Critical Public Health

Tackling health inequalities through partnership working: Learning from a realistic evaluation

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Tackling health inequalities through partnership working: learning from a realistic evaluation

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ABSTRACT   *UK government health policy now strongly supports local partnership working as a key mechanism for tackling health inequalities. There is, however, still a lack of evidence based operational guidance for the development of local partnerships in tackling inequalities in health, as well as continuing evidence of the deep-rooted political, organizational and cultural barriers to partnership working. This paper reports on the evaluation of a two year Health Education Authority programme of demonstration projects designed to test five different models of partnership working in tackling health inequalities. The evaluation drew on Pettigrew* et al.'s *(1992) concepts of receptive and non-receptive contexts for change as well as the 'realistic evaluation' of Pawson & Tilley (1997). Data were collected using a range of qualitative methods including semi-structured interviews with key stakeholders and non-participant observation. Six key themes were identified from the case studies: shared strategic vision, leadership and management, relations and local ownership, accountability, organizational readiness and responsiveness to a changing environment. The importance of understanding how project mechanisms worked in the context of national and local policy change is emphasized, and lessons are identified for UK Health Improvement Programmes, Health Action Zones and Primary Care Groups.*

Introduction

Throughout the 1980s and early 1990s a political debate raged in the UK over the question of whether inequalities in health were increasing, whether this mattered, and if so, what should be done about it. On one side was the then Conservative government; on the other were the Labour opposition and a wide-ranging alliance of public health practitioners, academics and activists. A central focus in this struggle was the Black Report (Department of Health and Social Security, 1980) on health inequalities which the government initially sought to suppress, and which took on almost iconic significance for the government's opponents. The argument shifted in the mid 1990s when the government accepted for the first time that health 'variations' existed, and sought public health guidance on how such inequality

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might be addressed (Department of Health, 1995; NHS Centre for Reviews & Dissemination, 1995). With the election of a new Labour government in May 1997, the political argument appeared won. Labour pledged to tackle health inequalities in line with its broader commitment to addressing social exclusion (Labour Party, 1997; Department of Health, 1998a).

By the mid 1990s, a huge body of research evidence was available on the determinants and extent of health inequalities in the UK, and the main national policy action needed. As George Davey Smith and colleagues have eloquently summarized it: 'ending poverty is the key to ending inequalities in health' (Davey Smith *et al.*, 1999, p. 163). Changes to national benefit and incomes policy are the best way to reduce inequalities in health. There is, however, much less certainty on how such inequalities should be tackled at local level. The new Labour government expressed its belief in 'joined up thinking' and strongly supported local partnership working as a key mechanism to tackle health inequalities. A series of English White and Green Papers (Secretary of State for Health, 1997; 1998; 1999) heralded a range of policy initiatives including a new inquiry into health inequalities (Department of Health, 1998b), Health Action Zones (HAZs), Health Improvement Plans (HImPs), Primary Care Groups (PCGs) and a new statutory duty of partnership between health and local authorities. This emphasis on local partnership was welcomed by health and local government stakeholders, many of whom were involved in Healthy Cities (Ashton, 1992) and other local partnership initiatives. An increasing body of research evidence also suggested that partnership working was an important prerequisite of strategies to tackle health inequalities (NHS Centre for Reviews & Dissemination, 1995; Gillies, 1998). There is, however, still a lack of evidence based operational guidance for the development of effective local partnerships in tackling health inequalities (Benzeval, 1999), as well as continuing evidence of the deep-rooted political, organizational and cultural barriers to partnership working, particularly between the health and local authority sectors (Popay & Williams, 1998; Hiscock & Pearson, 1999). It was to address this need for practical support for local partnerships that the Health Education Authority's Integrated Purchasing Programme (HIPP) was developed.[a]

The HIPP programme

The HIPP programme was launched by the HEA in 1996 following several earlier initiatives on health gain, primary care and inter-agency work. The overall aim was 'to provide practical support and guidance to health authorities, local authorities, and those working in primary care, for making progress on local health strategies and targets . . .' This support was delivered through four main programme elements: (1) the establishment of five demonstration projects, (2) a national Practice Exchange Network, (3) a learning and dissemination programme and (4) a resource base of knowledge. The HEA also identified four key themes which were to be central to the programme and defined the scope of 'integrated purchasing' (Table 1).

