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Evaluating Primary Care Development

A review of evaluation in the London Initiative Zone primary care development programme

Nicholas Mays, Virginia Morley, Seán Boyle, Penny Newman & David Towell

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Finally, we are grateful for detailed comments and suggestions received from Alan Glanz and Howard Malin, Department of Health, and from Peter Richardson and Peter Lemmey, NHSE North Thames; and Angela Dawe, Sally Bishop and Terry Stacey, NHSE South Thames.

Executive Summary

The Government's policies to improve health care in London, set out in *Making London Better* (Department of Health, 1993), established as a central objective the development of primary and community health services. Through the former London Implementation Group (LIG), a major programme of investment (in excess of £200 million over the financial years 1993/4 to 1995/6) was launched to support primary care development projects in the London Initiative Zone (LIZ). From the outset, there was a strong emphasis on 'evaluating' these projects, although what was to be understood by evaluation was less clear.

At the end of 1995, the King's Fund was commissioned to review this investment in evaluation. This project was funded by the Department of Health and the aims, which were developed in discussion with North and South Thames Regional Offices of the NHS Executive, were to:

- assess the current status of project evaluation in relation to the LIZ primary health care development projects;
- identify the role which project evaluation plays in the strategic thinking of the 12 inner London Health Authorities (HAs) in relation to future investments in primary care; and
- draw lessons for the inner London HAs in terms of helping them to make better use of project evaluations in future.

From late December 1995 to April 1996 semi-structured interviews were held with representatives from each HA, most usually with those responsible for the management of the LIZ programme, to discuss their plans for evaluating both individual projects and the impact of the programme as a whole. Through discussion with HA managers, a range of different types of project in each HA was selected for more detailed data collection. The focus was on revenue projects aimed at service development.

As a result, a further 36 semi-structured interviews were held with those responsible for leading the evaluation of the selected projects. Quantitative data on the nature of projects and their funding were collected for 1995/6, but the bulk of the data comprises the views and accounts of events provided by the interviewees. In addition, the emerging analysis of the issues raised through the interviews at HA and project level was further developed at two workshops held in June 1996. These brought together, firstly, those who had taken part in the project level interviews to compare experiences across London and, secondly, those involved in purchasing and primary care development at HA level.

The LIZ primary care development programme (Chapter 2)

The principal objectives of the LIZ primary care development programme can be summarised under the following broad headings:

- *'getting the basics right'*, bringing existing primary care services up to standard (i.e. improving premises and bringing in more core staff) (62% of projects);
- *developing innovative primary care* – supporting initiatives that would bring new forms of primary care to the inner city (e.g. extended primary care centres, services for populations with special needs, and primary care in A&E) (25% of projects);
- *shifting services from hospital to the community* – developing the interface between primary and secondary care so that more care took place in the community (e.g. poly-clinics, home care) (13% of projects).

The function of evaluation in health service commissioning (Chapter 3)

In theory, each of the LIZ projects was committed to providing some sort of evaluation. However, the vast majority had no earmarked budget and the term 'evaluation' was used very loosely. As is the case throughout the NHS, most routine effort concerned with assessment of how well projects attain their objectives comprised monitoring rather than evaluation. A distinction can be drawn between the different types of activity that may be considered as `evaluation' and the different levels at which evaluation can take place.

There is a key difference in approach between *formative evaluation* which aims to provide a stage-by-stage description of the development of a project with some reference to objectives, though these may alter over time, and often in response to the evaluation; and *summative evaluation* which is concerned with learning about the overall effect of a project, and is thus focused more on outcome evaluation of the mature project once its objectives have been codified, possibly in comparison with alternative uses of the necessary resources (section 3.1).

Evaluation may take place at different levels, extending from the health system as a whole, the primary care sector, across specific forms of primary care (e.g. out-of-hours care) and within specific projects (3.2). The amount and nature of the resources available to carry out evaluation is important, although it proved impossible to collect detailed data on the resources available for specific project evaluations (3.3).

The health authority and project level experience (Chapter 4)

Over 60 per cent of LIZ monies have gone into expanding the range and quality of primary care buildings. This was largely seen by HAs as appropriate and, therefore, in need of little evaluation. The interviews at HA and LIZ project levels concentrated on three aspects of evaluation: commissioning and managing evaluation; conducting evaluation; and, the dissemination and use of evaluation findings (4.1).

Commissioning and managing evaluation: An approach to commissioning the evaluation of LIZ projects evolved during the life of the programme. HAs commented on the *ad hoc* approach used in the first year, 1993/94, although, by 1995/96, HAs were commissioning evaluation in the context of primary care strategies and with attention to plans for 'pick up' of projects after the end of the programme.

The vast majority of projects were subject to simple monitoring. While a number of projects received more attention, only a handful of studies could appropriately be described as summative evaluations.

The overall management of the LIZ programme, with a short lead- time for setting up projects, limited project design. The vast range and number of projects also had a significant influence on the nature of evaluation which was possible on each (4.2).

Conducting evaluation: Typically, providers interpreted the request for 'evaluation' of projects differently and with varied levels of confidence and competence. The contribution of Public Health Departments to evaluation of LIZ projects also varied greatly from one HA to another. The majority of projects focused on collecting activity data, although a few had begun to look at process measures. To date, there has been little attempt to look at health outcomes or cost-effectiveness in relation to the LIZ projects (4.3).

Use of evaluation: Most project evaluations focused on the development of the individual service and its local benefits. There have been few attempts to share the results of work in progress between trusts and HAs. At the time of the study, HAs had limited plans for further use of findings although an understanding was emerging that the LIZ primary care development projects provided lessons that could inform future commissioning intentions (4.4). Explicitness in defining the appreciative framework required to shape judgements about future funding under conditions of uncertainty is still emerging.

Evaluation at the regional and national level (Chapter 5)

In each region, the Performance Management Directorate of the NHS Executive Regional Office has played a role in helping HAs to incorporate thinking about monitoring and evaluation into their management of the LIZ programme (5.1). However, there are few examples of successful engagements between those involved in the NHS Research and Development (R&D) process, and those at HA level in respect of evaluation of LIZ primary care projects (5.2).

Diagnosis and conclusions (Chapter 6)

Both strengths and weaknesses were identified in the LIZ primary care development programme evaluation process.

Strengths included:

- increasing sophistication in the commissioning, management and use of evaluation as a result of the learning which ensued from participation in the LIZ programme, albeit starting from a low base;
- development among staff at project and HA level of a critical evaluative perspective; and,
- increased clarity about the aims, objectives and working methods of projects due to the requirements of evaluation.

Weaknesses included:

- lack of an evaluative framework for considering the impact of the LIZ programme as a whole, either at a HA level, or for all of London;
- relatively little evaluation across similar projects and relatively little inter-HA working either to commission evaluations or to learn from them;
- lack of skilled and dedicated resources for evaluative activity leading to confusion between different types of activity broadly labelled as 'evaluation';
- limited interaction between projects, HAs, and Regional R&D Directorates; and
- the fact that criteria for selection of projects for different types and intensity of evaluative effort were not always clearly identified or consistently applied (6.1).

HAs were frustrated by the great speed with which LIZ projects had had to be set up, coupled with the inadequacy of resources to evaluate them properly. Most saw the LIZ programme as a bolt-on, short-term resource, outside mainstream commissioning. Moreover, the emphasis on monitoring the impact of individual projects has not always been related to the size and spend on projects. Subsequently, many HAs have had difficulties placing the project-level evaluation of their LIZ programme within their long-term strategy for primary care development.

If evaluation is a concern, then the LIZ experience does not provide a model of how to organise a programme. On the other hand, it has resulted in considerable and rapid investment in primary care in London. It is now important to examine the overall success of these developments in order to:

- evaluate how well the programme as a whole has achieved its objectives;
- inform the way in which programmes elsewhere may be developed; and,
- share lessons which may be learned both for managing individual projects and for managing a major development programme in future.

It would also be useful to determine the proportion of LIZ projects which eventually convert to mainstream NHS funding and the factors important in the 'pick up' process (6.2).

Recommendations (Chapter 7)

The recommendations for change and action in the future should not be interpreted as a dismissal of all the good work which has already taken place to evaluate the LIZ primary care development programme and its constituent projects. Particularly at project level, a considerable amount of useful learning has already taken place both in how to do evaluation and how to learn from it. The emphasis on *learning* is particularly appropriate if the LIZ primary care development programme is seen as a 'pilot' for developing new ways of strengthening primary care.

It became increasingly apparent during the course of the interviews that the lack of links between the roles of different parts of the NHS was one of the main things which informants wished to improve. Nineteen recommendations in the main report are directed at different parts of the NHS, including staff in Regional Offices of the NHSE, HAs, project managers and others. The key recommendations for each agency, extracted from the longer list in the body of the report, are summarised below (the numbers refer to those used in the body of the report).

Health Authorities (7.1.1)

A1 Health Authorities should plan to link the evaluation feedback process to mainstream commissioning

Hitherto, there has been relatively little use made of the results of evaluation by HAs in commissioning their future pattern of primary care. As HAs' primary care strategies become more refined, it should become easier to use the strategies as one way of assessing the priority which should be assigned to individual projects in the future. Equally, evaluative information needs to be made increasingly available on so called 'mainstream' projects and services.

A3 Health Authorities should establish formal links with relevant sources of external advice and expertise in health care evaluation

This external help should include how to commission good quality, useable evaluation as well as the capacity to undertake the studies themselves.

Health Authorities and NHSE Regional Offices (7.1.2)

B1 Health Authorities and NHSE Regional Offices should develop a regular mechanism for sharing experience and examples of 'good practice' in commissioning, managing and using evaluations of primary care development projects between Authorities and between projects

The review demonstrated both the current lack of sharing of 'intelligence' between HAs and projects and the value of such mutual learning. The exchange of 'intelligence' needs to include not only examples of 'good practice' and the findings of studies, but also how to obtain and use evaluation for practical decision-making.

Regional Offices of NHSE (7.1.3)

C1 Regional R&D Directorates, in conjunction with the Primary Care Support Force, should explore the scope for developing research networks linked to multi-site evaluations, focusing on key themes or major groups of projects in the LIZ programme

Given the project-specific, local nature of much of the evaluative activity on the LIZ programme to date, there is a strong case for more generalisable, larger scale,

thematic evaluations focused on areas of the programme which have received major investment, where important learning for the future may be possible and/or where the financial consequences of development may be considerable. The benefits of such research would extend beyond the current LIZ programme.

C2 *Regional R&D Directorates, working with HAs, should build on their recent experience of more proactive styles of working (e.g. attempts to increase the skills available in primary care research) by developing more widely a 'brokerage' model of commissioning R&D in relation to the LIZ programme*

In situations where innovative projects are still developing and research expertise and interest are not necessarily in place, there is a strong case for R&D funders to use part of their resources for 'brokerage' between researchers, projects and purchasers. The aims of this would be to shape frameworks for evaluation relevant to health services commissioning, identify appropriate research questions and methods, identify suitable settings for evaluation, identify interested professional researchers, facilitate research collaborations, obtain support for evaluation among service providers and contribute to the development of projects so that they can be assessed summatively and the results used in future commissioning decisions.

C3 *Regional Offices should develop a range of mechanisms designed to assist HAs to make judgements when comparing the costs and benefits of projects in different areas of their LIZ programmes and also between 'mainstream' and LIZ services, so that decisions about take-on funding can be made in an informed way*

The need expressed by purchasers was for ways of developing the findings of individual evaluations into useable 'intelligence' which would provide an informed basis for making the tricky judgements necessary to discriminate between the claims of fundamentally different types of projects under conditions of considerable uncertainty. While a comprehensive, rational decision-making model is likely to remain unattainable, a starting point might be to provide easily accessible summaries of different technical methods for thinking about and making priority decisions. However, this should be accompanied by experiments in more interactive and comparative approaches to better decision-making in which research evidence, local 'intelligence', the views of experts and professionals, HA views, the perceptions of the public, the objectives and targets in HA primary care strategies and other inputs to the process have to be weighed in combination with one another.

Department of Health, NHSE, Primary Care Support Force and Regional Offices (7.1.4)

D1 A programme-wide evaluation of the impact of the LIZ primary care development programme should be developed and undertaken as soon as possible

Given that the vast bulk of the evaluative activity surrounding the LIZ programme has been project-specific rather than concerned with the overall effects of the programme as a whole and given the scale of the investment, there is increasing interest in being able to assess the effects of the LIZ programme within the context of longer term and parallel trends to improve the quality of primary care in London. Three aspects are particularly important: the impact of LIZ capital spending; the uses to which the additional staff funded through the programme have been put; and the geographic and socioeconomic equity implications of the programme.

Chapter 1

Introduction: project aims and methods

This report is a review of the evaluation of the London Initiative Zone (LIZ) primary care development projects which were established through the former London Implementation Group (LIG) and which were in progress in 1995/6. It represents the product of approximately 60 days' study spread over an eight-month period between December 1995 and July 1996. The report particularly focuses on the evaluation of revenue projects aimed at service development in primary care in inner London. It was designed as Stage 1 of a project with possibly two or more stages. Stage 1 consists of a short 'diagnostic' survey of evaluation activity and is reported here. Stage 2 of the project will depend on the response to this report and was planned to consist of further feedback of the findings and lessons learned to inner London Health Authorities (HAs) and project staff and the development of a 'good practice' guide for use at local level, if required. The precise content of Stage 2, if it takes place, should relate to the development agenda of the HAs concerned and the wider recommendations that have emerged from the diagnostic study.

The report explores the nature of the LIZ primary care development programme and how the evaluation of projects was developed to review their success. Examples are used to illustrate some of the work that is underway and to highlight some of the challenges both the HAs and individuals involved in evaluating projects have faced and sought to overcome.

The report includes recommendations for action and thus aims to be useful to all of those interested in improving the commissioning of health services in the capital; in particular, the Department of Health (DH) which originally commissioned the study as part of its initiative entitled, '*Research into primary care in London*', the North and South Thames Regional Offices of the NHS Executive (NHSE) which became the main 'customers' for the work while it was being carried out, key staff in inner London HAs responsible for primary care development, and those involved in specific projects across the twelve inner London HAs wholly or partly in the LIZ. It concentrates first on the nature and function of evaluation and its relationship to the LIZ primary care development programme. Second, through discussion with key participants in the process, the report describes how the LIZ projects were evaluated in practice at HA and project levels. This is discussed in three sections – commissioning and managing evaluation, conducting evaluation and using evaluation findings. The regional contribution is then discussed before conclusions are drawn and recommendations made.

The wide range and scope of initiatives underway through the development of the LIZ projects has clearly influenced the diversity of the projects that are highlighted here. Successful learning from the major investment in primary care development represented by the LIZ programme now depends on local purchasers being able to identify effective innovations in services and projects which contribute to improving the basics of good primary care. To do this, the projects need to be described in detail and appropriately evaluated. This information then needs to be widely and accessibly disseminated and built into the process of commissioning services. It is hoped through wider discussion of some of the themes documented here that lessons emerge which may move us further towards an effective evaluation framework for the LIZ primary care development programme and other similar developments in future.

1.1 Aims

The aims of the project were to:

- assess the current status of project evaluation in relation to the LIZ primary health care development projects;
- identify the role which project evaluation plays in the strategic thinking of the 12 inner London HAs in relation to future investments in primary care;
- draw lessons for the inner London HAs in terms of helping them to make better use of project evaluations in future.

It was intended that the project as a whole would help to identify the policy framework, skills, resources and support required to increase the likelihood that evaluations of primary health care development projects could be used by local commissioners in shaping services and could contribute to primary care development. It was also intended that the exercise would help to improve the commissioning and use of evaluations more generally in the future (Mays *et al*, 1995). Stage 1 represents principally the 'diagnostic' phase of the work, albeit resulting in practical recommendations for change and development.

As the field work progressed and issues began to emerge from informants at HA and project level, it became increasingly apparent that a 'systems' approach to considering the evaluation of the LIZ primary care development programme and its constituent projects would help improve understanding of the issues. The actions, experiences and views of staff at HA and project level were found to be related to those of other parts of the NHS, particularly at Regional level. The broader relationships between policy makers, purchasers, health service providers, local evaluators, academic researchers, the NHS Research and Development (R&D) programme at regional and national levels, Regional Directorates of Performance Management and intermediary bodies such as the Primary

Care Support Force combine to make up the 'system' for shaping and using evaluation in the interests of the Service. This 'system' perspective is particularly important in policy-led, large-scale investment programmes of this kind.

1.2 Methods

In 1995, the second King's Fund *London Monitor* reported that, '*it is difficult to give an overview of the impact of initiatives arising from the application of LIZ funds since 1993 as there has been no systematic attempt so far to gather and evaluate the evidence. In fact, a detailed comprehensive description of the kind of projects which have been supported is not available*'(Boyle, 1995).

This study, therefore, relied in its planning, on data about the type and size of projects by individual HA extrapolated from the former LIG project database as it stood in Autumn 1994. The database was used to obtain an indication of the range and scale of the LIZ primary care development programme in each HA area. All projects listed from this database were included for possible interviewing, in particular those that were labelled as evaluation projects (i.e. projects with what seemed to be a specific budget for evaluation).

Using this information as a starting point, the chief executives in the 12 inner London HAs were approached to discuss their plans for evaluating both individual projects and the impact of their overall LIZ programmes. From late December 1995 to April 1996 semi-structured interviews were held with representatives from each HA, most usually with those responsible for the management of the LIZ programme. Appendix 1 lists all those interviewed and the main topics covered.

From the outset, it was clear that it would not be possible to undertake interviews or collect data on all the projects in each HA. In a number of cases, it was not even possible to obtain an up-to-date, accurate list of all the LIZ projects in a HA. Instead, rather than take a random sample of projects in each HA, it was decided to maximise the likelihood of learning from the number of interviews which would be possible within the time and budget available by adopting a purposive approach to sampling, using the information derived from the first sequence of interviews at HA level. Through discussion with HA managers, a number of projects in each HA were selected for more detailed data collection. Each HA was asked to suggest a number of projects in which the HA felt that the evaluation had gone particularly well and had provided valuable information about the project, its progress and its likely future potential. The HA was also asked to propose projects where the HA felt that the evaluation had not worked as planned or where the project had experienced particular difficulties in developing an appropriate methodology

in new areas of service development. From these lists of possible projects for interview, the review team selected projects with an eye to achieving a range of different types of project in terms of size, methods of working, topic and perceived success in evaluation.

As a result of this purposive sampling process, a further 36 semi-structured interviews were then held with those responsible for leading the evaluation of the selected projects. Documentation about work to evaluate projects was collected from individual projects, although much of this consisted of proposals to undertake work or initial reports of work in progress. It was, therefore, not appropriate to undertake a content analysis of the data collected in this form. Both in the interviews at HA level and in the subsequent listing of possible projects for further interviews, respondents tended to concentrate on *revenue* projects and on the projects with which the inner London HAs had been directly involved since the inception of the LIZ primary care development programme. Capital projects, projects in mental health and projects undertaken by voluntary sector agencies were under-represented as a result. The reasons for this are given at the start of Chapter 4 which presents the findings from the HA and project level interviews.

A number of interviews were also undertaken towards the end of the data collection with other key participants in the evaluation 'system', namely the London Primary Care Support Force and representatives of North and South Thames Regional Offices' Performance Management and R&D Directorates in order to provide a different perspective on the evaluation process. A list of the main areas of discussion with both HA managers and with those involved in evaluating particular projects is included in Appendix I. In all, 65 people were interviewed either alone or with their colleagues. Their names and designations are also listed in Appendix I.

The interviews were mainly undertaken by one of the team (Virginia Morley) for greater consistency of reporting and interpretation. Each interview was noted at the time and a summary of the response to each topic/question prepared immediately after. An analysis of the themes emerging from the interviews forms the basis to this report.

It was not planned or possible in the time budgeted for the project to undertake a detailed analysis of the evaluation of each HA's LIZ primary care development programme, project by project, or to undertake critical analyses of individual evaluation reports. As a result, the report does not include a comparative guide to each HA's evaluation performance across all its LIZ projects. Rather the emphasis is on understanding how learning from evaluation can be related more closely to service commissioning in the future. As a result, individual authorities and projects are only identified to provide examples of good practice. These examples are generally included in boxes in the text to enhance visibility. Where things which went less well are discussed, the reports are anonymised

since the point is to learn from the past rather than apportion blame. In many cases, participants were dealing with difficult issues, often for the first time, and learning by doing.

The emerging analysis of the issues raised through the interviews at HA and project level was tested out and further developed at two workshops held in June 1996. The first of these brought together those who had taken part in the project level interviews to compare experiences across London. The second workshop was targeted at the purchasing and primary care development staff at HA level who had been interviewed previously. The latter particularly focused on ways of incorporating the evaluation of the LIZ projects into the future commissioning of health services.

1.3 Nature of the data collected

Quantitative data on the nature of projects and funding were collected for 1995/96 (see Table 2) but the bulk of the data collected in this short project comprises the stated views and accounts of events provided by the interviewees. With 12 HAs, hundreds of LIZ projects in primary care and a programme which had begun over two and a half years before the current review, it was impossible to corroborate statements made by interviewees using non-interview data (e.g. observations). The best which could be achieved was to compare the accounts and views of different participants in the evaluation 'system', especially between those at project, HA and regional levels.

As far as possible, efforts were made to interpret the accounts from the interviews in relation to the position, likely extent of knowledge and interests represented by each interviewee. Inevitably, in a large bureaucracy with a complex division of responsibilities, particularly one with a purchaser-provider separation, views and accounts of events differed. Judgements had to be made as to how much weight to give to different experiences and accounts.

Chapter 2

The London Initiative Zone primary care development programme

In October 1991, Sir Bernard Tomlinson was appointed as a Special Adviser to the Departments of Health and Education on London's health service, medical education and research, with a specific remit to address the provision of health care in inner London within the context of the reformed NHS. Following months of speculation, his report (Department of Health, 1992) was published in late October 1992.

