patient about outcomes, evaluations will be unsatisfactory.'

Local perspectives

Most programmes were being evaluated locally as well as nationally, with different aims and methods. The Sure Start Evaluation Specification for Requirements stated that 'the national evaluation should ensure that there is a collaborative, co-operative and sensitive relationship with local programmes... to minimise overlap and burden on parents, children and the local community as well as those involved in delivering the Sure Start programme'.¹¹¹

However, one Sure Start evaluator commented that it was a shame more thought had not been given to the relationship between the national and local evaluations. 'If they could reinforce each other, that would help get more bangs for your buck. For instance, one local programme has asked a university team to look at its maternity services, but they haven't all done that.'

The local interviews also reflected the confusion (discussed above) about the role of evaluation, at local and national levels.¹¹² Was it about checking on progress, measuring results or supporting and improving local practice?

An academic said of the NDC evaluation: 'This is not an experimental model, it is more a "critical friend" support role. But there is a real dilemma in evaluation about whether we are supposed to be helping the 39 areas to work their way through what they are doing. Should we get alongside local groups, or are we the department's objective evaluators who are not necessarily friendly at all? There is a real tension within the contract about that.'

A senior government researcher pointed to the risk of putting out confusing signals, so that local people would just see evaluation as 'all mixed up with monitoring as to whether they are performing against hard targets and meeting ministerial expectations, not as something that is going to give them information to help them improve their lives'.¹¹³

There were also worries that too much was being demanded of local people. 'Local programmes are bombarded with evaluation... it's an easy way to get people's backs up about research... one more burden to put up with.' Similarly, we were told by a HAZ evaluator that local participants in the HAZ programme were 'unable to keep up with evaluation on the ground... it was too complex and difficult to do local evaluations'.

At the same time, practitioners wanted national evaluations to show positive results: 'Public health activists wanted instant feedback and support,' said one evaluator. 'They wanted to demonstrate that their actions had been effective. People had a vested interest in projecting success.' A central government official told us: 'Communities will disengage if there is no evidence of improvement. I'm afraid they won't wait for six or seven years, either. So you have to focus on things that can be done in the short term to give you visible impact.'

Practitioners' views

For Sure Start practitioners, there was a formal requirement to carry out local evaluations to run alongside the national programme evaluation.¹¹⁴ Some practitioners working with LSPs and PCTs were engaged in practice-based evaluations; others were not, although most recognised the value of doing so, provided they had confidence in the quality of the research.

At best, practice-based evaluation helped them find out whether they were meeting their own objectives and how to improve their practice as they went along by getting regular feedback from residents and other stakeholders. It was also a way of demonstrating that they were meeting targets and 'feeding the beast' of performance management.

'We have to show that we are spending money to reduce inequalities,' said one health practitioner working with an LSP. 'Often those reductions can't be demonstrated in hard data because that takes time, so we use proxies like public involvement, organisational change, attitude shifts and different behaviours.'

However, contributing to local evaluations was fraught with difficulties. Most practitioners felt they lacked the skills and resources to undertake their own evaluations, and many were critical of the quality of advice they received. Some doubted how far evaluation findings would help them replicate success, even in their own area, because conditions varied so much between neighbourhoods.

One interviewee stressed the value of having 'more informal, regular dialogue with the people you work with in the field, just to feed you stuff and give you a flavour of what is happening'. Compared with this, she said, 'having some long-term and fairly complex evaluation programme isn't necessarily going to tell you what you need to know.'¹¹⁵

If an evaluation wasn't thought to be useful, it was likely to be experienced as a burden. 'They say "oh you should have your evaluation plan in six months". I'm like "okay, I'm trying to commission services, recruit teams, run a programme, I haven't got time to think about it".'

Some external researchers had been brought into local evaluations, but many interviewees felt the quality of their work was not reliable. The explosion of demand in recent years seems to have left skills and experience thinly stretched. Not uncommonly, senior researchers would head up the bid and then turn the work over to junior colleagues, who inspired less confidence.

None of the practitioners we spoke to expressed strong views about the relative merits of evaluation methods and most seemed uninterested in that debate. Some were impatient with the time it took researchers to produce their findings. 'We think they should be telling us stuff now, not tell us what's wrong in three years' time when the money's gone, all the effort's gone and you've missed that moment in politics when it was possible to change things.' Others were more worried about evaluations not taking long enough. 'How do you reduce death rates and prove you've done it in five years?'

Our interviewees shared a keen sense that what they knew and what they were finding out in the course of their work was not being adequately captured. 'We have just had to carry out a risk assessment,' said one. 'It's an utterly redundant exercise and demonstrates a real lack of understanding of what it takes to run a programme locally.'

A widely shared view was that the programme evaluations were geared to proving success. 'You are not rewarded for talking about risks and failures. There's no incentive to say "we spent £6 million and we messed it up". But we need to learn from failure.'

Evaluation: discussion points

- In spite of the growing enthusiasm for investing in evaluation, there is a marked lack of clarity or consensus about what evaluation is trying to achieve. Sometimes, this is because the aims of programmes themselves are unclear or in flux; sometimes it is because different interests are involved, with different and conflicting objectives.
 - Politicians almost invariably want 'quick wins'.
 - Government officials tend to want to measure progress towards specified targets, to assist performance management and to justify continuing funding.
 - Researchers are more likely to favour independent analysis, with sufficient time to measure impacts – although some feel their role is more one of monitoring local practice.
 - Local practitioners want help to get resources and to understand better how to get positive results from local initiatives. They are in danger of being overburdened by too much evaluation and confused about whether they are being judged or supported by the evaluations in which they are involved.
- These different needs and interests can create serious tensions between the parties involved, and bring uncertainty and confusion to the evaluation process.
- Evaluation findings are often prejudged or distorted in order to satisfy political imperatives.
- There is no shared theoretical framework for evaluation across government departments or among evaluators. There are few signs that those involved in the evaluations are learning from each other in any systematic way about how to find out 'what works'.
- Experimental methods are thought by many to be either impossible or inappropriate for evaluating complex, community-based initiatives. There is growing support for adapting 'theory of change' methods to identify and track pathways towards goals, and for flexible, multi-method approaches to evaluation. There are, however, different views about how theories of change are best applied in initiatives of this kind, and about whether they are primarily an evaluation or a developmental tool.
- Practical difficulties for evaluators include collecting and analysing reliable local data, and dealing with huge volumes of information. In many cases, national and local evaluations are running alongside each other, but do not always have integrated or even compatible aims or methods.
- Local practitioners are less interested in the competing claims of different research methods. Many feel they lack the necessary skills and resources to evaluate local practice. They also feel that their knowledge and experience is not being fed into the evaluation process.

- There are unresolved questions about how and in what circumstances evaluators should give priority to helping local practitioners improve practice, to monitoring their performance, or to appraising objectively the implementation and impact of the intervention.

Learning from evaluation and evidence: the barriers and opportunities

The third and final theme explored in our interviews was the extent to which organisations and individuals at all levels are able to learn from evidence and evaluation. Gathering evidence and insights is certainly a challenge, but it is not very useful if it doesn't help to effect change and to improve policy and practice.

Our interviews conveyed strong messages about the limits of 'evidence-based' policy and practice and the problems and uncertainties associated with evaluation. There were nevertheless some positive signs of people at national and local level learning from the last few years' experience and becoming more aware of what was needed to build knowledge effectively.

Barriers included gaps in knowledge and capacity at central and local levels, and failure to disseminate learning from research and practical experience. Opportunities were indicated by a changing approach to 'finding out what works' and emerging ideas about changes that would be needed for the future.

National perspectives

Barriers to learning

In government departments, one official told us, there is 'an important connection between providing evidence that is capable of generating learning, and the capacity to take evidence and learn from it. That connection isn't always very strong. We haven't yet established a proper learning culture here. It's absent in government generally, I think.'¹¹⁶

As the *Adding It Up* report from the Cabinet Office stated in 2000: 'A great deal of analytical work is carried out in central Government. But there is also considerable scope for improvement, to bring analysis in the UK up to the highest international standards. There needs to be a fundamental change in culture to place good analysis at the heart of policy-making.'¹¹⁷

'Local programmes are bombarded with evaluation... it's an easy way to get people's backs up about research... one more burden to put up with.'

Evaluator

Several interviewees remarked on failures by central government officials to make informed judgements about how evaluations should be designed, or to ensure that their findings were useful. 'Sometimes departments rely on individual academics or consortia to come up with a framework as part of a tender,' said one analyst, 'and actually they don't know what they want until they see something coming back from the research and they say "we want more of this or that or the other".'

Another problem was the limited capacity within government departments to manage the learning that arose from the evaluations. For example, one interviewee said the Department of Health assigned very few people to manage the learning from the HAZs. 'It's a classic departmental approach: they may fund some evaluation but they don't actually take on the role of supporting the gathering and dissemination of learning. The evaluation team always tried to share their information and a website was set up for the purpose, but their efforts were hampered by insufficient resources.'

We were also told that learning had not been passed on from one programme to another, or from one evaluation to another.¹¹⁸ 'I am not sure that when the policy team here are thinking what they might do to deliver floor targets, they are actively thinking "let's go and talk to X's team about the detailed findings of their evaluation and what we might do differently",' said one official in the Office of the Deputy Prime Minister (ODPM). A senior academic told us that when he started work on the LSP evaluation, he 'knew pretty little about either the HAZ or the Sure Start evaluation', because he 'was not doing work in those particular fields'. Nor had he found out more about them since.

Competition for contracts between rival academic teams did not create favourable conditions for learning from each other. They tended to want to distance themselves from one another and to assert the virtues of their own approach over that of competitors.

Opportunities for learning

There were, however, positive signs of learning from the evaluations and of more progressive thinking among officials and academics.

A Whitehall interviewee confirmed that those responsible for commissioning evaluations were themselves on a considerable learning curve: 'Our understanding and our practice of evaluation have changed. We are undergoing a review that looks at evaluation not as a process that is concerned with measuring change, but more as a learning opportunity. That requires a partnership between those providing evidence and facilitating its production, and those who are in a position to respond to that evidence.' Instead of 'delivering up an answer to policy colleagues', the management of research was now seen as 'maximising the learning... there is no good news or bad news, just evidence that is capable of delivering changed behaviour... and helping the policy side to understand how policies are played out in the real world'.

A senior colleague confirmed that the thinking of those commissioning research was moving away from asking 'does it work?' to thinking about why it does or doesn't work and 'how we might best intervene to improve those processes to deliver the sorts of outcomes that we want'.¹¹⁹

Where the evaluators were concerned, the fact that the Sure Start team regarded their design as sufficiently robust to withstand problems relating to programme change and complexity suggests they had benefited, if only indirectly, from the experiences of earlier evaluations. The LSP evaluators had also been able to learn from both positive and negative aspects of the NDC evaluation. Although there were few signs of systematic shared learning among the academics, they were beginning to develop more sophisticated approaches to finding out 'what works'.

One evaluator noted a significant change since the late 1990s, when the focus for evaluation had been on methodological rigour, without a theoretical framework. 'There was no theory at all and no request for any,' he said. Since then, he felt there had been an increasing realisation among government officials that the methods and the rigour they were expecting were difficult, if not impossible, to achieve in complex local settings.

