Health Action Zones

- the engagement of the voluntary sector

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Health Action Zones – the engagement of the voluntary and community sector

Summary

Health Action Zones require the involvement of the voluntary and community sector. This study, carried out over eighteen months, considers the ways in which this requirement has become a reality in two localities, and also considers a third area in less depth. It concludes that, while there is great willingness and enthusiasm for partnership in both the voluntary and statutory sectors, this enthusiasm has been tempered by experience and, in some cases, blunted. The capacity of voluntary and community organisations requires considerable development if they are to play a full and effective role. Equally, statutory planners and managers who need no convincing about the potential benefits of voluntary and community sector engagement need assistance in devising effective ways of achieving it. Without this, both sectors suffer from "partnership fatigue" and a sense that the costs are great for limited benefits.

In the period studied, a number of obstacles to full engagement were being tackled. At the same time, the expectations faced by both voluntary and statutory sectors have changed. The quest for public and community involvement in the planning and development of services, together with the preoccupation with internal re-organisation of the NHS, have produced a noticeable shift in emphasis. As a result, perhaps temporarily, the need to develop the ability of the voluntary and community sector to be involved has not received as much attention.

1. Introduction

Background to the research

The Baring Foundation has run a funding programme called "Strengthening the Voluntary and community sector" since 1996. The intention of this programme is to help voluntary organisations develop and respond to the many and different challenges they face. As part of this programme of funding, the Foundation has commissioned a number of different pieces of work, designed to offer practical support – and recommendations for good practice – to enable voluntary organisations to make a positive contribution both nationally and locally.

Health Action Zones are one of the significant new developments in the practice of public policy. They have a number of important features:

- A focus on a geographic area
- Demanding targets for improvement and change

- An expectation that the voluntary and community sector will be involved at all stages
- An emphasis on joint identification of need and remedy
- Accountability through joint local governance structure to the Secretary of State
- A programme of funding to be spent throughout the sectors
- An expectation that the statutory funding will attract other funding to the issue

This model is - essentially - the one also used in Education Action Zones, Single Regeneration Budget programmes, the New Deal for Communities and other programmes. In commissioning this piece of work the Baring Foundation recognised that there is some uncertainty about the way in which the voluntary and community sector should be and is engaged in initiatives of this type, and the nature of that engagement. Julia Unwin and Peter Westland were asked to examine the reality of voluntary and community sector engagement, obstacles to it and opportunities available to develop it, and in particular to identify positive ways in which it could be enhanced and supported.

Methodology

This work was conducted over 18 months in two distinct phases. After a review of the successful first wave Health Action Zone bids, Luton and Sandwell were chosen for further more detailed examination. In each of these areas interviews with key stakeholders and decision-makers were conducted in 1998 at the time at which the Health Action Zone was first announced. The purpose of these interviews was to:

- Get to know the two localities and gain an understanding of the pressures and opportunities
- Establish relationships with the key players to enable the research to be conducted
- Understand the attitudes and expectations informing the approaches to the Health Action Zone
- Get to know the background informing the relationships
- Understand the objectives and style of the particular locality

A first phase report was produced and a seminar held in June 1999 at the Baring Foundation to share the first phase findings. In the meantime, both the Health Action Zones shared information with the researchers who had visited both localities for a number of interviews and meetings in the autumn and winter. The second round of interviews in late 1999 and early 2000 focused on the implementation of the programme and the way in which the voluntary and community sector had been enabled to participate.

The work has been strengthened and enriched by a smaller, additional local study. At the stage of presenting the initial findings to the seminar, the Director of Wansbeck CVS invited us to visit Northumberland to examine the progress made there. This was an opportunity to look at the operation of the district level voluntary and community sector within a county- wide Health Action Zone. The findings from this visit are contained in Appendix 1 and help to inform the main report.

2. The Cont*e*xt: a cascade of exhortation, consultation and regulation

The creation of Health Action Zones by the Department of Health is not an isolated development. Across Government a locality approach to social problems is being developed. Local partnerships engaging different statutory organisations alongside business, voluntary and community organisations are being developed and funded. All take as their starting point the notion that success can only be achieved by cross-sectoral work, and all contain exhortations to "involve the voluntary and community sector." This study is an attempt to understand the ways in which this is working in practice.

The development of health policy is also extremely relevant. Health authorities and local authorities have been subjected to a torrent of government advice, consultation and direction since the Health Action Zone initiative was first announced. Many of these missives have, or will have, an impact on the way in which Health Action Zones function, and some can critically affect their success or failure. Almost all have placed a heavy burden on health authorities in having to deal simultaneously with new initiatives and many are wrestling with finding ways of linking these initiatives in a managerially efficient manner. It is too early to be sure that all these challenges will be met successfully. Many of the initiatives also lay great stress on the need to engage the voluntary and community sector in the planning and delivery of the services. They also, crucially, require the involvement of patients and the general public in this design and delivery.

Health Improvement Programmes have been introduced. This is – essentially – a requirement placed on health authorities and trusts to produce plans in association with local authorities. The plans have to indicate the most pressing health issues for which remedial action is required. National priorities – reducing heart disease, deaths from suicide, and teenage pregnancy – are then combined with local priorities to produce measurable targets.

> A typical example of a HimP target might be "to reduce deaths from coronary heart disease by 5% by 2005".

Performance against such targets will be measured and publicly highlighted. It is important to note that environmental, employment and housing issues will – in many instances – be more critical than clinical intervention.

Another change, which will significantly alter the map of the health service and shift influence and power, is the establishment from April 1999 of Primary Care Groups and their development as Primary Care Trusts. The degree of commitment of these organisations to the broader approach to health is likely to be critical to its overall success. Unless these groups are able to involve voluntary and community organisations in this collaborative way their impact may be stunted. Primary Care Groups have had to produce Primary Care Investment Plans, which relate the local situation to national over arching objectives and targets.

What is a Health Action Zone?

Health Action Zones have been established in areas which have very significant health problems, such as high mortality or morbidity rates, combined with poor housing stock, high levels of unemployment and other indicators of social exclusion and which require additional specific action to tackle them. They are local partnerships led by the local health authority. The task of the partnership is to bring together different authorities and agencies to agree what the problems are and devise and implement 7 year plans to tackle them. These plans should improve access to health services and, at the same time, improve the health of the whole population both through environmental and educational measures, as well as involving the local community in measures to improve its own health. The measures of poor health that form part of the rationale for creating Health Action Zones are the same measures that will be used to determine progress at the end of the process.

A typical Health Action Zone plan might therefore include:

- The establishment of a “healthy living centre” based around existing facilities, such as a gym or swimming pool, alongside nutritional advice, health assessment and community nurses. These “virtual healthy living centres” are not necessarily dependent on capital investment, but instead have their strength in bringing health enhancing services directly to the places which people already use.
- An education programme for young people helping them to improve their own health
- Nutrition classes for Asian women as part of a drive to reduce heart disease
- Review of air quality and a programme of action to improve it
- A campaign to reduce the number of accidents at home perhaps linked with a programme of minor repairs in houses to reduce the risk
- Targeted support for vulnerable young mothers to help avoid postnatal depression
- Working with transport authorities to reduce road traffic accidents

And so on.

Many of the Health Action Zones acknowledged in their plans that they would need to work with a strong voluntary and community sector and have adopted programmes specifically to improve the capacity of the voluntary and community sector. There is therefore an element of community development within many of the programmes developed by Health Action Zones, and this is a new departure for statutory organisations that might more normally have considered support for work with instantly recognisable health outcomes.

A typical programme will also include a number of improved processes, such as screening programmes for particular illnesses or improvement of electronic record keeping and shared access to information. The Health Action Zone programme has some modest additional funding specifically for it, but all the bids to the first stage assumed that they would be calling on other sources of funding, using charitable funds, other

Government programmes and existing funding to try to meet their Health Action Zone objectives.