TABLE 1. HIPP programme key themes

- The extent to which locality commissioning can be the focus for developing and implementing local health plans and programmes.
- How the different models of general practice involvement, as purchasers and providers, can help or hinder a health gain and health promotion perspective.
- How health and local authorities can and are addressing jointly shared priorities for health and social gain.
- The potential for targeting efforts and resources to address inequalities in health across the population.

HIPP was designed to be different from other project-based programmes in four ways. First, HIPP offered projects support through consultancy (provided by the Office for Public Management), evaluation and the Practice Exchange Network rather than through financial grants. Second, the programme intended to enable learning and dissemination to run concurrently with the project work. Third, HIPP planned to include unsuccessful bidders and other interested parties in the programme through the Practice Exchange Network. Finally, the programme aimed to strengthen the capacity of participants to implement change beyond the two years of project work.

The HIPP programme ran for three years from mid 1996, with demonstration projects and the learning network supported for two years from April 1997 to March 1999. A selection process for the demonstration projects was announced in October 1996 and completed with the selection of five projects in March 1997. The five selected projects were located in Northumberland, Nottingham, Tameside and Glossop, Sandwell and Telford and Wrekin. Each project involved a different local partnership arrangement and approach to tackling inequalities in health.

The HIPP policy context

The HIPP programme was launched by the HEA during a period when it was accountable to a Conservative government committed to a *quasi-market* approach to health policy, and which was ambivalent about initiatives directed to tackling health inequalities. Prior to HIPP, even the use of the term 'health inequalities' was effectively proscribed in official circles in favour of the more euphemistic 'health variations'. The HEA itself was on occasion a target of ministerial and official disapproval for its work programme in areas such as sexual health, which raised uncertainties for the organization's long term future. At the same time, there were a number of criticisms of the HEA from grassroots public health practitioners, academics and activists for its supposed timidity in not more explicitly addressing the inequalities agenda, and for its failure to respond to the views and needs of local organizations. Thus the HIPP programme was designed by the HEA to represent a new way of 'bottom-up' working, responsive to the views of local organizations and developmental in its focus. From the HEA perspective, however, this aim needed to be balanced with sensitivity to what was politically acceptable to the government

of the day. With the election of the new Labour government in May 1997, this policy context changed radically, with important implications for the programme which are discussed below.

The HIPP evaluation

Evaluation was a core element of the programme and in November 1996 the HEA commissioned the University of Southampton to undertake the 'independent evaluation' of the HIPP programme (although the contract later followed the lead researcher to the University of the West of England). The commission was to conduct a process-orientated evaluation, which took a developmental approach concerned with supporting project implementation and progress towards health gain objectives. As both 'independent' and concerned with a developmental process, the evaluation stood both outside and within the programme. Key objectives for the evaluation were: (1) to describe the different models for integrated purchasing developed by the five demonstration projects; (2) to identify enabling factors and obstacles to progress for each model in making progress towards achieving health and social gain and in reducing inequalities in health; and (3) to compare and contrast the different models.

The design of the evaluation was informed by recent developments in social science theory on the importance of understanding contextual factors in health and social change processes. Pettigrew *et al.* (1992) demonstrated the importance of receptive and non-receptive contexts for change in their study of strategic change in the NHS. They identified eight inter-connected factors related to receptive contexts for change (Figure 1).