Since the HAZ evaluation, ToC had come to be regarded as a more flexible analytical tool that could be adapted to large-scale evaluations.¹²⁰ One academic working on the LSP evaluation told us: 'We have really attempted to develop ideas about "theory of change" and related concepts and have kept that at the forefront and are writing reports about that.' Another said: 'The way in which ODPM now positively encourage people like us to at least talk in "theory of change" terms is a major change and a major challenge to evaluators.'

As far as practical changes were concerned, we were told that the HAZ evaluation had been influential in Scotland, where it helped to shape demonstration projects for healthy neighbourhoods. However, the most significant change to come out of the evaluations may be the growing enthusiasm in Whitehall for learning from the practical experience of those working to implement programmes at local level.

The Neighbourhood Renewal Unit has developed a Knowledge and Skills programme aimed at enabling practitioners in the field to learn from each other and from other sources, and this is now a key element of the Neighbourhood Renewal Strategy (see box below).¹²¹

The HDA has made efforts to integrate practical, field-level experience into its synthesis of research-based evidence (see box opposite). And the Cabinet Office has acknowledged the importance of practitioners contributing to, as well as learning from, the evidence base.¹²²

The views of practitioners about these initiatives are discussed below. We do not claim they are complete solutions; for the purposes of this discussion, it is their creation that is significant.

However, although the idea that the Government's social programmes had to involve continuous, action-based learning as well as formal evaluation was gaining ground, some of our interviewees indicated it had yet to win widespread approval at senior levels in government. 'You might think it is common sense,' said one Whitehall figure, 'but when it comes to the crunch, the traditional civil service view is that you create targets, monitor frameworks, produce guidance, that sort of thing. They see this as something that is additional to their work.'

Nor was this approach necessarily shared by politicians, who continued to want quantified monitoring to show whether something was working or not. 'A lot of political pressure on evaluation is like that,' said one senior government researcher. 'I don't find the question "is it working?" very helpful, but that is nonetheless the question that gets asked.'

SKILLS AND KNOWLEDGE PROGRAMME

The Skills and Knowledge Programme is part of the National Strategy for Neighbourhood Renewal (NSNR) and is designed to improve the use and quality of evidence and practice in its implementation. Its approach was set out in *The Learning Curve*, a strategy document published in 2002, which stated: 'Everyone involved in neighbourhood renewal should be equipped with the skills and knowledge they need.'

There are five main parts of the Skills and Knowledge programme:

Renewal.net: an on-line information resource for practitioners, which aims to bring together 'what works' in an accessible form.

Neighbourhood Renewal Advisers: offer advice and information to practitioners engaged in neighbourhood renewal.

Community Learning Chests: small grants of between £50 and £5,000 to develop the skills and knowledge of local communities.

Residents' Consultancy: a pilot project, testing how residents can share their experience and expertise in neighbourhood renewal.

Regional Networking: a project that aims to create opportunities for all those working in neighbourhood renewal to meet and learn from each other.

An evaluation of the programme, costing approximately £300,000, is currently under way.¹²³

HEALTH DEVELOPMENT AGENCY EVIDENCE BASE

The HDA Evidence Base (www.hda-nhs.uk/evidence) is an Internet information resource developed by the Health Development Agency. It consists of a searchable, on-line 'evidence' database, which includes systematic reviews, research reports, journal articles, internet sites, expert opinion, government guidance and unpublished research databases.

The aim is to provide access to the best available information on what works to improve health and reduce health inequalities. The resource is aimed at practitioners and researchers engaged in public health work.

The HDA sees the evidence base as a starting point for interventions and as a framework of plausible possibilities, not a blueprint for action, because it may be difficult for users to judge the strength of the evidence offered and to establish whether the findings are transferable to their own context.

Local perspectives***Barriers to learning***

As noted above, practitioners face a number of difficulties in using and learning from evidence. A major difficulty, which they share with policy-makers and academics, lies in weighing up the relative merits of different sources and types of knowledge. When is their own experience a sounder basis for judgement than published research findings?¹²⁴ When can knowledge about another programme or neighbourhood be applied to their own? When can evidence be allowed to override political or managerial imperatives, and vice versa? What should be done when the evidence base appears to contradict the views of local residents?¹²⁵ By what criteria and within what framework could different interpretations of need be ordered and analysed?

Lack of skills and assistance

Most practitioners said they found evidence rather abstract and removed from the day-to-day demands they faced.¹²⁶ Most often, they would give priority to delivering practical outputs at ground level and to meeting targets and performance indicators. Many said they didn't have enough time to learn and reflect, often didn't have funds to commission research, or had difficulty interpreting academic research. Nor did they necessarily have appropriate skills – or access to others who did – to interpret and weigh up different kinds of knowledge, navigate the evidence base, or design or execute evaluation studies. As one researcher observed, 'There is an important connection between providing evidence which is capable of generating learning and people who are capable of taking evidence and learning from it – and that connection isn't always very strong.'

The quality of advice and technical assistance available to practitioners often failed to bridge gaps in expertise. Several senior practitioners told us they were unsure of the quality of neighbourhood renewal advisers, for instance, and therefore seldom used them. A senior evaluator acknowledged that, while some neighbourhood renewal advisers were 'very, very good', others were 'useless'. These advisers were a key innovation of the NRU's Skills and Knowledge Programme, yet they had variable and limited ability to help practitioners understand and use evidence. An NDC practitioner told us she felt she had to rely on her own experiences and networks. 'I don't get advice from anyone. So I still go to the grassroots, people who I know and respect. Those who get to positions of power are not those who have the expertise or creativity.'

Another problem was that, in many practitioner organisations, learning was equated with training, which was seen as a separate process from 'doing'. It was often allotted specific times and venues, usually away from the workplace, which discouraged practitioners from finding and using evidence to generate, direct and support their local interventions. One practitioner said: 'I don't think there's enough work put into the organisational development bit. There's no point tossing evidence into an organisation that isn't ready for it. There's no point in throwing evidence at practitioners [who] don't see the benefits that it's going to give them or [who] aren't able to actually act upon [it]. There's a whole kind of developmental agenda that I think is largely ignored or hasn't been adequately considered.'

Some practitioners doubted how far any kind of formal evidence could improve practice and wondered just how effective electronic evidence bases were in providing evidence to practitioners. 'You don't learn by sitting people in front of screens and giving them information,' said one. 'It's more about dialogue. You need to discuss it and test it out in different scenarios.'

Few opportunities for peer learning

How much peer learning went on, and how far it was structured or consistent, varied from one programme to another. Some, including notably the NRU Skills and Knowledge Programme, aim to bring research evidence and local experience together. Yet many interviewees involved in these programmes reported that structured opportunities for learning from their peers were few and far between.¹²⁷

One said: 'That kind of realising we can work together can happen locally. But it's not happening nationally. What does happen is very much off our own bat. It's only informal liaisons in our area, it's been a fluke of coincidence based on people involved – there is no mechanism.'

There were few formal opportunities for Sure Start practitioners to learn from each other. Chance encounters seemed to be their best bet. 'We ran, as one of our pilots, some capacity-building for local voluntary groups,' said one Sure Start practitioner. 'Another programme manager said she'd heard about it on the grapevine and wanted to know more, then replicate. We realised we could work together locally like that.'

Practitioners' feedback undervalued

Many practitioners expressed frustration with the culture of the Government, which they felt left them unable to feed back their experiences and expertise to national policy. This view was echoed in central government. An official in the NRU told us: 'The Skills and Knowledge Programme has much less emphasis on evidence from practitioners and peer learning than on the provision of evidence to practitioners. We talk a good story about skills and knowledge outside the unit, but we aren't very good at learning within the unit. That's a central government trait actually: learning is for everyone else – not for us. I think it's an area we are weakest at.'

Another official remarked that intelligence from local programmes was being fed into central government, but no one knew how to use it. At least, he said, they were beginning to pick up messages by having a more interactive research and learning process. 'You won't get that feedback unless you make it happen, unless you engage with the field.'¹²⁸ Within the NRU there was at least an awareness that policy development would benefit from gathering evidence from practitioners. The official said: 'We are starting, for example, to bring together our neighbourhood renewal advisers to feed back to us some of the things they're finding out. But it's difficult nationally to find effective ways of doing that. We have a number of mechanisms

'We think they should be telling us stuff now, not tell us what's wrong in three years' time when the money's gone, all the effort's gone and you've missed that moment in politics when it was possible to change things.'

Local practitioner

like the Community Forum where people can speak directly to us, but I suspect that is rather ad hoc.'¹²⁹

The picture is further confused by differing views about what constitutes evidence, with practitioners justifiably suspecting that academic findings are more likely to be counted as evidence than their own experiences and knowledge.

Opportunities for learning

Community engagement

The idea that practitioners must engage with communities and patient groups when deciding how to implement local programmes has gathered force over recent years. Increasingly, they are encouraged to tap into the views and experience of local residents and involve them in decision-making.¹³⁰

However, one practitioner expressed anxiety about public involvement becoming a substitute for an evidence-based approach to decision-making: 'It's not measured, it's not long-term, it's very anecdotal and of course it's important, but when this actually becomes the basis on which you take decisions, other evidence gets discounted.'

Local staff were more at ease with the idea of listening to local people than with navigating the literature, he said, and it was more likely to provide 'speedy gratification... when you need to get some sense that things are working'.

Drawing on practitioners' knowledge and experience

Overall, our interviews with practitioners indicated that they had certain needs that would have to be met if they were to build and spread knowledge effectively. These included more clarity and better guidance on how to use evaluation and evidence to achieve their local goals, and more consistency between programmes in their approaches to evidence-based policy and practice. Many felt that evaluation studies and research could be more closely geared to meeting practitioners' needs. They agreed that researchers should focus more on research questions that practitioners want answered and tailor their research programmes accordingly. This, they said, would be a marked improvement on the more usual scenario of practitioners trying to find out whether the research they needed had been carried out, and whether it was relevant, accessible and helpful.

Practitioners indicated that they would like more opportunities for structured learning and discussion with peers and other experts, and the chance to improve their skills in navigating evidence, undertaking evaluations and critical appraisal of knowledge from different sources. If they are to realise these opportunities, they need more resources – time, money and skills. This would require organisational changes and development, with senior management prioritising learning and spreading good, and bad, practices.

One senior practitioner told us: 'I don't know why we haven't disseminated, because there's a wealth of knowledge there and we're guilty of not disseminating it within our own organisation to our front-line practitioners, which seems very remiss.' Another confirmed this view: 'There is a widespread feeling that we need to exchange information... there must be learning all around.'

There was a general consensus among practitioners that all parties (policy-makers, evaluators and practitioners themselves) would benefit from a culture shift that encouraged and enabled learning from those who were implementing policy at local level.

Learning: discussion points

- There is no 'learning culture' at the centre and there is inadequate investment in the dissemination of evaluation findings.
- There are signs that the centre is moving toward a more rounded and flexible approach to knowledge-building. More government officials are coming around to the view that evaluation should seek to understand processes and systems and to facilitate learning in order to improve practice, as well as tracking progress towards targets.
- However, there appears to be no diminution of pressure from ministers to produce clear 'answers' to immediate questions about impact.
- Progress is also hampered by differences between linear and complex views of how organisations behave and how they change. Linear views see pathways that lead from inquiry (including evaluation), to information (including evidence), to learning, to change. More complex views see change emerging less predictably as whole systems evolve over time.
- Practitioners need more clarity and better guidance on how to use evaluation and evidence to achieve their local goals. Knowledge-building is not integrated into the daily work of local programmes.
- To many practitioners, academic research seems like alien territory – frequently impenetrable, usually unhelpful, seldom directly relevant, often threatening and sometimes regarded as beyond contempt.
- They would benefit from more careful gearing of evaluation studies and of the evidence base to meet their own needs.
- More resources – time, money and skills – are needed at local level to enable practitioners to build knowledge more effectively; also needed is a change of culture within their own organisations, with stronger incentives and more opportunities for learning with peers and other experts.
- Many feel that local practitioners' knowledge and experience is not being adequately captured and that they lack opportunities to contribute to the evidence base. This calls for a change of culture within government and academia, as well as the further development of mechanisms for learning from practitioners.