Attention at the time focused upon the report's recommendations for the rationalisation of the acute sector. Yet, one of the key contentions was the need for a transfer of resources from the acute to the primary care sector, which was justified in terms of the substitutability of primary for acute care, an assumption which has since come in for fundamental criticism (Department of Health, 1992, para 28, p8). There was also an emphasis on providing acute care in primary care settings.

Among other things, Tomlinson recommended:

- the development of general medical services in London, through improvements in GP premises and more flexible local contracts;
- the enhancement of co-ordination between agencies responsible for the delivery of primary care; and,
- an increase in the level of nursing and residential home provision in London, particularly for older people, to help ease the pressure on acute beds.

In February 1993, the Secretary of State for Health responded to the Tomlinson Report, with *Making London Better* (Department of Health, 1993) in which she stated her determination to bring about major improvements to the health services of the capital. She accepted the broad thrust of Tomlinson, though demurring in certain details.

2.1 The purpose of the LIZ programme

LIG was formally established in late February 1993, with a remit to ensure the implementation of the changes necessary for improving London's health services as outlined in *Making London Better*. LIG was asked to establish the Primary Health Care Forum by 1 April 1993 to oversee the implementation of primary care development – the linchpin of the programme to improve health services in London – within the LIZ

covering those parts of London thought to have high levels of need, weak existing primary care services and where acute sector rationalisation posed further challenges.

The whole LIZ investment programme was established on the premise that primary and community health services in London were in need of substantial improvement. *Making London Better* based the Government's strategy for improving health and health care in London on four principles:

- people living and working in London must have ready access to the full range of health services which they need;
- services must be of a good standard and cost-effective;
- the internal market for health care should work in London, as elsewhere; and,
- high-quality medical education and research must be sustained and fostered.

It could be argued that all four principles bear some relation to the development of good primary and community care in London. These principles were translated into four strands of action relating to general acute hospital services, specialist hospital services, medical education and research, and primary and community care; this last spelt out as, '*...action to develop higher-quality, more accessible local health services – primary and community health care services provided through GPs, nurses and other professionals working in the community.*' (*Department of Health,* 1993, p3).

It was envisaged that the LIZ would have a limited lifetime of perhaps five years, and that projects would be implemented through existing service structures. Initiation of projects was to a very tight timetable, a factor which explains to some extent the approach to evaluation in the programme as a whole (see below, Chapter 4). The prime focus was to introduce changes '*... to improve primary care for London's population and to pave the way for more cost effective use of London's hospitals.*' (*Department of Health,* 1993, p5). At the outset, the programme was not evaluation-oriented.

The objectives of the programme were summarised under the following broad descriptive headings, which were assumed to contribute to the prime aim stated above. These were:

- '*getting the basics right*', involving bringing existing primary care services up to standard – i.e. improving premises and bringing in younger, better trained staff;
- *developing innovative primary care* – supporting initiatives that would bring new forms of primary care to the inner city, to meet its special requirements;
- *shifting services from hospital to the* community – developing the interface between the primary and secondary care sectors, so that more care took place in the community.

2.2 Projects in the LIZ programme

Following on from the Tomlinson Report and *Making London Better*, the 12 former Family Health Services Authorities (FHSAs) which were wholly or partly within LIZ submitted plans for service developments over a five year period between 1993/4 and 1998/9. The larger portion of LIZ is in North Thames with eight HAs and four in South Thames.

In 1993/94, 934 primary health care development projects were initiated in the LIZ based on funds additional to mainstream HA allocations and designed to 'pump prime' developments focused on the three principal objectives of the programme (see above). This number has gradually increased. There were approximately 1,000 in 1995/96. As part of the background work on the current review, an attempt was made to assemble an up-to-date inventory of all the primary care development projects under the LIZ programme. This apparently simple descriptive task proved far harder than expected since detailed descriptions of the LIZ programmes were not always readily accessible.

The original 1993/94 projects covered a very wide range of schemes designed to improve key aspects of primary health care. The most popular themes were staff training and development, advocacy, expanding primary care services, premises improvement, health promotion and health needs assessment. The balance of projects, as opposed to expenditure, across London between the three principal objectives was:

Getting the basics right (e.g. premises, core staff, professional development)	62%
Innovative primary care (e.g. extended primary care centres, additional staff, services for populations with special needs, provision of GP services in A&E)	25%
Primary/secondary interface (e.g. polyclinics and community beds, home care)	13%.

Approximately £210 million has been devoted to these projects over the financial years 1993/94, 1994/95 and 1995/96 (see Table 1).

In theory, each of the projects is committed to providing some sort of evaluation of the costs and benefits of its work. However, the vast majority of projects have no earmarked budget for this purpose and it seems likely that the term 'evaluation' has been used very loosely in most cases. Seventy-five projects initiated in 1993/4 and 1994/5 were specifically to undertake research and development activities in the field of primary health care development in inner London. A further 26 projects are described as *evaluations* of LIZ projects. Thus, a minimum of 101 projects had some resources explicitly devoted to a variety of different sorts of research on the effects of primary health care development activities.

Table 1 Expenditure on LIZ primary care programme since its establishment in 1993/94

Family Health Services Authority	1993/94 £000	1994/95 £000	1995/96 £000
Barking & Havering	1,716	1,927	2,094
Camden & Islington	2,920	6,036	7,095
City & East London	5,088	13,132	13,221
Ealing, Hammersmith & Hounslow	3,594	9,941	12,576
Brent & Harrow	1,210	3,292	2,048
Enfield & Haringey	2,786	6,808	5,258
Kensington, Chelsea & Westminster	2,436	8,182	6,029
Redbridge & Waltham Forest	1,318	3,887	5,876
Lambeth, Southwark & Lewisham	10,750	11,605	24,214
Bexley & Greenwich	3,085	2,181	7,834
Merton, Sutton & Wandsworth	3,928	4,490	4,425
Croydon	523	5,147	5,743
Total	**39,354**	**76,628**	**96,404**

Source: Hansard. Tomlinson Projects. Parliamentary Written Answer, PQ 1150/1995/96, 25 January 1996

In 1995/96, the third year of the programme, for which more detailed information was compiled from HA plans as part of the current review, over £96 million was allocated to develop primary care in the LIZ. This section describes the current state of the programme in detail and draws on the 1995/96 Primary Care Development Plans produced by each HA in the LIZ.

Table 2, which is based on data collated specially for this project, shows that almost 900 projects received funding during the year 1995-96. One of the most striking features of the development plans is the diverse nature of the projects being funded as was the case at the outset of the programme two years earlier. These include purpose-built primary care centres, multidisciplinary hospital-at-home schemes, services focusing on the primary care needs of the homeless, district-wide professional development schemes for GPs, and very small-scale projects of less than £2,000 per annum, for example, the purchase of single items of equipment. Projects are managed by primary care professionals, community trusts, former FHSA staff, the voluntary sector and staff in acute trusts.

Table 2 summarises the overall pattern of projects and expenditure by type of scheme during 1995-96. Most of the money has gone into 'getting the basics right', with 46% of funding going on premises development alone. Almost a third of projects (16% of expenditure) extend primary care services or widen access. Around a fifth of projects (16% of expenditure) involve some shift in the balance of services between primary and secondary care. Some types of innovation have been more popular than others.

For example, perhaps not surprisingly in a city with large numbers of acute hospitals, hospital-at-home has been much more prominent under LIZ than developing community hospitals or beds. Shared care, decision support and direct access to specialist advice are relatively insignificant. This may be because these forms of care are relatively well-developed already, as is the case for shared care for diabetes.

Figure 1 takes the 271 so-called 'innovative' projects from Table 2 and provides a more detailed categorisation of all of them. Mental health projects predominate (n=47). Like all classifications, the classification of projects used in Figure 1 is arbitrary. Other categorisations by client group or intervention type might be possible and some projects could be included under a number of headings.

Table 2 London Initiative Zone Primary Care Development Programme 1995/96

	Projects		Budget	
	n	**%**	**£000**	**%**
'Getting the Basics Right'				
Premises development	145	16	45,015	46
Core primary care staff and services	70	8	9,007	9
Information technology	20	2	2,604	3
Other equipment (including clinical)	16	2	539	1
Primary care organisation	14	2	630	1
Professional development	73	8	3,577	4
Total	**338**	**38**	**61,372**	**63**
Innovative Primary Care				
Developing Primary Care Services				
Primary and community services	147	17	8,142	8
Mental health services	47	5	4,918	5
Clinical guidelines for primary care	4	0	121	0
Primary care-led commissioning	13	1	698	1
Widening Access to Primary Care				
Advocacy	32	4	1,081	1
Other access schemes	12	1	285	0
Mobile/community outreach	16	2	685	1
Total	**271**	**31**	**15,931**	**16**
Shifting the Balance of Care				
Emergency Primary Care				
Primary care in A&E	11	1	898	1
Out-of-hours schemes/telephone advice	14	2	912	1
Minor injuries units	3	0	241	0
Crisis intervention services	6	1	898	1

cont/ . . .

Table 2 cont'd

	Projects		Budget	
	n	%	£000	%
Shifting the Balance of Care *cont'd*				
Managing Care Across the Interface				
Specialist outreach	15	2	510	1
Direct access to specialist advice	7	1	1,006	1
Liaison workers/coordinating care	10	1	475	0
Shared care/referral guidelines	7	1	209	0
Decision support for GPs	8	1	236	0
Intermediate models of secondary care				
Home-based care or support	29	3	2,137	2
Hospital at home/early discharge	20	2	3,435	4
Rapid response/admission prevention	7	1	1,728	2
Community beds	2	0	527	1
Community hospitals/hostels	3	0	1,136	1
Mental health hostels	6	1	927	1
Total	**148**	**17**	**15,276**	**16**
Management and Evaluation				
Evaluation, Research and Development				
Separate evaluation of LIZ projects	13	1	456	0
Audit, research and development	32	4	981	1
Health needs assessment	15	2	343	0
Project management support				
Project support (including staff)	46	5	2,407	2
FHSA administration	6	1	87	0
Public awareness programmes	7	1	144	0
Total	**119**	**13**	**4,417**	**5**
Miscellaneous	4	0	490	1
Unclassifiable	4	0	235	0
TOTAL	**884**	**100**	**97,721**	**100**

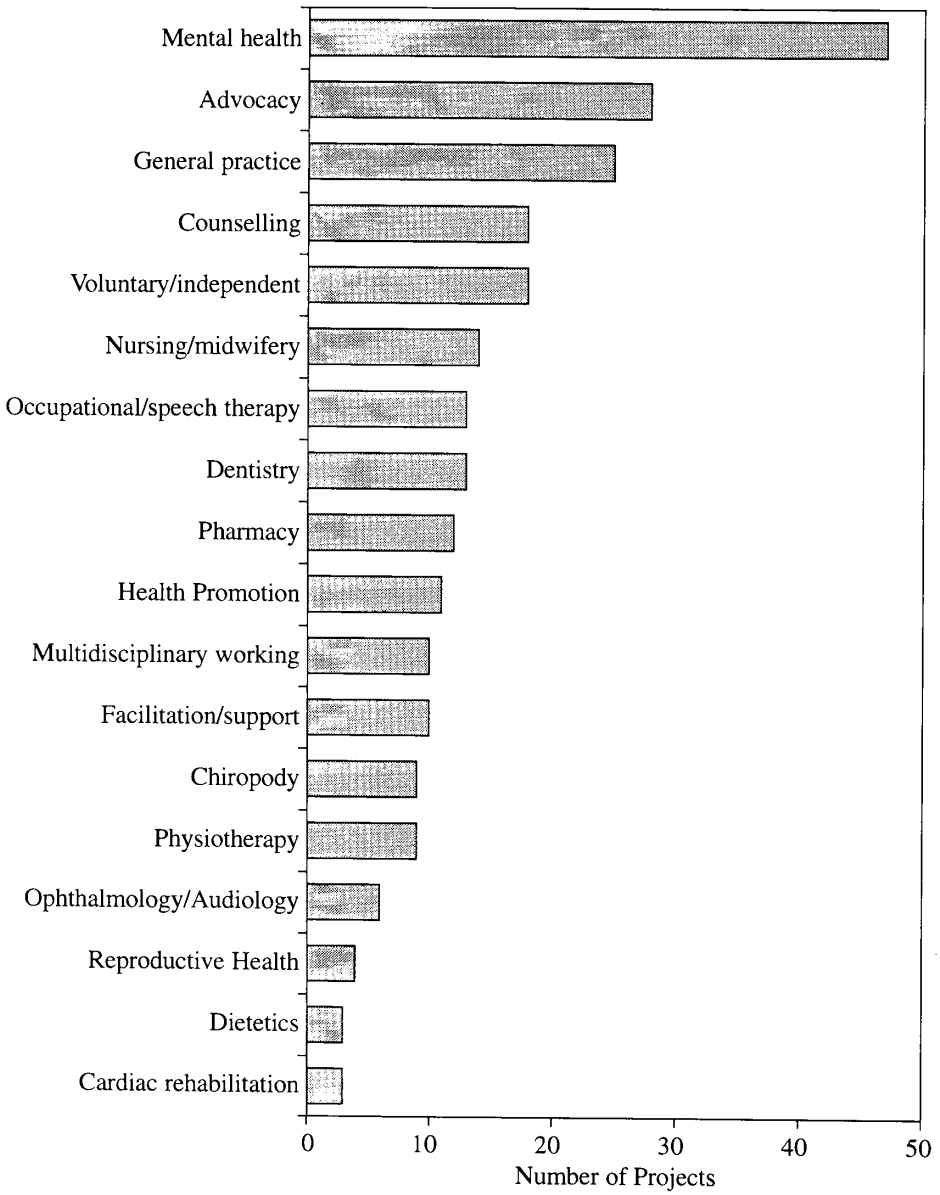

Figure 1 'Innovative Primary Care' projects by service type

Sources: LIZ district health authorities and their primary care development plans.

Chapter 3

Possible functions of evaluation in health services commissioning

If the LIZ primary care development programme was designed to tackle the limitations in London's primary care described above, then it is important to be able to determine the extent to which this has been achieved. This requires evaluation and subsequent chapters of this report attempt to describe how evaluation was commissioned, undertaken and used to this end. However, before embarking on this, it is important to be clear about what is meant by the term 'evaluation' and the different functions which evaluation may play in health services commissioning.

3.1 What is meant by the term 'evaluation'?

'Evaluation' has become widely used in the Health Service to include all sorts of activities in which data are collected on the activity and outputs of projects or services. It is helpful in a report of this type to be clearer than is customary about different types of activity which may trade under the banner of 'evaluation', the different levels at which evaluation can take place and the implications of the different amounts of resources available for evaluation for the work which can be undertaken. These three dimensions of *approach, level and resources* are summarised schematically in Figure 2. The fourth dimension indicates whether the evaluation is comparative or not.

It is possible to make the following broad distinction:

monitoring – usually associated with the description over time of the processes and outputs (e.g. cases treated, clients seen) of projects. This shades into good project management and is based on using data which are likely to be routinely available from the process of implementing and running a project in order to assess how well it is achieving project milestones. At its most simple, *monitoring* would entail checking that the financial resources allocated to a project have been deployed in a manner consistent with its broad aims in order to be able to demonstrate financial probity. In this very limited sense, all NHS projects and services might claim that they have been subject to a degree of evaluation;

evaluation – a more ambitious undertaking, often requiring additional funds over and above those needed to implement the project and frequently undertaken by dedicated

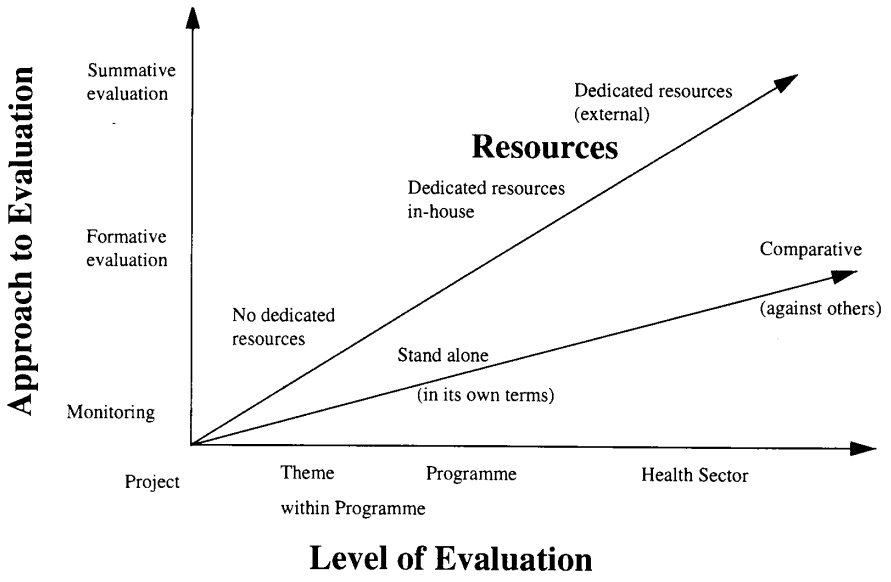

Figure 2: Dimensions of Evaluation

staff, in which the merit of a project is assessed against some comparator or formal standard or aim and/or the costs and outcomes of a project are quantified. Evaluation in the fullest sense attempts to relate the inputs, structure and processes in a project to its costs and outcomes (benefits) with a view to generating knowledge which can be generalised to other settings and projects.

Most of what is routinely undertaken in the Health Service to find out if projects are attaining their objectives comprises *monitoring* rather than *evaluation*.

Evaluation may itself be broken into a number of sub-types depending on its objectives. One distinction which is frequently drawn lies between *formative* and *summative* evaluation. The former aims to provide a stage-by-stage description of the development of a project with some reference at each stage as to whether the project is achieving its own objectives which may alter over time. *Formative* evaluation thus lends itself much more to a critical reflection on the *process* of project implementation than to an analysis of *outcomes* and to an *action-research* stance in which the evaluator is active in helping the project participants to improve the working of their project by providing regular feedback, discussion and advice. Although formative evaluation is frequently associated with qualitative methods of data collection, it is not intrinsically qualitative. For example, it is feasible to use a wide variety of routine quantitative data on the functioning of a project or service over time as part of a formative evaluation. The difference between the two approaches lies in the questions which the evaluator is trying to answer.

Summative evaluation is concerned with learning what the overall effect of a project has been in its final form (or even after it has been wound up) and is thus focused on *outcome* evaluation of the mature project once its objectives have been codified. It tends to be associated with more quantitative data collection and with defining the outcomes of a project in the researcher's terms rather than necessarily in the terms understood by the participants in the project. For example, a summative evaluation might measure the health status consequences of a new service on the grounds that such final outcomes were the best test of 'success' even if the project participants saw patient satisfaction as the prime outcome to be assessed. Alternatively, both patient satisfaction and health status changes might legitimately be included in a summative evaluation. In line with this, *summative* evaluations tend to be undertaken by researchers who do not attempt to influence the course of the project, rather than through an interactive, action-research process.

Of course, the two approaches can fruitfully be combined and phased with formative and summative stages built into the same study. Frequently this is the only sensible course of action since innovative projects may not have clear or researchable objectives when they start.

3.2 Levels of evaluation

The definitions and distinctions drawn in the preceding section tell us nothing about the subject matter of the evaluation. However, it will be immediately apparent that evaluation can take place at different levels of aggregation such as the health system as a whole, the primary care sector, across specific forms of primary care (e.g. out-of-hours care, extended primary care team working etc.) and within specific projects. The lower, less aggregated levels of evaluation are perhaps the more straightforward to conceptualise and design, to collect data for and from which to interpret the findings. Figure 3 sets out the LIZ primary care development programme with its three basic aims ('getting the basics right', developing innovative forms of primary care and substituting primary for secondary care) and is intended to show how it becomes increasingly difficult to assess the contribution of lower level projects to the aims of the parts of the programme, the programme as a whole and overall NHS goals. Simply aggregating the effects of disparate projects is unlikely to be possible since individual projects can have cross-cutting and unexpected consequences. Despite this, in policy and strategy terms, the most relevant evaluative activity tends to be that which attempts to take a broad view of the impact of groups of projects or, indeed, an entire programme area or goal. In terms of the LIZ primary care development programme, such evaluation would attempt to show how the programme as a whole had contributed to the improvement of primary and community care in inner London.

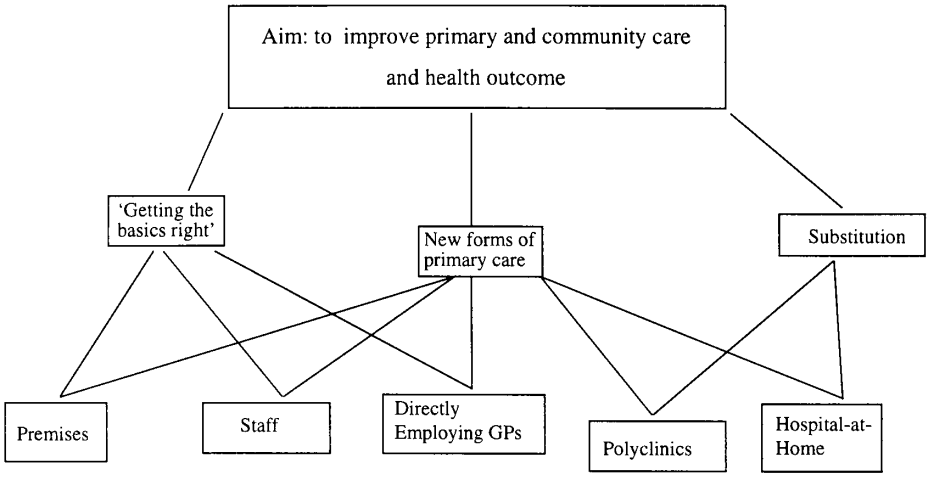

Figure 3: The level of evaluation

For example, at the lowest level, a project such as installing a ramp at a GP surgery might simply be evaluated against local cost and installation time targets with no reference either to other similar projects in other areas or to its contribution to wider health care objectives in London or nationally. Taking this same example further, however, the ramp might be evaluated as part of a broader assessment of the contribution of similar projects to premises improvements. More broadly still, the ramp and related projects might be evaluated in relation to the three aims of *Making London Better* (see above and Figure 3) in which case the existence of a ramp might be one of a number of characteristics of good premises which enabled better access for disabled people. Patient attendance data might be used to show if the change were effective. Finally, the ramp might be assessed as part of the overall goal of the LIZ programme to improve primary care in inner London by relating its existence to particular beneficial forms of primary care.

