UNTAPPED POTENTIAL:

Bringing the voluntary sector's strengths to health and care transformation

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April 2016

The
Richmond
Group
of Charities

FOREWORD FROM THE
DOING THE RIGHT THING PARTNERS

In October 2014 the NHS Five Year Forward View (5YFV) set out an ambitious agenda for the future of health and care in England. Its vision—of making our health and care system more person-centred, more embedded in our communities, and more effective at promoting health and wellbeing, rather than merely patching people up when things go wrong—is one we share. What's more, we believe that leading health and care charities have the right tools and expertise to help make it a reality.

The *Doing the Right Thing* project was borne of our determination to seize the opportunity of the 5YFV. In bringing together some of our evidence, we aimed to show that the Voluntary and Community Sector (VCS) is not just doing *the right thing* by its beneficiaries, but also *what works* to deliver the improvements in health & wellbeing and in productivity & efficiency that the health and care system now so desperately needs to replicate at pace and scale.

However, while the need for transformation becomes ever clearer, worrying signs have emerged that the full potential of the VCS has yet to be tapped.

In bringing together this evidence, for the first time, we have demonstrated powerfully the expertise and experience we can bring to bear. We have also articulated the breadth of work we do, the unique ways in which we do things, and the added-value that our sector brings to the health and care system.

Now we want to share this evidence, the new frameworks we have developed, and the insights we have uncovered with our colleagues across the health and care system. We hope that this will help to bridge the cultural gaps between sectors that can hamper relationships, and connect with leaders across the health and care system who already looking for new and sustainable solutions.

The great news is that this research has confirmed that there is a shared agenda across sectors in the health and care system.

We all want: more doing with people who use health and care, and less doing to; more prevention alongside the cures; more emphasis on people, and less on patients.

We have listened to what our statutory partners in the health and care system have told us about how we can work with them more effectively. And we will debate these findings with our colleagues in the wider VCS, to grow the evidence of the contribution we make to the health and care system, and to speak with a more coherent voice that is easier for our statutory partners to hear.

Next we want to hear from leaders in the health and care system about how they will respond to the challenges we have identified for them. We need their help to pave the way for our increased involvement, so that together we can wrap support around people in ways that work for them.

We look forward to hearing people's thoughts and to contributing to our future health as a nation.

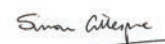**Michael Adamson**
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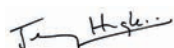
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Diabetes UK

Jon Barrick
Stroke Association

Kay Boycott
Asthma UK
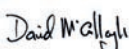
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Mind

Simon Gillespie
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Jeremy Hughes
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David McCullough
Royal Voluntary Service

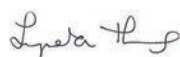**Michelle Mitchell**
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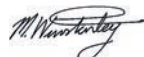
Delyth Morgan
Breast Cancer Now

Liam O'Toole
Arthritis Research UK

Duncan Selbie
Public Health England

Lynda Thomas
Macmillan Cancer Support

Mark Winstanley
Rethink Mental Illness

Penny Woods
British Lung Foundation

Tom Wright
Age UK

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EXECUTIVE SUMMARY

The health and care system is in a state of flux. Ambitious efficiency targets and rising need are forcing the NHS to find new ways of working. Integration is a watchword, and change is happening— including through Vanguard Sites and devolution.

The NHS Five Year Forward View outlines an ambition to harness the 'renewable energy represented by patients and communities'. Charities have a role to play here, with the Forward View also identifying the need for stronger partnerships with the charitable and voluntary sector.

The changes we need will not happen at the scale and pace required naturally. **The voluntary and community sector (VCS) needs to make a strategic case for its inclusion in the design and delivery of the future health system.** The Richmond Group of Charities and its partners commissioned charity consultancy and think tank NPC to undertake research to provide the evidence needed to support this.

The issues

The charity sector has evidence of its effectiveness in improving outcomes in the health and care system, but this is fragmented and poorly understood.

The health and care system doesn't always see the breadth of what the charity sector can offer, and how this is relevant.

The charity sector struggles to articulate what it can offer in a way that resonates with the health and care system.

The health and care system instinctively recognises that charity sector approaches are essential for achieving outcomes, but doesn't effectively communicate this.