Other relevant changes

Health Action Zones have been introduced at a time of significant developments in the relationship between the Government and the voluntary and community sector more generally. The Compact between government and the sector was signed in November 1998 and provides a framework which is intended to guide the relationship between them at every level and includes undertakings by both Government and the voluntary and community sector. It is being developed by the introduction of codes or practice on specific issues such as consultation. More significantly for this study "compacts" are being developed between local authorities and the local voluntary and community sector and certainly in some of the areas reviewed for this work these were developing considerable significance. It is hard, at this stage, to assess the likely impact of the local compacts. While there was clear evidence that they had prompted and indeed helped to shape some of the developing relationships in the localities visited, these arrangements were still at an early stage. It is clear that local agencies, both statutory and voluntary, welcome the framework potentially provided by the Compact, but it is equally clear that they are currently uncertain about the practical implications of it. The absence of mechanisms for tackling disputes seemed to us to be a cause for some concern, although this is perhaps understandable in the early stages of development which are – inevitably – taking place in a positive and optimistic way.

3. Key findings

The key findings of this study concern:

- Dramatically changed landscape of the NHS and local government
- The capacity of the voluntary and community sector
    - different governance structures
    - different management and command structures
    - independence of the sector – and the implications of funding streams
    - status and capacity of Chief Officers
    - administrative and policy capacity
    - nominating and representative structures
- Changed expectations of voluntary and community sector engagement
- The complexity of public engagement
- Partnership fatigue
- The engagement of ethnic minority community groups and voluntary organisations
- Complexity of governance

Dramatically changing landscape

This study has taken place over eighteen months. During that time the pattern of local area strategies has developed significantly. A plethora of initiatives – within the health service and much more broadly – was launched during 1998. All of these had a common structure. They required a joint identification of need, shared plans for implementation, a governance structure for delivery and accountability to the relevant Secretary of State for meeting ambitious targets. Critically for this study, all the initiatives required high levels of voluntary and community sector engagement.

During the period of this study the local response to these initiatives - whether the New Deal for Communities, SRB, Education Action Zones, Health Action Zones, Sure Start or Safer Cities - had become much more sophisticated. In particular, attempts were being made to join up these various approaches and to provide some way of intelligently linking the number of partnerships created at government behest. In Sandwell this had taken the form of the creation of a Civic Partnership to oversee and co-ordinate all these activities. In Luton proposals for such an over arching response were embodied in the Luton Forum which will be the strategic focus for these activities. This has meant that the status and nature of the Health Action Zone itself has attracted rather less attention with some of those we interviewed arguing that the real question was the engagement of the voluntary and community sector at these authority wide levels.

It seems likely that this approach to Area Strategic Partnerships will be encouraged by government in the next year or so, and the Civic Partnership model may well be promoted as one way of ensuring that the plethora of initiatives has at least one common reporting point within the locality. Throughout this study it became clear that functions such as community development were essential to the successful delivery of Health Action Zones, New Deal for Communities and all the other initiatives, and the lack of some central decision making arena for these interventions meant that the response tended to be piecemeal. Critically it was also clear that unless some co-ordination could be developed, the various initiatives were simply operating in a competitive recruitment market place, and there were a number of examples of good staff leaving because alternative initiatives funded particular pieces of work at a higher rate.

Within the Health Service the changing organisational structure has particular and dramatic implications for the development of the Health Action Zones. The rapid development of the Primary Care Groups' commissioning responsibilities, and their imminent emergence as trusts, means that the attention of the health authorities is – inevitably – focused on the new configurations which involve very significant change. The local Health Action Zone concept will need to fit into and adapt to these new structures. Strikingly, the task of the Primary Care Trusts will be to get to grips with commissioning services, and in this context their external attention will be much more clearly focused on the views and aspirations of the public, rather than the voluntary or community sector. A key question for the voluntary and community sector is the extent to which the new arrangements should have a voluntary and community sector perspective.

The capacity of the voluntary and community sector for partnership

Central to this report is an assessment of the way in which the voluntary and community sector is managing to engage with the developments described. Its contribution will depend in part on the attitude of statutory organisations and in significant measure on the capacity of the sector itself. This section of the report describes some of the obstacles that arise from the capacity of the sector itself and concludes with some recommendations.

The Health Action Zones require a range of contributions from the voluntary and community sector on:

- Needs identification
- Planning of responses
- Monitoring developments
- Delivering services
- Representing users of particular services
- Strategic direction and governance.

In each of the three study areas a complex governance structure had been developed to manage this range of activities in which the voluntary and community sector was represented.

We identified 6 problems with the voluntary and community sector that related to capacity. Broadly:

1. The **different governance structures** of the voluntary and community sector may not fit easily with the structures of local authorities and health authorities. Voluntary organisations make a clear distinction between paid staff and trustees in the same way that statutory organisations do between staff and, often elected, members. The representational structure of the voluntary and community sector may not sit easily in these new arrangements. Most Councils for Voluntary Service are governed by trustees drawn from the senior staff of member organisations. It is often neither appropriate nor possible because of time commitments for them to serve on the boards of Health Action Zones. Consequently, there are a number of instances in which the Chief Officer of the CVS was participating both at board and at various executive levels reporting to the board. This is enormously demanding on the individuals. More critically perhaps, it raises questions of accountability within the voluntary and community sector. In particular as the Health Action Zones move from planning to implementation it will involve these individuals in making difficult expenditure decisions that will affect their own members (many of whom are also their trustees). In the politically fraught environment of locality planning of this sort,

this can make both the representative organisations and the whole voluntary and community sector vulnerable.

2. The different **command structures** in the sectors also cause difficulty. The fact that the voluntary and community sector is a group of autonomous independent organisations means that a representative of a sector cannot – under any circumstances – "deliver" particular changes in the way that, for example, a Director of Social Services can. This can lead to misunderstanding or make the representative of the voluntary and community sector appear comparatively powerless and reduce their ability to influence. However, as many of the respondents pointed out, the new culture of public services, and particularly the reconfiguration of the Health Service, means that frequently very senior people in the statutory sector no longer hold levers of control in quite the same way that they used to. Although this may in the long-term result in more equality between the sectors, at this stage the voluntary and community sector clearly perceives the statutory sector as a large, more powerful, more homogenous group of organisations, and this important perception of difference influences collaboration. However, as many pointed out, both local authorities and health authorities are now operating much more as a collection of inter related business units, and managers within these services are learning to collaborate in ways that were unthinkable a decade ago. However, this change is a gradual one, and the independence of voluntary organisations from each other is not easily understood by all those involved.

3. There were also concerns within the voluntary and community sector about **independence**. While those to whom we spoke recognised that much of the strength of the sector lay in its independence, there was also recognition that there was a danger that this would be compromised if representation and engagement was entirely financed by the statutory sector. The ability of a cash starved voluntary and community sector to engage on equal terms was therefore not simply a question of the capacity of the voluntary organisations. It also related to the source of their funding, and absolute dependence on statutory funders, at a time when they are all working much more closely together, allows little scope for independence. This in turn may threaten their effectiveness.

4. The expectations placed on the **Chief Officers** within the voluntary and community sector – and particularly the CVS Chief Officers - are very significant. We witnessed extremely competent chief officers of the local council for voluntary service performing effectively in joint bodies where they sit alongside statutory chief officers. We believe that the voluntary and community sector is often fortunate in attracting the services of skilled individuals who are able to operate at this level. However, the salary levels attached to these posts[1], as well as the considerable pressures facing post holders, must make recruitment and retention into these posts a problem. In effect the Chief Officers are expected to act as champion, negotiator and decision maker, and face the possible hostility of their own sector while representing their interests. In doing so they are working with statutory colleagues on salaries that are (at least) three times as large, with much more significant organisational back-up. Moreover, their

[1] NACVS payscales

statutory colleagues will almost certainly have received specific training and development for their strategic roles.

5. Associated with this, it is striking the extent to which the voluntary and community sector lacks the **administrative and policy capacity to support** the chief officers - and other representatives - in their role. In almost every case the sector's representatives - whether from umbrella bodies or from individual organisations - reported that they received little or no support in their role, and specifically had no training, administrative or policy resource on which to draw. While in many parts of the country umbrella organisations have become proficient at supporting representatives on, for example, community care planning groups[2], the new challenges presented by the strategic partnerships such as Health Action Zones do not seem to have resulted in similar responses. There is a significant policy dimension to this. Newly elected members of sub groups of the Health Action Zone in both localities reported that they felt unprepared for the meetings, and lacked either the policy back up or the training to be really useful contributors.