3.3 Resources for evaluation

The final dimension which underlies the differences in *approach* and *level* of evaluative activity which have been discussed briefly above, relates to the amount and nature of *resources* made available (see Figure 2). Clearly, there is an overlap with the first two dimensions in that, for example, monitoring is likely to require fewer resources than a stand-alone evaluation in many circumstances and a project-level evaluation is likely to require many fewer resources and skills than a programme evaluation. Nonetheless, in assessing the evaluative activity which has been undertaken on the LIZ programme of primary care development projects, it is worth distinguishing between the following:

- projects with dedicated resources for evaluation/monitoring versus those without;
- evaluation/monitoring undertaken by project staff versus those undertaken by 'outsiders' including academics and consultants;
- multi-disciplinary evaluation/monitoring versus uni-disciplinary work.

In describing and assessing the evaluative work at project and HA level, reference is made to the level and appropriateness of the resources going into the research. However, it is not always easy to discover the level of resources going into a study, particularly when there is no separate budget for evaluation and when project staff are directly involved in service delivery and evaluative work. In the timescale of this exercise, it was not possible to collect detailed resource use data on specific project evaluations.

3.4 Uses of evaluation

These differences in the level and resourcing of evaluation/monitoring reflect the degree of ambition and the variety of different objectives which can underlie the evaluative process. They also reflect the different interests of different parts of the health sector in using the results of enquiry. How evaluation is used will depend to a large extent on the nature of the evaluation; whether it is simple *monitoring*, *formative* or *summative* in the sense which we have discussed (see Figure 2). Simple monitoring typically helps project teams to review whether the inputs, processes and activities associated with an innovation are consistent with intentions. However, a more *formative* approach is required if the evaluation is to be used developmentally in determining the direction of the project.

The service provider may wish to know the *relative cost-effectiveness* of new methods of working versus old ones in achieving the same goals. The provider may be relatively uninterested in such data in the case of well established interventions widely regarded as a 'good thing'. The purchasing HA may wish to have the same cost-effectiveness information as the provider as well as far more difficult to acquire *cost-utility* data to weigh the costs and benefits of one type of project against alternative uses of the same resources. This is particularly likely towards the end of a time-limited programme such as the LIZ primary care development programme when HAs have to decide which projects to take onto mainstream funding. A more *summative* approach to evaluation might be used to inform the take-up of projects. Most evaluations help identify whether a project is meeting its objectives, but are far less useful to help choose between projects or groups of similar projects. At national level, the government might wish to assess the effectiveness and efficiency of the whole programme in which all the projects are located in order to determine future directions for investment regionally and nationally.

However, in aspiring to make informed decision-making at the HA and 'higher' levels of the NHS, it is important to be conscious of the limitations of the kinds of technical/rational analysis implied in cost-utility comparisons. Real-time decision-making is influenced by a whole range of factors, including central directives, local political pressures, inter- and intra-organisational relationships, implementation opportunities and difficulties etc. Evaluations of particular initiatives have to be considered in the context of strategic intent – which may or may not be very explicit, and the values and principles adopted by HAs in setting priorities. Information on particular projects will typically be incomplete – for example, that required to assess the impact of introducing particular service changes on a larger scale. Systematic, comparative judgements will be very difficult because data about different projects and existing provision will mostly be at different orders of clarity and relevance. In short, the challenge facing commissioners is typically to develop the appreciative frameworks which inform the process of making judgements under conditions of considerable uncertainty, perhaps best described as 'muddling through intelligently'.

Chapter 4

The health authority and project-level experience

This chapter reports the findings from the interviews at HA and LIZ project levels concerning the monitoring and evaluation of LIZ primary care development projects and the HA programmes as a whole. The length of this chapter in relation to the rest of the report reflects the main focus of the field work and the fact that the vast majority of the monitoring and evaluative activity has taken place at project and HA level rather than at higher levels. The chapter is in four main sections: the emphasis of the interviews at project level (4.1); commissioning and managing evaluation (4.2); conducting evaluation (4.3); and, using evaluation (4.4).

4.1 The emphasis of the interviews at project level

The sequence of interviews was from HA managers responsible for LIZ programmes to staff at individual projects. It became apparent that at HA level interviewees tended to concentrate their remarks on revenue-, rather than capital-related projects, projects in fields other than mental health and general practice and projects provided by NHS trusts rather than the voluntary sector. The list of projects in Box 4.1 shows this. These were chosen for interview through discussion with HAs. The cross section of projects listed is not intended to be a statistically representative sample of the LIZ projects. However, it includes a mix of projects typical of the LIZ programme as a whole (see above, Chapter 1, methods section, for more on this). A few remarks on each of the other areas will help show why the choice of projects to be interviewed emerged as it did.

Box 4.1: List of projects interviewed, by HA

Continence	Barking & Havering
Leg Ulcer	Barking & Havering
Pharmacy	Barking & Havering
Lisson Grove Welfare Benefits	Brent & Harrow
Brent Carers	Brent & Harrow
Dietetics	Brent & Harrow
Prescription for Exercise	Camden & Islington
Public Health Criteria for Evaluation	Camden & Islington
Condom Distribution	Camden & Islington
Health Promotion Projects	Croydon
GP Link Office	Croydon

cont/ . . .

Box 4.1: cont'd

Clinical Guidelines	East London & the City
Physiotherapy	East London & the City
Psychotherapy	East London & the City
Alzheimer's Disease Society	Ealing, Hammersmith & Hounslow
Community Mental Health Teams	Ealing, Hammersmith & Hounslow
The Lymphoedema Project	Ealing, Hammersmith & Hounslow
Primary Care in A&E	Enfield & Haringey
Physiotherapy	Enfield & Haringey
Home Treatment Team	Enfield & Haringey
Grabadoc (out-of-hours co-operative)	Greenwich & Bexley
Practice-based care managers	Greenwich & Bexley
Community Development Officer	Greenwich & Bexley
Health Promotion in general practice	Greenwich & Bexley
Physiotherapy in general practice	Greenwich & Bexley
Hospital-at-Home (West London)	Kensington, Chelsea & Westminster
Mental Health Projects	Kensington, Chelsea & Westminster
Out-of-Hours	Lambeth, Southwark & Lewisham
Lewisham Hospital-at-Home	Lambeth, Southwark & Lewisham
St John's Therapy Centre	Merton, Sutton & Wandsworth
Going Home	Merton, Sutton & Wandsworth
Adult Rapid Response	Merton, Sutton & Wandsworth
Chronic Wound Management	Redbridge & Waltham Forest
Hospital-at-Home	Redbridge & Waltham Forest
The Orthodontics Project	Redbridge & Waltham Forest

Capital Development Projects

The majority of the responses to questions in the interviews with HA staff related to projects which have had revenue funding aimed at pump-priming service developments. However, our data (see above, Chapter 2, Table 1) suggest that over 60% of LIZ monies has gone into capital development in primary care. Capital was seen as an overall addition to the general medical services budget to improve and expand the range and quality of general practice and primary health care buildings in London rather than a subject for evaluation. Most HAs commented that it was self-evident that improving primary health care premises, in particular where the facilities that existed were outmoded, was appropriate and therefore needed little evaluation.

However, the need to review where monies to improve premises have been spent was seen to be valuable when it was suggested. It was felt by HA staff that providing answers to questions such as the following would be useful:

- Has investment in premises continued to be greater in some areas of London than in others?

- Have the initial priorities for those primary care premises in need of development been achieved?

- Has there been greater investment in larger than smaller practices?

- What requirements were made on practices where they received substantial investment?

General practice

It would seem that most of the resources for developing LIZ projects have been project-managed through a negotiation between the purchasers and local community and hospital provider units. This may in part be due to the inadequacy of a bidding process for ideas and the likelihood that provider units as organisations would have a better sense of what was a suitable project. Evaluation of general practice run projects however has not featured highly in the discussions we have had to date. While projects developed with LIZ monies have clearly been directed at supporting general practice, GP involvement seems to have been limited to taking part in initial discussions about the overall allocation of LIZ project funding. GPs have also been part of service development projects aimed at supporting them in practice.

In some HAs, the establishment of LIZ project teams with GP representative input has been evident, however the real value of having been able to develop priorities for service development with GPs and other primary care team input is more difficult to assess. This would perhaps have been more in accordance with overall national priorities to move decision-making about services closer to primary care as embodied in fundholding and latterly primary care led purchasing.

Mental Health

In many HAs, mental health projects seem to have been grouped separately from the overall LIZ projects and thought about separately, too. The main reason for this seems to have been the fact that the mental health projects were funded later and from a separate source from the rest. They were developed in 1994/95 rather than 1993/4 which was the start date common to many primary care developments. As a result, project staff typically began to consider evaluation after the project management stocktake of all primary care projects in 1994. Through this study we have only had the opportunity to consider a very small number of projects related to mental health.

Voluntary Sector

Similarly, those projects funded through the voluntary sector were very limited in our sample of projects selected for interview. These projects were initially funded centrally through a bidding process to LIG with little reference to local HA plans and priorities. Their accountability and project management changed in 1995 to integrate them within the overall LIZ programme in each HA. This seems to have been a more satisfactory arrangement for HAs. These four voluntary sector projects reported that the experience of working within the LIZ programme under LIG's auspices had been challenging since they felt that their skills and experience were not always fully understood by the NHS.

4.2 Commissioning and managing evaluation

The process of commissioning and managing evaluation of the LIZ projects has included aspects of several different activities. These are described below.

4.2.1 The approach to evaluation by health authorities

The approach to commissioning the evaluation of LIZ projects has evolved during the life of the programme. HA staff commented on the rather *ad hoc* approach used in the first year of the programme, 1993/94. This would seem to have contributed to the range of projects which have been evaluated. The programme has also developed in parallel with the development of primary care strategies in several HAs. It appears that by 1995/96 HAs had approached the task of commissioning project evaluations more appropriately within the context of these primary care strategies. A number of evaluation frameworks had been produced by HAs which reflected this learning process (see below for examples).

Individual HAs have each chosen to approach the process of commissioning and managing evaluation according to their own local circumstances. However, through an analysis of the data gathered by interviews in the twelve inner London HAs, an overall pattern emerges which reflects the process of negotiation that has taken place between purchasers and providers.

In 1994/5, most HAs made statements about how individual projects would be evaluated. In primary health care development plans, they made more general comments about their overall commitment to evaluating projects. More recently, the expectations of HAs have been further clarified through the issue of comprehensive frameworks for evaluation, for example, those of Croydon or Merton, Sutton and Wandsworth.

Example 1

Merton, Sutton and Wandsworth HA: Draft Evaluation Process for the Primary Care Development Plan, 10th January 1996

Introduction
The Primary Care Development Programme needs to be evaluated on a number of different levels.

Level 1
At a strategic level the plan needs to be evaluated against the HA's strategic aims for primary care in Merton, Sutton and Wandsworth.

Level 2
It is important to consider individual projects in groups or strategic strands. All projects are reviewed over and above quarterly monitoring. For larger revenue projects and those projects supported by non-recurrent funding a review will take place after two years. Continued funding for projects is subject to the results of the evaluation.

Adjustments to projects may be made in the light of evaluation, although it is likely that adjustments will have been made to improve effectiveness by providers with the commissioning team.

The outcome of reviews may include consideration of continued funding and will include disseminating learning and identifying specific action points.

The largest projects have a built-in independent evaluation.

For example, the 'Going Home' scheme evaluated by the Department of General Practice at St George's Hospital Medical School. A number of projects such as counselling, physiotherapy and chiropody have an element of evaluation built into the original specifications.

For smaller projects the following criteria will be used to assess projects.

- The project should support practice-focused primary care, unless there are demonstrable reasons why it is not appropriate.
- The project should meet general or specialist health needs which are not otherwise serviced or sufficiently served by mainstream services.

From the assessment of health needs, it was agreed to invest more uncommitted resources available in 1995/96 to target the vulnerable elderly and areas of high deprivation.

- There have been a number of health needs assessment projects. This information will be used to inform the evaluation criteria for current projects.
- We are also seeking opportunities to combine projects, or to add successful projects to mainstream contracts.

Level 3
It is still necessary to evaluate projects on an individual basis and to have an agreed process for this. The following is proposed

1.1 Providers will be expected to produce an evaluation report based on the objectives of each project, prior to its completion.
1.2 Reports will be received from providers at quarterly intervals and a final report.
1.3 On receipt of the final report providers will present to a panel consisting of the project lead, representative from Primary Care Commissioning and Public Health.
1.4 A summary report with recommendation for continuation will be given to the Steering Group for approval.

cont/ . . .

Example 1 cont'd

Level 4
In addition to the above an evaluation of the whole Tomlinson process locally is needed. This should include issues such as the effect of uncertainty over funding levels, changes in resource assumptions and the expectations set with regard to the timescale.

Measuring Progress
This is difficult given the number of variables involved in service development. There are however a lot of baseline data, which should enable assessment of change over time.

Dissemination of Learning
The management arrangements should enable learning to be transferred within the HA. Relationships with GPs, providers and other organisations are also enabling the lessons from projects to be spread to key opinion-formers and stakeholders. The Steering Group is used as a mechanism for sharing project experience with providers and the local authorities.

Example 2

Croydon Health Authority: Framework for Evaluation of Project Requiring Agency Pick-up, 19th December 1995

Introduction
The total investment in service development over 5 years will be in excess of £20 million and comprise more than 90 projects.

There is a requirement to measure the performance of projects in order to inform decisions about continued investment, as well as a need to evaluate existing services to inform decisions about where resources may be released from.

Principles
The following principles underpin the evaluation framework:

- the costs of evaluation should be kept to a minimum.
- the development of new projects should not be burdened by the demands of excessive data collection.

The Purpose of Evaluation
Evaluation should inform Croydon Health about:

- How successfully the service has achieved its aims
- The effect on its target client group, and on other services
- Value for money
- Whether a new model of service provision is more successful than other services.

A Framework for Evaluation
In order to use resources effectively a broad classification is proposed against which the available 'effort' could be allocated. This will be largely finance orientated, but will also take account of the innovative nature of a project, or the size of the target population.

cont/ . . .

Example 2 cont'd

The suggested classifications are:

Classification	Future* Revenue Costs per Annum(£)	Evaluation
A (Top)	200,000+	Detailed analysis, possibly involving independent experts
B (Medium)	50,001-199,999	Appropriate research to seek manager, user, carer and professionals views on service
C (Low)	0-50,000	Quick reporting reliant on readily available information such as throughputs etc, as well as a literature search on similar projects

* Future resources should take into account the expansion of schemes to cover whole populations

Under each classification, the evaluation should have a structured approach which will be common to all. Decisions may be made about the opportunity cost of one project over another, taking into account local sensitivity and other expert information.

To achieve Evaluation
Croydon HA has formed an officer-level evaluation advisory group who will manage the evaluation programme, develop appropriate methodologies (utilising focus groups), undertake evaluations and prepare reports for Directors who will then make decisions about the allocation of funds based upon opportunity costs. The advisory group will not decide upon future funding itself, but its report will inform Directors' decisions.

In some cases, HAs have specified particular areas of interest in reporting evaluation. For example, in Enfield and Haringey, the HA has identified a project's ability to demonstrate 'acceptability' and 'sustainability' as likely criteria for continued support from the HA.

In the main, it has been left to providers to produce detailed plans as to how they intend to go about evaluating individual projects.

Example 3

In Barking and Havering, a nurse was appointed responsible for overview, audit, quality assurance, training and evaluation of a leg ulcer project. She supported the ten district nurse coordinators of the service and developed the evaluation of the project. This evaluation ambitiously planned to look at variation in healing rates, costs of care per completed treatment episode, evaluation of cascade training and nursing compliance with protocols, needs assessment across the district, audit of patient information and measuring patient satisfaction.

Therefore, while most projects have been *guided* by broad HA statements in LIZ plans which set out expectations that all projects would be involved in evaluation, in many instances, the responsibility for the initial design of the project evaluation has remained with the provider, with or without academic or other specialist input.

In the same way that Regional Performance Management staff have sought to ensure that plans for evaluation were in place within HAs, HAs themselves have also offered advice and support to providers in beginning to think about their plans for evaluation. This has been through education and development aimed at generally increasing provider understanding of both the need for, and the process of, evaluation. For example, Ealing, Hammersmith and Hounslow ran a series of workshops for providers on evaluation. East London & the City HA also commissioned a series of workshops to develop the design of individual project evaluations. HAs have also spent time commenting on plans for evaluation prepared by staff in individual projects through a process of approving projects for funding. This has often resulted in specific additions or emphasis offered by HAs. For example, in Brent and Harrow, through a project management 'stocktake' of LIZ projects, it was made clear that projects would not be offered continued support without stated plans for evaluations. Some HAs also supported this process through specific visits and detailed discussion on a project-by-project basis.

Example 4

Lambeth, Southwark and Lewisham HA chose to focus attention on evaluating its so-called 'substitution' projects. Providers were required to produce evaluation with support from two substitution analysts appointed by the HA. An evaluation checklist sent to providers detailed the expected content of the evaluations. These included:

- outline of aims and objectives
- quantifying the extent of substitution versus unmet need
- structural evaluation (profile of team etc)
- process evaluation (activity data etc)
- measurement of health gain
- cost implications
- impact on other services

All providers were asked to submit a protocol based on this. Through this process, the HA Substitution Steering Group agreed a two-tier system of evaluation. They identified priority projects in terms of size, potential impact and reflecting corporate priorities and expected a detailed and rigorous evaluation. This included Paediatric Home Care Teams and a Hospital-at-Home Scheme. A cost comparison analysis with the acute sector was also expected.

A second group of projects were those where they saw a more qualitative analysis as appropriate. There were projects where they were not expected to be rolled out or were too small to demonstrate cost shifting.

Lambeth, Southwark and Lewisham HA's plan to evaluate the extent to which projects contributed to substitution of primary and community care for secondary care was perhaps theoretically appropriate, but posed major practical difficulties to staff at project level. The research resources, data and skills required to assess substitution in this way were not always available.

Providers also sought to extend evaluation where they felt it was appropriate. For example, some developed and submitted proposals for enhanced evaluation to Regional NHS Research and Development Directorates in areas which the providers recognised would benefit from a more rigorous approach to evaluating a new service than they themselves could undertake.

Providers also sought to extend their own skills through additional training in evaluation.

Example 5

At the Alzheimer's Disease Society in Hammersmith, two members of staff have undertaken training to learn how to carry out dementia care mapping to add to the evaluation of the project. Dementia care mapping was developed as a tool to augment other more structural types of evaluation with a detailed assessment of what is happening at the person-to-person level of care. As a technique it offers objective grounds for characterising the quality of care and is intended to indicate where care succeeds or falls short.

There has, therefore, been ongoing development of the design of evaluation of many projects which has been added to by both HAs and providers. Overall, this incremental approach to the evaluation of projects has contributed to the formative nature of most evaluations which have taken place as part of the LIZ programme. Information gathered by authorities through routine monitoring of all projects has also added to this.

Even in the early stages of the LIZ programme, considerable discussion took place in South Thames Region between the Region and HAs about plans for 'pick up' (i.e. selection of projects for funding after the end of the programme). During 1995/96, purchasers began to offer increasing guidance and direction about evaluation. They reported becoming more aware of the kinds of criteria projects would need to be measured against to justify future funding. On the understanding that HAs need to consider whether or not LIZ projects will be picked up for mainstream funding, HAs have begun to develop evaluation frameworks which allow decisions to be made about incorporating projects into future commissioning contracts (see previous examples of two evaluation frameworks).

4.2.2 Selecting projects for evaluation

Discussion with individual HAs and through the workshops held at the end of June 1996 provided little evidence of discussion between HAs about evaluation frameworks and priorities in selecting projects for evaluation. Further, while several commentators (Newman, 1993; Apfel, 1994) have previously recommended cooperation between HAs with respect to evaluation of the LIZ programme (see Chapter 5), there seems to have been little subsequent action.

However, at the time of this study, most HAs had developed broad criteria for selecting projects for different types of evaluation independently (see Chapter 3). In retrospect, it is easy to see how projects fell into one or other of the three most common approaches which are:

- *simple monitoring* – where project activities are assessed for their consistency against project intentions;
- *formative evaluation* – where activity is documented and progress critically reflected on in order to contribute to the internal development of the project; and,
- *summative evaluation* – more complex, often externally commissioned, primarily used to assess new and innovative services.

Most HAs seem to have developed a similar broad approach to selecting projects for evaluation/monitoring which is summarised below.

Reviewing all LIZ projects

Almost all HAs have at some point undertaken a stocktake of their projects. This has involved a review of all projects, encouraging them to state and/or restate their aims and objectives. In particular, HAs have sought to identify ways in which progress could be measured against these initial aims. For many HAs, this was regarded as appropriate for the large number of projects in which the main focus was to put in place services which could be considered commonplace elsewhere. This kind of review process was also described by HAs as appropriate where projects were considered to be small (i.e. less than or around £30,000 a year). To set up costly evaluation rather than monitoring or an internal review process was seen as inappropriate and liable to distort the service element of the project. Similarly, managers commented that some projects were so obviously beneficial, in their view there was little need to undertake review beyond keeping in touch with their progress and development.

Some managers clearly saw the value of the 'evaluation' as part of a process to justify their decision to invest in a project. Where it was felt that a project was seen to be successful by all those involved, including key stakeholders, there was felt to be little need to undertake more detailed evaluations.

It would seem that, in the main, smaller projects were encouraged to review their progress but the emphasis was clearly *formative* (i.e. to suggest how the project could best be developed in the future).