The potential

If health and social care decision-makers have a clear understanding of the charity sector's evidence in relation to their priorities, the charity sector can be more involved in **developing and delivering better health and care services**—which will support better outcomes for people and communities.

The approach

Creating a shared language

To facilitate consistent messages that resonate with both charities and health and care system.

Assessment of evidence

To see the strength of the evidence base across the charity sector and demonstrate which activities add value.

Aggregation of findings

Integrating the VCS offer

To support faster progress through the creation of joint solutions in the context of austerity.

The priorities of the **Five Year Forward View** have been central to all aspects of the research and analysis:

Health & wellbeing

Productivity & efficiency

Resilience & cohesion

What is the role of the VCS in health and care?

The research revealed striking differences in perceptions of the role the VCS can play and the value it can bring to health and social care—the breadth and depth is not always understood.

We developed frameworks for a shared language, to help charities describe their work and its value, and give commissioners and policymakers a way to identify the aspects of charities' work that most clearly match their needs and priorities.

What do charities do?

While the value of the charity sector is often thought of solely in terms of the role it plays supporting individuals, much of the value it adds is at the system level.

Supporting the individual

- Direct treatment and support
- Engaging people in keeping healthy
- Supported self-management
- Involving families and carers
- Integrating and coordinating care
- System redesign
- Support for health and care professionals

Supporting the system
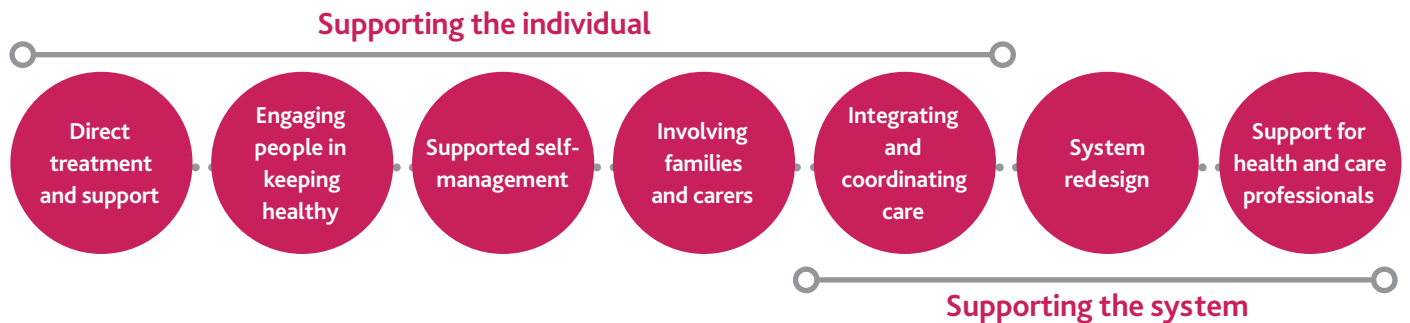
Where in the care pathway do charities help?

As well as supporting people at each stage of the patient pathway (and often across pathways), the work of the charity sector also relieves pressure in the health and care system across settings.

System

- Primary (community)
- Primary (statutory)
- Secondary / tertiary
- Emergency

Patient

- Diagnosis
- Living with a condition
- Escalation
- Crisis
- End of life
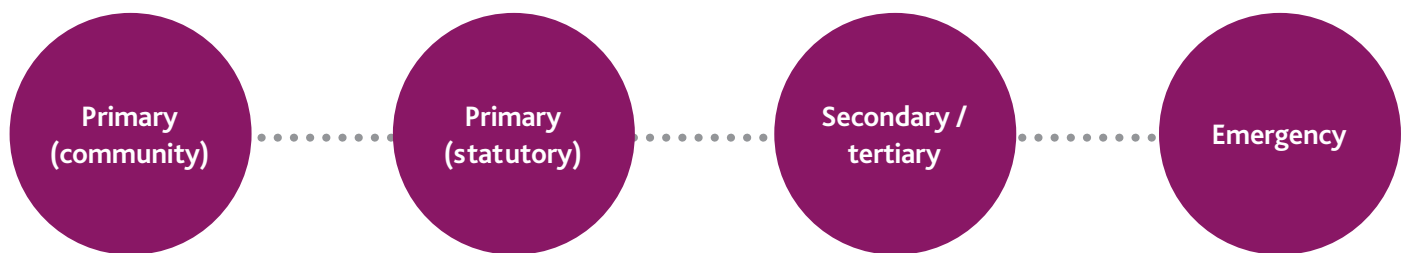
How do charities work?