   The administrative and internal management weaknesses of the voluntary and community sector were also evident in discussion of accounting for public money. Repeatedly, organisations referred to the onerous nature of the reporting and accounting mechanisms. They believed that they were expected to comply with fairly rigorous and unfamiliar audit procedures without the funding to enable them to do so.

6. The voluntary organisations in the areas we visited were in the process of devising different **nominating and representative structures** to deal with the multiplicity of bodies requiring representatives. In Luton this had taken the form of contested elections, while in Sandwell a slightly less formal approach had been adopted. In Northumberland the county wide character of the Health Action Zone meant that the primary representative body is the Northumberland Rural Community Council. This in turn had encouraged the development of networks of CVS' to work closely with the RCC to brief them on issues. These different structures are as yet untried. They have developed in the very different environments studied and are attempts to develop a coherent voice for the sector.

Recommendation

1. That there should be specific funding investments in the voluntary and community sector to enable it to play an appropriate role within the local strategic partnerships of which the Health Action Zones are only one. These might be grants for training, for administrative support or for development staff.

2. That grant making trusts have a particular role to play in funding some of the work associated with this not only to enhance the effectiveness but also to protect the independence of the sector.

[2] Ball and Unwin, Funding the Infrastructure – issues for grant making trusts, Baring Foundation, 1998

3. That councils for voluntary service and equivalent umbrella bodies pay particular attention to the ways in which they can support voluntary and community sector representatives, in particular providing them with training and policy support in carrying out their roles.

Changed expectations of voluntary and community sector engagement – moving from optimism to realism?

In the first phase of this study we encountered the enthusiasm of those from the statutory sector for involving the voluntary and community sector in their deliberations. Although there had been significant errors of process and many occasions when the nature of the engagement had been faulty, the overall impression was of officers from all parts of the statutory sector genuinely committed to the full engagement of the voluntary and community sector.

However, those interviewed for this study gave a number of different motivations for seeking the sector's involvement:

- as an articulator of need, perhaps closer to the ground than the statutory organisations that manage services
- as part of the civil society of a locality and, like business, therefore concerned with the health of that locality
- as a major provider of services – perhaps better than the health authority or social services department at getting particular sorts of service delivered to particular groups of people
- as an agent of community development, able to organise the community in ways that make it more receptive to health improvement
- as advocates of particular minority groups

These very different expectations and motivations were bound to have an impact on the nature and direction of the various partnerships described.

In practice, it became clear that these different expectations have resulted in some disappointment and in some re-alignment. We detected a much greater reluctance to rely on the sector for community involvement than previously, and some disillusion at the extent of its ability to act as a conduit of information.

On the other hand, there was considerable appreciation of the extent to which the sector was committed to the process, and appreciation of the pivotal roles of key individuals.

In our interviews with voluntary organisations we detected an equivalent confusion about roles. For those voluntary organisations that were major providers of services there was considerable self-confidence and growing certainty about their role in pursuing the Health Action Zones' strategies and an understanding that Health Action Zone targets could not be met without their assistance.

However, many voluntary organisations have a different role. Those voluntary organisations that had been established with a wider community development role seemed to us to have become more sceptical about the benefits of engagement by community representatives. In part this was because they recognised the strains placed upon individual community members. They argued that there were real dangers that a few articulate members of local communities carried the burden of community representation, and that the task for voluntary organisations was to provide support for these people. They also stressed that these individuals then became the focus of complaint and hostility from the community when delivery was not as swift as might have been expected.

Additionally, voluntary organisations with a community development remit raised other questions about the process. They believed that they were asked to perform complex tasks of community development without any recognition of the pace and scope of the project proposed. This meant that their skills and experience were used, but often in inappropriate ways. In particular it was felt that the concept of "capacity building" was loudly voiced within the Health Action Zone processes and plans, but there was little understanding either of the ways in which it could be done or the difficulty of the work. In particular, a funding regime that required outcomes within an annual planning framework was particularly inimical to effective work.

Recommendation

1. That the managers of Health Action Zones continue to recognise that community development and capacity building is necessary, but also that it is complex and difficult.

2. That those commissioning capacity building develop more realistic time scales, and more appropriate measures of success.

3. That grant making trusts may have a role in helping voluntary organisations that are committed to community development to have the means to measure outcomes themselves.

The complexity of public engagement

In all three areas there was a strong emphasis on engaging communities – or more generally "the public" – in the developing role of the Health Action Zone. In each area this took the form of a variety of means of public consultation. Those interviewed from the statutory sector were all committed to high levels of public engagement, and circulars and guidance from the Department of Health underpin this message. A separate but related theme is the requirement to involve "lay" members – as distinct from clinicians – on the Primary Care Groups.

These two strands have united to present a challenge to both the statutory and the voluntary and community sector. While in the first visits in November 1998 we detected some desire to consult the sector as a proxy for more direct community consultation, it became clear that in all three localities there now appeared to be a wish to institute direct consultation with the public, and a recognition that this could not simply be done through the voluntary and community sector.

In the localities studied, a clear distinction was made between consulting with the general public and with key stakeholders. Typical activities to involve the public included public meetings, postal questionnaires, citizens' panels and surveys of public views. The Health Action Zones were also keen to develop imaginative ways of gathering the views of

stakeholders. Different mechanisms were devised to gather these views, and typically they included face to face interviews and specialist focus groups.

These approaches stand in contrast to the expectation expressed by voluntary organisations that they will be represented on decision-making bodies as of right. Indeed, these approaches require all stakeholders – and this would include the voluntary and community sector – to demonstrate the nature and scale of their own public engagement. There was no sense that the voluntary and community sector could be assumed to have secured high levels of community participation. This was a significant change from the interviews we conducted in 1998 when there was some expectation on the part of some statutory services that the sector could somehow access local communities directly. Indeed, this had been seen by the statutory sector as one of the functions of the voluntary and community sector and we detected some nervousness on the part of the voluntary and community sector at that approach.

In Luton the Primary Care Group has three elected voluntary and community sector representatives with observer status on the board, in addition to the lay member. It has charged its Partnership Development Group with developing patient participation. This will involve some voluntary organisations – principally those that represent particular groups of patients - but will also have a much wider remit.

The emphasis on this level of public and community involvement has generated some scepticism among the voluntary and community sector. In both localities we heard comments about those members of the community who were repeatedly asked to speak for the community and were seen as doing so with diminishing credibility. This disquiet applies both ways. Many of the health authority staff to whom we spoke were also sceptical about the ways in which those voluntary organisations that are established to represent patients, users or carers had, in effect, become the mouthpiece of a small and unrepresentative group.

The capacity of the public to respond is also attracting some attention. Capacity building is again suggested as an appropriate response to limited public interest – or at least limited expressions of interest. It seemed likely that community development will become a significant feature of all the Health Action Zone work as it is in both Luton and Sandwell. Again, the lack of shared definitions of this activity and, in particular, the lack of recognisable measurements of success, have limited progress. Nevertheless, the Health Action Zone programmes do all rely on the ability of the community to start to live more healthily. Without this change in public behaviour it is impossible to imagine that the demanding targets in the plans will be met. It therefore becomes imperative that voluntary and statutory partners enable the public to become engaged.

Recommendation

1. Given that public engagement is at the heart of the Health Action Zone agenda, voluntary and community organisations need to pay more attention to the ways in which the public and users are involved in their own activities.

2. Health Action Zone managers may wish voluntary organisations to be agents for encouraging community and public engagement. If so they will either need to provide the funding, or help the organisation to raise it elsewhere.

Partnership Fatigue

In all the interviews and discussions we detected a high degree of "partnership fatigue". While there was an acceptance that joint working was the only way to deliver the desired outcomes, the strain of representation and shared governance was clearly beginning to tell. This was most often reported by the voluntary and community sector, citing the small size of their organisations and the burden placed on them by the extremely complex processes of partnership. It was also noticeable within the statutory sector. The creation

of smaller business units and, in particular, the very small staff size of the PCGs suggested that the stresses of working in this way were telling across the board.