In most instances, the responsibility for developing this kind of evaluation was primarily seen as resting with those in receipt of project funding (i.e. providers). It was, therefore, seen as the provider's responsibility to justify to HAs either continuation or development of the scheme through this work. For purchasers, this type of review was largely regarded as a way of generating progress reports on projects (i.e. there was little external reflection on success and reports were largely limited to financial monitoring and routine activity data).

Example 6

One HA commissioned an external academic unit to undertake an evaluation of all of their projects. While the point at which they identified the need to carry out some form of evaluation was clearly ahead of mainstream thinking on this issue, in practice, the approach was not as successful as the HA had hoped. In retrospect HA staff acknowledged that this process had potentially weakened links which were developing between themselves and providers. The broad approach with evaluation across *all* projects rather than selecting some projects for closer attention than others had its limitations. The process was also felt by several providers to have confused consultation about methods of evaluation with undertaking the evaluations themselves. Further, the 'descriptive' nature of much of the resulting data was felt to be insufficient for shaping future commissioning in this area.

Projects selected for more considered review by HAs

Within each HA's review of their local projects there emerged a group selected for more considered review. The reasons behind the selection of projects for more detailed consideration varied. In some instances, projects were selected because defining the aims and objectives of a project had proved difficult and/or those leading the project were struggling to find an appropriate way to develop an evaluation of the service; for example, in Brent and Harrow a number of projects were selected for help and support from the Public Health Department.

In Ealing Hammersmith and Hounslow, there was specific expertise available from the HA in the form of a part-time post to focus on evaluation of LIZ projects. This postholder provided additional advice and support to individual projects and sought to develop an overall evaluation framework.

Projects selected for more considered review also appeared to include some where there were already known to be questions about the value of introducing particular services. These included projects where those commissioning them had already identified a difference of opinion between two key stakeholders about the continuation of the service (e.g. where GPs expressed a wish for counselling services to patients and this was generally regarded locally as a 'good thing' as against the evidence that use of counselling in general practice has varying outcomes).

Projects selected for further scrutiny also included those where there was felt to be a need to provide external evidence as justification for the continuation of a development.

Example 7

In Croydon, a new service for GPs and primary care teams was developed, the GP Link Office (GPLO). This was intended as an umbrella agency bringing together key agencies involved in general practice with primary care staff who coordinate primary care development education and training. This includes the Croydon Medical Audit Advisory Group (MAAG), Croydon GP tutor, health promotion facilitator and the LMC. While there was an impression it had been successful, it was felt that an independent view could add substance to this impression.

Another group of projects which were selected for more considered review were those projects where individual HAs acknowledged that it would be difficult to obtain reliable results, even if they had spent substantial resources on a more complex evaluation at a local level. A reliable summative evaluation of certain kinds of development would require a multi-site study with a larger study group over a longer time scale than any one HA could organise or fund.

While the predominant approach to project evaluation undertaken by HAs themselves has been to monitor all projects and encourage formative evaluation; it would appear from the discussion with HAs and providers both individually and in workshops that these reviews are providing interesting data about activity and areas for future questioning using more summative styles of evaluation.

Commissioning external evaluations

A third approach which HAs stated that they adopted when commissioning evaluation was where they felt they were undertaking a project which was large, different and likely to be controversial and/or new.

Example 8

Brent and Harrow has invested in a number of projects which the HA has grouped together under a collective label of *Homeless and Rootless* projects. Here the projects themselves were felt to be breaking new ground and the HA wanted research expertise that it felt it did not have in house, in this instance in ethnographic methodology, which was believed to be more appropriate to evaluating these kinds of developments.

HAs stated that where they were investing large sums in a development and/or where they anticipated significant changes in the pattern of future resourcing, they should be able to evaluate progress using a summative approach. This was most often noted with respect to those projects often grouped under a heading of '*substitution projects*' (i.e. projects

which were receiving investment with a view to bolstering primary care so that a direct transfer of care could take place from the acute/hospital sector to primary care). Also, where successful, these projects might then enable disinvestment from the acute sector.

This included, for example:

- Lambeth, Southwark and Lewisham commissioning with the King's Fund to assist in certain aspects of the evaluation of the Lewisham/Optimum Hospital-at-Home scheme;
- South Thames funding the Policy Studies Institute to evaluate three midwifery group practices.

The interviews with HAs also showed that they had selected other projects for more in-depth evaluation where these fitted closely with their own strategic priorities for change and development in primary care. These external evaluations approach the criteria appropriate to *summative* evaluation.

Example 9

Lambeth, Southwark and Lewisham funded an Out-of-Hours project in the Academic Department of General Practice and Primary Care at King's College School of Medicine and Dentistry. This aimed to facilitate a number of Out-of-Hours service developments following an initial consultation phase. Evaluation was an integral part of the project in-built at the outset and aiming to enable evaluation to become an integral part of the service developments lasting beyond the life of the project. Having established South East London Doctors' on Call (SELDOC), a GP out-of-hours cooperative, the evaluation is looking at various aspects of the service including GP member and patient satisfaction, organisational and operational aspects of the service, as well as cost effectiveness. Reflecting the complexity of the new service being developed, a multi-method approach is being used, including questionnaire surveys, case studies, interviews and focus groups.

Evaluation in this instance has been central to the development of the service. It is also likely to provide the HA with useful information to inform future decision making.

The involvement of Regions in funding external evaluations is discussed in the next chapter.

4.2.3 Project management and its impact on evaluation

The management arrangements set up in HAs to run the LIZ programme as well as the skill and expertise available in provider units, voluntary organisations and general practice to develop projects, have clearly both been important in setting in place a framework for action on which evaluation can take place. Further, the range and number of relatively small projects which make up the LIZ programme adds weight to the view that LIZ is an exceptional case in terms of developing an appropriate framework on which the programme and its projects can be evaluated.

While it is not the intention of this report to assess the strengths and weaknesses of the LIZ project management arrangements, a number of issues arose in discussion with both HAs and providers about the characteristics of the LIZ programme and their effect on establishing an appropriate level of evaluation of projects and of the programme overall. These are described below.

Planning and preparation time

For all projects, the lead-in time for setting up was short and pressured. This meant that there was almost no piloting of projects which were being developed from scratch. Although a large proportion of projects were related to the aim of 'getting the basics right', many were in areas where there were only a few examples of success and these were not necessarily in the inner city. There was considerable pressure on HAs to ensure that all projects were set up, services developed and money spent in line with expenditure plans. This was acknowledged by HAs and Regions alike and although time was short, considerable effort went into making primary care plans and particular investment decisions as robust as possible.

Providers felt pressure to turn ideas into projects, recruit staff and begin to deliver services on the ground. Such a restricted introductory planning and development phase meant that opportunities to think through with expert input, develop or revisit aims and objectives against which the success or otherwise of projects would be measured was constrained.

The opportunity to review relevant literature and material about the areas of success within projects from elsewhere or network with other projects was also limited. Arrangements to allow for the future comparison between projects in similar fields across London were not put in place. Many projects took off without measures in place to assess their effectiveness such as a realistic assessment of baseline data: the large majority of these were instituted retrospectively.

Project design

Almost all projects approved to go forward in 1995/96 have done so on the basis of written proposals and a statement of intent concerning evaluation. Many projects approved in the first two years, 1993/94 and 1994/95, went ahead with much less comprehensive documentation.

A number of projects have therefore proceeded with less than consensus between stakeholders. In many instances, project aims and objectives were poorly defined at the

outset and were revisited at a later stage. This in turn has caused some HAs difficulties in assessing whether projects have achieved what they set out to do.

All of the LIZ projects have been set up at a time of rapid change and considerable financial pressure in the NHS generally. Although set up in response to an initial perceived need to develop services, some projects have not taken off as anticipated; for example, several hospital-at-home schemes have had fewer patients than anticipated. It has then been difficult to decide whether to re-focus or close them down and use resources elsewhere without sufficient evaluation on which to base these decisions.

Large range and number of projects

Moores Rowland (1995), in studying the LIZ programme in North Thames, commented that '*the LIZ programme represents a major developmental process with relatively large budgets to spend in an area of diffuse service provision dominated by independent contractors. The large number of projects involved mean that sound project management is essential in any authority*'. The wide range and large number of projects has clearly stretched the capacity of HAs both in maintaining adequate monitoring of projects, but also in offering an appropriate level of support to developing evaluation. With such a wide range of diverse projects it would be unrealistic to expect LIZ programme managers to have had expert knowledge in all of these areas.

Moores Rowland noted that the responsibility for developing evaluation frequently rested with project managers/leads who not only had a range of other commitments, but did not necessarily have skills or experience in service evaluation. They had also often played a major part in getting projects up and running and so might have found it difficult to stand back and look at the project with the necessary degree of independence required to develop an evaluation.

Financial monitoring

All HAs have used a quarterly monitoring process to generate information about progress of projects against financial targets. While this may have highlighted projects which needed help, it has been used primarily to identify variation in predicted and outturn *expenditure*. Programme managers felt their priority in the first phase of LIZ projects was to establish projects and ensure that money was spent rather than to develop evaluations.

Health authority management arrangements

Throughout the programme, management arrangements in HAs have constantly been changing. Moores Rowland (1995) described the management arrangements in North Thames Region in the first two and a half years as evolving to meet the growing needs of the programme. They characterised arrangements at the beginning of the programme as:

- a spread of responsibility between directorates;
- a programme manager, third tier in the management structure;
- identified project managers and project leads for all projects;
- a lack of skills in developing capital projects;
- no one designated person from finance with responsibility for monitoring and control.

Although it was recognised that arrangements were still changing, by 1995 Moores Rowland observed that many HAs in North Thames had in place the following:

- identified responsibility at Director level either as project leads or through direct management of others;
- consistency of approach within locality structures;
- full-time person responsible for capital schemes or access to specialist skills on a consultancy basis;
- designated finance input.

Moores Rowland also noted all North Thames HAs reported problems in successfully spending up to the limit of their allocation and for that reason introduced extensive financial reporting relatively early on in the programme. This provided quarterly monitoring of all projects and was used mainly to forecast the overall position for each HA on an annual basis through reports back to Region and LIG.

In South Thames, the Region invested a considerable amount of matched funding to develop primary care in London. All projects were expected to have objectives and an exit strategy before the Region would release funding.

Each HA was asked to have a named lead manager and quarterly meetings took place between the Region and the HA to discuss progress. Through this process each HA has developed five or six key themes which would have a significant impact on primary care and milestones have been agreed against which progress can be assessed.

It emerged in individual discussion with HAs that over the last year most have been seeking to integrate further the management arrangements as part of the overall commissioning structure. At the time of this study, this was still developing in most HAs and a lead manager continued to provide a focus for the management and development of the LIZ programme.

It also seems important to reflect on the numerous changes – both of staff in post and those responsible for managing the programme over the first three years. This rapid turnover must have contributed to changing perspectives on the goals and expectations of the overall programme.

The pressures of managing a considerable amount of slippage as individual projects were unable to meet their initial and often unrealistic timetable and the financial implications this had for the management of the whole programme, have also been important in reducing the relative priority that has been afforded to evaluation.

Provider project management

Providers taking on projects also found themselves facing challenges in setting up projects and in thinking about developing models for evaluation. These challenges included:

- managing relatively large-scale service developments from scratch sometimes in areas where they previously had little expectation of getting money and where the impact on their current services was considerable;
- taking on projects that were initially regarded as a list of ideas 'off the shelf' which at the time appeared to be local priorities, but which by the time they were supported, may have been overtaken by other priorities;
- managing a number of different projects within one provider unit without any phasing or decision about the relative priority of introducing one before another;
- finding themselves in receipt of additional funds for development projects while core services continued to be stretched for resources;
- resourcing LIZ projects where they were asked to separate out LIZ project activity from their existing teams and where they would have preferred to enhance existing teams through pooling available resources;
- having limited project management time, capacity and experience to devote to LIZ projects within existing management capability;
- recruiting skilled, experienced, high calibre staff with specific expertise able to work with limited supervision and with experience of development work to set up and run projects. These people had to be attracted on short-term funding in areas of London where recruitment and retention is known to be difficult. Some trusts reported taking

on staff on permanent contracts as they felt it was the only way they would be able to recruit suitable people;

- developing projects quickly combined with the need to show early demonstrable activity from service developments may have contributed to projects missing out a needs assessment and/or feasibility phase. Such a stage could have more realistically assessed the need, risk and viability of schemes as well as giving opportunities to consider how projects could be evaluated.

4.3 Conducting evaluation

4.3.1 Provider evaluation at project level

It is clear from the discussions with a selection of LIZ projects across London that the term 'evaluation' has been interpreted very differently by various providers involved in developing the projects.

Overall, providers showed a lack of confidence as to the potential benefits of carrying out evaluation. For a substantial number of projects they have developed some form of 'review process', because this was required by HAs. Further, they appreciated likely future funding would depend on their ability to demonstrate the service was valued.

HAs requested evaluation of projects by providers although the level and style was very varied.

Example 10

The service to distribute free condoms to general practices was organised by Camden and Islington HA. The Medical Audit Advisory Group (MAAG) was commissioned to evaluate it. Through direct reporting of the results of a relatively short term, small-scale project back to the HA, it would seem that further developments of the service took place.

Example 11

A voluntary sector project reported that the request for detailed evaluation by LIG seemed to be disproportionate to the resources needed to develop the project itself and poorly timed as the development was only just beginning to deliver a service. The project team was asked to answer questions such as how many acute bed days were being saved in their locality through the provision of their service. Understandably, this was a question which they found very difficult to answer.

In both of these instances, the purchaser directed the evaluation of the development project. However, in Example 11, it should be noted that LIG had funded *all* voluntary sector projects on the basis that they might reduce the requirement for acute inpatient days. Thus it was not surprising that this became part of the currency of evaluation.

For many providers acknowledging the need to carry out some formative evaluation occurred relatively late on. Projects were usually underway by the time the evaluation was planned and started. As previously discussed, although many providers expressed a wish to carry out a more systematic review of their activities than had been possible hitherto, for many projects this seemed inappropriate due to the project size.

Example 12

In Barking and Havering, there were a lot of small projects of £1,000-2,000 to develop the role of pharmacists. While those attending study days, as part of these projects were questioned as to how useful they were, it was seen as inappropriate to carry out a more detailed review.

It seems then that for many projects, evaluation has been interpreted as agreeing a set of aims and objectives with a representative of the HA and then setting out, through documentation, to justify subsequently whether these have been met, in the broadest terms. For some providers, understanding what was being asked for in terms of evaluation and trying to get to grips with HA expectations has been a major hurdle. This has been due to lack of clarity of expectation on the part of the HA as well as a lack of skill in appropriate methodology (e.g. analysing substitution effects of primary care projects), lack of experience in interpreting activity data collected and/or lack of expert knowledge in a particular field.

Some providers, however, appeared to have taken on the 'evaluation' as an additional and interesting element to the project. This was noted more often where the initial project had been submitted by enthusiastic experts in their own field, who saw the merits of evaluation and had a better understanding of the need to be involved in evaluation as well as perceiving its potential value.

Example 13

The importance of individual enthusiasm was particularly highlighted by the Lymphoedema project in Ealing Hammersmith and Hounslow. This project aimed at developing an outpatient Lymphoedema service based in a hospice. The plan to develop the service grew from a locally identified need for the service combined with the research experience of a senior nurse. It was therefore acknowledged at the outset that as a new service there would be a need to evaluate it although the demands both of developing the service and giving sufficient attention to the evaluation were considerable.

Some providers also valued evaluation as a formative process for their own services.

Example 14

The physiotherapy and psychology services received funding from East London & the City HA to develop a number of projects. In commissioning the evaluations both services appointed individuals with postgraduate experience and qualifications in research methods from their fields to undertake short-term evaluations. The evaluations were felt to be valuable to the providers who had specifically initiated this work because it offered them another perspective on what they were doing.

The evaluation of projects then has often been closely associated with those who were the lead provider project managers. Many project managers commented that they felt they had limited understanding of 'evaluation' as a concept. Many of these people were recruited to develop and implement services and were therefore not trained or experienced in service evaluation – which in itself could be said to be relatively new to these kinds of developments.

Many providers expressed interest in carrying out an evaluation of some sort where they felt it would inform the future development of their projects.

Example 15

Croydon Community Trust grouped together LIZ-funded health promotion projects and reviewed each one against its specific aims and objectives. As a result, these projects changed direction in their next phase and this was agreed with the HA. Health promotion elements of two projects were combined and incorporated subsequently into mainstream services after LIZ funding had come to an end.

Some providers commented that while they might not have recognised the potential benefits of investing in evaluation at the outset they had become convinced of its value through the process.

Example 16

In Hounslow, work was invested in developing an appropriate methodology for evaluating the Community Mental Health Team. Hounslow and Spelthorne Community and Mental Health NHS Trust received funding to set up a number of Community Mental Health teams. This in itself presented many challenges including recruiting and re-organising staff and premises. The evaluation also needed to be developed almost from scratch and this has involved a considerable investment on the part of managers and staff in the service with input from the HA. This is now felt to have produced useful analysis of data including information about caseload and referral pattern, admissions and discharge information and packages of care. Attempts have been made to combine activity with case study data. Its value in being able to use a similar approach to other developments taking place locally only became apparent in the later stages of the project.

It could be said that the ownership of evaluation by providers in this instance is much greater than was normally the case.

A different emphasis on provider input to evaluation is shown by the evaluation of Hospital-at-Home in west London. Here the Public Health-led comparative multi-site evaluation was supported with academic involvement from the London School of Hygiene. While providers are involved, they might, as suggested by those leading the project, be more appropriately described as participants in the process.

4.3.2 The role of Public Health Medicine at health authority level

Public Health Medicine is the most recognised focus for evaluation skills within a HA. It might be expected that Departments of Public Health Medicine would have the necessary skills and responsibility to contribute to all stages of project evaluation.

The varied role that Public Health Medicine staff played in the evaluation of LIZ primary care development projects ranged from the central one of identifying the need for evaluation, planning and conducting evaluations, and using results to influence commissioning intentions, to providing small amounts of *ad hoc* advice. The role and contribution of Departments of Public Health Medicine in the evaluation of LIZ projects varied from HA to HA. Examples of the contribution of Public Health staff to the different stages of evaluation included:

Agreement on the need to evaluate

- As core members of the project management group for all LIZ primary care development projects
- Involvement in initial ranking of projects for evaluation and review of all projects against their aims and objectives and their impact on health gain

Identifying the necessary resources

- Conducting training in evaluation for providers and purchasers in liaison with an academic department
- Liaising with other HAs on similar projects through Public Health networks
- Bidding for external resources (e.g. evaluation of hospital-at-home schemes)
- Identifying resources for evaluation (e.g. 10% of all project funds)

Conducting the project evaluation, collecting data, analysing results and reporting

- Designating posts within Public Health to undertake research (e.g. two 'substitution' analysts in Lambeth, Southwark and Lewisham to assess twelve projects looking at the primary/secondary care interface)
- Linking back to health needs assessment once a project was approved to determine its appropriate focus

Using project evaluation

- Managing the project evaluation, reviewing progress and linking findings to commissioning intentions and a primary care strategy
- Contribution to evaluation panels for assessment of projects

Overall, Departments of Public Health contributed to all phases of evaluation as described above in two HAs and were, therefore, central to evaluation of LIZ schemes. Four HAs received Public Health input but wanted more substantial support from their departments. Public Health was marginal to the process in the remaining six HAs, two of which received evaluation skills from resources outside the Public Health Departments.

4.3.3 The content of project level evaluations

The earlier parts of this chapter have set out the view shared by many HAs that LIZ projects should receive differing levels of attention with regard to evaluation.

It is apparent that a number of HAs gave some attention to thinking both about exit strategies for individual projects and the need for projects to undertake formative evaluations in order to review their individual progress. The attention given to commissioning summative evaluations through which projects of similar type could be contrasted and compared however has been limited. This is now the pressing issue for most HAs as they attempt to make decisions about investing in one type of development against another.

This was reflected in the types of data collected at project level. The majority of projects have focused on collecting activity data. From the projects about which we collected information, across the LIZ area there would appear to have been four broad types of data collection:

Descriptive and documentary activity data.

This has been characterised by:

- descriptive analysis based on relatively small populations of service users and isolated to one service;
- variables linked back to the aims and objectives of projects. In the main these have been very basic; i.e. did it do what it set out to do? Can this be demonstrated?;
- audit-style collection of data about certain aspects of services (e.g. number of patients seen, for what, when and by whom?).

For the vast majority of LIZ projects, this has provided broad details about services, their availability and uptake.

Process measures

This includes projects where attempts have been made to assess activity against some quality standard. In the main, these projects have been those commissioned with a relatively explicit aim (e.g. Hospital-at-Home projects). Many of those involved in evaluation, both HAs and providers, commented that they felt they had been over-ambitious in the number of areas they had hoped to evaluate, and this had not been possible due to:

- a paucity of readily available data
- the difficulties involved in collecting useful data
- the time involved in gathering and making sense of material collected when projects were not resourced to do this.

Health gain and clinical outcome

Several HAs have begun a process of discussion of health gain and outcome from primary care development projects, often initiated through their Departments of Public Health. For example, Camden and Islington specified the anticipated health gain for all projects in their plan, although they admitted that this had been relatively superficial due to lack of time. They were also aware that many projects would find it very difficult to measure their outcomes and that projects were in the main too short-term to evaluate in terms of impact on health outcomes which would only become visible in the longer term.

Cost-effectiveness and cost-utility approaches

It would appear from our discussions in this study that work in this area has been very limited. At least in part, this can be explained by the small scale of most project evaluations and limited resourcing made available for evaluations.

The exception to this from projects we have interviewed was the West London Hospital-at-Home project, which has used the London Health Economics Consortium to review some aspects of costs and benefits.

We found little evidence of work of this type being undertaken in other fields. Where there are a number of LIZ projects across London, and where some comparability of both contracting and outcome data probably does exist, there might be opportunities for

comparative study and, thereby, cost-utility comparisons between the merits of different types of project (see Recommendations in Chapter 7).

