Evaluating the evaluation: Understanding the utility and limitations of evaluation as a tool for organizational learning

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Abstract

Objective Organizational learning, underpinned by evidence-based health care, and greater user involvement in planning and delivery were key objectives of the NHS Plan. Evaluation, and specifically participatory evaluation, offers the potential to address these elements of the NHS modernization agenda. We discuss the strengths and limitations of evaluation in delivering the modernization agenda through use of a case study – the evaluation of a Healthy Living Centre project, catchon2us!

Setting A Healthy Living Centre project in Merseyside.

Results There was evidence that collaborative research can promote opportunities which foster significant learning and change, thus making the effort and time involved worthwhile. However, the two-way flow of information necessary for development of shared goals and learning at strategic, as well as provider, levels is not easily achieved. Barriers include the rigidity of organizational structures within large agencies such as the NHS, with priorities imposed from national levels overriding local priorities.

Conclusions The inherent contradictions in current strategic drivers in the NHS need to be addressed if services can ever deliver the goal of true organizational learning.

Key words: evaluation, Healthy Living Centres, NHS modernization, organizational learning
Introduction

The NHS Plan laid down the government’s commitment to modernizing the NHS. Key principles driving the changes included a greater emphasis on evidence-based health care, user involvement in all aspects of health services planning and delivery, and developing links with partner agencies. Education and learning are fundamental to the change processes needed to deliver the ambitious targets of the NHS plan, both at the level of individual care settings and at an organizational level. Developing the NHS into a ‘Learning Organization’ is central to meeting the Government’s aim to create an NHS which encourages innovation, learns from its past and therefore meets the targets of the NHS Plan.

Under the government’s plan, health care provision from the level of the individual patient to organizational management should be supported by research evidence. Yet translating research findings into practice is not without problems. Dash et al report that researchers feel frustrated that their work is not used to influence policy, but managers argue that research is not relevant to their needs. Policy makers question the timeliness of research in the decision-making process. Finding common ground between providers, users and funders of research is necessary if evidence-based health care and policy is to work in practice.

A variety of tools are being promoted to support the new modernization agenda. These include evaluation; especially evaluation of policies and strategies which involve the introduction of new initiatives to promote change. In this article, it is proposed that evaluation, and specifically participatory evaluation, offers the potential to address many elements of the NHS modernization agenda: contributing to an evidence base, promoting a learning culture and potentially integrating stakeholder perspectives. Using a case study of an evaluation of a local Healthy Living Centre project, we review the evaluation process. We discuss the potential benefits but also the barriers to this approach, which in turn highlight the contradictions within existing strategies for the NHS.

Principals of evaluation

Evaluation is a contested term. Some researchers talk of evaluation when they simply mean investigation, but a common view in health care settings is to regard evaluation as being synonymous with assessment of performance. Thus St Leger and Walsworth-Bell have defined evaluation as ‘the critical assessment in as objective a manner as possible, of the degree to which a service or its component parts fulfils stated goals’ (p.116). St Leger and Walsworth-Bell see evaluation as an information-gathering process to provide ‘objective knowledge’ about how a service has performed when measured against predetermined, often externally set targets.

However, in other disciplines (including health promotion, community development and the social sciences) evaluation of projects is understood to offer more than a monitoring function that focuses on measurable absolutes. Stufflebeam defines evaluation as ‘a study designed to assist some audience to assess an object’s merit and...’
worth’8 (p.11). This approach acknowledges that evaluation deals not only with ‘facts’, but with value-laden concepts of ‘worth’. Projects, evaluators and other stakeholders (including funders) will all have potentially different ideas about how best to evaluate a project since each may have a different definition of ‘merit’9. The core of the problem is thus about defining what is of value.