More recently, Mays *et al.* (1998; forthcoming) have applied the Pawson & Tilley (1997) model of realistic evaluation to the assessment of the total purchasing policy experiment. Pawson & Tilley strongly argue that an understanding of causality is fundamental to evaluation. They argue for a theory of 'generative causation', which gives contextual factors their proper place in investigation. In this conceptualization, social programmes work by introducing new ideas, processes or resources (i.e. mechanisms) into existing social relations (i.e. context). Context may include historical, cultural, political, organizational and other factors and may change over time. The crucial task of evaluation is to investigate via theoretical and empirically based hypothesis making and testing the extent to which context enables or disables the intended mechanism for change. Outcomes are explained by the action of particular mechanisms in particular contexts. In Pawson & Tilley's elegant equation, Context + Mechanism = Outcome. For a programme like HIPP, the crucial question is therefore about the causal relationships between different contexts ($C_1, C_2, C_3 \ldots$), mechanisms ($M_1, M_2, M_3 \ldots$) and outcomes ($O_1, O_2, O_3 \ldots$). Pawson & Tilley call these causal relationships 'CMO configurations'. They conclude 'the task of a realist evaluation is to find ways of identifying, articulating, testing and refining conjectured CMO configurations' (Pawson & Tilley, 1997, 77). The ultimate goal is to identify regularities of context, mechanism and outcome within social programmes.
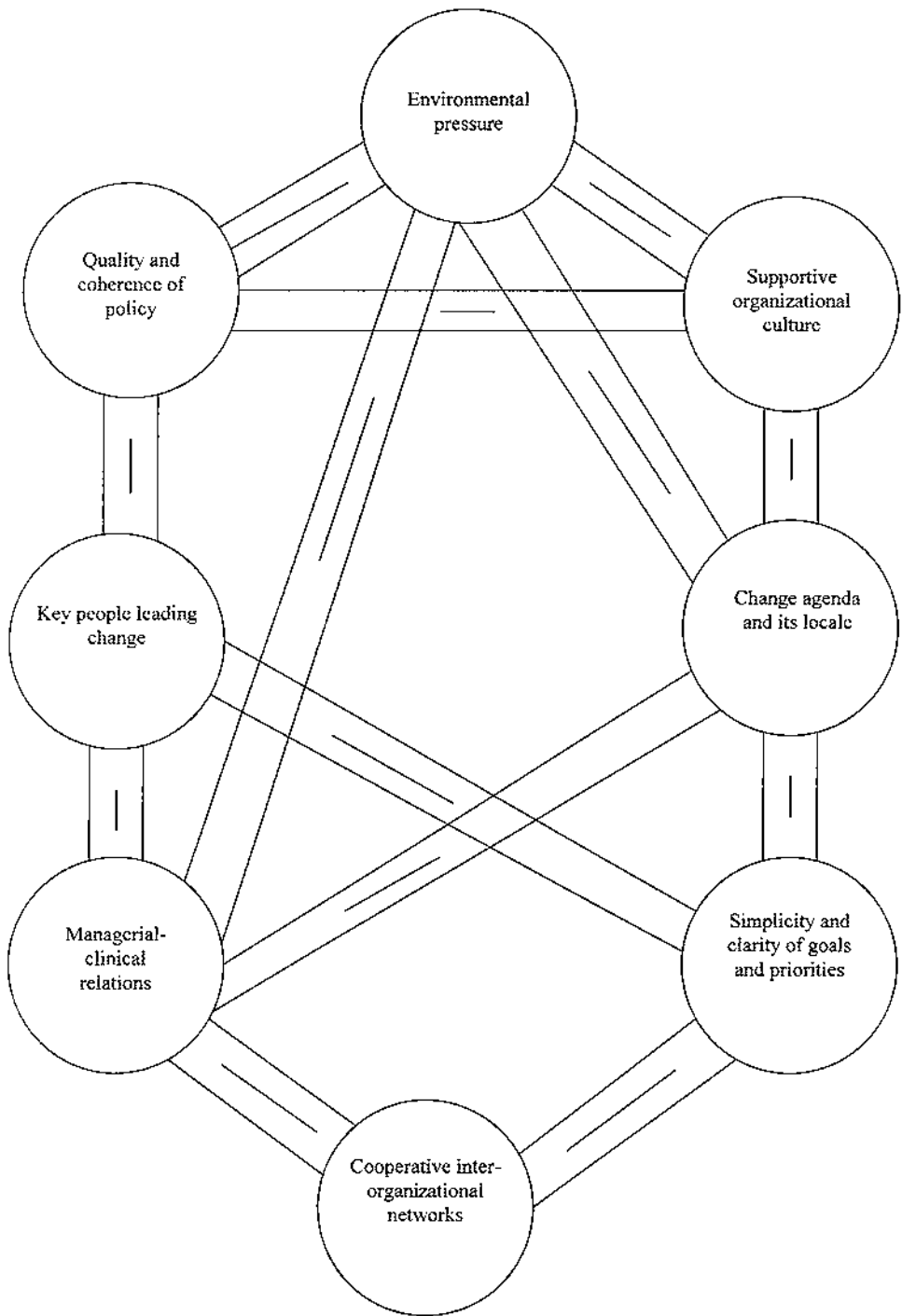
FIGURE 1. Receptive contexts for change.
(From: Pettigrew *et al.*, 1992)