4.4 Dissemination and use of evaluation

4.4.1 Evaluation and networking

The majority of project evaluations seem to have focused on the development of the individual service and its likely benefits in the local setting. Even across individual trusts and HAs, there would appear to have been relatively limited attempts to share the results of work in progress. However, examples where this has taken place include:

- presentation to the Trust Board of findings from the Leg Ulcer Care Management Project in Barking and Havering which it was felt served to raise the profile and understanding of the project; and,
- the process set up by Merton, Sutton and Wandsworth whereby, as part of the LIZ project review process, all project teams were asked to present their work to a panel comprising individuals from different directorates in the HA.

In the main, networking and exchange of evaluation ideas and development options between individuals has taken place where either:

- projects were professionally linked to a network which kept them informed of other developments in their topic area, such as the regional network of pharmaceutical advisers run by North Thames which helped to support the pharmacy projects in Barking and Havering; or,
- the individuals involved in the evaluation were professionally and academically familiar with the literature and aware of developments in their field of interest, such as the evaluation of Prescription for Exercise Project by the University College Hospital/Middlesex Department of General Practice and Primary Care.

There appear to have been some difficulties in developing networks for evaluation of projects. It also seems to have been fairly low on the list of priorities for projects themselves and those managing LIZ programmes. The relatively low level of networking developed around evaluation may also be a result of the limited planning time available for project development. A large number of projects did not incorporate evaluation in their early stages. As a result, contacts with others in the field which may have led to developing networks did not seem to have readily arisen.

A significant exception to this is the Hospital-at-Home research and development network that was set up through the DH R&D initiative 'Research into primary care in London'. This has involved all projects across London and elsewhere in an ongoing group for sharing ideas and developments.

4.4.2 Possible uses of evaluation

This review indicates that, at project level, the prime interest in evaluative activity throughout the period of the LIZ programme lay in simple monitoring with substantive additional interest in *formative* work which would help with the development of individual projects. Increasingly, as future funding decisions have loomed larger, interest has grown in *summative* or outcome-oriented data, particularly at HA level as LIZ funding comes to an end.

However, most evaluations were designed and developed before purchasers developed clear evaluation frameworks. It may well be the case, as several HAs pointed out, that the largely formative evaluations that have developed with their consent and approval do not sufficiently answer the questions purchasers now want answered to support future investment decisions. These include the following types of questions: would this project be appropriate to roll out across the whole HA area as it has shown limited benefits in one particular set of circumstances; and would further investment in developing this service in primary care bring about a change in the pattern of services used in acute care and with what financial consequences?

In some instances, the lack of evidence for answering such questions is due to the limited size and scale of both of the projects themselves and the scope, nature and quality of the evaluation that was undertaken. The diversity of projects commissioned by many HAs, their relatively small scale and the lack of comparative summative evaluation, all contribute to the difficulties many HAs now face in trying to incorporate these LIZ service development projects into their future commissioning intentions.

Where more summative evaluation has been undertaken, there are already concerns that the pressure on timescales will again force HAs to make important decisions about future investment before the studies have had time to report fully. This is particularly likely where the timetable to develop LIZ projects was short and where plans for evaluation of projects were largely developed *after* projects had already been set up, so that their results lag behind the life of the projects.

Furthermore, it may take time for a newly established development to become regarded as a model of good practice by a large number of stakeholders. For example, Hospital-

at-Home projects require local GPs and hospital consultants to incorporate changes into their long-established routines which takes time.

Another key factor influencing whether evaluations will be incorporated into the future commissioning process of HAs is the fact that some were still without strategies for primary care against which the introduction of these developments could be measured.

Whether evaluations of the LIZ projects will be incorporated into the future strategy and commissioning intentions of HAs is also dependent on their perception of the role of LIZ funding. A few HAs commented that they had seen LIZ monies as part of their development funds. Through using LIZ monies, they had learned about the process of developing relationships with providers, enabling change both in clinical practice and in the balance of services between primary and secondary care: lessons which could be incorporated into their mainstream contracting processes. More, however, saw LIZ projects as a bolt-on to their mainstream funding that only now needed to be considered critically in relation to other activities since their funding was coming to an end.

4.4.3 Informing the commissioning process and disseminating information more widely

From discussion with both HA managers and those involved in developing project-level evaluations, we found evidence of limited plans for the further use of findings. First, interviewees at project level commented on using findings for review and further development of individual projects. In particular, they highlighted the opportunities for project teams to share this information between projects and so develop their thinking. Second, project and HA staff both reported their wish to use evaluative findings to inform future commissioning of services locally. Through discussion with HAs, this was where most of the interest at project level was currently focused. The major interest at HA level was to be able to justify so-called 'exit' strategies with projects (i.e. to be able to decide whether or not to support continuation when project funds expire). It was felt that any kind of evaluation process would help to inform the decision making process in this instance. There was, however, a considerable lack of clarity as to whether the data gathered through the majority of formative evaluations would be a sufficient basis on which to decide whether to incorporate a project into the mainstream commissioning process. Furthermore, there was an understanding that the data provided would be unlikely to offer much to a debate focused around how to support future investment in one group of services as against disinvestment in another, which for most London HAs was felt to be a likely scenario.

The limited nature of HA plans to use LIZ project evaluations in the commissioning process is highly likely to have been due, in part, to the fact that the LIZ monies were initially channelled to the former Family Health Services Authorities (FHSAs) and not to the HAs. With their abolition, the HAs inherited the LIZ programme without having been involved directly in its initiation.

From the discussion with the HAs, some understanding emerged that the LIZ primary care development projects provided lessons that could inform future commissioning intentions. How this would take place was less clear, although several HA representatives mentioned incorporating findings into their future primary care strategies.

They also proposed sharing findings more widely for information and debate. This was put forward as appropriate between different directorates within the HA. It was also suggested by a couple of HAs that they intended to share findings amongst their relevant local providers.

Third, although HAs and providers showed little interest in wider forms of dissemination, there were a few proposals to disseminate the findings from the various evaluations more widely across London as a whole. It was recognised that there was a significant opportunity for shared learning about new developments in primary care and their effectiveness. This was also acknowledged as important in developing knowledge about primary care amongst both managers and professionals working in primary care. Possible routes by which this could take place included both the London Directors of Primary Care meetings, the LIZ programme coordinators' meetings, the London Chief Executives' meetings and through the Regional R&D structures. However, few individual HAs saw this as part of their broader responsibility.

Chapter 5

Evaluation at the regional and national level

5.1 Previous reviews of the evaluation process

Within the first six months of the LIZ programme, the need to evaluate projects was identified. The then Regional HAs were considered to be responsible for leading this process. LIG which was at that time coordinating service developments in London and reporting to Ministers expected *'to see evaluative criteria built into every project, and allowance made for associated costs when budgeting'*. This was included in guidance for 1994/5 plans.

5.1.1 Regional role in performance management

In each Region, the Directorate of Performance Management has played a role in helping HAs to incorporate thinking about monitoring and evaluation into their management of the LIZ programme and, increasingly, encouraging HAs to think how the findings of such activities can assist in decisions about which projects to take onto mainstream funding when the Tomlinson monies come to an end. However, the main Performance Management role has been to assist HAs spend their Tomlinson monies in a timely way in line with previously agreed plans. At the beginning of the LIZ programme, inner London HAs were asked to submit bids for primary care development projects against planning guidance from the centre. These plans were then commented on by each Region with recommendations as to whether they should be funded or not. A LIG group then took the decisions on acceptance or rejection of the projects.

Subsequently, each Region devised its own arrangements for project management and for ensuring that the LIZ programmes in each HA were being properly implemented. For example, the former South East Thames RHA established a clear performance management framework for the LIZ programme of each HA. Each project was required to have clear objectives, project management arrangements and an 'exit strategy' for the end of the LIZ funding before the RHA would release the funds previously agreed by LIG. Quarterly monitoring meetings were set up between the Region and a lead manager at each HA to assess progress against milestones. This process was facilitated by the fact that the RHA put considerable additional funds into primary care development alongside the LIZ monies.

Currently, both Regional Offices are working with the Directors of Finance of inner London HAs to assist them in deciding which projects should move onto mainstream funding. When LIG was disbanded, the two Thames Regions acted in concert to produce joint guidance on the objectives, main themes and management of the LIZ programme. This guidance, both in 1995/96 and 1996/97, highlighted the role of evaluation and related it to decisions about future funding of projects.

5.1.2 Reviews of the evaluation process north of the Thames

Three regional reviews specifically of evaluation in the LIZ programme were undertaken by the former North West Thames RHA and its successor, North Thames RHA, between October 1993 and November 1994. A more general review of the management and monitoring of the LIZ programme north of the Thames was undertaken by Moores Rowland Consulting (1995). The findings of each of these exercises are summarised in Table 3. Each review:

- specified the need for a distinction between monitoring, descriptive evaluation and academic research, the last, for example, commissioned by the NHS R&D programme, or identified different 'levels' of evaluation suitable to different projects;
- identified the different stages of project development and hence the need to match evaluation objectives and methodology;
- reported variable progress and the difficulty in conducting evaluation of schemes;
- identified a need for support for HAs in evaluation.;
- recommended a Regional Office role in coordinating cross-HA evaluation.

Following the first North West Thames RHA review by Newman (1993), consultation was undertaken in the former North West Thames Region to identify schemes suitable for a formal, independent academic evaluation. Mental health projects, polyclinics/ primary care resource centres including consultant outreach services, A&E projects and hospital-at-home schemes were identified as areas suitable for regional R&D-funded evaluations and an R&D steering group was established. Lead HAs were then identified to co-ordinate potential cross-district, generalisable evaluations of schemes. Thus Kensington Chelsea and Westminster was to take the lead on hospital-at-home, Ealing Hammersmith and Hounslow on primary care and A&E, and Brent and Harrow on primary care resource centres. In a small number of areas, preparatory work was commissioned to explore the feasibility of multi-site evaluations and to refine the questions and methods.

Encouraged by the level of interest in evaluation, research proposals were prepared by a number of groups. Two studies were eventually funded – an evaluation of hospital-at-home schemes in a number of districts and a preliminary study of a number of different 'GPs in A&E' schemes.

Table 3 Summary of previous reviews of LIZ evaluations

Review by	Aim	Method	Findings	Recommendations	Action taken
Newman P. *Evaluation of primary care developments in LIZ North West Thames.* October 1993	• review evaluation • develop a framework for evaluation	• Interviews with HAs • review of 1993/4 LIZ plans • focus on service innovations	• little evaluation underway • similarities in schemes across agencies	• developed framework for evaluation and identified 'levels' of evaluation • specified criteria for identifying projects for R&D evaluation • identified HA leads for cross-agency evaluation • need to identify resources for evaluation • identified hospital-at-home, A&E, polyclinics and consultant out-reach and mental health as suitable areas for R&D commissioned research	• reported to all HA Chief Executives • set up R&D steering group
Apfel F. *Evaluation of LIZ project R&D priority areas in North Thames (West): a status report with recommendations.* King's Fund College, July 1994	• identify progress in project management and evaluation • identify needs for support	• interviews with HAs	• difficulties in undertaking evaluation as projects at differing stages of development • problems with data collection • co-ordination and cross-agency evaluation limited	• need for Regional R&D to fund developmental evaluation and enhance project management and evaluation competencies • outcome or process data needed depending on stage of project • tools or resources needed including manuals, toolkits, workshops, learning sets	• research commissioned into hospital-at-home and primary care and A&E
Bardsley M, Richardson P. *An overview of LIZ evaluation* (North Thames RHA). November 1994	• assess the state of evaluation and the role of the RHA	• interviews with HAs • interrogation of the LIG database	• 660 projects in North Thames, £70m capital, £90m revenue, 50% service innovations • 102 projects specifying evaluation • variability in quality of evaluation and stage of project development • need to integrate evaluation into regional performance management	• all projects should have defined project management • focus evaluation on 6 projects per HA • each RHA to commission 6 projects for R&D evaluation • guidance needed on evaluation methodology	• not clear, what specific action taken
Moores Rowland Consulting. *Managing and monitoring the LIZ primary care programme: final report.* 1995	• review the management and monitoring of the LIZ programme	• interviews with HAs, the Regional Offices, and Primary Care Support Force • questionnaire on financial monitoring • review of 4 projects	• limited progress with evaluation • difficulty in measuring project objectives and identifying level of evaluation • little information on effectiveness • constraints on economic evaluation	• role for Regional Office in setting up evaluation frameworks • HAs to develop evaluation methodologies • HAs to develop 'exit strategies'	• Recommendations implemented by Regional Offices through Performance Management and HAs

Example 17

Evaluation of Hospital-at-Home schemes in North Thames

Kensington, Chelsea and Westminster Department of Public Health was funded to evaluate seven hospital-at-home schemes (five adult, two paediatric) across three commissioning agencies (Brent and Harrow, Kensington Chelsea and Westminster and Ealing Hammersmith and Hounslow). The schemes were funded to varying degrees by the LIZ programme.

The evaluation has been conducted in two stages. First, a descriptive study looking at numbers of patients, lengths of stay and clinical outcome. Second, an evaluative study aimed at determining whether the hospital-at-home services are an effective, accessible, acceptable and efficient way of transferring care from an acute to a primary setting. This included an economic evaluation of three orthopaedic hospital-at-home schemes in west London carried out by the London Health Economics Consortium.

Example 18

Primary Care in A&E.

This project was a one year review of developments taking place in North West Thames, including initiatives taking place both in LIZ and across the Region as a whole. Through responses to a postal questionnaire the project has identified a large number of different primary care initiatives in A&E. This work has been complemented by Ealing Hammersmith and Hounslow commissioning an initial evaluation of five A&E and primary care initiatives in west London.

Meanwhile Franklin Apfel of the King's Fund Management College had been commissioned to investigate the needs for evaluation of LIZ primary care development schemes and the local capacity to undertake these. He highlighted a number of factors which help explain why only a few evaluations were funded from R&D resources, particularly the underdeveloped nature of many of the schemes themselves, the relative salience for participants in schemes of process rather than outcome-oriented evaluation and the limited local capacity to do research (Apfel, 1994) (see Table 3).

In the former North East Thames RHA the approach to evaluation at regional level was similar with active process management of the HA LIZ programmes, principally aimed at ensuring that projects were successfully initiated and sustained so that LIZ monies would be spent in line with expectations. Links were developed with the Regional R&D Directorate which initiated a 'stocktake' of evaluative activity in relation to the programme (Bardsley and Richardson, 1994) (see Table 3). This review eventually covered both the former North East and North West Thames Regions. It recommended that rigorous evaluations should be concentrated on approximately six projects in each HA which should be put forward for Regional R&D funding. It was also hoped that NHS R&D programmes could be used to evaluate some LIZ primary care development projects.

Currently, North Thames R&D Directorate has an Organisation and Management Research Group which encourages evaluation of any projects which display innovative 'Organisation & Management' features. In 1995/96, the Group's budget was £800,000, of which £300,000 was allocated to the evaluation of service innovations including LIZ projects. Not all this money has been committed. It may be that the sums of money are inadequately publicised or that many projects are still too underdeveloped to be confident of being funded. There is also a difficulty defining what is meant by a 'service innovation'.

5.1.3 Reviews of the evaluation process south of the Thames

South of the Thames, the pattern of regional involvement has been different with an emphasis on helping HAs better to understand the scope for secondary to primary care substitution and how to evaluate such shifts. No regional framework specifically for the evaluation of LIZ schemes was prepared and, so far, no specific evaluations of schemes have been funded from the regional R&D budget. However, at least one LIZ project has been evaluated with South Thames R&D funds as part of a wider study of midwifery group practices.

While the two former South Thames RHAs did not produce an evaluation framework or take specific steps to fund schemes from Regional R&D, based on the work undertaken within North Thames, South East Thames RHA published *Primary Care in Focus, Contracting for Substitution – Secondary to Primary Care* (South East Thames RHA, 1994) which, together with other documents, supported their strategic framework. In addition, South Thames Commissioning Network commissioned the University of Brighton to provide an outline for commissioners at HA level on how to evaluate examples of substitution (University of Brighton, 1994).

South Thames Region R&D Directorate has been keen to support research in primary care in a general way as part of its responsive project grant scheme rather than specifically to promote evaluation of projects in the context of the LIZ programme. Research must be generalisable to the wider NHS and must be of high scientific quality to be funded. Advice is available to anybody who contacts the R&D staff. In order to encourage primary care access to the scheme South Thames maintains an adviser in primary and community care research to assist people preparing applications, provides access on demand to experts in a range of quantitative and qualitative methods and ensures that primary care researchers are well represented on the Regional Scientific Advisory Panel which reviews applications for funding. Recently, the R&D Directorate established the *STaRNet* Project which provides the resources for 15 general practices to act as a base for research which will be accessible to all members of the primary health care team.

During 1996, South Thames R&D Directorate began to move beyond an advisory role to beginning to build specific links with individual HAs through a series of visits to HAs organised with the help of the Regional Performance Management Directorate.

5.1.4 The Primary Care Support Force

The Primary Care Support Force has undertaken a number of projects with a bearing on the evaluation of the LIZ primary care development programme, including :

- A 'snapshot' review of substitution schemes in LIZ to share good practice including identification of which have been evaluated. This will inform a published briefing.
- Evaluation of the workload implications of hospital-at-home on GPs through a survey of three pilot schemes.
- Specification of how to commission and effectively manage hospital-at-home schemes to ensure schemes fulfill their potential.
- A 'snapshot' survey of LIZ schemes which have obtained continued funding.

Discussions have been held by the Support Force with the Primary Health Care Forum with a view to deciding how best to obtain an overview of the impact of the whole LIZ programme using whatever indicators of change can be devised from data which are already available (see below, Chapter 7, for more on this).

5.1.5 The contribution of national research initiatives

At national R&D level, two initiatives have had some bearing on the evaluation of primary care developments and the LIZ programme. In the first of these, the national programme of studies on the Primary-Secondary Interface sponsored as part of the NHS R&D programme has supported 53 projects since 1995. Some of these will undoubtedly provide findings relevant to understanding the likely effects of primary care developments in London, although the programme was not specifically devised with this in mind and there is no guarantee that findings will be available before important decisions have to be made about the continuation of funding of LIZ projects.

In the second initiative entitled '*Research into primary care in London*' the DH called for proposals and funded six studies in London. They were as follows:

- evaluation of specialist outreach services;
- investigation of pathways to treatment of people with mental illness from different ethnic groups;

- assessment of ethnic minority communities' knowledge of and need for health advocacy services in East London;
- evaluation of a nursing-led intermediate care unit;
- development of a framework for evaluation of hospital-at-home schemes;
- review of evaluation in the LIZ primary care development programme (i.e. the current project).

In each case, the emphasis was on the *scientific quality* of proposals which were solicited under a number of very broad headings. It was not possible in the time available for commissioning the studies or with the R&D staff resources available to develop and broker effective proposals in areas which had not been fortunate enough to receive good proposals in the first place. The notable exception to this was the 'brokerage' work which DH commissioned in relation to hospital-at-home schemes (see Chapter 7 below for more on this). Thus the feasible contribution of national R&D initiatives to the systematic evaluation of the LIZ schemes and programme as a whole could only be limited and indirect. Nonetheless, together the North Thames R&D-funded projects and the DH initiative will provide studies in eight quite different types of primary care service development relevant to future commissioning.

5.2 The relation with the Regional R&D process

5.2.1 The assessment process

Despite all the activity described in the previous section and the availability of advice and help with proposals at Regional R&D Directorate level, it was apparent that the contribution of regional and national R&D to the evaluation of the LIZ programme was considered to have been marginal by a number of interviewees at HA and project level. Irrespective of whether this verdict is a fair or accurate one, it suggests that the causes of this dissatisfaction should be understood. At least one other recent report has identified a similar perception among practitioners and managers in North Thames that the Regional R&D Directorate has achieved a great deal in its first four years, but has still not managed to address all the issues of greatest concern to those working in the service at local level (NHS Executive North Thames, 1996).

A number of people in North Thames HAs believed that they had been encouraged to become interested in evaluation, had been told that what they were involved in deserved to be evaluated, and had put considerable amounts of time into preparing proposals and revising them only to be rejected after external peer review. It is clear that only a small number of LIZ projects have been the subject of NHS R&D-funded evaluations. At the same time, relatively few proposals on LIZ projects have been put forward given the size

of the overall programme. While the uncertainty of this process is nothing out-of-the-ordinary for researchers familiar with the competition for scarce research funding, it is not generally the way in which staff in the NHS are accustomed to bidding, say, for development monies. HA staff are more familiar with the idea of bidding for resources which have been earmarked for a particular priority and where the aim is to ensure that the money is spent on that priority. The likeliest explanation for the perceived dissatisfaction with the R&D process in North Thames was an assumption by the HAs that the money for evaluation was guaranteed. In this sense, there was a mismatch of expectations and requirements between those involved in the NHS R&D scheme and those at HA level, primary care development and project managers involved in implementing the LIZ primary care development programme. This was one of the principal obstacles to a close relationship between the two sets of interests although there were others.

5.2.2 Differing requirements from evaluation

At the time that the LIZ programme was getting under way, the NHS R&D infrastructure and strategy were also in their early stages. At Regional level, the LIZ programme and the R&D Directorates came into being at about the same time. For example, the former North East Thames RHA R&D Directorate was only established in January 1993, followed a month later by the LIZ programme. The priority at that time was to commission and obtain the findings of as much good quality research relevant to the needs of the NHS as possible which would then naturally lead to a period with a much greater emphasis on 'development'. The general field of health services research was relatively underdeveloped and the NHS R&D programme was charged with improving this situation. By contrast, the LIZ primary care programme, if it was understood at all by participants in an overall sense, was seen as a development activity rather than as an opportunity for research. It should not be assumed that HAs shared the NHS R&D programme's emphasis on high quality, generalisable research on costs and outcomes which could be widely disseminated. At HA level, the staff interviewed for this review expressed the view that evaluation, particularly at the beginning of projects, was at least as much if not more so about local learning, refining project objectives and methods of working, helping staff gain experience of evaluation and contributing to managerial accountability for the use of public resources.