There were however different manifestations of the strain within the voluntary and community sector and this is worth exploring. In all three areas there was a simple question of staff capacity, and this is critical. In both Luton and Sandwell the Health Action Zone had been able to offer funding to the CVS to strengthen its staffing. In Sandwell this had enabled the appointment of a Deputy Chief Officer who was charged with co-ordinating some of this work, and in Luton a part time post had been created. This welcome increase in resources for the co-ordinating body is a helpful response.

However, even this approach is clearly not without costs. In the early stages of the Health Action Zones we witnessed co-ordinating bodies that were reluctant to expand their staff in order to deal with the demands of the new environment, arguing that to do so might deflect them from their mission. Over the period of the study it has become clear that CVSs no longer feel that they can remain distant in this way and have willingly taken any funds available to aid their participation. In both Luton and Sandwell it means that they now have core posts devoted to these processes. This does mean that their main programme work inevitably focuses on the demands of the Health Action Zone, and over time they may find that some of their members query this stance.

Most strikingly, this sense of "partnership fatigue" could be identified in all parts of the statutory sector as well. Many of those interviewed were themselves setting up small organisations – both PCGs and Health Action Zones - and recognised that the structures and processes of partnership were immensely time consuming. Currently it is asserted by all those involved that this time spent will have a positive impact on health outcomes. At this stage, however, these are only assertions, and it is only when they can be demonstrated that participating organisations may feel the benefits – and not just the undeniable costs – of partnership.

The engagement of ethnic minority community groups and voluntary organisations

In the areas studied – Sandwell and Luton - there is a significant ethnic minority population. In both localities there is a strong recognition that achievement of health improvement will not be possible without the full involvement of the black and ethnic minority communities. Both localities also contain a number of energetic voluntary organisations. Both reported levels of previous inter-faith and inter-community dissent and commented on the weaknesses of past approaches that had too often simply assumed a commonality of interest between the various groups. However, while such recognition was welcome, there did seem to be a real uncertainty about the ways in which these communities could be more effectively involved. Both the statutory and the voluntary and community sectors shared this uncertainty. Resolution seemed to lie in the conscious

and planned development of voluntary organisations within those communities with the expertise and capacity to represent needs and deliver services. The challenge must be to do this effectively and quickly enough to deliver the sort of responses required. In all voluntary and community sector co-ordinating bodies there is frequently a tension between the newer parts of the voluntary and community sector and the more established parts, just as there is often tension between the better funded organisations and those that are not receiving external support.[3]

It has to be said, however, that in both areas there is evidence of continuing tension on this issue. In Sandwell considerable encouragement has been given to the creation of an umbrella organisation for the different umbrella ethnic minority organisations. SEMUF – Sandwell Ethnic Minorities Umbrella Forum – has been supported financially by the various statutory bodies and by the Health Action Zone. It has had a difficult time in the last 18 months since its inception and has suffered some rapid changes of leading staff, as well as some public dissent among the committee. These are inevitable early problems for any new umbrella organisation within the voluntary and community sector. However, the pace of change described in this report means that there is little leeway for these early teething problems to be sorted out.

In Luton there is similar evidence of tension, although the ethnic minority voluntary and community sector is better established. It also has close links with the political management of the Borough Council. Nevertheless there is evidence of some dissatisfaction with the Council for Voluntary Service.

It seemed to be the case that each area had adopted different strategies, based largely on their history and previous experience. Sandwell had sought to develop a parallel structure for black voluntary organisations, while Luton had sought to be more inclusive within the umbrella organisation. While it is too early to say which of these has had most success, both have been fraught with problems and have been enormously time consuming.

The development of parallel structures, such as the Sandwell one, raises particular questions for the Council for Voluntary Service which will, in itself, always expect to speak for the whole sector. In Sandwell this has been managed through overt support from the CVS to the new body, but in a time of major spending decisions the tensions between the two organisations are evident. More significantly perhaps for this study is the question of timeliness. The announcement of a Health Action Zone in any one area sets the clock ticking for achievement. Although 7 years is a comparatively long time in voluntary and community sector funding terms, it is an extremely short time in which to achieve major changes in local health outcomes. The need to develop voluntary organisation capacity within the black community is clearly frustrating for some managers within the statutory sector. On the other hand, it is clear that, without prior attention to the development of an infrastructure, the teething problems of the new infrastructure were always bound to take place at the time at which the greatest demands would be made of it.

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[3] Peter Westland and Julia Unwin, Resourcing the Voluntary and community sector ACF 1996
Ball and Unwin ibid.

The longer established approach of integration, as developed in Luton, has also had problems. Managers from the Health Action Zone are clear that the CVS is not able to speak for the black and ethnic minority community organisations, and yet believe they need a direct channel to them. Strikingly, in the process of election that Voluntary Action Luton recently organised, only one representative of an ethnic minority voluntary organisation emerged with a place at the table.

Recommendation

That the different models for ensuring engagement of black and minority ethnic communities are rigorously monitored, and that funders recognise the exceptionally demanding time faced by such organisations as they establish themselves and at the same time engage with this challenging agenda.

Complexity of governance

Both the Health Action Zones in Luton and Sandwell are governed by a complex committee structure. This is perhaps inevitable in an environment where active engagement with partners is so critical and where there is such a premium on the development of a sense of joint ownership. The partnership itself is accountable to the Secretary of State, but all of those engaged within it have their own separate accountabilities. Within the governance of both Health Action Zones there is voluntary and community sector involvement. On both of them, the Council for Voluntary Service is represented at the most senior strategic level, as well as throughout the structure at more operational and specialist levels. This complexity will only increase – at least in the short term – with the advent of Area Strategic Partnership bodies (see page 9).

It is clear that this form of inclusive governance, securing the active involvement of all through a series of inter-related and reporting committees poses challenges for voluntary organisations. While the approach is suitable for the larger organisations, with a clearer separation between strategic and operational control, it can be difficult for the typically flatter voluntary and community sector structures. In theory, at least, this could be resolved by the more active engagement of the trustees of the voluntary and community sector. In this model the trustees of voluntary organisations would relate to the elected members and this would enable the right sort of distinctions to be made. However, in practice this would simply be too time consuming for many trustees. Moreover, in representative organisations these trustees are themselves frequently employed by voluntary organisations. It did seem to us that real engagement in the governance of a Health Action Zone would stretch both the time and the abilities of the voluntary organisations involved, and that the promoters of these collaborative frameworks will need to be mindful of this.

Recommendation

1. That clear protocols are developed – perhaps by NACVS and delivered through local compacts – governing the expectations on voluntary and community sector representatives.

2. That councils for voluntary service and other umbrella bodies devise different ways of supporting and training representatives.

4. Descriptions of each area

Luton

Luton became a unitary local authority in 1997. This means that it is a relatively new creation, assuming responsibility from Bedfordshire County Council for education and social services. The old Luton District Council did have responsibility for housing and environmental health, but the new body now has a greatly increased range of responsibilities, and has recruited new officers to provide these services. Like all local authorities it is also challenged by the present government's questioning of the appropriate roles and responsibilities of local government.

Luton is a poor area. It has a population of 181,400, which makes it a smaller area in population terms than the other Health Action Zone areas. 20% of the population are from ethnic minority communities, and this figure rises to 60% in the inner Luton wards that are the focus for much of the activity proposed for the Health Action Zone. It is an area of very poor housing: almost 40% of the houses in some parts of the town are unfit for human habitation. The health risks experienced in inner Luton are four times the national average, with a significant rise in the number of inhabitants over 85 years of age.

Over many years Luton has been a strong and fairly traditional local authority. One of our respondents described it as a "northern town stranded in Southern England", and this is a reflection both of the political ethos of the elected councillors and of the social problems they are trying to address. The voluntary and community sector has been funded through grant aid and had not been consciously developed by the local authority although rapid changes are now taking place. There was no history of using voluntary organisations as suppliers of services on a large scale, although at the time of this report that is now very definitely changing. Service Level Agreements have replaced grants for voluntary organisations supported by the Social Services Department. Luton Social Services Department in 1998/9 spent £1.5 million on voluntary organisations out of its budget of some £30 million. There are an estimated 400 voluntary organisations of which 120 are members of Luton Voluntary Action. In addition, there is a large number of very informally structured community organisations, particularly within the large and diverse ethnic minority community.