HIPP evaluation hypotheses

Initially, the evaluation was based on the hypothesis that the five demonstration projects represented different models of integrated purchasing for health gain, and that the implementation of different models in varied geographical settings would generate learning about the value of the different models in tackling health inequalities and the enabling factors and obstacles they encountered. The work of Pettigrew and colleagues on receptive and non-receptive contexts for change was drawn upon during the baseline data collection period to develop six categories of enabling factors: (1) shared strategic vision; (2) leadership and management; (3) relations and local ownership; (4) accountability; (5) organizational readiness; and (6) responsiveness to a changing environment. An initial set of hypotheses were generated (Table 2) which were tested and refined through an iterative process of data collection and analysis.

Midway through the evaluation the appearance of Pawson & Tilley's (1997) book provided an additional conceptual framework for analyzing the data emerging from the evaluation. In particular, the original hypothesis was reconceptualized in Pawson & Tilley's terms by asking 'what mechanisms within the HIPP programme worked in what contexts for whom?' The evaluation began to apply Pawson & Tilley's model of CMO configurations to hypothesize links between HIPP context, mechanism and outcome. An illustrative example of such a hypothesized configuration is given in Table 3.

Methods of data collection

Data were collected in each project over the two-year period through primarily qualitative methods. Two main phases of data collection took place during the first and last six months of the programme, with less intensive data collection during the intervening period. Semi-structured interviews were conducted with project managers, project sponsors, steering group members and other local stakeholders for each project. In addition, project steering group meetings, seminars and other events were attended and observed. Project proposals, planning documents, reports and other documentary data were collected and analyzed. Draft interim and final

TABLE 2. HIPP evaluation initial hypotheses

- Achieving a shared strategic vision between partner organizations requires shared language and shared definitions
- Effective project management depends upon the project manager/team operating at both strategic and grassroots levels
- Shared ownership among participating agencies requires equity of participation and accountability
- Effective local relationships are achieved where projects develop mechanisms to overcome inequalities in power
- Project work will be sustained where there is a culture of organizational learning
- Effective projects will adapt their objectives and actions to the changing policy context

TABLE 3. An example of a HIPP Context-Mechanism-Outcome Configuration

Context	Mechanism	Outcome
Socio-economic	*Project level*	*Process outcomes*
Defined disadvantaged communities and groups experiencing worse health	Stakeholder events Locality teams GP practice based initiatives Community based needs assessment	Shared strategic vision Shared ownership of tackling health inequalities Intended project outcomes achieved
Cultural	Partnership development work	Effective local relationships
Shared language/definitions between stakeholders History of working together	Local champions Community development workers	Targeted investment of resources
Political		*Service outcomes*
Project consistent with new Labour health agendas	*Programme level* Consultancy support	As per project plans
Organizational	HIPP network	*Health outcomes*
Culture of organizational learning Responsiveness to changing policy environment Co-terminous health and local authorities		Not realistic to measure within project timescales and resources

evaluation reports were shared with project stakeholders to test and seek validation of the analysis.

The five demonstration projects

The Northumberland project aimed 'to develop a locality strategy for health improvement' in the rural community of Tynedale 'which was based on a structured assessment of need, has the active support of key stakeholders, set clear priorities for development, . . . and sought to address identified health inequalities'. The project was a partnership between Northumberland Health Authority, Northumberland Community Health Trust and the Tynedale Total Purchasing Pilot. A three day whole systems event, Living Well in Tynedale, involving key professionals and community stakeholders, was the key milestone for the project. The project experienced a number of major changes in the local context including the transition from total purchasing to PCG, the merger of the Community Trust with two other NHS Trusts, and local government reorganization. It achieved its main objectives of undertaking health needs assessment, and developing a mechanism for priority setting through the whole systems event. The project provided a foundation for strategic development by the newly created West Northumberland PCG, the Northumberland HImP and the Northumberland HAZ. However, not all identified stakeholders were directly involved (in particular, the public) and others did not feel equal ownership of the process (e.g. local government stakeholders).