3

Lessons from case studies

This section raises the question: what lessons can be learned from other work in the field? It examines six case studies, drawn from community-based initiatives in the United Kingdom and the United States and picks up on the key discussion points that emerged from our interviews. These case studies help to shed light on questions arising from the field research discussed in the previous section, and suggest lessons for each of the paper's three main themes – evidence-based practice, evaluation, and learning.

Here we examine six cases, picking up on the key discussion points that emerged from our interviews. These case studies represent smaller, more specific initiatives and in each case we have focused on a key dimension of the initiative that addresses one of our three main themes.

Evidence-based practice: The Healthy Communities Collaborative (UK) and Plain Talk (US)

Our interviews suggested that basing practice on evidence is fraught with difficulties. It may be the stated aim of the UK Government in relation to its social programmes, but often the evidence base is not up to the job: it may be thin, patchy, contradictory, inaccessible or even inappropriate. Those who work at local level often find it hard to find and apply formal evidence to meet the needs of their own communities.

Yet it is also acknowledged that evidence of what has 'worked' elsewhere can provide invaluable assistance in addressing health and social problems, by helping to identify what kind of interventions and processes are likely to be effective in what circumstances, and how these might be replicated in other areas. That depends not only on the quality and relevance of the evidence, but also on how it is applied in practice. The case studies below, both related to health, are examples of apparently successful applications of evidence to practice and replication of good practice.

The Healthy Communities Collaborative (HCC)

This is a model for introducing structured, evidence-based practice at local level, under the control of local people. The HCC engages communities to improve health and reduce inequalities, and aims to strengthen their capacity to address health risks.¹³¹ So far the collaboratives have focused on preventing falls among older people in disadvantaged neighbourhoods.

Falls were chosen because they were seen as a widespread and costly health risk, and because there was strong evidence of effective interventions to prevent them. Every five hours, someone over 65 dies from a fall in the United Kingdom; half of all those who fracture a hip can no longer live independently; fractures from falling cost the NHS £1.7 billion a year.

'There are things...
that have worked
in American cities
with black youths
that are just not
transferable to the
north-east of
England because
it's a different
culture, a different
kind of
community.'

Local practitioner

The HCC has been piloted by the National Primary Care Development Team (NPDT), using evidence gathered by the Health Development Agency (HDA). It was first tested in three areas, Nottingham, Gateshead and Easington, achieving a 30 per cent reduction in falls in the first year. In 2004 it was rolled out to eight further sites across the United Kingdom.¹³² Each site receives £55,000 annually from the National Primary Care Development Team to fund a project manager and other costs. The total cost per site, including all workshops and training, is approximately £600,000.

The collaborative brings together older local residents – the average age being 65 – with a project manager from the NPDT, and provides them with evidence from the HDA evidence base (see p 33) about how falls may be prevented. The residents decide which interventions to adopt and how to implement them locally. Interventions have ranged from introducing battery-run night lights to exercise programmes and the replacement of unsafe footwear.¹³³ The local participants are engaged in three residential workshops, interspersed with periods of local action. They follow a structured model of reflective practice, known as 'PDSA' (plan, do, study, act), aimed at gaining rapid improvements on specific issues. This was initially developed for health professionals learning from each other to improve clinical outcomes.¹³⁴

Clear milestones are set and progress measured against them, by submitting monthly data to the NPDT and conducting a qualitative questionnaire, developed by participants and administered to residents in the wider community.

Some groups formed through the collaboratives have extended their activities to address the issue of healthy eating.

Plain Talk

Plain Talk is a four-year, \$5 million initiative aiming to help adults and community leaders to communicate effectively with young people about reducing sex-related risks. It does not aim to encourage or discourage sexual activity, but to engage with life the way local people experience it.¹³⁵

The initiative was tested in five urban areas in the United States in 1993–97, and is now being extended over 2004–06, through a national replication programme, based on the evaluation of the test sites.

Plain Talk is funded by the Annie E Casey Foundation, which engaged a consultancy, Public/Private Ventures (P/PV), to conduct the evaluation and lead the replication programme.

The residents of each Plain Talk community developed strategies suitable for their own culture and circumstances by adapting the same five basic components: community mapping to gather critical local data, a resident network of supportive local opinion leaders, adult peer education, re-enforcement of key messages through outreach activities, and sustained resident involvement and leadership development.

The evaluation found that increasing adult–youth communication about sex and making contraceptive services available to sexually active youths were linked with decreases in unwanted pregnancies and sexually transmitted diseases. In 1994, 33 per cent of the sexually experienced youths had been pregnant or caused a pregnancy. Four years later, in 1998, only 27 per cent of the sexually experienced group surveyed had been pregnant or caused a pregnancy, whereas the projected rate among the new group of teenagers had been 39 per cent by that date. Analysis of the survey data suggested that most of the 11 per cent decrease was due to the improvement in the quality of communication during the four-year period. It also

'Should we get alongside local groups, or are we the department's objective evaluators who are not necessarily friendly at all?'

Evaluator

found that success could be repeated, but that each community's approach needed to be tailored to suit its own character and history.

P/PV lays claim to generic skills in replication, which include developing capacity for 'cost-effective growth in political environments', managing the initial stages of replication to increase the chances of long-term success, evaluating progress and establishing strategies for improvement.

It conducted a 'replicability assessment' of the Plain Talk model, and designed a replication programme that comprised site selection, technical assistance, an implementation manual and training curriculum called Walking the Plain Talk, training, and data management.¹³⁶

Lessons for evidence-based practice

- The main strengths of HCC are that it combines a rigorous approach to evidence with community development and capacity-building. Local people are invited to appraise the evidence and make judgements about which interventions are appropriate for their own neighbourhood. This enables them to take ownership of an evidence-based approach, building confidence in their own efficacy as well as knowledge about how to apply evidence to practice.
- A clear, simple model of reflective practice (plan, do, study, act) is useful in that it can be adapted to a range of different circumstances and is accessible to health professionals as well as to local residents.
- The HCC model relies upon clear, verifiable evidence of interventions that are effective. It is also designed to address a highly specific and relatively straightforward health risk (falls among the elderly). There are other health risks for which there is far less – or no – evidence of 'what works'; the more complex a risk, the less likely it is that there will be clear evidence of how to address it. This raises the question of how far the evidence base should drive decisions about which health risks to tackle. Is it better to address simpler and more specific risks than to try to tackle multiple causes of illness? What risks are likely to be ruled out by this approach, and what are the potential consequences for health?
- The HCC is a fairly resource-intensive model, suggesting that evidence-based practice requires substantial and continuing investment – not just in building the evidence base, but in building the capacity of communities to make good use of it.
- Plain Talk provides a useful illustration of what it takes to replicate an effective intervention. Evidence, based on sound evaluation, that something has 'worked' is a good start but not enough.
- The P/PV Plain Talk replication programme has identified the key components of Plain Talk and has developed tools to ensure that they are introduced in ways that are sensitive to the specifics of each new site. Community mapping, networking, leadership development and effective communication appear to be essential not only to the success of Plain Talk, but also to the process of replication itself.
- If the aim is to use evidence of 'what works' to reproduce a successful intervention in other settings, a well-considered, systematic approach to replication is no less important than a rigorous approach to evaluation. There are generic functions that are likely to be useful in replicating other interventions as well as Plain Talk.

- Building the capacity and confidence of local residents is likely to encourage them to think for themselves and may not predispose them to follow directions or copy what others have done. It is important to ensure that they have plenty of scope to make decisions for themselves and to adapt the original programme to suit their own needs and circumstances.

Evaluation: The Employment Retention and Advancement Demonstration Project (UK) and California Works for Better Health (US)

Our interviews suggested that there was a marked lack of clarity among those commissioning and carrying out evaluations about purpose and method. While everyone agreed that multi-method approaches were suitable for evaluating complex initiatives, there were considerable differences of opinion about the value and appropriateness of different methods, including randomised controlled trials (RCTs) and 'theory of change' (ToC).

There were also unresolved dilemmas about how evaluation related to local practice. Questions were raised about how far evaluators should give priority to supporting local practitioners, monitoring their performance or keeping enough distance to be objective in appraising the implementation and impact of the programme as a whole.

The following case studies both deal with employment, which is an important determinant of health. One illustrates a demonstration project designed to include RCTs; the other indicates a very different approach in which ToC features strongly and evaluation is closely aligned with local capacity-building, considered in this case to be a prerequisite for sustainable employment.

Employment Retention and Advancement Demonstration Project

The Employment Retention and Advancement (ERA) Demonstration Project has been designed to test a new strategy for improving job retention and advancement for low-wage workers through multi-method evaluation, of which the centrepiece is a randomised and controlled impact assessment.¹³⁷

ERA is directed at three low-income categories known to have difficulty retaining jobs or advancing to better positions: unemployed people aged 25+; non-employed lone parents; and lone parents working part-time in low-paid jobs. Up to 27,000 individuals are involved in the trial, drawn from six sites in England, Scotland and Wales, with half randomly assigned to the ERA programme and half to the control group. A total of £30 million has been allocated to run, implement and evaluate ERA until 2010.

Individuals selected for the ERA programme receive intensive support from an Advancement Support Adviser (ASA) for up to 33 months. Advisers help to identify the barriers that are hindering the individual from getting or keeping a job, or advancing to a better one. They offer help with finding a job, getting promotion, improving net income, dealing with workplace pressures, finding appropriate education and training, and getting access to child care and other support services. Individuals also receive financial bonuses if they stay in full-time work for a minimum period and undertake approved training.

Those in the control group are drawn from the same three low-income categories, but they do not receive intensive ASA support or financial incentives. They do remain eligible for services and benefits routinely available to job-seekers and low-paid workers.

'There is an important connection between providing evidence which is capable of generating learning, and people who are capable of taking evidence and learning from it, and that connection isn't always very strong.'

Government researcher

The evaluation includes an impact study to determine the effects of ERA on participants' employment, income and quality of life; a process study to examine individuals' participation in ERA-related and other activities, how implementation varies between the sites, what problems are encountered and how they are addressed; a cost study to determine the cost of the different elements of ERA per participant; and a cost-benefit study to estimate the net economic gains and losses over five years or more. Results are expected between 2005 and 2007, and there are no plans for any roll-out until the final results are known.

This programme, which is inspired by a similar initiative in the US,¹³⁸ is intended to tackle some of the problems and difficulties associated with evaluating welfare-to-work policies, to help understand the limits and potential of random assignment, and to act as a guide for future government research in this and related fields.

California Works for Better Health

California Works for Better Health (CWBH) is a six-year, \$37 million programme funded by the Rockefeller Foundation and the California Endowment, a private, statewide health foundation that was created in 1996 as a result of the demutualisation of Blue Cross of California, creating WellPoint Health Networks, a for-profit corporation.