**Tools of evaluation**
The use of evaluation as a tool for organizational development is still a relatively new concept in the United Kingdom. Experience in the United States is further advanced, and a number of models of evaluation have developed9–12. These can arguably be placed on a continuum from the traditional models encapsulated in St Leger and Walsworth-Bell's definition7 (arguably more like project monitoring) to participatory and empowerment models10–13. The latter emphasize an iterative process of experience-reflection-action (based on Kolb's learning cycle14) and involve all stakeholders in the learning and development process. Participation seeks to ensure that the process meets the needs and reflects the experiences of all stakeholders, thus creating an evaluation and learning process that can be sustained15. Learning is fostered at all levels – from staff and clients at the frontline to strategic decision-makers. If effective, the process of working to develop shared understanding of, and approaches to, the evaluation (including defining merit) requires that all voices are heard. This may therefore contribute to promoting the two-way flow of information between strategic/management levels and grassroots that is sought in mature organizations, including the NHS5.

Such participatory approaches are not without problems. They are more time-consuming and resource-intensive, and conflicting value systems become more evident9. Some have also raised concerns that an emphasis on participation, empowerment and learning may result in less attention to objectivity16,17. It has been argued that a shift in focus towards learning represents a confusion of role that prevents the necessary scientific, objective study. Nusbaumer warns of the risk of turning objective data collection and analysis into a public relations exercise that presents untested assumptions as fact16.

Yet the potential for contributing to bridging gaps between strategic/management levels, service providers and service users is huge, and also greatly needed4,18. The individual learning from a participatory approach can be a powerful health promotion tool in itself13, and may also help to motivate staff. But it will only work if the powerful organizations (such as strategic bodies) want to empower others (including service providers/users), and if the latter are able or willing to take on the responsibility19.

**Case study: Evaluation of a Healthy Living Centre project**
To explore these issues further, we present a case study: the evaluation of a local Healthy Living Centre (HLC) project, catchon2us! The Healthy Living Centre programme was established in 1999 as part of the Government’s broader agenda to promote and improve...
health. Funding came from the New Opportunities Fund (NOF) and the initiative involved many of the core elements outlined in the NHS Plan. Requirements included local involvement in all aspects of development and delivery of services, joint working between local agencies including the NHS, and evaluation of individual HLC projects to provide an evidence base. In 2001, an evaluation of the whole Healthy Living Centre programme, to be led by the Bridge Consortium, was also announced. As well as monitoring health impacts and key programme objectives (including quality of partnership working and sustainability of projects), it also aimed to evaluate the evaluations: to identify developmental needs and support tools for a project level approach to evaluation.

Existing projects which potentially met the HLC programme aims could bid for funding: catchon2us! was one such project. Here we review the project evaluation process, focusing on the benefits and weaknesses of participatory evaluation, and discuss their relevance for the government’s strategic aims for modernizing health services.

**Introduction to the project and its learning culture**

Catchon2us! was a community project established by local people in Merseyside. It consisted of 12 therapeutic care workers (all long-term unemployed people from the local community who were trained up by the project) and a manager. The project provided a package of care, including a number of complementary therapies (see Figure 1), aiming to address the individually defined health needs of fellow residents. The emphasis was on improving the quality of life of local people, including development of skills and confidence in self management. With staff and clients living locally, the project sought to promote development of both individuals and the local community. This emphasis on the collective offered potential to develop social capital: the ‘glue’ that holds communities together, and which is critical for sustainable human development and health. Figure 1 summarizes the overall project approach, although it is recognized that individuals may follow a less linear path than the one depicted.

Thus the emphasis was on learning; supporting a process of personal development and empowerment of the individual, aiming to produce autonomous adults who operate to their fullest potential and take responsibility for their own decisions, but also learning and development of the project and the community. At catchon2us! weekly staff meetings underpinned by reflection on the experiences of the week were fundamental to both the philosophy and developmental learning of the staff and project. Learning for clients emphasized empowerment through acquisition of knowledge and skills together with promotion of autonomy. Clients were also encouraged to be involved in the development and running of the project, thus promoting Step Three of the model shown in Figure 1.