At issue, were different approaches to the nature and aims of programme and project evaluation which transcend even major methodological divergences such as the distinction between qualitative and quantitative methods. Evaluation can be undertaken for many different reasons and can fulfil many different purposes at different times in the life of a single project or programme. However, as was set out in Chapter 3, there is a basic difference between:

- *formative evaluation* which aims to contribute directly to improving an existing programme or project by focusing on understanding issues of process, project management, clarifying of goals, team building etc, often using local staff themselves to collect data; and,
- *summative evaluation* which aims to contribute to knowledge about the effects of projects or programmes by, at its simplest, answering the question, has the project achieved the changes in practice and benefits to patients which were sought?

This distinction bears repetition since it played an important part in the relations between the LIZ programme and NHS R&D.

Summative evaluation tends to require that the project or programme is relatively well defined and understood by the participants and that its objectives can be set down unequivocally. Formative evaluation, as its name indicates, tends to work on the assumption that projects change almost continuously and that 'D' may often need to precede 'R', intertwine with it and also follow it. In fact, many of the LIZ projects were too underdeveloped when the issue of regional R&D funding first arose to stand much chance of satisfying the criteria of a summative type of evaluation. In many cases, projects are only now after two years reaching a stage when a summative evaluation would be appropriate and feasible. While the R&D programme has increasingly recognised a wider range of methods as legitimate, its focus remains the production of 'generalisable' knowledge rather than a direct involvement in service development. Furthermore, there was no formal requirement on the Regional R&D Directorates to make the evaluation of the LIZ programme a priority. Accordingly, LIZ-related bids were judged in the same way as any others, to the frustration of those who might have felt that the NHS R&D programme, especially at regional level, had an obligation (which it did not) to ensure that evaluations were commissioned by whatever means available.

By contrast, the problem from a Regional R&D perspective was the lack of a well-developed research community in primary care capable of collaborating with local project staff to produce sufficient high quality applications which stood some chance of being funded. In this sense, the small number of LIZ projects evaluated with R&D funds may have been at least as much a reflection of the small numbers of applications as a comment on the R&D project funding process.

5.2.3 'Projectitis'

Another problem in the relation between the LIZ programme and regional bodies which had more general implications for the evaluation of the LIZ programme as a whole, was the emphasis in thinking about and funding evaluation on specific projects or, occasionally of

groups of similar projects (e.g. hospital-at-home) rather than on attempting to commission evaluations of the impact of the programme as a whole or large parts of it. In contrast to a number of other centrally inspired development programmes such as the DH Care in the Community Demonstration Programme in the 1980s, there was no evaluation strategy for the programme as a whole either from LIG, the former RHAs, Regional Performance Management or from Regional R&D Directorates (see below, Chapter 7, Recommendations, for more on this). Neither Regional R&D Directorate was specifically asked to develop a programme-wide set of evaluative activities and there is no reason why they should spontaneously have taken on this responsibility. As a result, the majority of the attention given to evaluation has been devoted to carrying out or improving the evaluations of individual projects. The emphasis in the HA and regional feedback which led to the brief for the current project was similarly focused on project level evaluation.

No group was commissioned to attempt the difficult task of monitoring and evaluating as far as was possible, the programme as a whole. Equally, with the exception of the linked evaluations of some of the hospital-at-home schemes north of the Thames, there has been little research at the middle level between the individual project and the whole LIZ programme. Again, this is not an easy option since it requires understanding projects in sufficient detail to be able to identify their common features and objectives, bringing disparate groups together, deciding common evaluative methods and obtaining significant funds. The hospital-at-home, multi-project evaluation only came about because a decision was taken to devote a small amount of money from the DH London programme (see above) to supporting an academic to spend time assessing the support, feasibility and methods for such a study and network of projects (see below, Chapter 7, for more on the need for this type of 'brokerage' or facilitation work). South Thames R&D Directorate reported exploring the possibility of encouraging a thematic evaluation of some of the LIZ projects involving ethnic minorities, but was unable to identify sufficient common ground between projects to justify linking their evaluations in a more ambitious way. In the recommendations of this report (Chapter 7 and Appendix II) a number of possible clusters of projects are identified which deserve investigation to assess the feasibility of more thematic, multi-site evaluations (e.g. outreach/access projects, patient advocacy projects, domiciliary care etc.).

HAs sensibly attempted, sometimes with regional help, to select the more innovative, unusual or simply, bigger projects for more formal evaluation either internally or externally. The rest were subject to a variety of forms of monitoring clothed in the contemporary language of 'evaluation' (see previous chapter). This approach is perfectly satisfactory as one part of the evaluative effort; however, it does have limitations if the opportunity to quantify the impact of the majority (over 60% in 1995/6) of the primary care development funds is not to be missed. These resources were devoted to improving

ordinary primary care capacity in the capital ('getting the basics right' in the terms of *Making London Better* (Department of Health, 1993), see Table 1). The apparently humdrum investment in better premises may be the programme's lasting legacy to better primary care in London but, at present, it is impossible to say to what extent, except within a few geographical areas assessed by individual HAs (e.g. Lambeth, Southwark and Lewisham).

It would seem plausible that this research 'projectitis' is at least partly a reflection of the way in which the programme as a whole originated in a six-week rush to put together funding bids. The funds made available to inner London HAs to allow them to invest in primary care development allowed some flexibility in moving money between projects, but were principally intended to support specific *projects.* Projects were the subject of individual bids at the beginning of the programme. As a result, the programme was seen from the outset in terms of a series of projects loosely held together by the three aims of *Making London Better.* With approximately 1,000 separate projects, it is not surprising that all concerned have struggled to decide what, how and when to evaluate. What has emerged, predominantly, is a series of evaluations of individual projects while health care commissioners, faced with decisions as to which projects to 'take up' onto mainstream funding, ideally need comparative evaluative information across groups of projects in order to choose between alternative uses of their scarce resources.

5.2.4 Other difficulties

The post-Tomlinson programme of primary care developments came at a time when the NHS R&D initiative was still in the process of developing its relationships with the Service and its operating policies and systems. There were a large number of national R&D initiatives which had to be managed through the regional R&D Directorates. Secretariat time to assist with the *development* of specific proposals was limited although there was considerable willingness to *advise* aspiring groups. This process was not made any easier by the fact that professional research expertise in primary care was in short supply. Developing good proposals in strategically important parts of the LIZ programme would have required a considerably more proactive style than simply making funding and advice available and waiting for proposals to emerge.

There was the further difficulty, certainly not unique to this case, which arose in the form of the dilemma between ensuring a good quality of evaluation while at the same time ensuring that the evaluative process and the results will be understood and accepted by the participants in the project ('ownership' of the evaluation is the current cliché for this). HAs were trying to change the culture of the Health Service in favour of evaluation by encouraging more and more staff to play some part in evaluating their work while the R&D strategy was primarily built around professional, mainly academic researchers.

Furthermore, there was no guarantee that staff at project level would welcome the help of experts in evaluation for at least two important reasons; namely a fear that the questions posed by outsiders would not correspond with their own views of what they were trying to achieve and that the findings would be used in ways over which they would have no control (e.g. in decisions about future funding after the end of the LIZ programme monies).

Another difficulty in the relation between the NHS R&D programme and the LIZ primary care development programme was provided by the perennial problem of lack of information. Despite significant efforts to publicise all aspects of the R&D process and to point to sources of help and advice in order to make the programme accessible to the NHS, a common perception at HA and project level was of the remoteness of Regional R&D and an unfamiliarity with its objectives and working practices.

A final difficulty in the relationship between the LIZ programme evaluation and the NHS R&D initiative lay in the timescale of projects. Since there were delays before a number of projects were able to start and since all projects were time-limited, there was often limited time over which to assess the consequences of projects. This was a particular handicap in dealings with NHS R&D with its emphasis on summative forms of evaluation requiring rigorous follow-up of costs and effectiveness. Many projects were only in a position to contemplate this type of evaluation 18 months to 2 years after starting by which time concerns about whether they would be taken onto mainstream funding were beginning to loom.

Chapter 6

Diagnosis and conclusions

6.1 Diagnosis

This report illustrates the variety and range of attempts at evaluation which have been undertaken. This chapter draws together the evidence, first focusing on the problems of evaluation in the LIZ programme, then relating these more broadly to how the NHS R&D strategy contributed to the type of development process which LIZ represents.

6.1.1 Evaluation and the LIZ programme

The earlier parts of this report have highlighted both the strengths and weaknesses of the ways in which the LIZ primary care development programme has been evaluated. While, inevitably, the focus on doing better in the future tends to draw greater attention to problems rather than examples of 'good practice', there are several positive aspects to report about the LIZ programme and evaluation. Box 6.1 summarises the main points. Perhaps the biggest strength relates to a comment made in a number of interviews and in both the feedback workshops organised at the end of the project, namely, that the LIZ projects have been subject to far more critical appraisal, including monitoring and evaluation, than most other areas of service provision in London in the last few years. In fact, a number of staff at project and HA level resented having to justify what they were trying to achieve in a way in which they perceived their acute sector colleagues were not.

Box 6.1: Strengths in the LIZ primary care development programme evaluation process

Previous chapters of this report have identified the main strengths of the evaluation process and given examples of 'good practice'. In summary, the main strengths of the process to date have been:

- a major learning process during the life of the LIZ programme resulting in increasing sophistication in the commissioning, management and use of evaluation (as seen in the recent evaluation frameworks produced by a number of HAs);
- a conscientious effort by staff at project level to look critically at their services and to engender an evaluative culture in the field of primary care;
- he ability to use evaluations in a formative way to help clarify the aims, objectives and working methods of projects;
- involvement of a wide range of staff in evaluation activity thereby increasing their skills and understanding of evaluation;
- production of some evidence on the benefits and costs of alternatives to traditional forms of service delivery.

Focusing on the challenges facing the development of better evaluation strategies within the LIZ programme, it is apparent that problems arose at the outset through:

- the short time leading into the programme;
- the emphasis on finding ways to spend the allocated LIZ monies; and
- the large number of diverse projects of different sizes which resulted.

It was predictable that these would lead to:

- a lack of a thematic and programme-level evaluation;
- uncertainty and inconsistency as to which projects to evaluate at which level;
- little inter-project or inter-HA research and sharing of intelligence; and,
- weak links between parts of the health care system, for example between HAs and the NHS R&D programme.

Box 6.2 summarises the main weaknesses in what has occurred, and some of the issues are picked up in more detail below.

Box 6.2: Weaknesses in the LIZ primary care development programme evaluation process

This report has identified the main problems inherent in the way in which evaluative activity has been undertaken in relation to the LIZ programme. In most respects the description echoes the conclusions of the earlier enquiries mentioned in Chapter 5 (see section 5.1). In brief, the main problems of the LIZ primary care development programme from an evaluation perspective appear to be as follows:

- the vast bulk of the evaluative activity has taken place at project level with a concomitant lack of an overall evaluative framework and the lack of an ability, so far, to describe the nature of the investment across the programme or its short- or medium-term effects in terms of structure, process, outputs or outcomes in inner London as a whole;
- the majority of the evaluative activity has been in terms of descriptive and process evaluation, although the rhetoric of evaluation has emphasised the measurement of more ambitious effects such as 'health gain', 'equity', 'efficiency' and 'substitution';
- where the costs and benefits of projects have been measured, this has rarely been within a framework (e.g. of cost-utility or cost/QALY analysis) which enables purchasers to compare the relative priority of different sorts of project for scarce funds, and as a result the *use* made of the findings of evaluations for commissioning decisions, so far, has been limited;
- there has been relatively little evaluation across similar projects and relatively little inter-HA working, either to commission evaluations or to learn from them;
- relations between projects and HAs and R&D in the Regions have been limited and, on occasions, a source of misunderstanding;

cont/ . . .

Box 6.2: cont'd

- skills and dedicated resources for evaluative activity have been in short supply while many project staff have been obliged to become involved in a range of evaluative activity which was not always appropriate to their skills or experience;
- on occasions, there has been confusion between different types and functions of activity broadly labelled as 'evaluation';
- projects were conceived in a short time meaning that staff have had to think about evaluation and project development at the same time;
- many projects began with diffuse aims which subsequently changed, making *summative* forms of evaluation difficult to develop to the timescale of the LIZ programme;
- the programme has consisted of a very large number of projects with an extremely wide range in size and resources, making the integration of evaluative activity across the programme difficult;
- the criteria used to select projects for different types and intensity of evaluative effort have not always been clearly identified or consistently applied, since there has been, at the same time, a general presumption in favour of 'evaluation' of all projects which made selective evaluation problematic;
- with increasing pressure on all purchasers' budgets, the time to develop and assess new ways of working has been curtailed and may force premature judgements to stay within cash limits.

Scale and Timing

The size and scale of the programme – over 1,000 projects – meant that it was not sensible to attempt formal evaluation of all projects. Some projects were so small as not to warrant closer consideration. In the case of others, for example some of the major capital projects, the benefits may have been considered obvious. Nonetheless, it is unclear whether any guidelines existed at the outset to determine where the main evaluative effort should lie.

The issue of the speed with which projects were expected to start came through very clearly from the interviews. The speed of establishing the first wave of projects in 1993/94 left little time to structure evaluation, which was therefore added when projects were often up-and-running. Timescales for evaluation were short and often health commissioners wanted much more immediate information than was possible. Some projects were slow starting so the opportunity to evaluate was even more time constrained. Slippages have created tension around agreeing future investment and using evaluation to help in this process.

Resources for Evaluation

Frustration with the speed of the process was coupled with the inadequacy of resources to evaluate properly. Evaluation resources were spread too thinly with spend on evaluation small as a proportion of the whole LIZ expenditure. No separate monies were identified for evaluation at the outset. Internally, both project teams and HAs had limited evaluation skills and so needed access to external assistance. Many authorities felt it inappropriate for them to use their monies to evaluate projects in the 'summative' sense or were unable to undertake or commission *comparative* studies across HAs.

Relation to the commissioning process

The LIZ programme has been seen by most HAs as outside the mainstream commissioning process constituting a bolt-on, short-term extra. This partly reflects the fact that, compared with the total investment in primary care in each HA area, the LIZ primary care development projects were relatively modest. At a time when the main energies of HAs were directed at managing substantial changes in their own internal organisation and coping with acute sector issues, it is perhaps not surprising that no clear strategy for evaluation existed at the start within authorities. Many authorities identified difficulties placing project-level evaluation within any long term strategy.

Knowledge about evaluation at HA level

To some extent this reflected the limited nature of local knowledge and also the local nature of commitment to evaluation which did not extend to the production of generalisable knowledge on costs and effectiveness. Projects themselves changed since many, once established, required considerable development in practice. This lack of in-house skills was not helped by a lack of knowledge about what might be available within the Regions. There were limited networks for sharing evaluation findings, a lack of knowledge about comparative studies in similar fields nationally and a lack of baseline data in primary care against which progress and success of projects could be measured.

The purpose of evaluation

There has been more focus on *monitoring* the impact of individual projects than on other types of evaluation. This may have been appropriate. But the intensity of such 'evaluation' activity was not always related to the size of spend on projects. At the same time, there was confusion and conflicting guidance on the emphasis which HAs should appropriately give to evaluation. Some authorities were of the view that it was better to spend the money to develop new services in primary care, not to review its success and effectiveness.

The newly established NHS R&D programme was not tied in directly to any part of the LIZ programme. A number of projects were worked up for evaluation and then rejected by Regional R&D, on the grounds of scientific quality and rigour. This process was not well understood by staff at HA and project level and led to some resentment.

This was coupled with confusion about whether the evaluative process was to help projects themselves, to inform the purchaser, or for some other reason. This reflects also the fear that evaluation might be used as a way of closing down projects whatever the outcome. One consequence is that while in one sense the projects as a whole were under-evaluated, people involved in LIZ projects feel as if they have been subject to intense scrutiny.

There was an apparent lack of measurable objectives to show strengths and weaknesses: project objectives were often too diffuse or general to be amenable to evaluation. Those evaluations that have gone ahead on a reasonably large scale still have not provided answers to the more 'summative' issues. To some extent this reflects the amount of time it takes to complete these types of evaluations.

Health authorities would want to be able to answer 'summative' questions, and, particularly, to be able to compare projects across the LIZ and wider primary care programmes for their ability to contribute to the HA's primary care development aims. However, this is not where the efforts of project teams lay, nor was it appropriate that it should be. Producing evaluations that would inform purchasers sufficiently not only to be able to say that investing in one type of hospital-at-home scheme is more valuable than investing in another hospital-at-home scheme, but that investing in one part of the programme is more beneficial than investing in another part of the programme is a taxing, strategic evaluation task requiring R&D funding and expertise.

Evaluations often did not attempt to establish more cost-effective ways of doing things. There may have been a missed opportunity here to make comparisons between LIZ projects and alternative modes of provision, both in the primary and acute sector. A common view expressed in interviews with project leaders was that provision in the acute sector just goes ahead without any focus on evaluation, the implication being that lasting change would not be introduced unless comparisons were undertaken across a range of different modes of provision. In such circumstances it is hard to see how the LIZ investment programme could have been expected to bring about a shift in resources between primary and secondary care on the grounds of hard evidence alone. An article of faith was still required.

6.2 Conclusions

The LIZ programme was set in motion quickly and on a large scale. As a result, although evaluation was rapidly recognised as potentially important, it was not the prime concern of those involved in taking the work of the programme forward. In addition, there were few models available within the NHS to assist with thinking about evaluation of a programme on the scale of the LIZ programme, still less to relate such evaluative effort to the commissioning of mainstream services.

Important also is a recognition of the difference in nature between the projects which constituted the LIZ programme (essentially grounded in the need for speedy development) and those which are the more traditional subject of formal, external evaluation (where evaluation is built in as part and parcel of the project). It was important that LIZ monies were spent on developing projects with a reasonable chance of success. It could be argued that investment was, or should have been concentrated on such projects. In such cases, where the intervention is reputed to be effective, the worth of evaluation other than in the 'monitoring' sense may be unclear. It was a priority to get projects up and running and there was little time to consider how such projects might best be evaluated.

Evaluations carried out at an individual HA level have been largely linked to individual projects with little attempt to assess their fit into the overall primary care strategy of the HA. Moreover, there has been no attempt to consider on an ongoing basis the overall programme at a national level, though there are signals of an intention to provide a systematic review of the programme, albeit now starting at a late stage. Currently, there is no description available of the work of the whole programme, and this in itself is a considerable task. It is undeniable there should be some evaluation of the impact of the £210 million spent between April 1993 and March 1996 on LIZ primary care development projects, both at the individual local level and at a national level.

While many of the LIZ primary care development projects seem to have been innovative and to have contributed to improving the infrastructure of primary care in London, it is not clear how the overall pattern of investment has changed primary care. For example, it is not possible to say how levels of access to primary care have changed and to what extent any changes are attributable to the 1,000 plus projects in the LIZ programme except perhaps in one or two HA areas. Similarly, it is not possible to say that the new infrastructural investment has been appropriately targeted on those parts of London which were least well provided for at the beginning of the process. It is not clear how the quality of primary care has changed and to what extent any changes can be attributed to the programme. It is even more difficult to say how the investment has affected patients' perceptions of primary care services. The health benefits are still more formidable to assess.

If evaluation is a concern, then the LIZ experience does not provide a model of how to organise a programme. On the other hand, it has resulted in considerable and rapid investment in primary and community care in London. The focus of the LIZ programme has not been to provide complex evaluations of individual projects. While individual HAs are now beginning to look at the impact of the programme within their own areas, there has been no real effort yet to assess the overall impact of the programme across London. It is now important to examine the overall success of these developments: first to evaluate how well the programme as a whole has achieved its primary objectives; second to inform the way in which programmes elsewhere may be developed; and third to share lessons which may be learned both at individual project level and at the level of how to manage such a major development programme. It would also be useful to determine the proportion of LIZ projects which eventually convert to mainstream NHS funding.

Chapter 7

Recommendations

Although the main focus of this review was to make recommendations which would assist HAs and LIZ primary care development projects develop their evaluative activities, it became increasingly apparent during the course of the interviews that many important recommendations relevant to assisting them in this objective would be overlooked if the contribution of other agencies such as those at regional level were excluded. The linkages between the roles of different parts of the NHS were one of the main things which informants wished to improve. Hence the recommendations are directed at different parts of the NHS, including staff in Regional Offices of the NHSE, HAs, project managers and others.

The recommendations for change and action in the future should not be interpreted as a dismissal of all the good work which has already taken place to evaluate the LIZ primary care development programme and its constituent projects. Particularly at project level, a considerable amount of useful learning has already taken place both in how to do evaluation and how to learn from it. Projects have been developed and refined, accountability for the use of resources has been improved and a more evaluative culture engendered in the NHS as a result of all this activity. However, as has been shown above, the challenge now is to improve the learning across projects and between HAs and to make greater use of evaluation in support of health services commissioning decisions. Some HAs have been better able to do this than others and some HAs are better at some aspects of the process than others. Thus all HAs and other participants will be able to claim with justification that certain of the recommendations concern things which they are already doing, but we doubt any will be able to claim that *all* the recommendations refer to activities which they are already engaged upon.

The emphasis on learning is particularly appropriate if one regards the LIZ primary care development programme as a whole as a 'pilot' for developing new ways of strengthening primary care. In this sense, even if nothing quite like the various Tomlinson programmes is mounted in the future, there are highly likely to be major investment (and disinvestment) programmes requiring evaluation. For example, a very considerable range of activities is currently underway in London concerned with the improvement of mental health services in the capital. Some of the experience and learning gained through the LIZ primary care development programme could be of use in this context. As a result, there are recommendations below which extend beyond the current LIZ programme to include the evaluation of programmes in general in the future.