Launched in 2000, it is intended to test the hypothesis that building capacity in impoverished communities should help to create sustainable, high-quality local employment and that this, in turn, should lead to better health for community residents.¹³⁹

CWBH works with groups of community-based organisations, known as collaboratives, in four areas in California where there are pockets of poverty and ill health in prosperous regions: Sacramento, Fresno, Los Angeles and San Diego. It is based on the premise that sustainable change needs to be built from the grass roots upwards, which takes time. The first phase, focusing on community capacity development, was allotted three years, with a further five or more years for the communities to design and lead interventions to improve employment and health.

Evaluation is a key component of the programme because it is CWBH's ambition not only to improve jobs and health in the four chosen areas but also, if possible, to demonstrate important links between jobs, income and well-being to policy-makers at state and federal levels. The consultancy MDRC was engaged to evaluate the programme.¹⁴⁰ As part of this process, it supports local researchers who work closely with technical assistance providers and the collaboratives in each area.

The four collaboratives receive help in building ToC planning capability as well as technical assistance in organisational, management and workforce development, IT and data management, policy analysis and action, and support in developing research skills. The evaluation is participatory, with the collaboratives providing formative feedback in the planning stages, agreeing subjects for evaluation and working with local researchers. Evaluation is closely allied with community development and capacity-building, using ToC to identify goals and pathways, and working with the collaboratives to identify indicators and benchmarks to track progress over time. Randomised assignment and controlled evaluation were considered inappropriate for this venture.

In the first phase, capacity-building was found to take longer than expected, with the needs of different groups varying widely. The implementation phase, now in progress, focuses on

helping the sites develop feasible strategies to improve health through employment-related initiatives; for example, reducing language barriers to employment and encouraging employers to provide a safe working environment and health benefits to their workers.¹⁴¹

Lessons for evaluation

- The ERA project indicates that, if an intervention is to be subject to a randomised and controlled trial, this has to be central to the design of the intervention and factored in at the earliest stage.
- RCTs can make a valuable, if limited, contribution to knowledge-building. They are likely to produce more precise and verifiable findings about impact and attribution than other forms of evaluation.
- RCTs can measure specified impacts on individuals more easily than complex changes occurring over time within communities. They can show *what* has happened, but other methods are required to understand *why* things happen, *how* they might be replicated and whether they have been worthwhile.
- Controlled trials need to be protected within fast-moving political environments, so that comparators remain in place over the time needed to complete the experiment. They should be understood by all concerned as demonstration projects first and foremost, rather than as interventions for social change – although the former may lead to the latter.
- The experience to date of CWBH suggests that combining evaluation with community participation and technical support can make it hard for evaluators to maintain objectivity. Local researchers have become advocates for their collaboratives and have acted more as providers of technical assistance than as objective researchers. It can also cause confusion among local participants, who are unclear whether local researchers were spies for the programme sponsors, facilitators or advocates.
- Technical assistance needed to be finely attuned to the needs of different groups within collaboratives, as their capacity was found to vary widely. Some had greater skills than local researchers and others needed very basic help with building and running their own organisations.
- ToC was found to be a worthwhile approach to planning, but it was hard to get the collaboratives to focus on outcomes and understand key concepts. ToC needs to be deployed from the start of the programme design. Even then, it can be hard to reconcile plans developed through ToC with the sponsors' original ideas of what the programme was supposed to achieve.
- If the main aim of CWBH had been to convince policy-makers of causal links between employment and health, then a different programme and evaluation design, possibly including RCTs, might have been worth considering. If, on the other hand, building and sustaining capacity at community level was thought to be a prerequisite of successful impact, then a complex, bottom-up, long-term programme, with a ToC approach to planning and evaluation, might have been the best available option. In this case, however, it is likely to remain difficult to trace causal pathways.

'I still go to the grassroots, people who I know and respect. Those who get to positions of power are not those who have the expertise or creativity.'

Local practitioner

- Technical support, evaluation and demonstration are different aims with different functions. When the lines are blurred between them it may become harder to achieve any of them.
- It is only through experiences of this kind – both ERA's and CWBH's – that it is possible to build knowledge over time about 'what works' in complex, community-based initiatives, and how to set about building that knowledge. Problems and failures are as valuable for knowledge-building as solutions and successes.

Learning: Social Action Research Project in Salford (UK) and the East Tennessee Foundation Peer to Peer Learning Project (US)

A strong message from our interviews was that there was little or no 'learning culture' within central government or at local levels. There were different views about how organisations learned and what made them change. There were tensions between two objectives: the desire for clear answers about 'what works' and the need to understand processes and systems, because each implied a different approach to learning.

There was some degree of consensus about the need to develop a better understanding of how local practitioners and communities learn, and what they can contribute to the learning process, as well as about the need to provide more opportunities for peer-to-peer learning at all levels.

The following case studies focus on learning processes. The first is concerned with understanding how communities learn and change and how they contribute to local policy and practice. The second aims to develop an effective model for peer-to-peer learning.

Social Action Research Project, Salford

The Social Action Research Project (SARP), Salford, was one of two action research projects in Salford and Nottingham that aimed to deepen understanding of how strengthening community capacity and community involvement in local policy and practice could help to improve health and reduce health inequalities. Funded by the HDA with £600,000, the projects ran from 1999 to 2002.¹⁴²

The Salford project worked with four neighbourhoods and employed a locally based action co-ordinator in each. Drawing on their own experience, residents decided what local issues to address and how to do so.

They adopted a 'whole systems' approach, viewing the issue in the round, bringing people together with a range of perspectives, identifying areas of common ground, and deciding what they could do to achieve shared goals. Their chosen issues ranged from working with young people and gaining more control over local regeneration projects, to developing a community centre and using IT to support lay participation in decision-making.

More generally, Salford SARP aimed to shift conventional wisdom about how communities and statutory organisations work together and relate to one another.¹⁴³ This involved: moving from a focus on individuals as drivers of social change to a focus on collective social action;

identifying assets that already exist within communities, instead of just thinking about problems and shortfalls; finding ways to release the capacity and resourcefulness of communities, rather than focusing on how to build capacity; supporting organisational change and taking risks with new ways of working.

Significantly for this discussion, Salford SARP found that what communities and local organisations needed was not training as such, but development and shared learning. It also became apparent that it was as important to strengthen capacity within local statutory organisations, so that they could engage effectively with local communities, as it was to strengthen capacity within the communities themselves.

Methods for shared learning included co-mentoring and 'action learning sets' for local co-ordinators and public service managers, opportunities for learning within and between public service organisations, and structured thinking time for people involved in the project.

SARP has been evaluated by a team from Keele University. Broadly, this was a process evaluation that described the context in which the two projects were set, the outcomes experienced within the communities involved and the mechanisms by which they were produced.¹⁴⁴

East Tennessee Foundation Peer to Peer Learning Project

The East Tennessee Foundation (ETF) is a public charity that aims to create permanent resources to enrich lives and strengthen communities in impoverished and largely rural East Tennessee. It manages and invests money from a variety of donors to build permanent endowment funds, and grants money (\$17 million in 2003) to a variety of organisations in the region.¹⁴⁵

Five years ago, ETF and four other rural community foundations were chosen to participate in a peer learning group managed by the Aspen Institute's Community Strategies Group and funded by the Ford Foundation. The Aspen Institute has developed a model of peer-to-peer learning to assist community foundations such as ETF to improve the standards of their work and to undertake effective poverty-related rural development work. The model allows them to remain flexible enough to deliver what rural communities need and maintain the commitment of their boards and donors.

ETF staff and board members, Ford Foundation staff, other rural practitioners and all ETF grantees are involved in peer-to-peer learning. This aims to develop organisational capacity, enable institutional change, explore programme strategies and facilitate shared learning. The process also provides a framework for informing the field about evidence.

Experience has led ETF to the view that successful peer learning depends on recognising the way different people learn, providing a highly structured, rigorous and participatory learning environment, and insisting on active engagement, with facilitated dialogue that ensures everyone participates. It must be clearly oriented towards action and outcomes, give participants an opportunity to bring their own challenges to the workshops for peer advice, and foster strong, enduring networks.

It requires high levels of long-term commitment from all those involved, and appropriate skills to facilitate and develop shared language and understanding. Results are best where there is

'There's no point tossing evidence into an organisation that isn't ready for it. There's no point in throwing evidence at practitioners who don't see the benefits that it's going to give them, or aren't able to actually act upon it. There's a whole kind of developmental agenda that hasn't been adequately considered.'

Local practitioner

some existing capacity and where people and organisations are willing to make sometimes difficult changes to organisations and programmes.

This approach to peer learning has been developed as a transferable model and is being used by the 150-member Rural Development Philanthropy Network convened by the Aspen Institute and by learning groups with African foundations.

Lessons for improving learning processes

- In order to build knowledge about 'what works' in complex, community-based initiatives, it is essential to recognise and learn from the wisdom and experience of local practitioners and community residents. They must be enabled to contribute to the evidence base, not just learn from it.
- It is helpful to focus on releasing capacity in communities and utilising assets that are already there, rather than building capacity.
- Communities may benefit more from active, shared learning than from training.
- If the aim is to get community-based groups and public-sector organisations to work together productively, then as much effort needs to be put into developing the capacity of public-sector organisations to enable them to engage with local people, as into developing capacity within communities.
- Peer learning is a key to developing institutions that are sufficiently flexible to be able to meet communities' changing needs and to sustain support from funders and other contributors.
- Enabling practitioners and community residents to learn from each other requires tried and tested methods; finding out which approaches and methods of learning are effective, for whom and in what circumstances, is a vital part of the knowledge-building process. There are likely to be widely differing levels of need and capacity.
- Elements of successful peer learning are likely to include: sensitivity to individuals' learning needs; a programme that is rigorous and structured, with facilitated, active engagement by all participants; an opportunity to share problems and advice on how to tackle them; a focus on action and results; and development of strong networks.
- It demands high levels of commitment and time from all those concerned, and works best where there is some initial capacity and willingness to learn and to change accordingly.

4

Conclusions

This section draws together key issues arising from the study, identifies problems and opportunities, and suggests next steps. It points to unresolved tensions between different objectives and interest groups, and a largely unacknowledged gap between political rhetoric and practical experience. It calls for more open and inclusive discussion, a stronger learning culture, a keener emphasis on building knowledge by integrating local experience with research findings, and a more explicit understanding of political trade-offs.

In this paper we have explored the role of evidence, evaluation and learning in relation to complex, community-based initiatives in the United Kingdom that are expected to influence health and health inequalities.

We have sought to find out the extent to which five of the major social programmes introduced by the current Government are really evidence-based, how they are being evaluated and what could be done to facilitate learning and build knowledge to improve policy and practice.

To do this, we examined the views of people involved in commissioning, evaluating and implementing these programmes, and looked at six further case studies, based on smaller projects in the United Kingdom and the United States. We have also drawn on five seminars held between 2001 and 2004 involving leading organisations in this field on both sides of the Atlantic, and we have conducted an extensive review of relevant literature.

As we said at the beginning, our aim is to stimulate reflection and debate among policy-makers, evaluators and practitioners, not to present a definitive analysis. In this final section, we identify key issues arising from the study, consider why these matter for public health, and suggest opportunities for moving forward.

The UK context

The current Labour Government has made a strong commitment to tackling social exclusion and reducing health inequalities. To this end it has invested considerable amounts of taxpayers' money in complex social programmes aimed at achieving these and related goals. It has done so at high speed, across the whole country.