There had been in the past significant tension between the members of the old Luton District Authority and the health authority. Establishing the Health Action Zone required the active engagement of both Chief Executives of the local authority and the health authority to try to minimise old tensions. Some key elected members of the local authority have been very conscious of the need to work more collaboratively, but the pace of the current developments has clearly created difficulties for all sides. Luton local authority has also suffered from the funding arrangements of the past; although the town provided half of the caseload of Bedfordshire County Council's Social Services Department, the new unitary authority only received 33% of the funding previously available.

Since then some financial recovery has been possible as a result of land sales and the development of the international airport will bring new jobs to the area and additional funds to the local authority. The Health Action Zone itself does not bring enormous funds to the district. The Luton Health Action Zone reported in its implementation plan expenditure of £119,700 as development funds, and the total allocation for the preliminary financial year from the Department of Health was £203,000.

The implementation plan for the Luton Health Action Zone explicitly brings together a number of existing strategies, and is based on an enthusiastic commitment to working together. In particular the health authority has made a significant commitment to joint work, through placing staff within local authority offices and employing new staff with Health Action Zone funds to work across the organisations. This collaborative approach is reflected in the way in which funds are also to be shared, with other funding streams - such as Home Office Drug Treatment Funds – also being devoted to the achievement of Health Action Zone targets. In this Zone this is a major contribution; the Home Office funding for 1999/00 was expected to be just under £0.5 million and is included by those interviewed and within the implementation plan, as part of this more co-ordinated, more locally collaborative method. Additionally Luton has been selected by the Home Office for one of the five pilots for the Active Community programme and Voluntary Action Luton has the lead role in co-ordinating this. This programme is a formal intervention in the recruitment and engagement of volunteers, and requires high levels of support from the intermediary bodies. It is a politically sensitive programme and one that needs to meet high political expectations.

The implementation plan lists 10 targets. These are:

- Increase employment in target groups
- Bring housing up to standard
- Reduce the incidence of heart disease and strokes in target areas
- Reduce rates of diabetes with complications
- Improve access to services
- Reduce admissions of older people to acute care by 10%
- Improve customer and carer involvement
- Raise rates of community participation
- Improve access to mental health services
- Improve access to primary care

For each of these targets the plan lists a number of ways of responding, including in most cases the engagement of the voluntary and community sector as alternative channels for service. Thus for example, the target concerned with reducing heart disease is largely based on preventive work including the extension of Asian Cookery clubs and community-based approaches to increasing physical exercise. The delivery of both of these will be done by community-based organisations.

There was already evidence from the funds spent in the development phase, i.e. in the year before the Health Action Zone was formally launched, that the voluntary and community sector was seen as an important partner. Funds had been allocated specifically to help the voluntary and community sector to participate, through a grant for administrative purposes to the Council for Voluntary Service. In addition a voluntary organisation working within the Asian community had been given funds to employ a co-ordinator and to link workers to ensure that the information is widely disseminated. The views of participating organisations had been given considerable weight in the development of services.

The evidence of continuing voluntary and community sector engagement in the process can also be found in the periodic "stakeholder conferences". These attracted over 200 people and will be repeated throughout the process of the Health Action Zone to facilitate engagement.

In Luton the health officials interviewed at the start of the Health Action Zone process welcomed the particular style of activity contributed by the voluntary and community sector. They were generally seen as alternative providers, better equipped than the statutory partners to do outreach work and to engage with parts of the community that were not readily accessed.

It was also clear from the start that the voluntary and community sector, in the person of the Director of Luton Voluntary Action (the CVS for the area), was to be involved in the governance arrangements for the Health Action Zone. The complex system of governance that had been devised to encourage good cross-sectoral work does illustrate some of the weaknesses of the voluntary and community sector involvement. Specifically, there seemed to be some difficulties for the voluntary and community sector in mirroring the split between the operational, or managerial, level of activity and the strategic. While the larger partners were able to send different individuals to represent their agencies at these different levels, the small size of the voluntary and community sector meant that there seem to be a number of points at which the same representative sat at the different levels of the hierarchy of governance. This illustrates some of the problems inherent in engaging smaller, and more diffuse, structures within governance frameworks largely devised by bigger institutions. In considering the operation of the Health Action Zone in Luton this seemed to have significant practical implications.

Elections have been held within the voluntary and community sector to provide representatives for the Health Action Zone Board, and this may as intended strengthen the role, primarily through providing some legitimacy for the representation, but also altering the balance of such representation.

In Luton it seemed to be the case that the emphasis on joint working had also exposed some of the weaknesses within the voluntary and community sector. One of those to whom we spoke described the barriers between voluntary organisations as at least as impenetrable as those between statutory bodies. The funding mechanisms in place encourage competition, but it was argued that these have not yet had the effect of reducing wasteful duplication. A much greater emphasis on partnership and on collaborative working seemed likely to turn the spotlight on to the voluntary and community sector performance. This would reveal some excellent work, but might also draw attention to a number of weaknesses.

There was already experience of joint working within Luton. The Partnership Board governing the Luton and Dunstable Single Regeneration Budget programme seemed not to have grasped the full potential of the voluntary and community sector in its work. There were a number of examples given of the voluntary and community sector being seen as only of peripheral value in the task of providing economic and social regeneration. It was clear that the Health Action Zone board has not made the same mistake. Whatever the limitations of the involvement of the voluntary and community sector in practice, at the board level it was clear that there was a commitment to the voluntary and community sector and recognition of the need to develop this genuinely multi sector approach. Such hesitations as were expressed were much more about the means of such involvement and not about the fact of the involvement.

Luton Health Action Zone was very conscious of the need to take a long-term view about its progress. More than once we were reminded that this is a seven-year programme, and that dramatic changes either in actual health outcomes or in the levels of collaboration could not be expected at this preliminary stage.

Sandwell

Sandwell consists of 6 towns, each with its own characteristics and history, but united in the decline of industry and employment in the last twenty years. The total population is 290,000 of whom 15% are from ethnic minorities, with Indians (at 8%) forming the single largest group. In March 1998 the unemployment rate was almost double the national average. Among Pakistani and Bangladeshi communities the rate was 38%. One third of all households are deemed to exist below the poverty line. Perhaps not surprisingly, educational and housing standards are both well below acceptable standards – 95% of Sandwell residents hold no post school qualifications. Cardiovascular disease, cancer and limiting long-term illnesses are all well above average. Sandwell reports the second highest rate of teenage pregnancies in the country.

It is to address this constellation of problems that Sandwell originally put together its proposal to be considered a Health Action Zone. Describing itself as “champions at partnership”, it submitted to the Department of Health an ambitious plan, including the creation of jobs, the development of model housing in an “urban village”, a plan to

improve workplace health, education about health and nutrition for young people and so on. Its plan clearly recognises that none of this is possible without the active engagement of the voluntary and community sector.

In Sandwell the initial allocation for 1998/9 had been £100,000, with a further contribution of £211,000 on a capitation basis. In 1999/00 the allocation was expected to be £1.2 million, and thereafter probably £1 million a year for a further two years. The health authority and the local authority had already contributed £50,000 each. This was cited as evidence of the high level of commitment to the joint approach.

There are more than 900 voluntary organisations in Sandwell, ranging from small community groups to large voluntary organisations with a national profile. The Sandwell Council of Voluntary Organisations is the umbrella body and is constituted in the conventional way, but it has recently been re-launched after a time of disruption and limited activity. There are also a number of major voluntary organisations in the area. Age Concern, a local organisation concerned with domestic violence and the community health council, which involves a number of voluntary organisations, are all heavily involved in the health care planning and development for the district. In addition, Murray Hall, a pioneering organisation in Tipton, is at the centre of a large new project known as the "Neptune Health Park". The chief executive of Murray Hall has been appointed as a non-executive director of the Health Authority, thus illustrating the close working relationships between the two sectors and the high regard in which some key individuals are held.