The value offered by charities goes beyond simply the activities that they deliver and the outcomes they achieve. Instead, much of the charity sector's value comes from *how* charities deliver services. This needs to form part of the narrative about the role of charities in health and care.

- Listening to patient voice and co-producing services
- Collaborating and brokering engagement
- Taking a holistic perspective
- Finding solutions through user-focused research
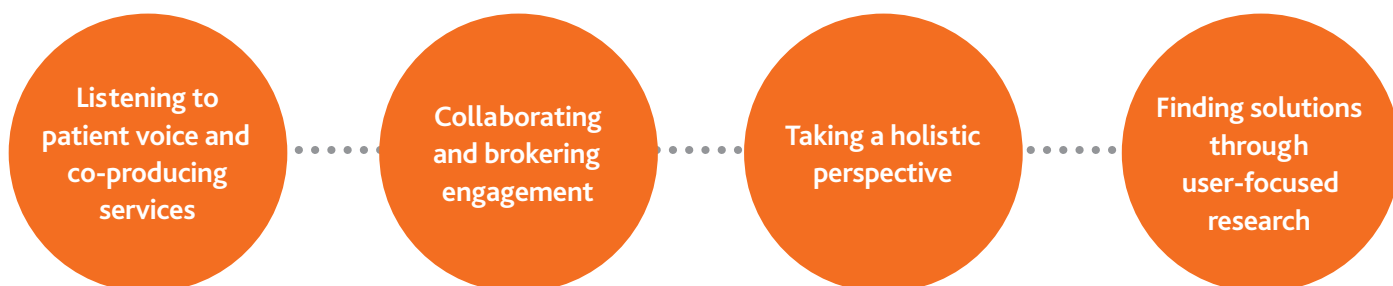
What additional value do charities bring to the system?

There are concepts particularly associated with charities that set them apart from other types of providers.

- Brand and credibility
- Positioning and reputation
- Flexibility and innovation
- Access and reach
- Leveraging additional resources

What is the evidence to support the health and care system's increased engagement with the VCS?

The evidence review was designed to find examples of strong evidence and summarise evidence across a broad range of organisations, activities, issue areas and evaluation approaches.

It was not designed to be comprehensive and cannot identify gaps in the evidence base. The review is also not representative of health charities as a whole: the evidence review only assessed the work of project partners—a group of large, national charities.

Characteristics of the evidence

From our evidence review, we identified 175 findings—the majority of which related to health & wellbeing.

62%
Health & wellbeing

22%
Productivity & efficiency

16%
Resilience & cohesion

88%

of the findings reported an overall **positive impact.** None reported a negative impact, 3% were neutral and 9% were mixed.

44%

of findings were assessed as using **high quality evaluation approaches** (mixed methods, comparative approaches or RCTs).

Strength of evidence across areas of work

	Health & wellbeing	Productivity & efficiency	Resilience & cohesion
Direct treatment and support			
Engaging people in keeping healthy			
Supported self-management			
Involving families and carers			
Integrating and coordinating care			
System redesign			
Support for health and care professionals			