Three political objectives have been significant in all this. The first has been to design programmes that are nationally determined with explicit goals, but which are implemented locally, with communities and grass-roots organisations 'empowered' to make their own decisions about how to move forward. The second has been to promote 'evidence-based' policy and practice, which implies basing decisions on existing evidence as far as possible, and thoroughly evaluating new interventions. The third has been to demonstrate success in tackling previously intractable problems in order to keep political opponents at bay and the electorate on side.

'Research is never the engine for social change – policy is. Research can give a push or a nudge in the right direction.'

Evaluator

There are certain obvious tensions here: between central direction and local 'empowerment'; between the desire to innovate and the desire to be guided by evidence of what has 'worked' in the past; and between the need to act at speed on a large scale, producing timely and positive results, and a commitment to evaluating new interventions to build the evidence base.

These tensions are hardly surprising. Any government with radical intent is likely to find itself juggling with ill-fitting objectives. More serious is a lack of transparency about such tensions, a tendency to overlook conflicts of interest and competing philosophies, and a seeming reluctance to reflect and learn.

Evidence

Despite the claims made in official publications, the social programmes discussed in this paper are not strongly evidence-based.

Some aspects of the programmes have been informed or inspired by evidence of what has worked at other times and in other circumstances, and by critical appraisal of past experience, but the programmes have not been planned or implemented in strict accordance with verifiable and relevant evidence drawn from robust and appropriate research. They have been designed, by and large, on the basis of informed guesswork and expert hunches, enriched by some evidence and driven by political and other imperatives.

This is as it should be. As we have noted, decisions based on evidence alone may be no better, and possibly may be worse, than decisions based on hunch and politics. However, there remains a gap between the Government's rhetoric – that decisions must be based on the best available evidence and guided by 'what works' rather than by ideology – and what actually happens, which is a great deal more complicated.

For example, the research that has produced the 'evidence base' has emerged haphazardly, as a result of many unrelated decisions by funders, researchers' idiosyncratic preferences and the limits of evaluation 'science'. These are not component parts of a single jigsaw that will eventually produce a coherent picture, but bits from many different puzzles, most of which are incomplete.

Investment in research has strongly favoured some kinds of research, such as drug trials, over others, such as interventions to prevent illness, or understanding change in complex local settings.¹⁴⁶ Doing only what has been demonstrated by research to 'work' could reduce the scope of activity to a small, eclectic band of simple measures that have little coherence between them. It could also discourage creativity and risk-taking, when these may be needed to tackle intractable social issues.¹⁴⁷

Evidence is, of course, extremely useful in many circumstances. Few would dispute that, in the right circumstances, appropriate evidence can help to avoid doing harm or wasting resources, and be used to help to design interventions that have a better chance of being effective.

But evidence is also widely used as a political tool. Critics of a particular intervention will demand to know what evidence it is based on, or seek to show that evidence is absent, weak, inconclusive or inappropriate. And because the evidence base is often rather flimsy, that can be an easy line of resistance. Proponents of an intervention, on the other hand, will select evidence to justify or defend decisions that have already been taken for other reasons, hoping to make it less vulnerable to criticism. They are far less likely to scrutinise evidence that is telling them what they want to hear.

There are significant differences in people's understanding of what 'evidence' means, how it is constituted and how it is or should be deployed. These differences are largely unacknowledged and unexplored.

At local level, where practitioners are under pressure to deliver tangible results, there are few opportunities to reflect on the gap between the rhetoric of 'evidence-based policy and practice' and day-to-day experience, or to validate practitioners' own expertise. This can generate confusion, exasperation and cynicism.

Evaluation

All the social programmes discussed in this paper are being, or have been, evaluated. Two of these evaluations (of the New Deal for Communities and Sure Start) rank among the largest and most expensive ever to be conducted in the UK. All are expected to produce unprecedented volumes of material and to offer insights into what impact such interventions have on communities and individuals.

The programmes are hard to evaluate, because of their size and the speed with which they are being rolled out, and because they are trying to address multiple problems in complex settings within shifting political environments. The fact that they are centrally determined but locally implemented adds to their complexity, not least when local and national evaluations are proceeding side by side.

Different stakeholders want different things from the evaluation process. For example, politicians favour 'quick wins', senior civil servants seek clear results that satisfy ministers, researchers prefer to pursue academic credibility and kudos, and practitioners in the field want to secure funding and get help with improving local practice.

These conflicting interests set up a range of tensions, for example: between the need to address complex interventions in community settings and the need for clear research findings; between the desire of politicians to get positive results quickly and the requirements of robust, impartial evaluation; between monitoring local practice and supporting it; and between measuring impact and action-based learning.

'They get the reports, they crawl all over them. They take out all the bad messages and then they publish them. Whether they look at them to improve policy, I don't know. "Give us some good news!" That's what they say.'

Evaluator

Complex interventions seem to demand complex appraisal. The more complex they are, and the more devolved and widespread the action, the more elaborate the task of evaluation can become. And because evaluations on this scale and of this kind of intervention are without precedent, the people who commission and contribute to them may lack appropriate experience.

There are also unresolved questions about who are supposed to be the main beneficiaries of evaluation: national government, local residents or other stakeholders. There are differing views as to whether their main purpose is to measure impacts, to understand what is happening, to monitor performance, or to help local practitioners improve their practice. Lack of clarity about purpose can affect decisions about method, timing and scale. Mountains of material may be produced but it is uncertain whether they will lead to firm or useful conclusions.

A range of methods and approaches is being used and these vary from one programme to another. There is no shared conceptual framework among those who commission or carry out the evaluation, nor is there a shared understanding about how to decide about purpose, methods and standards of investigation.

If the aim is to find out about impact and attribution, there are grounds for conducting more randomised and controlled evaluations. But as the ERA Demonstration Project suggests¹⁴⁸ (see p 40), if this approach is to succeed, it needs to be designed into the programme from the start and to remain central to its purpose for the duration. If the programme design gives priority to other objectives, it may not lend itself well to an RCT.

Other methods are equally valuable and most also need to be factored into the initial planning process. Some methods are still not very well developed, most notably with regard to how best to learn from practitioners in the field: how can local implementers and residents contribute their own experience and insights and take some ownership of the evaluation process? Progress on this front may be hampered by fears among practitioners that they are being 'spied upon' by the evaluators.

In the research community, it may be hindered by entrenched values and lack of experience in methods that acknowledge and incorporate local knowledge. New kinds of intervention may require innovative approaches to evaluation, yet research conventions tend to attach low status to new methods.

There are well-established methods of participatory and action research. Less well developed is a shared understanding of standards in research design, data-gathering or reporting mechanisms, and how these relate to other methods of evaluation. The 'theory of change' approach is still evolving as a tool for programme planning and evaluation, and is being put to widely different uses, for example in California Works for Better Health¹⁴⁹ (see p 41) and in some of the UK evaluations.

Learning

Ideally, evaluations and research findings are part of a continuing process in which all those involved – politicians, civil servants, academics and local practitioners – are building knowledge over time that enables them to improve policy and practice.

As we have seen, there is not yet a well-developed 'learning culture' in government. Most politicians lack awareness about what it takes to 'find out what works' or to get the results they want.

There is insufficient expertise among civil servants in commissioning appropriate evaluations. Some departments are reluctant to invest in disseminating and learning from the findings. Political imperatives, such as the need to demonstrate success within tight time frames, tend to inhibit rather than encourage learning.

Learning from the development and combination of research methods can be more difficult where researchers are prone to form factions, each with a vested interest in the supremacy of their own speciality, usually because of rivalry over contracts and funds. There are few signs that researchers are keen to learn from each other's efforts to evaluate social programmes.

Meanwhile, local practitioners often say they are too busy 'getting things done' to reflect and learn. Many feel their knowledge and experience is not being adequately captured or even recognised, and that they lack opportunities to learn from their peers or from policy-makers, researchers or other experts. The quality of neighbourhood advisers is variable and often fails to inspire practitioners' confidence. The concept of 'technical assistance', which is central to California Works for Better Health, is far less well developed in the UK than in the US.

Overall, it seems helpful to focus on knowledge-building, rather than merely on promoting 'evidence-based' policy and practice. However, knowledge-building will require a synthesis of radically different cultures: that of politicians wanting clear answers to the question 'what works?', that of academics committed to independent and impartial research, and that of managers and practitioners who want to get the job done and deliver worthwhile results. Each position is valid but the discrepancies and potential conflicts between them have not been adequately explored and are largely unresolved.

Underlying all this are competing philosophies about how people and organisations learn and change. A mechanistic or linear view of change can accommodate the idea of clear causal pathways between government policy, practical interventions, and measurable outputs and outcomes in communities.

A complex view of change pays more attention to history, culture and relationships, and sees change emerging from whole systems as they evolve over time.¹⁵⁰ These views are not easily reconcilable. So far there has been little debate about their significance for government, for health and social policy, or for learning and improving practice in this field.

Implications for public health

These problems with evidence, evaluation and learning are of concern to the King's Fund mainly because of their implications for public health policy and practice.

As we have pointed out elsewhere,¹⁵¹ a great deal is already known about the extent and causes of illness and about the wider determinants of health and health inequalities. The costs of failing to prevent ill health have been forcefully presented in two reports for the Treasury by Derek Wanless.¹⁵² Yet public health policy is still fraught with uncertainty about what is the best approach to tackling illness and inequality and what kinds of interventions should be given priority.

'Ministers are driven to spend money and want to see results. Unless and until they can be persuaded to take a longer view and invest in capacity building and be more patient about outcomes, evaluations will be unsatisfactory.'

Senior government researcher

Investment in health-related research remains dramatically skewed towards treatment and cure. Too little has been invested in exploring how change occurs at all levels, and in how the expertise of local practitioners and residents can be recognised and shared more widely.

There is no shared understanding of what criteria should be applied to decisions about investment in programmes, planning programme design, implementation and evaluation.

Uncertainty about the reliability and status of different kinds of evidence, and competing ideas about 'what works', mean that innovations – especially those addressing complex, interrelated causes of ill-health – are particularly vulnerable to attack.

The fate of the Health Action Zones (HAZs) is a case in point. If the HAZs were to work at all, they needed freedom to build local relationships and experiment with new ways of working over a sustained period. But this suggests an underlying philosophy that was not clearly acknowledged at the start, and that soon clashed with the dominant ethos of a government bent on driving performance towards specific, nationally determined targets. The HAZs thus became an easy target for incoming ministers at the Department of Health, who wanted to try something else.

The key factor here is not whether HAZs were or were not a good idea, but that if they had any potential, their chances of fulfilling it were jeopardised by a profound confusion over how to

build and act on knowledge about 'what works', and a failure to expose and confront that confusion. At the time of writing, it seemed entirely possible that Neighbourhood Renewal would suffer a similar fate. The problem is endemic, rather than specific to these programmes. Meanwhile, health inequalities continue to widen.¹⁵³

Opportunities

There are nevertheless significant opportunities for addressing these problems. In the UK, there is still a strong political will to intervene for social change, backed up by vast resources. There is a stronger commitment than ever before to preventing illness and reducing health inequalities. There is a chance to learn from a series of very large social experiments. And there are unprecedented levels of investment in evaluation and related efforts to build knowledge about 'what works'.

The Department of Health has committed new resources to public health research. The Health Development Agency's evidence base will continue to be built when the Agency's functions are moved across to the National Institute for Clinical Excellence (although this may seem an unlikely setting in which to nurture complex or lateral thinking about causation and change).