**Developing the evaluation protocol: The participatory approach**

Catchon2us! was granted HLC status on condition that the project undertook a formal evaluation of its work – to be supported by Liverpool Health Authority and the...
Regional Health Authority (RHA). The project had always embraced an evaluation culture. From the outset, they collected data on clients’ experiences of using the service; used to inform development of the project through reflective learning. A participatory evaluation model therefore captured the spirit of this project as well as the broader HLC programme aims.

An Evaluation Working Group was formed in April 2001, consisting of representatives from the project staff, users, local academics, Public Health and the Health Authority (also acting on behalf of NOF), the City Council and a local GP. Stakeholder representatives were identified by the project (those delivering/using the service), the Health Authority (responsible for wider service planning) and NOF (the funders of the service). Conflicting value systems leading to contrasting priorities for the evaluation quickly became evident: for example, the need to focus on the community development aspects of the project versus its impact on local NHS service use. Competing priorities created by the reorganization of local NHS management structures at the time also contributed to difficulties in getting all stakeholders engaged in the process of developing the evaluation protocol. Feedback on development of the evaluation protocol from key organizations such as the RHA and the NOF was often delayed. After much debate between all parties, aims and objectives for the evaluation were agreed (see Box 1). However, with time running out, the agreement was primarily made from necessity rather than a true sense of shared aims.

The finalized protocol was eventually signed off by NOF in February 2002, 10 months after work began. Data collection began the following month. The protocol had three strands in an attempt to meet the needs of all parties: a qualitative evaluation of clients’ experiences, a quantitative survey of change in quality of life scores, and a participant observation study of the processes and outcomes of one aspect of the therapeutic work of the project (therapeutic group workshops). The aim of this

**FIGURE 1** The *catchon2us!* model

<table>
<thead>
<tr>
<th>STEP ONE:</th>
<th>LEARNING and training for clients and staff</th>
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<tbody>
<tr>
<td>Use of the <em>catchon2us!</em> tool bag*</td>
<td></td>
</tr>
<tr>
<td>STEP TWO: Increased quality of life including empowerment and raised awareness of skills and abilities</td>
<td></td>
</tr>
<tr>
<td>LEARNING of clients and communities**</td>
<td></td>
</tr>
<tr>
<td>STEP THREE: Community empowerment and ability to implement change</td>
<td></td>
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</tbody>
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*Tool bag includes shiatsu, massage, aromatherapy, qi gong, reflexology, stress awareness and skills in facilitation

**Includes staff who are members of that community (development of social capital)
The tripartite method was to capture different perspectives and to allow triangulation to add to validity and rigour. Having been instrumental in developing the evaluation protocol, a client steering group assisted in establishing the focus of the evaluation questions. Catchon2us! staff actively took part in data collection and interpretation of findings. External evaluators (including DP) worked with the project and the Health Authority (including JR) to undertake the work.

**Learning from the evaluation: Achievements**

The details of the outcomes of the evaluation are described in the final evaluation report. A key aim was to learn from the evaluation process and to understand how evaluation could contribute to future learning for all stakeholders in the project. It is this aspect that we focus on here.

At the outset, the catchon2us! team believed the evaluation could add little to their existing learning and evaluation mechanisms; the evaluation was largely viewed as a necessity to provide more formal and comprehensive evaluation to satisfy funders. However, despite an initial anxiety and sense of vulnerability, the team found the participatory approach fitted in with, and contributed to, their personal learning styles. The further opportunities for reflection and learning contributed to personal and practice development. There were some practical difficulties with data collection interfering with normal working patterns, but overall there was a positive response to the process together with evidence of motivation of staff to further develop the evaluation process.

Clients also reported predominantly positive experiences of being involved in being able to ‘give something back’ to the project, but also showed evidence of a deeper learning. One client reported a therapeutic benefit from the reflection process stimulated by completing the quality of life questionnaire. A client group was established to help with the development of the evaluation – in setting aims and objectives as well as guiding data collection and analysis. It could be argued that such involvement was another example of catchon2us! operating at Stage Three in the model in Figure 1, albeit as yet in only a subgroup of its client population. The project provided evidence of the health promotion effects of involvement in evaluation.