7.1 Recommendations in relation to the LIZ primary care development programme

7.1.1 Health authorities

A1 *Health authorities should plan to link the evaluation feedback process to mainstream commissioning*

Hitherto, partly because of the timing of evaluations and of decisions concerning 'take-on' of projects for mainstream funding, there has been relatively little use made of the results of evaluation by HAs in commissioning their future pattern of primary care services. As HAs' primary care strategies become more refined, it should become progressively easier to use the strategies as one way of assessing the priority which should be assigned to individual projects. The evaluation frameworks put forward by Merton, Sutton and Wandsworth and Croydon (reproduced above, Chapter 4) may go some way towards this. Appendix III also provides useful pointers to HAs. Evaluations should not, however, be used as another bureaucratic 'hoop' through which projects have to jump and their absence should not automatically lead to a project not being eligible for 'take-on' funding. Equally, evaluative information needs progressively to be made available on so called 'mainstream' projects otherwise seemingly more stringent requirements are being expected of LIZ projects simply because of their status rather than their intrinsic merits.

A2 *Health authorities should assess the impact of their LIZ programmes, including premises improvements, on primary care services, learning from those authorities which claim to have done so already*

For example, Lambeth, Southwark and Lewisham has undertaken work to assess the quality of local general practice and related primary care services in localities across the HA and linked this with the pattern of LIZ investment. A similar attempt to assess the impact of LIZ programmes as a whole, particularly including the effect of premises investment and staffing increases should feature in the plans of all HAs.

A3 *Health authorities should establish formal links with relevant sources of external advice and expertise in health care evaluation*

A number of HA staff reported the need for help and advice in various activities associated with obtaining and using evaluation of projects (e.g. how to tender for an evaluation, how to find out who has a research track record in an area, how to judge a research proposal etc.). One way of obtaining better advice and help would be to increase the number of joint appointments between academic departments and HAs, but there are other routes.

A4 *Health authority staff should make greater use of the resources available at Regional R&D level*

The evidence of this review is that regional R&D resources are not well known about at local level and that HA staff are uncertain about the likely benefits of the involvement of the NHS Regional R&D Directorate. Yet resources exist to help with the development of research thinking and specific proposals, as long as the aim, ultimately, is to generate rigorous, generalisable findings (e.g. South Thames maintains an adviser in primary care research available to assist people in preparing applications). It should not be assumed that R&D staff and members of grants committees and advisory panels are ignorant of or unsympathetic to research in primary care settings or to a wide range of non-clinical approaches to research.

7.1.2 Health Authorities and NHSE Regional Offices

B1 *Health authorities and NHSE Regional Offices should develop a regular mechanism for sharing experience and examples of 'good practice' in commissioning, managing and using evaluations of primary care development projects between Authorities and between projects*

The interviews and the two workshops organised as part of the current review demonstrated the lack of sharing of 'intelligence' between HAs in inner London particularly at the level of managers responsible for primary care commissioning and managing the LIZ programmes. Working on an individual LIZ project can also isolate staff from others doing similar work elsewhere and from an understanding of where their work fits into the wider picture of primary care development in their HA or in inner London. The experience of the workshop organised with project level staff as part of the current review showed that hardly any of the participants had ever met before or had any idea of what others were doing even when they were engaged on similar tasks. With the exception of hospital-at-home schemes where there appeared to be some networking, there is a clear need for more opportunities for project level staff to interact and learn. Making contact with other projects in the same field could even be a requirement placed on projects.

Valuable opportunities for mutual learning are currently being missed, yet there is a high level of interest in such activity. The exchange of 'intelligence' needs to include not only the findings of studies, but also the practicalities of securing good quality, appropriate, timely evaluations and means of using them in practical decision-making (e.g. to assist with decisions about 'take-on' funding). Collating reports from projects and producing them in a format which would make them accessible to others interested in undertaking similar work would also contribute to improved understanding of the work that has gone on to date.

There are many examples of 'good practice' contained in this report which are worth building on by other HAs and projects. Appendix III sets out useful tips in this area.

B2 *An up-to-date, comprehensive description of the LIZ programme should be developed and maintained*

It was not possible to obtain information on the current or past composition of the LIZ programme from a single source when this review began. Instead, the data used in Chapter 2 had to be assembled from a range of sources HA by HA with varying amounts of information available on individual projects. Given the scale of the programme, the need for improved links between similar projects and the interest in the possibility of undertaking some form of mixed retrospective and prospective evaluation of the programme as a whole (see below recommendation D1), a description of the programme and its projects would be valuable.

B3 *The potential for appointing local R&D Directors in HAs should be explored as a way of improving the links between rigorous evaluation and local health services' commissioning*

In order to overcome some of the perceived remoteness of the Regional R&D function from local service commissioning and to increase the proactive and interactive aspects of the R&D function, it may be worth increasing the visibility of local R&D Directors who would develop local programmes of research relevant to local commissioning needs, but according to generally accepted standards of rigour. This function would have features in common with a research 'brokerage' model discussed below (see recommendation C2).

7.1.3 Regional Offices of NHSE

C1 *Regional R&D Directorates, in conjunction with the Primary Care Support Force, should explore the scope for developing research networks linked to multi-site evaluations, focusing on key themes or major groups of projects in the LIZ programme*

Given the project-specific, local nature of much of the evaluative activity on the LIZ programme to date, there is a strong case for more generalisable, larger scale, thematic evaluations focused on areas of the programme which have received major investment, where important learning for the future may be possible and/or where the financial consequences of development may be considerable. The emphasis in this would be on selecting projects for summative evaluation. Evidence from the interviews in the current review suggests that there are still a number of innovative

projects which are only now reaching sufficient 'maturity' to be capable of summative assessment.

Appendix 2 summarises the results of a preliminary inspection of the content of the 1995/96 LIZ programme to identify a number of clusters of similar projects which might be suitable for this treatment. The categories are the same as those in Table 1, Chapter 2, which describes the composition of the programme. In addition to the so called 'innovative' projects grouped in Appendix 2 (e.g. counselling, outreach, advocacy, primary care in A&E, direct access services etc.), it would be important to explore the scope for thematic evaluation in two other major areas of the programme, namely, investment in new buildings and new primary care staff.

In order to bring about thematic evaluations based on research networks similar to the one which already exists in relation to hospital-at-home projects there will need to be extensive preparatory work, for example, to identify suitable candidate projects for collaboration, to bring potential researchers and projects together, to create opportunities for bids to Regional R&D based on expertise in a particular field and to ensure the commitment of HAs to fund projects for long enough for outcomes and costs to be reasonably reliably assessed. How this work might be carried out would be for Regional Offices to decide through dialogue with HAs, but it could be undertaken directly by staff in the Regional R&D Directorates or by specially appointed people acting in the role of research 'brokers' (see below, recommendation C2).

C2 *Regional R&D Directorates, working with HAs, should build on their recent experience of more proactive styles of working in R&D (e.g. attempts to increase the skills available in primary care research) by developing more widely a 'brokerage' model of commissioning R&D in relation to the LIZ programme*
It would appear from the experience of the LIZ programme to date that one of the most successful examples of interaction between NHS R&D, HAs and projects occurred in relation to hospital-at-home projects and was carried out by Steven Iliffe from University College and the Middlesex School of Medicine. Resources were made available through the DH central research initiative on *'Primary care in London'* (see above, Chapter 5 for details) for 'brokerage' between researchers, projects and purchasers to shape frameworks for evaluation relevant to health services commissioning, identify appropriate research questions and methods, identify suitable settings for evaluation, identify interested professional researchers, obtain support for evaluation among service providers and contribute to the development of projects so that they could be assessed summatively and the results used in future commissioning decisions.

Iliffe spent time interviewing and obtaining the views of purchasers, providers, researchers and others on how best to evaluate the new hospital-at-home schemes which were being developed in London as part of the LIZ programme. He produced an 'evaluation package' which outlined from a number of different perspectives (e.g. purchaser, provider, etc.) how evaluations of schemes might be undertaken, together with a paper on the feasibility of mounting a multi-centre randomised controlled trial of hospital-at-home. Iliffe's work with further regional encouragement has led to a number of linked evaluations and to the emergence of a network of researchers involved in hospital-at-home with regular meetings to exchange tips on methods and to exchange information on progress and pitfalls.

The 'brokerage' model seems to be worth persevering with as a way of bringing the worlds of research, service development and management closer together and to increase the likelihood that summative, generalisable evaluations may take place. The role might also include work with those wanting to undertake evaluations to improve the quality and relevance of their proposals. The 'broker' would also be in a position to encourage a number of projects and evaluations to consider collaborations, if appropriate, in order to avoid large numbers of separate studies of individual schemes using incommensurate methods and measures and with insufficient sample sizes. The final role for the research 'broker' would be to market and interpret the findings of evaluations for HAs so that they could relate the findings to their specific circumstances. In sum, the 'brokerage' role is a response to the experience to date which is that simply making advice and facilities available at Regional level is insufficient to ensure that the correct people become aware of and make use of these facilities.

The 'broker' would either need to be recruited and paid specifically to undertake this work as in Iliffe's case or might be a member of regional R&D staff seconded. Whoever did the work and however it were funded, the 'broker' would need to understand both research *and commissioning* of services. The resources for such a role should be built into the budget of any major development programme in the future on the grounds that good evaluative proposals and studies often require considerable preparatory work, especially when the aim is to encourage those at service delivery level to become involved in evaluation.

There is no reason why 'brokerage' should not include involving projects and initiatives funded from other than the Tomlinson programme.

C3 Regional Offices should develop a range of mechanisms designed to assist HAs to make judgements when comparing the costs and benefits of projects in different areas of their LIZ programmes and also between 'mainstream' and LIZ services, so that decisions about take-on funding can be made in an informed way

Chapter 4 showed that the use made of evaluations by HAs had been limited so far. In part, this was because either evaluations had not yet reported or decisions about future funding of Tomlinson projects had yet to be taken. A third explanation, which became particularly salient in the second workshop with HA level interviewees, was the fact that the decisions which were most preoccupying purchasers, and about which they most needed the support of evaluative data, required them to make comparisons between the costs and benefits of very different projects in order to determine which projects could continue on mainstream funding. Most evaluations could only tell them, at best, about the costs and outcomes of individual projects or of groups of similar projects, occasionally including comparisons with 'mainstream' services in the same field. By contrast, HAs sometimes appeared to aspire to comprehensive, rational decision-making based on the costs and benefits of each project (ideally, measured in the same terms in each case for ease of comparison), however unrealistic this aspiration might be in technical terms.

The need is for ways of developing the findings of evaluations into useable intelligence which will both increase the value-for-money of the original studies and provide an informed basis for making the tricky judgements necessary to discriminate between the claims of fundamentally different types of projects under conditions of considerable uncertainty. A starting point for this might be to provide easily accessible summaries of different methods for thinking about and making priority decisions. For example, cost-utility comparisons such as cost per QALY analysis might be relevant or forms of programme budgeting incorporating marginal analysis of the claims of different programmes. These methods could then be used within the framework of each HA's primary care development strategy.

However, decision taking under uncertainty and with limited information is as much an art as a science and HAs might equally benefit from more interactive and comparative approaches to improving the decision-making process in which research evidence, local 'intelligence', the views of experts and professionals, HA views, the perceptions of the public, the objectives and targets in their primary care strategies and other inputs to the process have to be weighed in combination with one another.

C4 *Regional Offices should make available guidance on the main components of successful project and programme evaluation covering each stage from selecting projects for different levels of investigation to the use of findings in health services commissioning*

Throughout this report there are examples of 'good practice' in obtaining and using evaluation. The examples in boxes in Chapter 4 are particularly relevant to this. However, there would be advantages in bringing together in a single guide the lessons from the experience of all those who have contributed to the current report and circulating copies of particularly helpful documents (e.g. different HAs' evaluation frameworks). The guide would cover all steps in the evaluation process (e.g. project specification and development, evaluation specification, commissioning evaluations, managing evaluations, reporting, dissemination and use of findings) and would include a brief description of the distinctions between monitoring, formative evaluation and summative evaluation used in the current review (see Chapter 3) and the different functions which monitoring and evaluation can play, in order to help HAs and project teams decide whether and, if so, how best to evaluate projects and groups of projects.

Appendix 3 of this report provides the basis for such a guide. It is derived from analysis of the material in Chapter 4, from the interviews at HA and project levels and from discussions at the workshops held to feed back and validate the interim findings from the current review.

C5 *Regional Offices, in collaboration with the Primary Care Support Force, should establish a mechanism for the dissemination of findings from the evaluations of strategically important or innovative projects or groups of projects in the LIZ programme*

Existing channels of communication between the different parts and levels of the NHS in inner London are inevitably imperfect in such a large, complex organisation split into a considerable number of purchaser and provider organisations and stand-alone projects. The successes and difficulties of individual projects as seen through their description and evaluation should be widely disseminated, particularly in areas of major investment or where there are likely to be service changes required in future (e.g. out-of-hours services).

C6 *Regional R&D Directorates should further develop within the limits of what is permissible within the NHS R&D scheme, their capacity to commission evaluations which relate flexibly to the stages of development of innovative projects*

One of the difficulties typically experienced in putting forward detailed proposals to evaluate innovative development projects lies in the tendency for research funding

bodies to require a level of detail and precision about the objectives and methods of studies which it is almost impossible to achieve at the early stages of a project's life.

Similarly, the focus of interest in evaluation commonly changes over time as a project matures – an early interest in project refinement linked to a formative style of evaluation being progressively replaced by a later interest in more summative, external forms of evaluation designed to assess the costs and consequences of a project. It is a challenge to funders of R&D to facilitate funding of evaluation designs which retain the flexibility to respond to changes of aim and approach over time in this way without simply being a recipe for woolly thinking. This problem is increasingly recognised at Regional R&D level. One way to alleviate it is to ensure that proposals are evaluated by research experts with appropriate topic and methodological knowledge who appreciate the need for this kind of flexibility. Another is to fund preliminary investigations (primarily formative evaluations) with a view to laying the foundations for more summative work.

7.1.4 Department of Health, NHSE, Primary Care Support Force and Regional Offices

D1 *A programme-wide evaluation of the impact of the LIZ primary care development programme should be developed and undertaken as soon as possible*

The vast bulk of the evaluative activity surrounding the LIZ programme and documented in this report has been project-specific rather than concerned with looking at the overall effects of the LIZ programme as a whole or of significant parts of the programme. There is increasing interest in being able to assess these effects.

The Primary Health Care Forum began to think early in 1996 about how the programme as a whole might be evaluated using a range of indicators of change in the structure of and pattern of activities in primary care in London. This thinking should be further developed. The outline prepared for the Forum by the *Health of Londoners Project* based in East London & the City HA also raised the possibility of including a range of health-related indicators (e.g. abortion rates, uptake of screening, etc.) which could theoretically be related to changes in primary care. However, as far as is known, no decisions have been taken to date. The emphasis on making use of routinely available data suggests that such an evaluation will look at change overall rather than those changes which can be attributed specifically to the LIZ programme. There are also very reasonable suggestions to look at the consequences for primary care of some of the more major innovative LIZ

investments such as primary care in A&E, mental health crisis intervention schemes etc. However, with the exception of the oft quoted example of hospital-at-home schemes, it is unlikely that evidence is available of the impact across groups of projects since the multi-site studies do not exist.

When major investment programmes are planned in future it would seem appropriate to set aside some resources for evaluative activity *from the outset* rather than in mid-stream. These should be devoted to a broader, less easily defined form of evaluation which takes an entire programme or series of different projects as its subject matter rather than a single project. Again, this requires researchers and funding bodies to pursue and support more diffuse, less predictable forms of evaluation which may be harder to describe at the outset in clear terms in a brief research proposal, but which, at the end of the investment period, may enable policy makers to reach a judgement about the worth of a substantial range of expenditure. To do this well, research funders and researchers need to understand more about how policy makers and, in this case, HAs, make decisions.

Thus in the current example of the LIZ primary care development programme, it is noteworthy that the majority of the investment has been in capital projects (50% in 1995/96) and primary care staff (9%) associated with 'getting the basics right' in terms of buildings and core staff to perform established primary care tasks; the bulk of the evaluation has been on so called, 'innovative' service projects such as hospital-at-home schemes. There is a need, therefore, for work into the health service consequences of the injection of new and better buildings into the primary care infrastructure in inner London and of the use to which the additional staff have been put and into the extent to which any changes in primary care can be attributed to the LIZ programme rather than 'mainstream' investment by HAs.

Programme-wide evaluation should also include some reference to the equity implications of the LIZ projects by attempting to collect geographic and socioeconomic data on the distribution of the investment across London and the identity of those who have benefited from the services which it has created.

A final point to note in relation to the recommendation that there should be an overall evaluation of the LIZ programme of primary care development is the possibility of building at least part of it on the work already undertaken by certain of the inner London HAs. Over time, some HAs have begun to put in place means for assessing trends in the quality of their primary care with particular emphasis on general practice. Thus Lambeth, Southwark and Lewisham reports being able to assess within its boundaries the effects of its own and its Tomlinson investment in general practice structure and process measures of 'quality'.

7.2 Recommendations in relation to potential future development programmes

E1 *The potential demand for and utility of a NHS Evaluation Advice Centre should be investigated*

The current emphasis on developing an evaluative culture in the NHS suggests that project and programme evaluation advice will be useful to HAs and others. There would appear to be demand for such a service in inner London as shown through the experience of those involved in managing the LIZ programme, but no particular reason why this should not be seen as a national resource. For example, organisations such as the National Primary Care Research and Development Centre might be funded to take on this role. It must be emphasised, however, that an evaluation advice centre can never be a substitute for HAs and others developing ongoing relationships with their own local advisers in evaluation and in the use of findings in commissioning.

E2 *In light of the continuing likelihood that health care in inner London will be the subject of major development initiatives in the future, work should be undertaken to develop a generic framework for evaluating health service development programmes*

The evidence collected in this review and the experience of previous programme evaluations suggest that the following elements should be built into such a framework:

- an overall programme-wide focus for evaluation linked to intermediate level (themed) and project-level evaluation activity;
- a programme of investment over a reasonable time period for evaluation, designed with an integral evaluative stream of activity in mind and with an emphasis on *learning* based on strong *vertical* and *horizontal* links;
- strong and continuous interactive opportunities for all involved to keep abreast of the development of the programme and its evaluation;
- a broad definition of evaluation which allows for the selection of appropriate perspectives and methods flexibly in relation to the nature and stage of development of projects and of the programme, including pilot studies;
- an approach to planning evaluation which is based on reviewing existing knowledge;
- a core group of researchers and staff with involvement in and experience of service development and commissioning to manage the process of evaluation, dissemination and facilitation of the use of findings in practice and policy making. The management of services and evaluation should be integrated. The core group would pick up the 'brokerage' roles discussed in recommendation C2 (above)

and might have direct links to a recognised centre of expertise in the relevant research field such as the National Primary Care R&D Centre in the case of primary care. The core group would have responsibility for all the research activity but would not necessarily execute all of it so that there would remain scope for local evaluations and for hands-on experience in evaluation for front-line staff;

- explicit criteria for the selection of projects for in-depth *evaluation* as against *monitoring* which relate to the overall aims of the programme and which might also include criteria such as: degree of innovation/originality of the scheme; resources consumed; potential benefits if successful in terms of resolving or ameliorating important limitations in primary care; and opportunities for networking and wider learning. The broad approach would be based on a recognition that not everything can or should be the subject of a full evaluation and that some selectivity is important;
- good project management, routine monitoring of progress against objectives and financial accountability undertaken by staff involved directly in service development and delivery would be operationally separated from evaluation activities in order to avoid putting excessive and inappropriate pressure on front-line staff to become both experts in service delivery and evaluation;
- a protected higher percentage of the overall programme budget for evaluation;
- joint academic and service posts for evaluation.

As far as the projects themselves are concerned, the aim would be to go for projects which were clearly related to the rationale and goals of the programme and which would have some likelihood of amounting to a coherent response to the identified problems and limitations of current primary care arrangements. In terms of implementing projects, there would be a longer lead time than was available in the LIZ programme in order to allow evaluation to be planned from the outset rather than bolted on after projects were already running. Similarly, the life of projects which are the main focus of the evaluative effort should be sufficient to allow a reasonable likelihood of being able to assess some health-related outcomes.

Although the elements sketched out above would fit most easily with a stand-alone programme of investment with special funding such as the LIZ programme of primary care development projects, the general approach, with modifications, could be made to work to support the evaluation of 'mainstream' HA activities and priorities. A prime candidate for this sort of treatment in London at present is the wide range of initiatives in the field of mental health services.

The Department of Health and Social Security's *Care in the Community Demonstration Programme* of the 1980s provides a valuable, relatively recent example of successful evaluation of a major innovative programme. £25 million (at 1991 prices) was set aside for the programme over four years from joint finance budgets to support a wide range of different innovative projects to assist long stay residents from a range of client groups move from institutions to community settings. Health and local authorities submitted project applications and 28 were funded. To ensure that the experience of the programme, which included a range of new ways of organising and delivering community care, generated knowledge which could be widely disseminated and used, an evaluation team was appointed to promote, monitor and evaluate the programme. The evaluation team worked closely with those charged with the development and management of the programme as a whole and with staff in the 28 projects. The team from the Personal Social Services Research Unit at the University of Kent at Canterbury undertook a wide variety of dissemination activities including seminars, conferences, briefings, newsletters and information exchange for a wide variety of staff.

E3 *Service and project evaluation should be required as much from 'mainstream' services as from so called 'innovative' or 'pilot' projects*

There is a tendency, reported by a number of respondents in this review, to require a higher level of proof of cost-effectiveness from so called 'innovative' services than from established services, irrespective of the quality of evidence available on each type. While evaluation as opposed to routine monitoring as part of good project management should always be selectively undertaken, established services should be expected to demonstrate evidence of cost-effectiveness, for instance from existing literature where available, to ensure fair treatment of old and new services. Despite a limited budget for evaluation, it should not be presumed that established services have a lower claim on research resources.