The UK Cabinet Office is making concerted efforts to develop shared standards for evaluation, to create opportunities for controlled experimentation, and to promote multi-method approaches.

There is increasing awareness within government and among academic researchers of the value of involving local practitioners in evaluation. More government officials, as well as researchers, are coming round to the view that evaluation should seek to understand processes and systems and to facilitate learning in order to improve practice, as well as to track progress towards targets and try to identify causal pathways.

There are signs in some parts of government that a more sophisticated understanding is emerging about how change occurs and about the need to develop a learning culture. There is some awareness of the need for evidence and evaluation to be part of a continuing learning process. And models are being developed to facilitate peer learning among local practitioners, and among officials at local and national levels.

Recommendations

All this can be built upon and we make the following suggestions for building knowledge more effectively in future:

Evidence

- ✓ There should be continued investment in building the evidence base, but this should be in the context of open dialogue and broad-based, critical appraisal.
- ✓ There should be much more open discussion at all levels of the complex and varied roles that different kinds of evidence can play in helping to plan and implement social programmes.
- ✓ Methods for review, appraisal and synthesis of different kinds of evidence need further development and should be subject to critical examination.

- ✓ Evidence should be disseminated more widely in accessible forms, but the risks of oversimplifying and removing evidence from its context should be more openly acknowledged.
- ✓ There should be more investment in helping people at all levels to acquire skills and techniques for using the evidence base effectively.
- ✓ Models for introducing and replicating evidence-based practice need further development and dissemination.

Evaluation

- ✓ There should be sustained investment in time and resources to develop a wider range of evaluation techniques, and to work out the best ways of effectively combining multiple methods.
- ✓ A broad consensus needs to be built about standards for evaluation, to promote an approach that is rounded, practicable and appropriate to the task in hand.
- ✓ More open and extensive dialogue is needed about the challenges of evaluating complex, community-based initiatives, the different functions of evaluation and the range of methods needed to fulfil them.
- ✓ The value of involving practitioners in evaluation and learning from their experience should be more widely recognised – and skills and techniques must be developed to enable this to happen.

Learning

- ✓ The need for a stronger learning culture within government should be more openly acknowledged and addressed.
- ✓ There should be more widespread discussion about conflicting interests and competing philosophies, and how these influence the knowledge-building process.
- ✓ More efforts should be made to promote shared learning and organisational change at national and local levels.
- ✓ Sustained investment is needed to develop ways of facilitating peer-to-peer and organisational learning, and to bring them into the mainstream.

‘There’s a wealth of knowledge there and we’re guilty of not disseminating it within our own organisation to our front line practitioners, which seems very remiss.’

Local practitioner

The main goal of this study has been to address problems that currently beset policy and practice aimed at preventing illness and reducing health inequalities. These include lack of clarity and consistency in approaches to policy-making and programme design; muddled messages and confused incentives at all levels; unresolved tensions between different objectives and interest groups, and a largely unacknowledged gap between political rhetoric and practical experience.

Such problems are not new. As John Maynard Keynes famously observed more than half a century ago: ‘There is nothing a government hates more than to be well-informed, for it makes the process of arriving at decisions much more complicated and difficult.’¹⁵⁴ However, it would appear that the current UK Government would like to be seen in a different light and is

endeavouring to make a virtue of knowledge rather than ignorance. Our recommendations are intended to assist that endeavour.

Above all, four broad changes are required:

- ✓ It is important to acknowledge the problems and open up the debate: there should be more explicit and inclusive discussion about the unresolved tensions and dilemmas outlined in this paper.
- ✓ Stronger efforts should be made to develop a learning culture in government, among evaluators and among practitioners in the field.
- ✓ Priority should be given to building knowledge, rather than just to promoting evidence-based policy and practice.
- ✓ Knowledge should be built by integrating the experience of practitioners and local residents, the findings of researchers and a more explicit understanding of the trade-offs required by the political context of the day.

Appendix 1: Methodology

The research was designed to inform our central objective, which was to examine the role of evidence and evaluation in the context of contemporary UK social policy. We addressed three main questions:

- How far are major social programmes of the current Government evidence-based?
- What is being done to find out whether they 'work'?
- What is required to facilitate learning and build knowledge to improve policy and practice?

We did this through initial scoping research, a seminar series, literature reviews, field research and in-depth interviews.

Scoping research

In 2002, we ran three workshops (n=44) and conducted 12 one-to-one interviews with senior people involved in large, voluntary sector organisations that lead complex, community initiatives in the United Kingdom and abroad.¹⁵⁵

The participants discussed their understandings of evidence, how they tried to use evidence and what they felt would improve their use of evidence in practice. The findings of this research, in conjunction with our seminar series and literature reviews, highlighted concerns about evidence-based policy and practice and informed our research programme and this policy paper.

Seminar series

The King's Fund, the Rockefeller Foundation and the Aspen Institute jointly ran a seminar series over four years (2000–04), with additional support from the UK Cabinet Office. All of the seminars focused on using, generating and learning from evidence in the context of social change and public health in complex, community-based initiatives.

Each of the four seminars lasted at least three days and consisted of commissioned papers and presentations, questions, discussions and future agenda-setting. The seminars were attended by 95 individuals, drawn from US foundations and UK government departments, and other organisations: these are listed on p 57.

This policy paper draws from the presentations, workshops and discussions generated by the seminars. In addition, from the papers presented at the seminar series, we chose six case studies for further documentary analysis and discussions with project managers. We felt these case studies illustrated particularly interesting and important approaches to some of the issues raised in the rest of the paper and they are explored in Section 3.

Literature analysis

We conducted a thorough literature review. We analysed published and unpublished ('grey') literature relating to government policies and discussions about policy direction, the use of evidence, evidence-based policy, evaluations, evaluation methodologies, complex community initiatives and evidence-based practice and learning.

From this analysis, and from our seminar series and scoping research, we selected five UK social programmes for further field research. These were all area-based initiatives; each included key strands of government policy to target disadvantaged areas; each was being evaluated; and each claimed to encourage evidence-based practice and learning.

Field research

For each of the selected social programmes, we undertook a thorough examination and analysis of related literature including published and unpublished reports, government guidance materials, on-line descriptions and analyses, published and unpublished evaluation reports, academic analyses and media reports. In addition, we attended external seminars concerned with the five programmes.

Throughout our seminar series, people involved with each of the five programmes were invited to attend the seminars, give presentations and contribute to discussions.

Our understanding of the policy areas therefore developed during the seminar series, through our literature reviews and during a further series of 31 in-depth interviews with people central to the design, evaluation and local implementation of the programmes.

Interviews

We conducted 31 semi-structured interviews with key people involved in the five field research programmes. For each programme, we interviewed people responsible for the policy and national evaluation, and at least one local practitioner.

All the people we approached were willing to be interviewed, and all were keen to express their personal views and to discuss the issues openly and in detail, particularly as anonymity had been agreed.

Although we were restricted to 31 interviews, mainly by resource constraints, the views we heard were remarkably consistent across the range of interviewees. They also corroborated what we had heard during the scoping study, seminar series and literature review, and resonated with other areas of our work.

The interviews lasted 45–90 minutes; all were recorded and additional notes were taken during the interview. The tapes were then fully transcribed and analysed and the notes taken were added to the transcripts.

All the interview material was verified with the interviewees. Key points drawn out in the policy paper were cross-referenced with relevant literature and with material from our seminars and scoping research.

The interviews were based around key themes, selected according to issues that had arisen out of the scoping research, seminar series and literature reviews. The questions were open-ended and we allowed the interviewees to discuss at length the areas they felt important.

The emphases of the interviews altered according to whether we were speaking to people responsible for policy, evaluation or practice, but were based around the following key themes:

- the use of evidence in the overall policy design
- commissioning evaluations
- evaluation theories and methodologies
- results and impact of evaluations
- relationships between civil servants, evaluators and practitioners
- using evidence in local practice
- learning from evaluations and from practitioners
- practitioner learning and training
- what could and should be done differently?

Papers given by the authors

- 'Troubling Evidence', UKPHA Conference, Cardiff, April 2003
- 'The Trouble with Evidence', King's Fund Research Seminars, March and November 2003 and April 2004
- 'Evaluation and Planning: Working with children in disadvantaged communities', Every Child Training Event, Romania, January 2003
- 'Using Evidence to Improve Practice', Every Child Evaluation Workshop, Lima, Peru, April 2002
- 'Evaluation and the Planning Cycle', European Children's Trust Regional Symposium, Prague, Czech Republic, August 2001
- 'Making a Difference with Evidence', Health Development Agency Conference, London, April 2001
- Three papers presented during our seminar series.

Other seminars attended

- Understanding Neighbourhood Change Seminar, Neighbourhood Renewal Unit, London, March 2004
- Evaluation of LSPs Seminar, London, January 2004
- Healthy Communities Collaborative Conference – Reducing Falls: A Healthy Communities Event, London, March 2004

Seminar participant list

Job title and organisation at the time of attendance

Garland Allen
Project Manager
US Department of Housing and Urban Development

Jessica Allen
Researcher, Public Health
The King's Fund

Lori Allio
Research and Policy Manager
California Works for Better Health

Andrea Anderson
Research Associate
Roundtable on Community Change
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Patricia Auspos
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Sir Roger Bannister
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Jacqueline Barnes
Professor of Psychology and Director Sure Start Local Programme Evaluation
Birkbeck College, University of London

Marian Barnes
Professor and Director of Social Research
Institute of Applied Social Studies
University of Birmingham

Marihelen Barrett
Vice-President
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Diane Bell
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Niall Dickson
Chief Executive
The King's Fund

Sue Duncan
Chief Social Researcher
Government Chief Social Researcher's Office,
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Teresa Edmans
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Bill Feinstein
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John Fox
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Co-Director, Institute for Learning in
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Appendix 2: Five UK social programmes

Health Action Zones

In June 1997, the new Labour Government announced the creation of Health Action Zones (HAZs) to begin work in 1998.

HAZs exemplified the new Government's approach to health policy. They were intended to improve and modernise local health services, reduce health inequalities and regenerate communities via increased local flexibility, innovation and partnership working.¹⁵⁶

Their key objectives were to tackle inequalities in health in the most deprived areas through health and social care modernisation programmes. They were given three strategic objectives:

- to identify and address the public health needs of the local area, in particular by trailblazing new ways of tackling health inequalities
- to modernise services by increasing their effectiveness, efficiency and responsiveness
- to develop partnerships for improving people's health and health services.

HAZs were partnerships between the NHS, local authorities, the voluntary and private sectors and community groups, and were co-ordinated locally by a partnership board. In total, 26 HAZs were created in England, with populations ranging from 180,000 to 1.4 million per HAZ, bringing a total of 13 million people within HAZ areas.

The Government provided a collective allocation of £320 million to fund HAZs for three years (1998/99 to 2001/02). This amounted to about 1 per cent of the overall NHS budget. In May 2003, a further three years' worth of funding was announced, amounting to £45 million to £47 million per year from 2003/04 to 2005/06, while a further £10 million per year for three years was allocated to all HAZs for smoking cessation programmes and £7.2 million for anti-drug programmes.

HAZs were meant to be seven-year programmes, running from 1998 to 2005. However, since 2002 most HAZ functions have been incorporated into primary care trusts.