The external evaluators also gained much from the process: in the development of skills and knowledge of evaluation and local health services, in the benefits and

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**BOX 1  Aims of the evaluation of the catchon2us! project**

1. To demonstrate whether catchon2us! can address unmet health needs of people from deprived communities.
2. To demonstrate whether catchon2us! promotes a positive definition of health, focusing on empowerment and perceived control, emotional health, and self-defined quality of life.
3. To act as a pilot study – developing the methodology for further evaluation of the community development approach to improving health.
frustrations of participatory research and of the realities of health services research against a background of competing political priorities.

**Learning from the evaluation: What didn’t work**

However, whilst the ‘grassroots’ learned from the evaluation process, this failed to translate into learning at strategic levels – notably for the decision-makers. Key organizations such as the RHA and the NOF had largely disengaged from the process near the outset. The final reports were sent to a number of agencies, but neither the project nor the evaluators received any feedback. The evaluation met standards laid down by the Joint Committee on Standards for Educational Evaluation, providing robust evidence that catchon2us! was achieving the aims and objectives that had been funded by NOF, and that it was also of merit and worth to the community. The evaluation engaged with clients, staff and evaluators, resulting in valuable learning for many at individual and organizational levels. But the evaluation and its findings failed to engage with strategic decision-makers – to promote learning about both evaluation and the merit of community approaches to health, and to secure ongoing funding for the project. Despite the attempted participatory approach, Dash et al’s observation of evaluation as leaving both researchers and managers frustrated, was once again borne out. The evaluation was unable to help bridge the gaps between strategic/management levels and service users and providers. The two-way flow of information necessary for organizational learning was not achieved.

**Why was the evaluation unable to contribute to wider organizational learning?**

In understanding why the evaluation was unable to deliver the hoped for learning, it is useful to consider Berkeley and Springett’s distinction between barriers and constraints. A constraint is something which is ‘temporary, or subject to change or interpretation’ (p.180); barriers are things which are ‘relatively inflexible and difficult to overcome’ (p.180), stemming from ‘fundamental forces operating in society over a period of time’ (p.181).

A key problem was the failure to establish shared priorities and aims; arguably the result of time pressures and competing priorities. Despite considerable effort spent on setting up the evaluation project, the strategic and grassroots levels had not achieved a shared understanding of what would be considered ‘of merit and worth’. A truly collaborative approach above all takes time. This evaluation project was undertaken at a time of major upheaval in the NHS. It was perhaps unrealistic to expect a model that required flexibility and compromise to work at such a time. The agreed evaluation aims (Box 1) were arguably over-ambitious; but the project (and perhaps the strategic levels) also had other aims. catchon2us! believed that evaluation (and evidence of effectiveness) would help secure funding; something that was not explicit in the project aims. Issues such as the delayed responses identified previously, and transparency of aims are
arguably constraints which could have benefited from, for example, approaches such as the development of a written contract between all stakeholders.

However, there were also significant barriers. The whole evaluation was a compromise between the cultures and ideals of three very distinct organizations – catchon2us!, NOF and the NHS. Catchon2us! staff reflected on the frustrations of attempting to collaborate with the rigid, vertical management structures in NOF and the NHS – a model that was in stark contrast to the horizontal organizational structure that was at the heart of both the catchon2us! philosophy, and arguably its success. The project team felt that all the compromise had come from them; perhaps because the project was better able to accommodate the flexibility required by a participatory approach compared with the larger and more rigid structures of the bigger organizations, which demand predictable evaluation frameworks over more emergent ones.