The implementation plan submitted by Sandwell was very different from the Luton submission. It focuses much more explicitly on the need for involvement by "the people" of Sandwell and is much more firmly based on past collaborative work. In particular, respondents cited the exemplary work of the "Neptune Health Park" in Tipton which brings together a voluntary and community sector based Community Trust, a primary care team, a leisure centre and various community initiatives in health promotion. This model of joint work at a very local level has provided much of the framework for the Health Action Zone as a whole and illustrates the past experience, and perhaps expertise, at partnership working. Examples of partnership approaches to health in Sandwell date back to the early 1990's and include the imaginative use of Single Regeneration Budget funding to meet health and other social objectives. This was the principal funding source for the Neptune Project, but Sandwell has also been able to develop a Disability Living Centre, as well as developing joint commissioning for both learning disability and mental health services. Several of those interviewed in Sandwell attributed some of their success in receiving Health Action Zone status to their proven expertise in this way of working.

In order to ensure the inclusiveness of the project, a complex web of governance, executive and consultative groups has been set up. In common with Luton the governance arrangements seem, to the outsider, to be rather cumbersome. They are described in detail in the implementation plan "Transforming Sandwell". Those managing the process describe the structures as a genuine attempt to engage all interest groups. There does seem to be a diversity of representation from the voluntary and community sector that allows the burdens of accountability to be shared rather more widely. For example, three project groups within the Health Action Zone are led by people from the voluntary and

community sector: the projects on domestic violence, on “age well” and on the work on public consultation are led by voluntary and community sector representatives.

It is important to note also that the Sandwell Health Partnership, which is the over-arching strategic body for the health services in the area, includes the Health Action Zone in its remit. It is also responsible for the Health Improvement Plans, which are required of both health and local authorities, and will also expect to influence the health aspects of regeneration funding. In short, Sandwell appears to have embraced, at least at political, strategic and senior levels, an approach that acknowledges that the necessary change can only be achieved by joint collaborative working. The complexity of the structure, they argue, is an attempt to ensure that all relevant interests can have an influence and, perhaps most critically, share responsibility for the outcomes. In Sandwell this appears to apply to voluntary organisations equally. One criterion proposed for the success of this Health Action Zone, along with the health improvement targets, is the robustness of the collaborative arrangements. It is our view that these arrangements will be severely tested over the next year or so when priorities have to be further refined and some major disappointments faced. While at the time of this study the emphasis has been on planning and development, the allocation of scarce resources is bound to be challenging for the individuals involved.

Those we interviewed acknowledged this risk right from the start. They recognised that the changing configuration of planning and services meant that it was hard to predict the future. In particular in Sandwell there was a ready recognition that there might be further changes in the not too distant future. The approach taken to date in Sandwell has been very much based on a locality approach, reflecting the six towns of Sandwell. This has included local officer networks and locality commissioning (where decisions about expenditure are carried out at the local level). Given that the Health Action Zone covers the whole area and not just selected wards, as it does in Luton, the Sandwell respondents recognised that an immediate challenge would be in connecting this strong inter-agency approach at local level to the strategic approach that the Health Action Zone requires. Achieving this without losing the strong local focus will inevitably result in compromise.

The establishment of Primary Care Groups to take on, over time, the provision of all primary care and to commission secondary care further complicates the picture. The Primary Care Groups for Sandwell do not coincide with the existing locality boundaries and these may therefore have to be re-aligned themselves. In this complicated and shifting pattern of services and planning methods the engagement of the voluntary and community sector is going to be critical but hard to ensure. To do this at a time when those same planning mechanisms will need to be re-allocating funding will be a real test for the arrangements so far established.

Sandwell is still experimenting with different ways and means of engaging with the black community and voluntary and community sector. While an independent voluntary organisation – Black Voices – was in existence for some time, it seems to have foundered. The alternative structure involves 6 different ethnic minority forums, each organising their own representation to Sandwell Ethnic Minority Umbrella Forum (SEMUF) which will in turn have a place on one of the co-ordinating groups. This

method is, as yet, untested, but is an attempt to ensure that the inter community conflicts do not prevent these communities from having an effective voice.

Both the Health Action Zones considered are governed by a complex committee structure. This is perhaps inevitable in an environment where active engagement with partners is so critical and where there is such a premium on the development of a sense of joint ownership. The partnership itself is accountable to the Secretary of State, but all of those engaged within it have their own accountabilities. Within the governance of both Health Action Zones there is voluntary and community sector involvement. On both of them the Council for Voluntary Service is represented at the most senior strategic level as well as throughout the structure at more operational and specialist levels. In Sandwell there does seem to be a greater diversity of representation within the Health Action Zone and this model seems from the outside to be more robust.

However, it is clear that this form of inclusive governance, securing the active involvement of all through a series of inter related and reporting committees, poses real challenges for voluntary organisations. While the approach is suitable for the larger organisations, with a clearer separation between strategic and operational control, it can be difficult for the typically flatter voluntary and community sector structures. In theory, at least, this could be resolved by the more active engagement of the trustees of the voluntary and community sector. In this model the trustees of voluntary organisations would relate to the elected members, and this would enable the right sort of distinctions to be made. However, in practice this would simply be too time consuming for many trustees. Moreover, in representative organisations these trustees are themselves frequently employed by voluntary organisations. It did seem to us that real engagement in the governance of a Health Action Zone would stretch both the time and the abilities of the voluntary organisations involved, and that the promoters of these collaborative frameworks will need to be mindful of this.

5. The development of voluntary and community sector engagement in each locality

Luton

At the initial stage of the Health Action Zone funds were allocated specifically to help the voluntary and community sector to participate. This consisted originally of a grant to enable Voluntary Action Luton, the local council for voluntary service, to strengthen its administrative support to allow the chief officer to participate in the various groups being set up. Funding was also made available for a worker to develop stronger contacts with the Asian community. All local voluntary organisations were invited to participate in early discussions about the Health Action Zone. Through Voluntary Action Luton their views were sought in the development of policy. During the interviews in the autumn of 1998 considerable regret was expressed at the way in which the voluntary and community sector contribution had been hurried at the preliminary stage to meet Department of Health deadlines and we identified a strong commitment to making sure

that these initial mistakes were not repeated. Indeed as the Health Action Zone developed it seemed to us that considerable weight was attached to much of the voluntary and community sector input into policy formulation.

The governance arrangements included Voluntary Action Luton and elections were being proposed for voluntary and community sector representation on the various strategic and operational bodies within the Health Action Zone framework. At that stage it seemed to us that problems of liaison with voluntary organisations were being recognised and, to a considerable extent, tackled. The emphasis on the actual and potential roles of voluntary organisations was bound to place voluntary organisation performance under a spotlight, but all those interviewed were convinced that a long-term view needed to be taken about outcomes.

Just over a year later we observed changes in practice, expectation and emphasis, all of which have implications for voluntary organisations and which are the subject of this report. Some of these developments were positive, while others reflect underlying problems that require response and intervention.

Further health service appointments have been made, including that of a Communications and Business Manager who is, in effect, responsible for the day to day operations of the Health Action Zone and for its operational relationships. Expenditure had been increased to an anticipated £1.4 million in the year in 1999/2000 and further large stakeholder events had taken place. While the integration of the voluntary and community sector into the infrastructure of the Health Action Zone had proceeded and was underpinned by infrastructure support and grants to facilitate capacity building, there was a growing recognition of the limits of the voluntary and community sector. This concern was most often articulated in the context of government expectations of high levels of public engagement. Election of voluntary and community sector representatives had taken place and was completed, with appointments made both to the strategic bodies and to the five groups dealing with specific issues.

Interestingly, and almost imperceptibly, it seemed that the focus of attention had shifted from the more established voluntary organisations towards processes to engage the wider community and work with natural neighbourhoods. The focus of the Single Regeneration Budget and, latterly, the New Deal for Communities programmes have encouraged this. The main impetus, however, sprang from a clear conviction that achievement of ambitious health improvement targets was only possible with high levels of public and community involvement. This resulted in different requirements of the voluntary organisations in the programme and specifically much higher expectations about the extent to which the voluntary and community sector could engage with the community. Perhaps not surprisingly these expectations were frequently unfulfilled.