The Nottingham project was set up to be part of a wider Nottingham Health Authority strategy for tackling health inequalities. The aim of the project was to devise and test a model for examining and addressing the specific needs of a disadvantaged community. This was the overarching aim, with the model being developed and tested through application to the Mirpuri Punjabi speaking community in Nottingham. The project focused on (1) enabling this population to access appropriate primary health care services and (2) on influencing and supporting GPs and other members of primary health care teams in understanding and meeting their needs. Although a model was devised for examining the needs of disadvantaged communities, and its consultation techniques were regarded as having wide applicability, it was not tested as a generic model. However Health Authority funding was successfully obtained for the prioritized interventions identified for the Mirpuri Punjabi speaking community. The facilitation skills of the external consultant and the 'project champion' role of the project manager were important enabling factors; a combination of internal project management problems following changes in management arrangements, and a lack of sustained communications with the community and primary care stakeholders, were obstacles to the implementation phase during the last nine months of the project.

The Sandwell project involved piloting locality commissioning in two localities within the co-terminous areas of Sandwell Health Authority and Sandwell Metropolitan Borough Council. The primary objective of the project was 'to develop a working model of locality commissioning, in which the Health Authority, Social Services and local practitioners develop partnerships with local people, other agencies and voluntary organizations in commissioning services and health promotion initiatives to address inequalities in health.' Locality commissioning teams were identified comprising two general practitioners, a Health Authority commissioning manager, a Social Services Department locality manager and a senior health promotion officer. Both teams developed distinct models of locality commissioning, but had very different experiences due to the differing interplay of local and national contextual factors. One locality team played a major role in building local inter-agency health partnerships but was relatively marginalized in PCG development while the other team did not develop such wide locality partnerships but managed a relatively smooth transition to PCG status. External consultancy and the devolution of budgets to localities were major enabling factors while the turbulence created by national policy (e.g. the HAZ, PCGs) was an obstacle to sustaining the locality developments.

The Tameside and Glossop project focused on developing the role of general practitioners in undertaking health needs assessment and in formulating and implementing strategies for health promotion and health gain. The project's aim was to develop model processes which other practices could follow, by comparing the experiences of two practices with different characteristics and different environments. The project was made up of three strands of work which came to be recognized as three separate projects. In addition to the overarching HIPP project, there were increasingly separate developments in the two practice sites. One practice site was able to use a community development approach and, with the support of

the Health Authority and the Trust, proceeded to identify and prioritize health needs and plan for investment of resources. The other practice focused for a time on an information technology project, but this was later changed and this project transferred its attention to a diabetes management project. Being selected as a national demonstration project and a continuing commitment from a core group of people were the main enabling factors. A major obstacle was the lack of shared understanding and ownership of the project amongst stakeholders, particularly over the first year.

The Telford & Wrekin project focused on two linked development and evaluation components concerned with health partnerships and the reconfiguration of the health promotion service. First, the project aimed to develop and evaluate health partnership in tackling health inequalities in Telford & Wrekin. Second, it aimed to develop and evaluate the reconfiguration of the health promotion service on a community development basis. The project was a joint initiative of Shropshire Health Authority and Telford and Wrekin Council. Much of the work of the project was carried out through existing informal partnership networks and forums. Two lead officers played an important role in linking strategic thinking on health inequalities between the two authorities. In particular, the project work facilitated an emphasis on partnership in the Shropshire HImP and the strong focus on health inequalities in the Council-led strategy for combating poverty and social exclusion. The development of national policy emphasis on partnership working and health inequalities, and the support of the external consultant, were important enabling factors for the project. The lack of an agreed conceptual model for the proposed evaluations, or local resources for carrying them out, were barriers to progress on the evaluative objectives.

Learning about enabling factors

The six themes identified in the baseline period and the linked initial hypotheses proved a useful framework for understanding and analyzing the enabling factors and obstacles to progress experienced by the projects in seeking to tackle health inequalities through partnership working. This learning can be best illustrated by comparing and contrasting the experiences of two projects, Nottingham and Sandwell, in terms of this framework.

Shared strategic vision

The Sandwell project built on a substantial long-term history of collaborative work and shared strategic vision between the health and local authority on tackling health inequalities. The shared strategic vision demonstrated by the two authorities continued to be evident following the election of the Labour government and the major shifts in national policy which followed. Despite a very tight timetable and high levels of uncertainty regarding national policy developments, the two

authorities proceeded with locality commissioning plans and the devolution of substantial health authority budgets to localities. In Nottingham, by contrast, the overarching aim of devising and testing a generic model of working with disadvantaged communities was important at a strategic level, but the specific aim of testing this model with the Mirpuri Punjabi community was not widely shared or understood. In particular, some operational level stakeholders did not agree with a project that was perceived to be putting resources into just one disadvantaged community. Thus in Sandwell the project was enabled by a shared strategic vision built on common understanding and valuing of locality development; in Nottingham, the project encountered an important barrier in the lack of shared understanding of what it meant to devise and test a 'model' of working with disadvantaged communities.