The structure of the NHS may be, as yet, an unmovable barrier. However, others are perhaps more potentially open to change. For example, the failure to establish shared priorities and aims also came from competing priorities: a truly collaborative approach above all takes the ability to compromise. External pressures on strategic organizations limited their capacity to make meaningful compromise. Whilst Government urges local strategic organizations to engage local users and service providers in decision-making, simultaneous external priority-setting limits their ability to do so in practice. An environment of short-term funding is also a further barrier. The need for projects to secure funding from strategic bodies skews the balance of power, making shared learning difficult if not impossible. Stephen Dunmore (Chief Executive of NOF) commented that even if 40 per cent of HLCs close, he would still regard the programme as a success. Gosling, commenting on the wider HLC programme, stated that it is ‘of huge concern’ that whilst evaluation shows that HLCs are meeting the health objectives set out by the Government, there is no requirement for NHS organizations to continue to fund the work once Lottery funding ends. How realistic is it to truly engage stakeholders for whom sustainability is not their responsibility?

Stufflebeam states that ignoring difficulties created by conflict between clients, evaluators and decision-makers in terms of their different perceptions of an evaluation means a project will inevitably fail. Constraints may be addressed by the research process; overcoming barriers requires debate and change at a strategic, rather than a project, level.

**Identifying barriers: Implications for service development and evaluation policy**

At present there are many health care initiatives that seek to encourage change, but face difficulties in encouraging strategic thinkers to recognize their worth. Longer-term funding tends to go to projects that meet centrally driven targets and offer a more traditional evaluation process in line with that outlined by St Leger and Walsworth-Bell. Yet this potentially results in loss of valuable learning for all parties.
The evaluation of catchon2us! showed that a participatory evaluation model can offer more than just information gathering. It is a potentially powerful learning tool supporting individual and organizational learning and development. It is possible to produce objective, validated data using participatory approaches. It can help in defining merit and worth, at least from the perspective of some stakeholders, although this is time consuming and needs proper resources.

But this evaluation failed in that it was unable to contribute to, and promote, a sustainable learning model which worked across all levels of the organizations involved. Failure was not the result of anxiety or resistance from the project members, who embraced the opportunity. Instead, it was the result of an insurmountable challenge to engage with those stakeholders at strategic levels. The PCT blamed competing NHS priorities. NOF argued that sustainability was not their problem.

Should we question the NHS commitment to organizational learning? Ultimately, processes that are designed to promote autonomous individuals have the potential to conflict with target-driven management processes. In a review of the HLC initiative (including catchon2us!) in the Guardian newspaper, Derek Campbell, Chief Executive of Central Liverpool PCT, said: 'Unfortunately we are not in a position to offer PCT funding to this project ... We have many competing NHS priorities ... including tackling heart disease [and] improving access'. Yet the priorities which act as potential barriers to collaborative developmental work come from the same source which states that collaborative working is both desirable and necessary.

If the learning from such evaluation is to contribute to true organizational development and NHS modernization, mechanisms are needed to ensure that learning translates upwards as effectively as current management philosophy is being imposed downwards. Senior management staff need to be supported in taking risks such as supporting projects like catchon2us! - which do not directly contribute to immediate targets, but have the potential to make valuable contributions to the broader 'health' of our local communities, as well as learning about service development. Furthermore, there needs to be a greater focus on medium-to-long-term thinking, rather than the 'projectism' of current health agendas. The process of supporting short-term projects then leaving them potentially to flounder results not only in the loss of innovative services that have the potential to address need, but also the learning from, and long-term development of, those projects. Evaluation is about long-term learning.

Our case study provides empirical support for Denis and Lomas’ assertion that collaborative research can promote learning opportunities which foster significant organizational learning and change, thus making the effort and time involved worthwhile. It is proposed that greater use of collaborative research approaches could lead to research better suited to solve the practical problems faced by health service planners, users and staff. However, our case study also demonstrated that the two-way flow of information necessary for development of shared goals and learning at
strategic as well as provider levels is not easily achieved. Barriers include the rigidity of organizational structures within large agencies such as the NHS and NOF, with priorities imposed from national levels overriding local priorities.

**Conclusion**

Researchers can work with projects to overcome some of the constraints affecting evaluation research, for example through the greater use of contracts. Ultimately, however, barriers resulting from the inherent contradiction in current strategic drivers in the NHS need to be addressed if services can ever deliver the goal of true organizational learning.

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