Stronger evidence   Weaker evidence
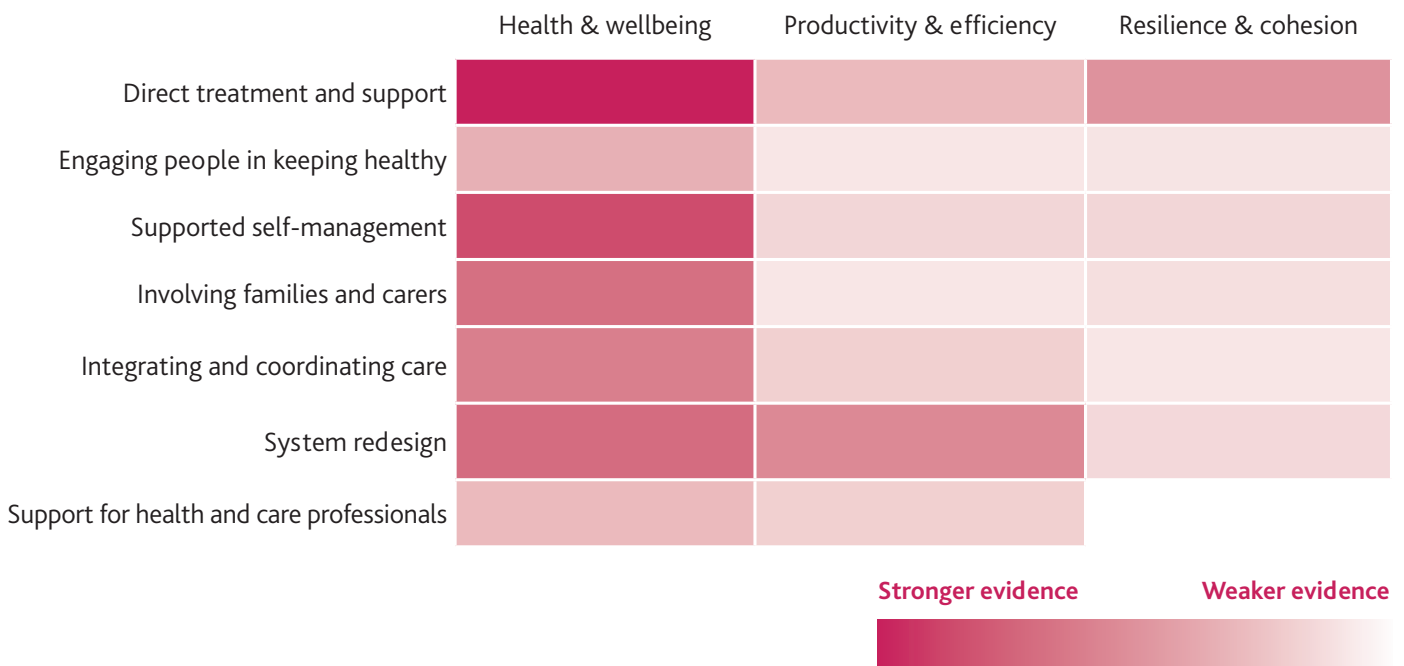
There is **strong evidence** that charities achieve health & wellbeing outcomes through direct treatment and support and supported self-management.

There is **good evidence** that charities deliver health & wellbeing and productivity & efficiency outcomes through system redesign.

71%

of cases targeted multiple points in the **patient pathway.**

48%

of cases targeted multiple points in the **system pathway.**

35%

of findings related to improvements in the way the **system functions.**

The evidence review shows that charities can add value to the health and care system in a range of ways, and have a legitimate role in the transformation of the NHS and the wider health and care system.

How can the VCS and the health and care system work together?

The relationship between charities and the health and care system is already changing. Clinicians and managers recognise the need to do things differently and the charity sector has started taking a more strategic role. We have identified a number of areas that could support this change to happen at a faster pace, with recommendations developed through qualitative research involving charities, commissioners and policymakers.

Our recommendations make clear that there is work to do for both charities and health and care system partners. However given that NPC is already engaging closely with charity partners, we have pulled out the priority actions for the health and care system.

Recommendations: Creating evidence-based solutions

The health and care system needs to:

- Enable and support good evaluation—rather than simply demanding it—through data sharing and investment in scaling effective approaches.

The charity sector needs to:

- Collect and manage data in a way that is useful to partners.

Priority action
Check that evidence standards are not a barrier to testing new approaches, and be pragmatic about the evidence required.

Recommendations: Properly integrating the VCS offer in health and care

The health and care system needs to:

- Draw on the strengths of the VCS in reshaping the NHS.
- Ensure more consistent representation of charities in bodies leading transformation efforts.

The charity sector needs to:

- Find a set of 'good enough' common messages and coordinate the way these messages are communicated at both a local and national level.
- Be clear where individual organisations have strengths and where others can add more value.

Priority action
Incorporate the VCS perspective into decisions about health and social care at a national and local level. Seek out existing forums through which to do so, or create them where they don't exist.