Evaluation

One of the seven underpinning principles of HAZs was that they should take an evidence-based approach to their work. A £1-million evaluation ran in parallel with the programme from 1999 to 2003, funded by the Department of Health and led by Professor Ken Judge at the Health Promotion Policy Unit, University of Glasgow, in collaboration with colleagues at Queen Mary College (University of London) and the University of Birmingham.

The evaluation was based on 'theory of change' and realistic evaluation approaches. The overarching aim was to identify and assess the conditions in which enhanced capacity for local collaboration resulted in the adoption of change mechanisms that led to the modernisation of services and a reduction in health inequalities.

The evaluation was also supposed to inform the Department of Health and the wider policy and practice community about partnership working, building capacity and enabling change. There were four main components:

- an overview of all 26 HAZs
- an in-depth look at partnership working in eight HAZs
- detailed case studies in five HAZs
- an examination of the impact on health inequalities via three tracer topics: employment, early childhood interventions and coronary heart disease.

In addition, HAZs were required to evaluate their programmes locally.

The evaluation concluded that it was too early to judge the impact of HAZs on health inequalities. It was able to assess how successful HAZs had been at setting up and sustaining partnership working, designing and implementing programmes and related issues. It concluded that particular challenges for HAZs included partnerships and planning mechanisms, performance management, changing policy priorities, and engaging voluntary sector and community groups.¹⁵⁷

New Deal for Communities

The New Deal for Communities (NDC) is a key programme in the Government's strategy for tackling multiple deprivation in the most deprived neighbourhoods. The aim is to bridge the gap between these neighbourhoods and the rest of England, by funding local, partnership and community-based strategic programmes.¹⁵⁸

The Government intended that NDC programmes should be long-term partnerships with community involvement. It also intended that their actions should be based on evidence. There are five key policy areas that programmes must focus on: health, education, worklessness, housing and the physical environment, and crime.

Seventeen partnerships were announced in 1998, followed by a second round of 22 partnerships in 1999. Over the ten-year duration of the programme, they will receive a total of £1.9 billion.

Because of the relatively lengthy time horizon and the scale of investment involved (about £50 million for each NDC partnership), the programmes are seen as an unprecedented opportunity to inform neighbourhood renewal. The NDC is the Government's pathfinder programme for the National Strategy for Neighbourhood Renewal.

Evaluation

In 2001, a consortium of organisations, under the direction of Professor Paul Lawless at the Centre for Regional Economic and Social Research at Sheffield Hallam University, was appointed to carry out the first phase of a national evaluation, due to end in 2005.¹⁵⁹

The evaluation has been commissioned by the Office of the Deputy Prime Minister, which is running the NDC programme through the Neighbourhood Renewal Unit (NRU).

Overall, the evaluation is examining the interventions and impacts of partnerships locally, focusing on the five key policy areas. The national evaluation's 2002/03 annual report suggests the keys to change are improving local services, increasing community capacity and enabling people to do more for themselves, and adopting an evidence-based approach to delivering change (in other words, getting proof of what works in practice).¹⁶⁰

The evaluation's methodology includes:

- household surveys in all 39 NDC areas. These were carried out in 2002 and repeated in 2004/05 to measure change across the programme
- identifying, collecting and assessing secondary data across all partnership areas, to track changes in relation to the five key policy areas
- collecting and reviewing qualitative data relating to key process issues such as partnership working, community involvement, mainstreaming and service co-ordination
- assessing the value for money provided by the NDC programme, analysing outcome indicators against expenditure to estimate net impacts within and across the programme and in relation to specific groups of beneficiaries
- detailed case-study work that will take place in six NDC areas in order to provide additional evidence in relation to key process issues and questions such as the impact of NDC programmes on particular groups – for example, black and minority ethnic communities, and young people.

Part of the evaluation programme is to provide support and information for those involved in policy development and implementation. The evaluation team will support the Neighbourhood Renewal Unit's Skills and Knowledge Strategy and strengthen the evidence base, particularly in relation to the five key programme areas.

Neighbourhood Renewal

A New Commitment to Neighbourhood Renewal is a national strategy action plan launched by the Prime Minister on 15 January 2001.¹⁶¹

The strategy sets out the Government's vision for narrowing the gap between deprived neighbourhoods and the rest of the country, so that 'within 10 to 20 years, no one should be seriously disadvantaged by where they live'.

In producing the strategy, the Social Exclusion Unit (and the 18 Policy Action Teams that supported it), identified six barriers that had impeded earlier efforts to change the poorest neighbourhoods.

The strategy aimed to address these barriers, which were: failure to address the problems of local economies; failure to promote safe and stable communities; poor core public services; failure to involve communities; lack of leadership and joint working; insufficient and poor use of information.

The National Strategy for Neighbourhood Renewal (NSNR) identified its long-term goals as: to improve outcomes on worklessness, crime, health, skills, housing and the physical environment in the poorest neighbourhoods; and to narrow the gap between the poorest neighbourhoods in England and the rest of the country.

The NSNR set new policies, funding and targets. The Neighbourhood Renewal Fund (NRF) was established to enable the 88 most deprived authorities, working with their Local Strategic Partnerships (LSPs), to improve services. NRF grants can be spent in any way that tackles deprivation, particularly in relation to the floor targets and to local targets set out in the Local Neighbourhood Renewal Strategy (LNRS).

The NRF was worth £900 million over the three years 2000–03. The 2002 Spending Review made available an additional £975 million for the NRF in 2004/05 and 2005/06. And the

Comprehensive Spending Review of 2004 made available a further £525 million, although, at the time of writing, this had not been allocated.

Other programmes linked to Neighbourhood Renewal include:

The New Deal for Communities programme This has been running since autumn 1998 and has been a test-bed for many of the ideas and policy initiatives being developed to support renewal (see p 62).

Neighbourhood Wardens This programme grants aid for a uniformed semi-official presence in a residential area with the aim of improving the environment, quality of life and safety. Street wardens are similar to neighbourhood wardens, but put more emphasis on caring for the physical appearance of an area. Street crime wardens play a role in reducing crime in targeted high-crime areas.

The Neighbourhood Management Programme A total of £45 million has been made available over three years to test new ways of delivering priority services. These include better management of the local environment, increasing community safety, improving health care and education, and encouraging economic growth in the neighbourhood.

The Deprived Urban Post Office Fund This is a £15-million programme, which aims to prevent post office branches closing in deprived urban neighbourhoods.

The Single Community Fund From April 2004, the NRU's three existing community participation programmes have been merged into the Single Community Programme, which aims to: maintain Community Empowerment Networks; support community learning through small grants and learning strategies; support active and resourceful communities through small grants; support community involvement in neighbourhood-level partnerships.

On a national level, the Neighbourhood Renewal Unit (NRU) has also set up a Community Forum to provide a 'grass-roots' perspective on the National Strategy and advise on how local communities can be effectively involved in neighbourhood renewal.

Evidence and learning

A key part of the NSNR was a commitment to promoting a learning culture within government and for everyone involved in neighbourhood renewal. Two major strands of the NRU aim to improve learning and skills and knowledge:

The NRU's Research and Development Division Its objective is to develop understanding of the causes and consequences of deprivation, and identify means of reviving blighted communities. It aims to: respond to policy-makers' and practitioners' needs for research and evidence, and develop a research strategy to ensure that policies and decisions build on existing knowledge and are evidence-based; work with other government departments and stakeholders to improve knowledge of the spatial and distributive effects of policies and programmes relevant to neighbourhood renewal; establish mechanisms to promote and communicate the evidence base widely; support the NRU's Knowledge Management and Learning and Development Strategies; and develop neighbourhood information and analysis.

Skills and Knowledge The Skills and Knowledge Programme is committed to bringing about a step-change in the level of skills and knowledge for all involved in neighbourhood renewal, and to ensuring that everyone involved in neighbourhood renewal has the support they need to improve neighbourhoods (see case study, p 32).

Evaluation

Specific programmes of the Neighbourhood Renewal Strategy are being evaluated. These include the New Deal for Communities, the Neighbourhood Management Pathfinder Programme, Skills and Knowledge, Neighbourhood Wardens and LSPs.¹⁶²

The NRU will commission an overall evaluation of neighbourhood renewal in autumn 2004, and therefore there are so far no evaluation findings for the whole of the Neighbourhood Renewal Strategy.

Sure Start

Sure Start aims to improve the health and well-being of families and children before and from birth. It is a major part of the Government's drive to tackle child poverty and social exclusion.¹⁶³

It emerged as the result of the 1998 Comprehensive Spending Review, which contained a wide-ranging review of the state of services relating to children and made a number of recommendations. Its most important conclusions were:

- The earliest years in life are the most important for child development.
- Multiple disadvantage for young children was a severe and growing problem.
- The quality of service provision for young children and their families varied enormously across localities and districts.
- The provision of a comprehensive, community-based programme of early intervention and family support, building on existing services, could have positive and persistent effects.

Sure Start also drew on Head Start and the EPPE study (see p 17). The first Sure Start local programmes were set up in 1999. There are now 524, concentrated in neighbourhoods where a high proportion of children are living in poverty, covering up to 400,000 children, including one-third of under-fours living in poverty.

The Sure Start local programmes work by bringing together early education, child care, health and family support providers to:

- increase the availability of child care for all children
- improve health, education and emotional development for young children
- support parents in their role and in developing their employment aspirations.

This is achieved by:

- helping services to develop in disadvantaged areas
- providing financial help to enable parents to afford quality child care
- rolling out the principles driving the Sure Start approach to all services for children and parents.

In 2002, the Sure Start Unit expanded. Sure Start has also extended beyond the local programmes to cover early-years education, the Government's child care strategies and the provision of health and family support.

The Sure Start Unit's budget has grown from around £800 million in 2002/03 to more than £1.5 billion in 2005/06. The Sure Start Unit works with local authorities, primary care trusts, Jobcentre Plus, local communities and voluntary and private sector organisations.

Evaluation

The National Evaluation of Sure Start (NESS) is led by Professor Edward Melhuish from Birkbeck College at the University of London with a national team and a budget of £20 million. The first

phase started in January 2001 and will run till 2007. The aim is to evaluate the efficacy and cost-effectiveness of Sure Start local programmes in reaching their goals of enhancing child and family and community functioning.¹⁶⁴

Three core questions guide evaluation:

- Do existing services change (how and if so for whom and under what conditions)?
- Are delivered services improved (how and if so for whom and under what conditions)?
- Do children, families and communities benefit (how and under what conditions)?

NESS addresses these three questions through five component parts:

- implementation evaluation
- impact evaluation
- local community context analysis
- cost-benefit analysis
- support for local evaluations.

1. **Implementation evaluation** This looks at what is actually being done in local Sure Start programmes. It investigates management and co-ordination, access to services, quantity of services, allocation of resources, quality of services (including degrees of appropriateness) and community involvement. It consists of three core activities: a national survey of all local Sure Start programmes, repeated three times over the course of the evaluation, an in-depth study of 25 local Sure Start programmes and a series of themed evaluations.
2. **Local context analysis** This describes all Sure Start communities, looking at the social, demographic and economic context of each community and the provision of local services. This part of the evaluation changes over time and concentrates specifically on demographics, economic characteristics, the degree of danger and disorder, the health of adults, the health and development of children, parenting and the home environment of families and local provision of services.
3. **Impact analysis** This will assess children, families and communities in Sure Start and non-Sure Start communities, in order to determine which features of the Sure Start programme prove most effective in enhancing the lives of children, families and communities. In addition, the evaluation will investigate for whom Sure Start works best and in what circumstances.