Leadership and management

In Nottingham, strong project leadership was provided by the Health Authority's Health Promotion Manager as project manager, and by its Director of Public Health as chair of the steering group. This high profile leadership and the leadership skills of the project manager, and the role of several team members as 'project champions' at a more operational level, were important ingredients in progressing the project. Project leadership and management was less clear in Sandwell. Although a Health Authority director chaired the project steering group, project management was the responsibility of one of the locality managers, but she did not have direct responsibility for the management of the other locality team. The second locality manager was not a member of the steering group, and these blurred management responsibilities were never resolved. As the project continued the two pilot teams developed largely independently of each other, and did not share learning and assist each other with problem solving as initially envisaged. In both Nottingham and the first Sandwell team, the project managers' leadership and management skills were enhanced through external consultancy support. Effective project management, however, depended on the project structures allowing the project managers to operate at both strategic and grassroots levels.

Relationships and local ownership

A good relationship between project stakeholders was an important early enabling factor in Nottingham, and the project explicitly identified the need to develop a communications programme to ensure continued commitment to the project. However, in the later stages of the project some tensions began to emerge, particularly related to the lack of ownership of the project's aims and the focus on the Mirpuri Punjabi community. In Sandwell the degree of local ownership and the quality of local relationships were important factors in the very different experiences of the two pilot locality teams. In the first pilot, the team established good working

relationships early in the project, facilitated by external consultancy and a team organized local information sharing event focusing on community health needs in the locality. By mid 1998, other professionals saw the team as a focus for grassroots inter-agency partnership and community development work addressing inequality. The other Sandwell team struggled to establish good internal relations, and did not do so until the team was expanded to include more GPs. In both projects, the extent of shared ownership of the project was a key factor in making progress.

Accountability

Both projects experienced increasing tensions regarding accountability arrangements for the project work, which led to difficulties in sustaining the work of the projects. In Sandwell, the project was formally accountable to a steering group, which included Health Authority, Social Services and GP representation. However, as noted above, the accountability arrangements for the second pilot team were never resolved, which led to management difficulties when that team encountered internal tensions. Moreover, although technically a partnership initiative, the reality of the project was that it was largely concerned with Health Authority budgets, and that other partners were not equally accountable for the management of these funds. In Nottingham, the commissioning phase of the project highlighted real difficulties in project accountability. The process of commissioning the appointment of a worker by the Trust as an outcome of the project demonstrated difficulties in identifying responsibilities of a project steering group and project manager vis-à-vis the mainstream responsibilities of the Health Authority and Trust. In both projects tensions over accountability reflected previously discussed issues about ownership and levels of participation by different stakeholders in the projects. Moreover, in neither project was accountability to local communities significantly addressed.

Organizational readiness

The Nottingham project was built on a substantial foundation of previous work. Needs assessment work had already been undertaken with the Mirpuri Punjabi community. Tackling health inequalities was already a priority for the Health Authority. A new structure to enable GP participation in commissioning was already being planned, and a multi-agency forum, Nottingham Health Action Group, for taking forward multi-agency health promotion work was already in existence. The Sandwell project was based on an attempt to extend a strong existing health and local authority partnership, and shared strategic vision about tackling health inequalities, to locality level and to include GPs and other partners. The two authorities demonstrated differing degrees of readiness to develop this model at a strategic level. The Health Authority was able to move more quickly towards implementation due to a number of factors including its smaller size and relatively unified management structure. This difference in organizational readiness was a

recurrent tension. In addition, an early issue was the lack of attention given to pilot team organizational development by the parent authorities. This contributed to tensions in the second pilot, and was recognized by the Health Authority as an important lesson to learn in its planning for PCG development. The experiences of both the Nottingham and Sandwell projects suggest that organizational readiness is a necessary but not sufficient factor for project success; the application of organizational learning is equally important.