'The statutory sector cannot fully meet needs without engaging the voluntary sector. They're absolutely crucial in knowing what people at the grassroots need.'

Helen Walker, Deputy Director for Equity and Communities, Department of Health

Recommendations: Making progress within austerity

The health and care system needs to:

- Ensure funding and contracting arrangements support collaboration between charities and other providers, and minimise the burdens on providers.

The charity sector needs to:

- Be wary of 'asking for more' in a resource-starved system. Frame conversations in terms of added value, not just the resources required.

>> **Priority action**
Review commissioning and procurement processes and consider how they could be made less adversarial.

Our current model of health and care is unsustainable and this presents an unprecedented opportunity to redesign systems to focus on holistic, integrated, preventative and person-centred care. This research shows that **charities can add value** to the health and care system in a range of ways.

But to make the changes required a reality means both the VCS and the statutory system shifting their behaviour, with a sense of urgency. By fully understanding each other's needs and priorities, and by making small compromises, partnership between charities and statutory organisations can **build a health and social care system which is sustainable and fit for purpose**.

'*The NHS is beginning to recognise that health is about more than just health care and living longer—it's about living with good health, and that's affected by a much broader array of factors.*'

Duncan Selbie, Chief Executive, Public Health England

INTRODUCTION

Background

NPC was commissioned by the Richmond Group of Charities and a wider group of partners to conduct this research as part of the *Doing the Right Thing* project. The project emerged from a belief that the charity sector has evidence of its effectiveness in improving outcomes, but that this evidence is fragmented and poorly understood. If the evidence about the charity sector's contribution could be better understood by potential partners in the health and care system, it would facilitate a greater involvement of the charity sector in developing and delivering better health and care services.

In the context of conversations about the design of the future health and care system, the aim was to ensure that the value offered by the Voluntary and Community Sector (VCS) was well understood—by charities themselves and by statutory health and care system leaders. Articulating this value was important, to ensure that the VCS is included in and able to contribute to the design of future health and care services.

Through the initial phase of the project, assessing and aggregating the evidence held across the project partners, we confirmed that there are examples of strong evidence for the contribution of charities to the NHS priority outcomes of health & wellbeing and productivity & efficiency. However, as we shared these findings with partners within the health and care system, it became clear that while evidence is crucial, it is not the only barrier to more effective joint working.

One of the key barriers is the lack of a shared understanding of what the VCS offers the health and care system: What roles it plays in delivering services, and in generating ideas about how the system could work more effectively for patients; where within the system it adds value; and what—if any—are the key features of charities which allow them to achieve outcomes in a way that other providers cannot. In exploring these issues with stakeholders from across the health and care field, it became clear there was a lack of common frameworks for understanding and articulating what is important about the VCS and its role in health and care.

Through this research process we have heard strong encouragement that the door is open for greater charity involvement in the health and care sector, but the practical challenges in making this happen are substantial. This goodwill needs to be translated into action on the ground.

Who this report is for

This report is for everyone working in the health and care system in its widest sense—including statutory system leaders at national and local levels, health and care providers in the public, private and voluntary sector and interested commentators.

The evidence presented here will be of interest to those seeking to forge partnerships and commission services, the recommendations for action are aimed at statutory health and care system leaders, health and care commissioners, and voluntary sector leaders. While this research has drawn primarily on the evidence and experience of large VCS organisations,* it includes the views of health system leaders relating to charities of all sizes. Its recommendations will be therefore be relevant for national, local and federated VCS organisations.

Our recommendations make clear that there is work to do for both charities and health and care system partners. However given that NPC is already engaging closely with charity partners over the recommendations relating to them, we have pulled out the priority actions for the health and care system in each section of the report.