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Appendix I

Interviewees and interview prompts used at health authority and project levels

List of those interviewed, by health authority

Sue Kingett	Director of Primary and Community Services Commissioning	Barking & Havering HA
Bernhard Crede	Commissioning Manager	Barking & Havering HA
Lucy Turvil	Annie Prendagast Clinic	Barking & Havering Community Trust
Andree Hillas	The Continence Department	Barking & Havering Community Trust, King George Hospital
Ms Catherine Attlee	Director of Commissioning	Brent & Harrow HA
Dr Margaret Guy	Consultant in Public Health	Brent & Harrow HA
Fatima Walji	Lisson Grove Welfare Benefits Project	Brent & Harrow HA
Julie Mallett	Brent Carers Project	Wembley
Farah Hamid	Dietetics Department	Wembley Community Hospital, Wembley
Caroline Taylor	Director of Primary Care	Camden & Islington HA
Glyn Barnes	Director of Development	Camden & Islington HA
Dr Melanie Smith	Senior Registrar Public Health	Camden & Islington HA
Bridget Turner	MAAG Office	Camden & Islington HA
Dr Steve Iliffe	Senior Lecturer, Department of General Practice and Primary Care	UCH/Middlesex School of Medicine
Andrea Young	Locality Manager	East London & the City HA
Ms Louise Wakeling	Head Physiotherapist	Tower Hamlets Healthcare Trust

Dr Gene Feder	Department of General Practice	St Bartholomew's Medical College
Ms Mary Burd	Head of Community Psychology	Steels Lane Health Centre, Tower Hamlets Community Trust
Rebecca Sparks	Director of Primary Care & Community Commissioning	Croydon HA
Matthew Willis	Primary Care Service Development Manager	Croydon HA
Pip Robinson	Assistant Director of Primary Care	Croydon HA
Janet Smith	Associate Director, Corporate Development	Croydon Community Health NHS Trust
Julie Dent	Director of Primary Care	Ealing, Hammersmith & Hounslow HA
John Spargo	Tomlinson Coordinator	Ealing, Hammersmith & Hounslow HA
Liz Lewis	Tomlinson Evaluation Facilitator	Ealing, Hammersmith & Hounslow HA
Val Howell	Director of Mental Health Services	Hounslow & Spelthorne Community & Mental Health NHS Trust
Maria Brennan	Senior Nurse Manager	Meadow House Hospice, West London Health Care NHS Trust
Ruth Finch	Alzheimer's Disease Society	London SW6
Richard Ellis	Director of Primary Care	Enfield & Haringey HA
Debbie Feltsz	Tomlinson Coordinator	Enfield & Haringey HA
Simon Griffiths	Assistant Director, of Primary Care: Enfield	Enfield & Haringey HA
Dr Rusen Yildrim	Project Manager: Medical Directorate	Enfield & Haringey HA
Tom Easterling	Assistant Director of Primary Care: Haringey	Enfield & Haringey HA

Jacky Gealer	Physiotherapy Manager	Chase Farm Hospitals NHS Trust
Sheila Falconer	Primary Care Commissioning Assistant Manager	Greenwich & Bexley HA
Michael Greenwood	Tomlinson Projects Monitoring Officer	Greenwich & Bexley HA
Sue Milne	Tomlinson Project Advisor	Greenwich & Bexley HA
Amina Mangera	Commissioning Developments Officer	Greenwich & Bexley HA
Barbara Wren	Health Psychologist	Greenwich & Bexley HA
Dave Tawney	Project Manager, Localities Dept	Greenwich & Bexley HA
Keith Ford	Director of Commissioning	Kensington, Chelsea & Westminster HA
Lorna Haddow	Project Management, Mental Health	Kensington, Chelsea & Westminster HA
Dr Irene Higginson	Consultant in Public Health	Kensington, Chelsea & Westminster HA
Sonya Hood	Manager, Hospital-at-Home Scheme	Kensington, Chelsea & Westminster HA
Peter Holland	Associate Director for Lewisham	Lambeth, Southwark & Lewisham HA
Margaret Jones	Primary Care Development Manager	Lambeth, Southwark & Lewisham HA
Dr Candia Brace	Project Manager & Medical Co-ordinator, Lewisham Hospital Hospital-at-Home Scheme	Lambeth, Southwark & Lewisham HA
Jo Winskell	Nurse Manager for Special Projects, South Lewisham Health Centre	Optimum Health Services Trust
Dr Jeremy Dale	Department of General Practice & Primary Care King's College School of Medicine and Dentistry	Lambeth, Southwark & Lewisham HA
Dorothy Raison	Service Development Manager	Redbridge & Waltham Forest HA

Helen Fentiman	Director of Primary Care	Redbridge & Waltham Forest HA
Pam Fenner	District Nurse Manager	Forest Healthcare
Stephen Evans	Deputy Director of Primary Care Commissioning, Wilson Hospital	Merton, Sutton & Wandsworth HA
Stephen Warren	Strategic Commissioning Manager, Primary Care Commissioning, Wilson Hospital	Merton, Sutton & Wandsworth HA
Edmond Dyer	Wandsworth Primary Care Development Worker, Primary Care Commissioning, Wilson Hospital	Merton, Sutton & Wandsworth HA
Helen Walley	Director of Community Services and Nursing	Wandsworth Community Health NHS Trust
Judith Williams	Specialist Services Manager	Wandsworth Community Health NHS Trust
Gill Black	Development Manager	Wandsworth Community Health NHS Trust

Other

Judy Hargadon	Director	Primary Care Support Force
Peter Richardson	R&D Manager	NHSE North Thames
Terry Stacey	Director of R&D	NHSE South Thames
Sally Bishop	R&D Project Officer	NHSE South Thames
Peter Lemmey	Senior Performance Manager	NHSE North Thames
Angela Dawe	Senior Performance Manager	NHSE South Thames

List of prompts for interviews with senior managers in health authorities

Selection of projects

Of the X projects listed as those with evaluation in the former LIG database of August 1994, have all of these projects been evaluated? If not, why not?

Are there any other evaluation projects not included on the list which we should include?

Of the X number of projects labelled as evaluation in your area for 94/95 why did you choose to evaluate these projects?

How did you choose those to be evaluated? (Did evaluation proposals need to be prepared? Who was involved? At what level – RHA, providers, others? Who led the process? Over what time period was this decision taken?

What was the process of selection? Where there pre-set criteria?

What do you mean by the evaluation of these projects? Could you describe the nature of the evaluation in relation to each project? What main questions does each evaluation aim to answer?

Project design and evaluation design

How were the objectives/questions for the evaluation decided on?

What role did the project teams play in developing the evaluations?

To what extent were the evaluations and the projects developed together?

Resources

How much was allocated overall for evaluating these projects? Total spend per project? Any uncosted HA staff time?

How did you decide the balance of expenditure between projects?

Strategy

What are the HA's main aims in setting up evaluation of these projects?

What have been the main barriers to evaluation if any?

How does the evaluation of these projects fit into the stated priorities of the HA's strategy for primary care development?

Did this change between 1994/5 and 1995/6 and if so, how and why?

Skills

How did you identify those with evaluation skills?

Who are they? How are they employed/how were they commissioned?

How are they supported – by Public Health, academic departments etc? How well has this worked?

Did the HA approve evaluation methods – if so, how did it assess appropriate methodology/ resources/timescale etc?

Project management

How do evaluation of projects fit into the project management structure of the Tomlinson programme?

What were the timescales for the evaluation projects?

How are projects managed and their progress monitored? Does each project have its own project plan and objectives?

Are any of the project evaluations linked to evaluations of projects elsewhere; i.e. part of a multi-site evaluation?

Do you see a difference for the HA in monitoring and evaluation of projects?

Use of evaluation

In what ways do you expect evaluation results to be used? How do you plan to do this?

What would you consider a successful evaluation?

What plans and policies do you have for disseminating learning from the evaluations and use of the findings both locally and nationally?

Feedback

What would you find most useful in our report?

Are there any other issues associated with the evaluation of LIZ projects that you would like to discuss?

List of prompts for interviews with staff at individual LIZ projects

1 the questions being asked in each study and why;

2 how the research relates to the objectives of the project;

3 the variables being used in each study to assess the cost and benefits of the project (e.g. outcome measures, costs, etc.);

4 the design of each evaluation and how it was decided on (e.g. how providers were consulted);

5 links to and comparability with other evaluations and the scope for networking and support (e.g. links to local resources such as NHS and academic Departments of Public Health Medicine and epidemiology);

6 the identity and background of those doing the 'hands on' research;

7 details of the budget and other resources for the evaluation;

8 links of the project team to the HA strategy process;

9 how the project team plans to disseminate the findings and ensure that the findings are used.

Appendix II

Clusters of LIZ projects potentially suitable for thematic, multi-site evaluation

The following clusters of projects emerge from a review of LIZ projects which received funding in 1995/96. From discussions with individual HAs in collecting these data it is evident that projects changed year on year. Many of the individual projects will therefore have changed during this time. Individual HAs also varied both in the resources allocated to them through LIZ and in their approach to allocating resources to projects. Some chose to allocate resources across a large range of different initiatives while others focused on investing more heavily in a smaller number of projects.

It is important to note that these projects only represent activity funded through the LIZ programme. It may be that some authorities invested in priority areas for development through other funding sources.

Innovative Primary Care

Developing primary care services

Mental health (47 projects listed of which 18 are in Kensington Chelsea and Westminster and 10 in Ealing Hammersmith and Hounslow).

These include community mental health teams, community rehabilitation and day care.

Counselling (17 projects across nine HAs).

This largely represents projects aimed at developing counselling services for particular groups such as young people, the bereaved, the Turkish and Asian communities and those with mental health problems.

Widening Access to Primary Care

Outreach/Access (43 projects across 11 HAs, 11 of which are in Ealing Hammersmith and Hounslow).

These include a varied mix of projects although about a quarter focus on minority ethnic groups. Eight projects are linked to the development of general dental care. A number of projects in this group are associated with increasing developments of the professions allied to medicine including speech and language therapy, physiotherapy and chiropody.

Advocacy (32 projects across 10 HAs of which 13 are in ELCA).

The majority of these projects are supporting advocacy projects for minority ethnic groups in primary care.

Shifting the balance of care

Emergency primary care

Emergency care outside hospital (23 projects across 11 HAs).

This cluster is made up of eleven projects associated with the development of out-of-hours services. Other projects are aimed at developing minor injury/minor accident treatment services, crisis support for mental health and one project looking at emergency dental services.

Primary care in A&E (11 projects across 7 HAs).

These all aim at developing primary care in A&E including general practitioners and nurse practitioners at a number of different hospital sites.

Managing care across the interface

Intermediate focus of care (11 projects across 6 HAs).

This cluster includes projects mainly aimed at intermediate care for the mentally ill. A number of projects are also aimed at developing GP beds and respite care.

Shared care/direct access (fourteen projects across 9 HAs).

This includes projects aimed at improving management of chronic diseases such as asthma and diabetes as well as initiatives taking place to develop minor surgery, direct access physio and haemoglobinopathy services.

Intermediate models of care

Domiciliary care (29 projects across 9 HAs of which 12 are in Ealing Hammersmith and Hounslow).

This cluster includes voluntary sector home care including Age Concern and Alzheimer's Concern. They also include a wide variety of different home care services including paediatric home care, pharmacy and respite care.

Management and evaluation

Evaluation, research and development

Health Needs Assessment (15 projects across 8 HAs).

This cluster includes a number of projects focused on community and user involvement. It also includes projects looking at health needs assessment with particular groups such as minority ethnic groups and the homeless.

Appendix III

Towards guidance for successful commissioning and use of evaluation of primary care development projects

Recommendations arising from interviews at HA and project levels and group discussion at the King's Fund Workshop, 7 June 1996

Commissioning evaluation

Effective commissioning of all forms of evaluation would be improved if the process by which R&D priorities were defined and sorted was more interactive between the Service, R&D Directorates and the research communities.

Issues needing to be tackled to commission evaluation well

There are a number of practical difficulties which managers at HA level encounter in commissioning evaluation externally:

- how to find out who is experienced in evaluation in a particular field, whether their style of work is relevant to the needs of the HA and whether their work could be regarded as of good quality;
- how to recognise a good quality proposal and good quality evaluation;
- where to get advice about the options available for commissioning external evaluation (e.g. formal tendering, closed versus open tendering, direct commissioning, ongoing relationships with research teams etc.);
- how to build in sufficient interaction with prospective evaluators during the development and selection process to have confidence in their appropriateness and competence;
- how to make the best use of in-house expertise in commissioning evaluations (e.g. in other parts of the HA).

Recommendations for better commissioning of evaluation

- Develop a detailed research brief which reflects the views and priorities of the main stakeholders and those influential in the use of the findings.
- Think through the implications for quality, cost and credibility of the evaluation of going to different evaluators (e.g. in-house versus academic versus commercial consultancies).
- Commission the project evaluation earlier rather than later in the life of a project and allow the design some degree of flexibility to reflect this
- Consider process and outcome oriented evaluations.
- Try to collect data *prospectively* rather than relying on piecing data together after the event.

Managing evaluations once commissioned

The following recommendations emerged from the personal experience of HA and project-level staff:

- It was very important not to lose interest in the evaluation process once the initial commissioning effort was over. There needed to be plenty of interaction between the research team and the sponsors/customers throughout. Externally commissioned research had noticeable internal managerial costs if done well.
- Evaluations should not be managed as an 'add-on' to the main business of programmes and should not automatically be give to junior managers to look after.
- In the context of primary care development, the HA's Primary Care Development Strategy could be a useful template against which to judge the progress and relevance of the study as it developed in order to keep it 'on track'.
- Since it is almost inevitable that the evaluation will take longer than the average period in post of the managers who commissioned it, it is vital that all meetings, decisions and changes to the original aims are fully documented for the benefit of successors.

Conducting evaluation

Overlapping with the two sections above, the following recommendations on what is required to ensure that evaluations are well conducted can be made:

- Evaluation needs to be carefully planned:
  - bringing the right people together at the beginning, being clear about the questions to be addressed and how far these can be translated into questions for realistic research
  - thereby clarifying the purpose of evaluative research and its main audience(s)
- Evaluation needs realistic time scales and resources, appropriately synchronised with the evolution of the project and the timing of judgements about its success.
- The 'pros' and 'cons' of evaluation by internal or external parties need to be weighed in relation to points 1 and 2 and the intended use of the evaluation.
- Evaluation researchers need to take care to share with commissioners what can or should be learned from their work and present results in a meaningful and useable format.
- It is essential to be clear whether evaluation is intended mainly as a vehicle for improving particular services or whether 'summative' judgements are intended (i.e. whether to continue or close the service).
- All this needs to be in the context of some understanding of what will be necessary for the service to continue: from both the health services commissioning and providing perspectives, there is rather limited merit in demonstrating 'this works' if it cannot in any case be funded!

Using evaluation findings and integrating LIZ projects into mainstream commissioning

Currently all authorities are struggling to develop an appropriate process for deciding which of the funded LIZ projects should be incorporated into the future commissioning

of services and how to make best use of the findings from the evaluations that have taken place to date.

- The difficulty of deciding on priority areas for future funding within the programme when it consists of a large number of diverse projects in different service areas (e.g. how to balance future funding of a substitution project against a mental health project) could be reduced by clustering projects together into topic areas (e.g. developing 6 categories of projects rather than 120 projects) and relating these to a discussion of overall strategy.
- Sharing the findings from evaluation of services which had been developed in different part of London but which were along similar lines (e.g. all counselling projects, physiotherapy, etc.) would be helpful in guiding Authorities in being able to review the success of their particular project in the context of other service developments taking place elsewhere in London.
- Authorities would also benefit from identifying project areas where is had already been possible to negotiate a transfer of future funding from a budget within an Authority other than primary care (e.g. where the future development of primary care in A & E services had been incorporated into the acute contracts).
- Despite the often poor level and quality of information, some of the data gathered both from individual projects within authorities and pooled data from projects across London could be used to negotiate changes in the quality and range of services commissioned through mainstream contracts.
- It is important in completing the development cycle to think through how best to inform GPs and others of the findings of the evaluations. They are an important group who would be able to facilitate changes into the mainstream through their influence over commissioning either as fundholders or through locality commissioning. Consideration should be given as to how new and best practice could be introduced to GPs.

Sustaining an NHS culture which encourages critical review of service provision in the wider context of population need, strategic direction and service innovation

Whatever the strengths and weaknesses in the actual programme of evaluative work which the LIZ initiative has produced, a potential long term gain to the NHS is the encouragement this programme has given to creating or strengthening a culture in which constructively critical review of service provision is an everyday component of professional and managerial work. This is however only a *potential* gain: in the face of financial pressures and understandable defensiveness, such a culture is always likely to be fragile. Recommendations focus, first, on clarifying what is meant by critical review and the processes involved and, second, on ways this culture might be strengthened in the medium-term.

Purpose and processes

The purpose of critical review is to ensure that all participants in the health care system (policy-makers, commissioners, provider agencies, clinicians, users and community interests) are continually seeking to ensure that the resources (of all kinds) available for health care are used creatively to achieve maximum benefit for the population being served. It needs therefore to involve all relevant players; to be part of their commitment

to the NHS; and to embrace a wide variety of activities which contribute to critical review, accepting that judgements of benefit are often complex.

Evidence of such a culture would be found in:

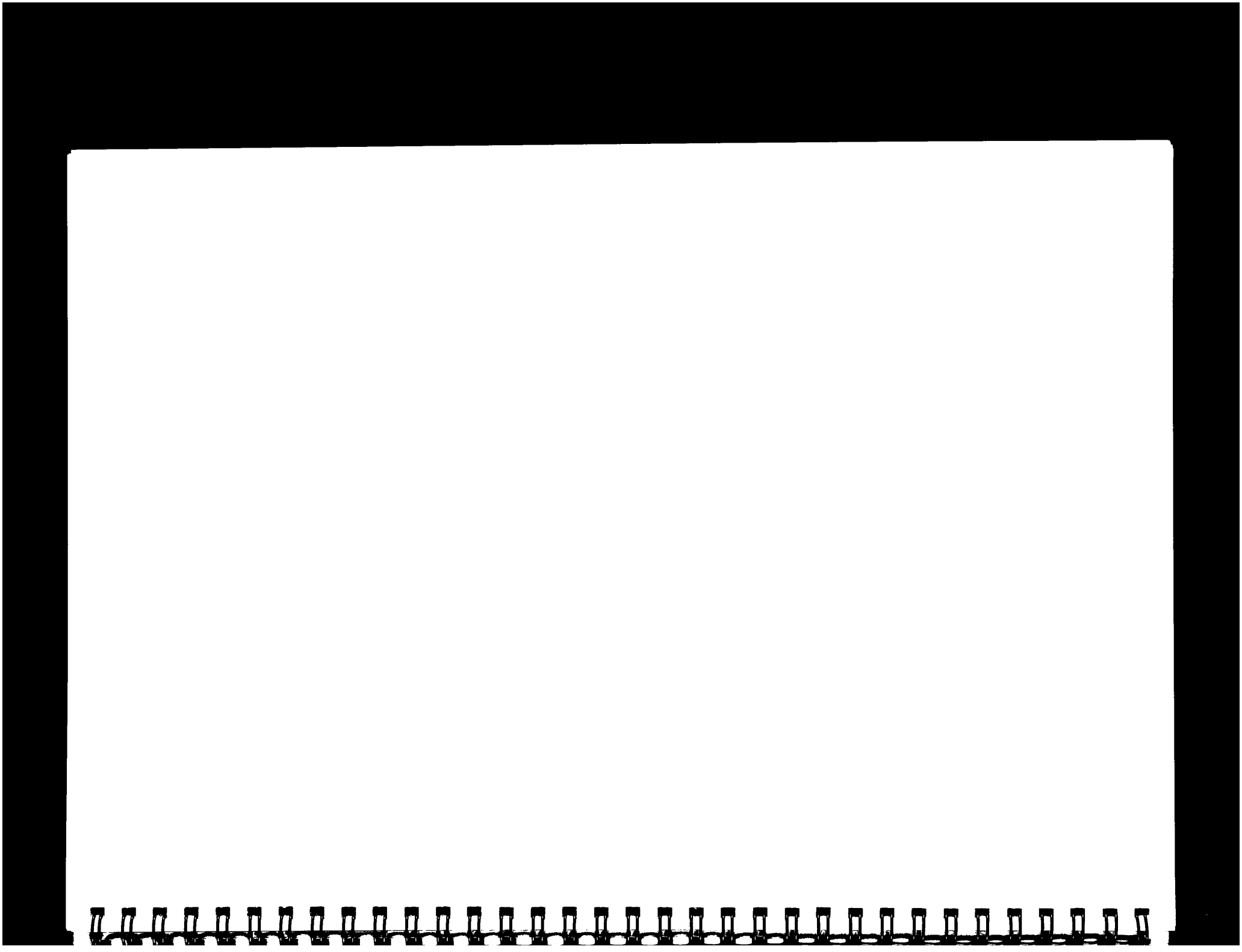
- the efforts of providers to be explicit about the aims of services and to be monitoring performance against these aims;
- the engagement of clinicians and others in ongoing review of clinical practice, in which the experience of users is an essential input;
- the selective investment in formative and summative evaluation, selected that is according to agreed criteria so as to use evaluation resources wisely;
- the development of forums (e.g. linking commissioners and providers, and linking providers across organisational boundaries), in which experience and evidence is used as part of creative exploration of better ways of doing things.

In the face of the perceived 'mechanical' characteristics of much formal interaction between commissioners and providers (e.g. contract meetings), this approach will require more investment in building creative partnerships between players and better facilitation of the processes which bring people together to consider ways forward. Sometimes this may be easier to achieve if the focus is similar services in a small cluster of districts.

Moving forward

Strengthening this culture is a medium-term objective. It requires:

- appropriate educational investment for all the main players;
- a real effort to draw lessons from the LIZ evaluation programme and spread experience 'laterally' within providers and localities;
- specific support to commissioners in developing their appreciation of appropriate processes of critical review, using a variety of current examples from the LIZ programme and more widely;
- exploring how similar appreciation can be developed in the new arrangements for 'dispersed commissioning' (i.e. through fund-holders and locality arrangements);
- testing new 'creative forum' models of informed service change (i.e. bringing together key players in a facilitated dialogue supported by good information and the capacity for experiment);
- ensuring that some resources (of cash, expertise and time) continue to be ear-marked for these processes and for specific evaluative work.



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