Responsiveness to a changing environment

As noted above, the UK health policy environment changed dramatically after May 1997 with the election of a Labour government committed to tackling health inequalities. In different ways the two projects both demonstrated the importance of the ability to respond to this changing environment. Both districts were successful in achieving HAZ status, and thus were impacted by the full range of new policy initiatives. In Sandwell, the new policy agendas meant that the locality model was quickly superseded. At a strategic level the two authorities sought to retain the locality focus as much as possible within the new agenda. Locality needs assessments were incorporated into the Sandwell HImP and the three Sandwell PCGs were asked to build on locality work. In Nottingham, the focus of the Nottingham Health Action Group moved to other priority areas within the Nottingham HImP, and the interventions following from the HIPP project therefore were addressed through a new multi-agency partnership working group. The project manager also moved on to co-ordinate the HAZ, thus losing continuity within the project. Together, the experience of the two projects demonstrate how destabilizing national policy can be even in projects which are attuned to the new national agendas, but that responsive organizations were still able to respond creatively and sustain at least part of their project work.

Implications for local partnership work to tackle health inequalities

Health and wider government policy in the UK now acknowledges a socio-economic model of health in its commitment to tackling inequalities. It seeks to promote improvements in community health and well being through integrated action at national and local levels. HImPs, HAZs and PCGs are intended to be key vehicles for securing local community health and regeneration. Health strategies and programmes will need to address such 'upstream' determinants of health as poverty, unemployment and poor housing if the health of the worst off in society is to be improved. This is the language of 'joined up thinking for joined up problems'. However the experience of the HIPP projects demonstrates the difficult reality of securing integrated action on the ground. Although the NHS has been given the notional lead responsibility, Health Authorities face a profound challenge in engaging local partners in a process of strategic change built around working with

communities. Development of local integrated working across sectors to tackle health inequalities will need to be a basic building block for HImPs, HAZs and PCGs. Indeed HAZs are expected to be 'trailblazers', pioneering new forms of partnership working. Despite being established in a less conducive policy context, the learning derived from the HIPP demonstration projects is highly relevant and provides some important insights into the management of change process for health improvement. In particular, a number of common themes (or regularities, to use Pawson and Tilley's term) were identified regarding the way in which HIPP project mechanisms worked in the context of changing local and national health agendas (Table 4). Overall, HIPP projects were much more successful in developing partnership processes than in delivering service changes on the ground during their two-year life spans. None of the projects were in a position to demonstrate any health outcomes.

While none of the projects experienced, or were able to create, consistently favourable conditions, the combination of certain factors was sufficient for some successes to be achieved. Projects with a strong sense of purpose, focused on community needs, and which were able to operate effectively at the micro level and connect strategically were more likely to make progress.

The early creation of a shared strategic vision about the focus of the project and how it would impact on inequalities was a critical enabling factor. The absence or partial agreement of the strategic vision, both within and between partner organizations undermined progress. Although partner organizations might sign up to the vision, their actual commitment can be constrained by differences in priorities, structures, processes and cultures. In some cases projects had an important role in forging the vision at a strategic level and influencing organizational attitudes and priorities regarding tackling inequalities. HImPs, HAZs and PCGs have the explicit remit of promoting a shared vision for tackling inequalities, however the experience of HIPP projects demonstrates that a shared understanding and agreement of a vision takes considerable time and effort.

Shared ownership for project work was related to the degree of participation in, and accountability for, the project among stakeholders, as well as the quality of relationships between parties. GPs found it more difficult to feel ownership for what they perceived as broad and conceptual objectives; on occasion, some GPs challenged local relationships by bypassing project partners to engage directly with more senior stakeholders. Local authorities found it difficult to participate as fully as health sector partners. Developing and maintaining good relations required mutual understanding and respect of other stakeholders' professional backgrounds and contributions, and this could be facilitated through the project. An early focus on joint assessment of community needs proved important for deepening a shared vision, identification of contributions and engendering ownership of practical steps. HImPs, HAZs and PCGs will face the challenges of achieving shared ownership and good relationships between partners. An audit of the quality of relationships between parties would seem to be a pre-requisite of developing integrated working. Furthermore partnership structures and processes must seek equity in participation and accountability.