In April 1999 the Luton Primary Care Group had been set up. In the first phase of our study we noted that the way in which these new organisations developed would be critical to the long-term engagement of the voluntary and community sector in the Health Action Zone. Whilst the Luton Primary Care Group participates in the Health Action Zone in a serious and committed manner, it is developing its own distinctive approach to involving users, the general public and the voluntary and community sector. It has held

its own stakeholder meetings and consultations with the voluntary and community sector, both through the umbrella of Voluntary Action Luton and with voluntary organisations that are not actively represented within that organisation. It has established a Partnerships Development Group which is concerned with patient and public participation in its work. As part of this open and participative approach it has co-opted - as non-voting members – representatives of the local authority, community health council and Health Action Zone. Linked with this is a positive attitude towards voluntary organisations. So whilst it is part of the Health Action Zone it has adopted a distinctive style.

In discussion it emerged that the officers of the Primary Care Group are conscious of the limits to voluntary and community sector capacity, but nevertheless wish to engage with voluntary organisations both for assistance in identifying needs and as providers of community based means of responding.

There are also changes in the approach of the local authority. It has continued to move towards a partnership and strategic approach with voluntary organisations and has noted that it has some distance to travel in this respect. While it recognises the value of the council for voluntary service and of its contribution, the local authority also recognises that some key organisations are outside this network – and some deliberately so. The view of officers is that there are two distinct forms of voluntary and community sector capacity building that are required: help for umbrella bodies to enhance their strategic abilities and help for front line organisations to improve the quality and scope of their operational work.

The local authority recognises that voluntary organisations are much more than simple providers of services commissioned by the local authority and it was noticeable that the Health Action Zone process had partly shaped this more subtle and complex perception of role. As Luton moves towards a more devolved structure, with six neighbourhood areas each with some devolution of authority and a high expectation of community group involvement, there is likely to be a continuing interest in developing this wider role. There is a view that the success of some of the bids in the area, such as the New Deal bid for Marsh Farm, can be attributed to the effective, coherent and collaborative performance of the local community and voluntary organisations.

Luton has also recognised the dangers of multiple initiatives and partnerships. It is in the process of establishing a Luton Forum to pull together all these bodies. This body, called an Area Strategic Forum in some localities, will also need to engage the voluntary and community sector.

What does all this mean for the voluntary and community sector? Is there a danger that different initiatives are competing for the scarce resources available for voluntary and community sector engagement? Is it possible for a local voluntary and community sector – facing all the other demands on its time – to respond effectively to this new agenda of engagement? What does it need to do to participate?

In Luton we observed a council for voluntary service under considerable pressure and potential stress. The highly effective Chief Officer who has steered the organisation through these more recent changes was due to leave the organisation to pursue an entirely different – and unrelated – career. The task of replacing her, within restricted pay scales, is a demanding one. The Chief Officer is expected to operate at a strategic level with chief officers from larger and better-resourced organisations, who are themselves paid considerably higher salaries. It was our view that Voluntary Action Luton would be extremely fortunate to appoint a Chief Officer with the skills, stature and personal skills to maintain the high level of effective representation that is required and to which they have become accustomed.

Sandwell

In the second round of visits to Sandwell significant developments had taken place, which were having an impact on the nature and style of the Health Action Zone. Sandwell is the focus of a great many initiatives and the statutory authorities had decided to establish an over arching strategic body known as "the Civic Partnership" which would be responsible for all these initiatives. This is in an attempt to ensure that all the inter-relationships are properly acknowledged both in principle and in execution. This approach is very similar to one that may be recommended across all these localities, of creating an area-based body to bring together all the players.

The development of the Health Action Zone had brought some significant changes to the voluntary and community sector. In particular there has been, as predicted, an expansion in the funding particularly to enable the infrastructure to support the level of participation. The Sandwell Council of Voluntary Organisations has been funded to employ a Deputy Chief Officer whose primary role is to oversee the health input from the voluntary and community sector. The funding of this post is based on a service level agreement between the council for voluntary service and the Health Action Zone. It is clear that this strengthening of capacity, at a senior level, has enhanced the ability of the organisation to participate effectively.

Communication between all the elements of the Health Action Zone is a problem affecting all the players in this complex project. In response to this a new post has been created, but at the time of this study not filled, to maximise communication between the different bodies.

The arrangements for the Health Partnership Board – the strategic level of governance – include places for an additional voluntary and community sector representative and specifically for an ethnic minority group representative. This last post had not been filled at the time of our visit. The decision to develop Sandwell Ethnic Minority Umbrella Forum, as a device for organising the engagement of the black and minority ethnic sector, had not to date been successful. Internal disagreements and some significant staffing problems had marred the development. Such disagreements are not at all surprising in a newly formed umbrella organisation, and indeed the absence of such problems would be

more puzzling. However, they have taken place at a time when major demands are being made on this organisation and when the prize for engagement is very high.

On the face of it the voluntary and community sector is well placed to influence developments and seems appreciative of the co-operative and inclusive approach adopted by the statutory bodies. The statutory sector appeared to be coming to terms with the nature of the voluntary and community sector and in particular the limitations presented by the lack of a command structure. It is noticeable that the grants programme – some 30 projects are being funded - has moved away from service provision towards the capacity building of community and other less formal groups. Specifically the Health Action Zone has allocated £200,000 in the current year to pay for some of the costs of developing the community infrastructure through training, staffing and other measures designed to aid sustainability.

Some new problems have emerged. Voluntary and community sector representatives spoke convincingly of "partnership fatigue": many felt that the plethora of operational and strategic engagements was drawing them away from their core responsibilities to their own organisations. On the other hand, some recognised that – stretching as these activities were - they could provide a better way of achieving organisational objectives. Frequently trustees and member organisations found this apparent change of focus difficult to understand and support.

As in Luton there are tensions about recruitment. In both localities the chief officer of the council for voluntary service seemed to us to be highly effective at working with chief officers from the statutory sector, although the very large salary differential is noticeable. In both localities the directors of the council for voluntary service were operating as equals with statutory chief officers whose salaries were on average 300% greater and who could call on considerable backing – both political and administrative –as well as greater experience.

This issue also arose in consideration of field worker posts. There was one example of a post created within the voluntary and community sector to work on "Age well". The post was located within Age Concern and was therefore graded to fit that organisation's structure. Other government initiatives, however, and specifically "better government for older people" meant that the employment market for people with the required skills had altered and attempts to recruit and retain staff had foundered. To remedy this the post was now located within the health authority structure and consequently on a higher grade, thus illustrating some of the challenges of working with and through the voluntary and community sector. To have kept the post within the voluntary organisation would have required either appointing at a salary scale over and above that of the Chief Officer or re-configuring all the salaries within the voluntary organisation. Neither approach was seen to be suitable. In short, this was an example of the way in which the market value of some key posts, essential to the performance of the Health Action Zone, is greater than the voluntary and community sector can readily contemplate.

The introduction of Primary Care Groups (of which there are three in Sandwell) is a significant feature of the local voluntary and community sector experience. The features noted may well be a product of the immaturity of the current arrangements and the

limited resource available for them to carry out their task. We interviewed the Chief Executive of one Primary Care Group and believe that the approach is not untypical and, indeed, is reflected in many ways in the Luton Primary Care Group. The introduction of Primary Care Groups has not yet produced notable gains in cohesion. This is not in itself surprising. In Sandwell the Primary Care Groups have replaced a system of locality commissioning in which the voluntary and community sector had been heavily involved. The Sandwell Council of Voluntary Organisations employs a voluntary and community sector development worker whose job includes building up a Health Forum with a view to securing some legitimate voluntary and community sector representation of community interests in the development of the Primary Care Group. The organisation gives grants to voluntary organisations both for capacity building and for service delivery and expects to continue to do so. Strikingly, the Chief Executive of the Primary Care Group also makes a very clear distinction between community sector representatives, voluntary sector representatives and lay members, and believes that many of the problems in this area have been caused by confusing these different concepts.