The development and functioning of 18,000 infants, two-year-olds and four-year-olds and their families, from 150 Sure Start communities, will be compared with similar children selected from the Millennium Cohort Study.

In the second phase, infants and their families will be followed up when the children reach two and four years of age (and older, in the next phase of the evaluation). Comparisons between communities will also be made on health, education, employment and crime.

Both the first and second phases of investigation will focus on children's physical health, behavioural development and intellectual and academic functioning, as well as parents' economic circumstances, mental health, parenting practices, parents' perceptions of their communities and experiences of health, education and other community services available to themselves and their children. All these topics will be studied during the course of home visits to families and follow-up telephone calls.

- 4. Cost-effectiveness** The cost-effectiveness evaluation will determine the true cost of Sure Start. It will also determine whether the effects of Sure Start on child, family and community functioning justify the investment of resources and determine the most efficient way in which child, family and community outcomes were achieved.

In addition, a cost-benefit analysis will examine positive and negative effects of Sure Start, direct and indirect effects and anticipated and unanticipated effects. Examples of anticipated benefits are improved family functioning (short term), reduction in special needs (medium term) and lower crime rates (long term).

- 5. Support for local evaluations** This provides technical support to local Sure Start programmes conducting their own, local evaluation. Advice and support is available on issues of design, measurement and data analysis, and on ensuring links between national-level and local-level evaluations.

Local Strategic Partnerships

Local Strategic Partnerships (LSPs) were introduced in 2000 to help tackle social exclusion and enable renewal of deprived neighbourhoods.

The 'Joining it up Locally' Policy Action Team (1997) had suggested that one of the main reasons for a lack of progress in regenerating deprived areas was a lack of 'joined-up thinking'. To tackle this, it proposed that every area should have a single, overarching partnership to bring together the public, private, voluntary and community sectors.¹⁶⁵

It argued that such a partnership would ensure that different initiatives and services supported each other and worked together. LSPs were the result of these proposals and were introduced in The Local Government Act, 2000.

LSPs have been set up across England, coterminous with local authority areas. There is no compulsion to have an LSP, except in the 88 most deprived local authority areas that receive neighbourhood renewal funds, which must have an effective LSP and a neighbourhood renewal strategy.

Local partners decide on the range of work for their LSP. Core tasks for those in the 88 areas that receive neighbourhood renewal funds are to:

- prepare and implement a community strategy for the area
- bring together local plans, partnerships and initiatives
- work with local authorities to develop a local public service agreement
- develop and deliver a local neighbourhood renewal strategy
- have the agreement and commitment of all the key people and institutions with a stake in the neighbourhood
- set out an action plan that responds to neighbourhood needs.

LSPs are also expected to set targets for how things should change over time, especially in terms of the key outcomes of reducing worklessness and crime, and improving skills, health, housing and the physical environment.

Evaluation

In March 2002, the Government commissioned a national research programme to support LSPs and policy-makers at local, regional and central levels and to evaluate progress.

The research programme is sponsored by the Office of the Deputy Prime Minister and the Department for Transport. A consortium drawn from of the universities of Warwick, Liverpool John Moores, and West of England (Bristol), and the Office for Public Management (London) has been commissioned to conduct the first three years of the study.

The evaluation comprises a feasibility study (which cost £1 million), formative evaluation (March 2002–October 2005) and a summative evaluation (provisionally 2005–07). The aim is to develop and test a plausible 'theory of change' that can help to explain the behaviour, activities and outcomes of LSPs.

The feasibility study A variety of stakeholders were consulted to establish the issues on which LSPs want advice and support, how to identify and disseminate good practice and how best to provide LSPs with practical support. A survey of all LSPs was also undertaken.

The formative evaluation This is looking at the processes, preliminary impacts and effectiveness of LSPs. It includes nine case studies, a major postal survey of all LSPs, a range of targeted, smaller studies and action research on specific aspects of LSPs.

There are also eight, issue-based action research sets, bringing LSPs together to discuss one issue in depth and develop effective practice, and nine regional learning sets, bringing together the representatives of LSPs in one region to disseminate knowledge emerging from the research and share best practice across all issues.

The summative evaluation This will start in 2005 and assess the impact and 'added value' of LSPs against central and local aims and objectives. It will involve linking action research and formative evaluation findings with evaluation of the impacts and effectiveness of LSPs, LSP activities and policies.

Appendix 3: *Building Knowledge about Community Change*

A summary of the companion report from the Aspen Institute

Patricia Auspos and Anne Kubisch

Aspen Institute Roundtable on Community Change

The full report is available at: www.aspeninstitute.org

Introduction

The paper summarised here focuses on learning about community-based change and learning from evaluations and asks: where do we go from here? It draws on the seminar series organised by the Aspen Institute with the King's Fund and the Rockefeller Foundation and is a companion volume to *Finding Out What Works*.

It proposes a new paradigm for learning, comprising a more collective knowledge development enterprise than currently exists in the community change field. This would allow systematic comparisons, across sites and initiatives, of how strategies, implementation and outcomes vary according to local conditions. It would draw on a broad spectrum of disciplines and on a wide range of sources and methods for learning. It would aim to accumulate and disseminate knowledge in ways that benefit local practitioners and strengthen community capacity.

This proposal challenges the prevailing paradigm about evidence-based policy-making, which is that good evidence will produce changes in policy and that these changes will in turn change practice on the ground. Community change initiatives need a different approach because their aims, the way they develop over time, their funding sources and policy networks all make them unsuited to conventional methods of evaluation and policy development.

Evaluating Comprehensive Community Initiatives

Early interventions – known as comprehensive community initiatives (CCIs) – acknowledged the difficulties of using traditional approaches and had to make up the rules of good practice as they went along. Advances from the last decade that are important for evaluation include:

- being more realistic about change
- developing strategies for engaging community residents in evaluation
- understanding the different elements of community-building and how to assess them
- using multiple methods to evaluate implementation processes
- using multiple methods to trace causal links between interventions and outcomes
- using a Theory of Change approach to clarify the aims and processes involved in an initiative, and to help understand its effectiveness
- feeding back findings to different audiences in appropriate ways.

CCI evaluations have produced richly textured information about what is happening in communities, yielded useful cross-cutting lessons and documented 'first order' effects about

the outputs of initiatives. However, they have not been able to produce information about longer-term outcomes or evidence about the effectiveness of the approach. There are several reasons for this:

- Initiative implementation was not strong enough or long enough.
- Evaluation time frames were too short.
- The guiding Theories of Change were inadequate, tending sometimes to be overly detailed and sometimes underspecified, and remain under-developed.
- Data collection efforts became too comprehensive, expensive and burdensome.

Some CCI evaluations have tried hard to draw conclusions about longer-term outcomes as well as implementation, and with some success. Three case studies show that behind such success lay more central management and development, a narrower programmatic focus and a stronger emphasis on research needs than in most other cases. This approach has benefits and drawbacks for CCIs in general.

Future work should be based on the premise that the purpose of an evaluation is less to showcase accomplishments than to build knowledge. And not all initiatives are worth evaluating in a major way. Each evaluation should:

- be clear about its purpose and the question it wants to answer
- be realistic about what can be accomplished and learned
- integrate the design of the evaluation with that of the initiative
- focus the work around key outcomes, valuing community capacity as well as health, economic development, education and so on.

Thinking differently about what we need to know

A more thoughtful approach to knowledge-building is required, which seeks to deepen understanding of:

- connections between community capacity-building and outcomes that define community well-being
- interactions between capacity-building strategies and more conventional programme interventions
- the mutually reinforcing effects of improving outcomes across sectors such as health, education, employment and community safety
- the influences of history, context and connections
- how the strength of the 'dose' of an intervention relates to the outcome.

Knowledge about community capacity-building is poorly developed. It requires:

- clear definitions of key concepts, elements and outcomes
- standard measures or indicators
- a taxonomy of key assets of community capacity
- a diagnostic tool to identify the assets of specific communities
- theoretical models or hypothetical pathways of change to map processes whereby community capacity contributes to both programmatic and civic outcomes.

Thinking differently about how we learn

A more coherent system is needed for distilling and disseminating lessons learned so far, identifying new knowledge needs and designing next generation interventions and evaluations. This should involve:

- strengthening the role of practitioners in knowledge-building
- casting a wider net to capture insights about community change and capacity-building
- building a knowledge base that connects theory, social science research and practice
- developing new research around current and past initiatives
- developing an infrastructure to strengthen the knowledge development-to-practice-to-policy cycle.

This is complex and difficult work – a challenge for organisations involved in community change, which are typically small, underfunded and disconnected from larger systems and supports. There is also a supposition that, because all communities are unique, there are few universal lessons to be learned, and few opportunities for generic approaches to change or to knowledge-building. And the fact that the community-building field is made up of many diverse organisations and actors means the field is beset by multiple tensions and competing demands. Key challenges are:

- moving towards a more standardised approach, while respecting local circumstances and concerns
- learning and doing at the same time: dealing directly with operational issues and developing sequencing strategies for research activities
- addressing the political dimensions of change and broader systemic and policy issues
- crossing programmatic boundaries and committing to a longer time frame for learning
- translating and disseminating interim and longer-term lessons in the form of usable conclusions, tools, strategies and programmes.

Implications for key actors in the field

Community-building approaches to improving outcomes for poor communities have been shown to have great potential but we need to learn how to do them better. This means we must improve our knowledge base about how to bring about community change, how to implement appropriate strategies, how to assess what is working and why, and how to ensure that all the key actors apply that knowledge.

Public and private sector funders and policy-makers should:

- use their leadership role to focus evaluation research on well-structured learning for the field as a whole
- focus investments on deeper, high-quality, longer-term and, if necessary, fewer interventions and structure accompanying research around issues that have long-term policy value
- avoid the temptation to produce quick wins that do not test promising community-building approaches
- continue to press for outcomes accountability but be clear about what is plausible and reasonable
- recognise that achieving outcomes will depend on many community capacities that are, in themselves, an important focus for investment and learning
- target funds in ways that will build those capacities, assess and measure them, and ascertain whether and how they lead to desired outcomes
- be open and honest about everything that is learned, providing easy access to all materials produced through community change work
- make common cause with other funders and policy-makers, to overcome the current lack of coherence, co-ordination and collective effort.

Evaluators and researchers should:

- focus research on meaningful and answerable questions
- give priority to developing measures of community-building concepts and tracking their effectiveness
- learn how to assess implementation of community change efforts effectively but efficiently
- listen to practitioners and design research to respond to their needs
- keep track of how far research design is matching the pace, scale, 'dose' and so on of the intervention and be willing to make changes
- set high standards for open and honest feedback to all stakeholders at all points in the intervention.

Practitioners should:

- be as clear as possible about what they expect to achieve, over what period of time, and how (in other words, their theory of change)
- where their work emphasises community-building, be open about it so that it can be legitimised and tracked in the evaluation
- define community-building activities as precisely as possible and be clear about the expected outcomes
- if implementation is off-track, make sure the funder and evaluator know
- be clear about their own information needs and convey them to the evaluator, making sure that all necessary formative feedback, programme data and community information are supplied.

Community residents should:

- ensure that their knowledge becomes a key part of any change process
- be active and informed consumers of evaluations and other research about their community and hold researchers accountable for their products
- use information produced through all community interventions to make the case for investment in their community and for promoting its potential.

Endnotes

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