TABLE 4. HIPP regularities of context, mechanism and outcome

Context	Mechanism	Outcome
Shared strategic vision		
History of working together	Local champions	Shared strategic vision on health
New national focus on health	Partnership development work	inequalities
inequalities	Stakeholder events focusing on	Prioritizing process for health
Co-terminosity	community health needs	inequalities
	Strategic steering groups	Project outputs fed into HImPs,
		HAZs, PCGs
Leadership and management		
National policy turbulence	Local champions	Health inequalities higher up
Local organizational	Consultancy support	local agendas
turbulence	HIPP network	Project members taking on local
		leadership roles
Relations and local ownership		
Lack of GP involvement in	Attention to inter-professional	Shared ownership of needs
health partnerships	and inter-agency relations	assessment and strategy to
Limited local authority	Community based needs	tackle health inequalities
involvement in partnerships	assessment	
Accountability		
Different professional and	Formal project accountability	Accountability remained source
organizational accountabilities	arrangements	of tension
Lack of accountability to	Lack of explicit discussion of	Lack of accountability to
community	different/conflicting	community
	accountabilities	
Organizational readiness		
History of working together	Partnership development work	Project links with/outputs fed
Good inter-agency personal	Local champions	into HImPs, HAZs, PCGs
relationships	Stakeholder events	
Co-terminosity		
Responsiveness to a changing environment		
National policy turbulence	Ability to scan the policy	Raised profile for project work
Local organizational	horizon (linked to HIPP	Project outputs fed into HImPs,
turbulence	network)	HAZ, PCG
	Local champions	

Accountability for project work was a source of tension or at least of uncertainty. HImP, HAZ and PCG partners will need to acknowledge and address the complexities of fluid and multiple accountabilities in partnership working. HIPP project stakeholders played multiple roles and had different (and potentially conflicting) accountabilities. Project managers in particular had their organizational accountabilities in addition to the multiple accountabilities within their project role. Establishing formal accountability arrangements (e.g. steering groups) is not sufficient to ensure genuine accountability. Although projects sought to engage

communities in a variety of ways no significant steps were taken to develop account-ability mechanisms to local communities. This experience reflects the wider tensions which exist in UK health policy between hierarchical health care structures and processes, and recent movement towards more participative models (Lupton *et al.*, 1998). Given that democratization of structures and processes are an important aspect of building social cohesion in deprived communities with potential health benefits, much greater attention will need to be given to finding effective ways of genuinely engaging communities and shifting power balances.

Leadership provided by local 'champions' for integrated working was crucial. This was important at the strategic level, with project 'sponsors' seeking to position the project on the strategic agenda as well as ensuring that project has the space and resources to work. Leadership was also crucial at the project management level. Management of conflict proved problematic is some cases, and skills that enabled conflicts arising from the diversity of perspectives to be addressed and resolved were valuable to making progress. The turbulence in the local and national policy environment limited continuity of leadership, and the shift of focus of champions had a disabling effect, at least intermittently, in some cases. HIPP demonstrated that leadership can be developed through local facilitation and learning support to project leaders. Therefore the degree to which HAZs, HImPs partners and PCGs are able to identify and nurture networks of champions is likely to be an important factor in achieving change locally.

The organizational readiness of partners to engage in inter-agency working to tackle inequalities varied markedly between (and also within) projects and was influential in determining the extent and pace of progress. Some projects were based on histories of joint organizational and personal relationships, and were integrated within existing joint planning mechanisms. Other projects needed to establish new forums and structures and forge new relationships. Team building with external support was a factor in developing organizational capacity in several projects. Similarly HImPs, HAZs and PCGs have different starting points. In particular PCGs are likely to represent very new inter-agency groups. Investment in team building and establishing robust organizational arrangements for inter-agency partnerships that can evolve and be sustained over time will be crucial in building capacity for change.

The election of the new Labour Government brought a radical shift in the policy agenda in support of tackling inequalities. However the extent to which projects were able to respond and take advantage of this national agenda and its local impact varied. In some projects the new agenda helped raise the profile of project work up the local agenda. The pace and unpredictability of national policy change meant local developments could be overtaken by events. Integration of the projects within the mainstream processes of HImPs, HAZs and PCGs proved problematic and required proactive negotiation and project championing. The pace and scale of policy is unlikely to slow. HImP, HAZs and PCGs are at early stages and will evolve rapidly. The degree to which community-orientated inter-agency projects are fully integrated and enabled within these processes will be a critical test of their potential to reduce health inequalities.

Notes

(a) The Health Education Authority was the national health promotion agency for England. The White Paper *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999) led to the HEA taking on a transformed public health role as the Health Development Agency in 2000.

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