In a separate development the local authority has commissioned a study[4] of its relationship with the voluntary and community sector. It has recently signed a local compact, along the lines of the central government compact with the voluntary and community sector, and the expectation is that the relevant health bodies will also be party to the compact. While clearly there are high hopes and expectations for the compact, the approach is still a new and untested one, and in common with others does not yet have viable mechanisms for dispute resolution.

As in Luton it was clear that the energy of the Health Action Zone and of the health authority as a whole was now much more focused on the engagement of the public, rather than the voluntary and community sector. This, along with the need to pull together the various initiatives and partnerships, was the focus of much of the thinking and developmental activity. While to some extent moves had successfully been made to embed the voluntary and community sector in the processes of the Health Action Zone, the much greater challenge was to maximise public and patient participation. Those working in the statutory sector in Sandwell were clear that the voluntary and community sector alone was not the route to such participation.

In Sandwell as a whole there were considerable signs of strain. The high hopes of a new relationship had not been reduced by the experience of working closely together, but the conflicting pressures and priorities were clearly taking their toll. Perhaps the symptoms of partnership fatigue and scepticism, as well as concern at the problematic involvement of the black voluntary and community sector, reflect a wider anxiety at dealing with too much change too rapidly while at the same time seeking to run services effectively.

6. Conclusion

The challenge of improving the health of people in the poorest parts of Britain is an enormous one. To make progress it is essential that voluntary organisations are involved

[4] John Plummer Audax

as providers of service, as articulators of need and as voices within the community. Considerable efforts have been made in the areas studied to make this engagement a reality and to make sure that this engagement is meaningful and effective. However, all concerned also need to involve the public at large. All those involved recognise that this is a difficult task - and one that makes demands on voluntary and statutory organisations alike.

There is a danger that this commitment to public engagement will distract attention from the continuing need to ensure that the engagement of the voluntary and community sector brings maximum benefits. In the areas studied there is evidence of considerable commitment to doing so and examples of effective ways of maximising involvement. The costs of these are high, however, and for the voluntary organisations involved – as for their statutory colleagues - there needs to be continuing evidence of the benefits of such involvement.

Appendix 1

The engagement of the Wansbeck voluntary sector in the Northumberland Health Action Zone

The visit to Wansbeck was a very small part of the study. It involved a review of the written material, a meeting with some local voluntary organisations, and a meeting with some officials from the health service and the local authorities. It is presented as an appendix to give additional insight into the practical implications of this issue.

The locality

Wansbeck is a district 15 miles north of Newcastle located in the County of Northumberland. The district covers 25 square miles, bordering with Castle Morpeth and Blythe Valley. The main concentrations of population are the small towns of Ashington, Bedlington and Newbiggin. Wansbeck was traditionally a coal mining area, but the closure of Ashington Colliery in 1988 marked the end of the industry within the district.

Wansbeck is the most deprived district in Northumberland, and is ranked as the 63rd most deprived district in the country by the government's own indices of deprivation. There are few employment opportunities and very high levels of unemployment – 36% in the last survey commissioned by the District Council in 1996. Only 6% of the population have any higher level educational qualification. The health of people in the district is, unsurprisingly, poor. For example, death from lung cancer is 25% worse than elsewhere in the country, and, county wide, the death from stroke is the 9th worst for any health authority in England

Wansbeck is a district with a number of very urban features, within a largely rural county. Stakeholder consultation within the district has focused the attention of the Health Action Zone on employment, and housing, as well as on the need to support and maintain family structures and values.

The local voluntary sector

There is an active, though small voluntary sector in Wansbeck. The council for voluntary service has been successful in attracting resources to the area, and it has itself gone through a rapid period of growth. The district council is not, however, one that readily identifies a major role for the voluntary sector, and there is a strong sense that the district level voluntary sector believes itself to be excluded from many of the decisions that are made for the benefit of the locality. Therefore while the CVS has a strong track record in delivering support to voluntary organisations in the area, it has much less experience of the representational and negotiating role.

At county level the representative body for the voluntary sector is the Rural Community Council. This represents the countywide voluntary organisations and has a good

reputation for doing so. Recently, under pressure from the plethora of new initiatives the district CVSs have started to meet regularly with the Rural Community Council, and this approach has real potential in encouraging the cascade of information throughout the sector. In January 2000 this approach was still in its infancy, and has yet to be tested.

Engagement in the Health Action Zone

The Northumberland Health Action Zone bid and implementation was unusual in that these documents contain so little mention of the voluntary sector. While the original bid describes in some detail the range of partnerships brought together in the bid, the voluntary sector is only mentioned in passing as one of the contributors within the Drugs Action Team. Other bids and plans reviewed as part of this study placed a much greater emphasis on the contribution of the voluntary sector, and, as this report has sought to demonstrate, this has resulted in some disappointment on all sides.

This finding was borne out in the meeting held with Wansbeck voluntary organisations where it was clear that, for the most part they felt quite removed from the process. Many recognised that they might have a role to play, but did not see that they had been offered an opportunity to participate. Although the Chief Officer of the Council for Voluntary Service was now becoming engaged through the RCC, this was rather late in the process. Despite her very obvious skills and abilities, she recognised that the challenges of these new ways of working were new to both her and the organisation. They require a different style, and different priorities. In particular, the countywide Health Action Zone required a district CVS to take a more strategic view, and this could conflict with the need to represent the district level organisations. Strikingly, it was clear that the countywide voluntary organisations felt a greater sense of engagement in the process than the district level organisations.

This may also have been a function of the nature of the district. Although Wansbeck does have a number of very pressing social problems, they are in no sense typical of a rural area. The bid on behalf of a predominantly rural area concentrates on issues of isolation and rural poverty, and the district voluntary organisations have less of a role to play in meeting these needs. So any consideration of voluntary sector engagement needs to be tempered by an understanding of the different social problems this particular Health Action Zone is seeking to influence.

Attitudes of the statutory sector

The meeting with representatives from various statutory partners reflected the view that voluntary organisations are not seen as central to delivery. Those we interviewed found it hard to identify a particular function for voluntary organisations within the programme, except as organisers of patients' groups on particular conditions. Most notably they did not identify the voluntary sector as a sector, but rather spoke about the role of the individual voluntary organisations with which they have dealings.

In common with Luton and Sandwell the emphasis, and enthusiasm, was for high levels of public engagement. For this they did not see the voluntary sector as having a particular contribution to make, and indeed felt that individual voluntary organisations were not as committed to public engagement as they might be.

Key findings

- The Wansbeck voluntary sector is enthusiastic and keen to play in improving conditions in the locality.
- Although well developed in many aspects, it is not an experienced sector in terms of negotiations with the statutory sector.
- This lack of experience is exacerbated by the fact that Wansbeck is a relatively urban district within a largely rural county
- Nevertheless it is noticeable that both the written material, and the officials interviewed, do not envisage a significant role for the voluntary sector.

Appendix 2

List of people consulted

Luton

Val Bell	Luton Health Action Zone
Tina Bryant	South Bedfordshire Community Health Council
Sandy Dallimore	Voluntary Action Luton
Duncan Eaton	Bedfordshire Health Authority
Steven Goodman	Luton Borough Council
Sara Harvey	Luton Primary Care Group
Sarita Jain	Luton Citizens Advice Bureau
Clive Leach	Luton Borough Council
Bob Nessling	Luton Health Action Zone
David Pope	Luton Borough Council

Also a meeting at Voluntary Action Luton attended by a number of voluntary organisations

Sandwell

Mike Allen	Age Concern
Malcolm Bailey	*Murray Hall*
Patricia Brumont	*Sandwell SEMUF*
Marie Carroll	*Sandwell NHS Trust*
Sophia Christie	*Sandwell Health Action Zone*
Gill Combes	*Oldbury & Smethwick Primary Care Group*
Marion Drinkwater	*Sandwell Health Authority*
Leoner Gardner	*Sandwell Council of Voluntary Organisations*
Polly Goodwin	*Sandwell Council of Voluntary Organisations*
Bob Lloyd	*Tipton Action Group*
Neil Lockwood	*Sandwell Health Authority*
David Martin	Sandwell Metropolitan District Council

Wansbeck

Sheila McGuckin Wansbeck CVS
who arranged a meeting of several voluntary organisations