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* The partner charities range in size, from an income of a little over £6m to almost £290m. Nonetheless, all partners are large by the standards of the charity sector; data from the Charity Commission indicates that around 1% of all charities are operating at this scale.
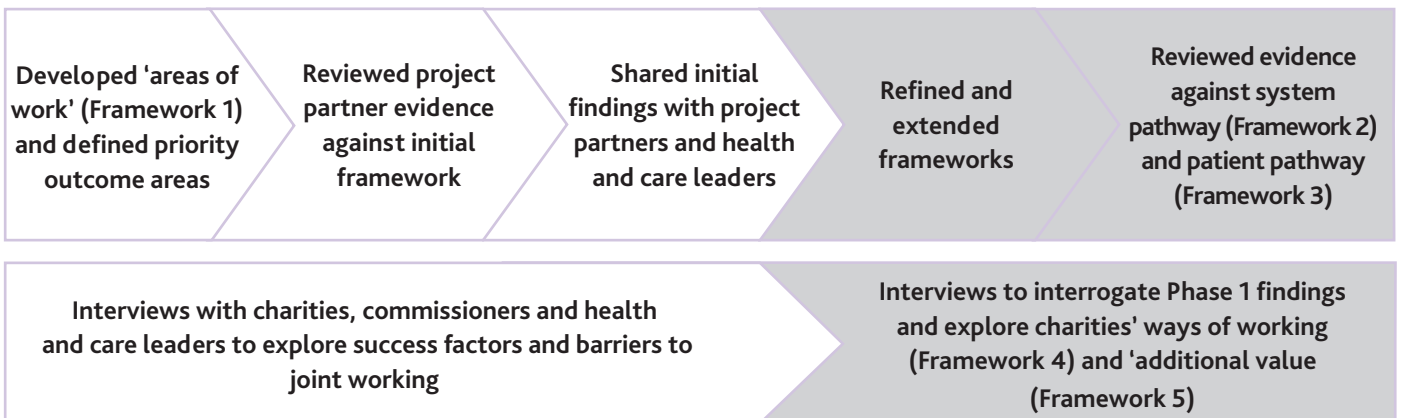
What you can expect from this report

- A series of frameworks designed to provide a shared language with which to describe:
    - The **breadth of charity activities** within the health and social care system.
    - The **value delivered by these activities** for people, communities and the system.
    - The **strength of evidence** to support that case.
- The application of those frameworks to a pool of evidence supplied by some of the UK's largest health and care charities to test the basis for deeper engagement between the VCS and the health and care system.

- Examples drawn from high-quality evaluations of VCS activities and their contribution to health & wellbeing, productivity & efficiency, and resilience & cohesion outcomes.
- Practical recommendations, based on qualitative research involving charities, frontline commissioners and system leaders, on: properly **integrating the VCS offer** into the future health and care system, **creating evidence-based solutions** that will help to bring about the vision set out in the NHS Five Year Forward View, and **doing so in the context of scarce resources.**

Our methodology

The research ran from July 2015 to February 2016 using the following methodology:

PHASE ONE   ## PHASE TWO

| Developed 'areas of work' (Framework 1) and defined priority outcome areas | Reviewed project partner evidence against initial framework | Shared initial findings with project partners and health and care leaders | Refined and extended frameworks | Reviewed evidence against system pathway (Framework 2) and patient pathway (Framework 3) |

| Interviews with charities, commissioners and health and care leaders to explore success factors and barriers to joint working | Interviews to interrogate Phase 1 findings and explore charities' ways of working (Framework 4) and 'additional value (Framework 5) |

There were three main strands to this research:

- **Framework design**—What is the voluntary and community sector's offer to the health and care system?
- **Assessment of project partner evidence**—Is there evidence to support increased engagement over the voluntary and community sector's offer to the health and care system?
- **Qualitative research**—How do we integrate this offer into the future health and care system?

Framework design focused on the entire VCS and was designed to create a language to communicate the common value that all charities can bring to the health and care system.

Similarly, qualitative research focused broadly on how the sector as a whole could be better incorporated into plans and discussions around system redesign.

The focus of the evidence review was less broad—considering only the evidence of project partners. This was designed to test the frameworks developed and to create the initial foundations from which to support deeper discussions between the statutory system and the VCS.

A full overview of the methodology can be found in Appendix A.

Context and priority outcomes

The NHS Five Year Forward View (5YFV)[1] identified **health & wellbeing** and **productivity & efficiency** as key outcome areas in which there must be improvement as the health service develops. **These outcome areas have therefore been central to all aspects of this research**. We have also focused on the broader value of charities, in their ability to unlock community assets, engage people and bring communities closer together (which we have called **resilience & cohesion**).

This research fits within a wider context of growing interest in how to involve the VCS in health and care system reform, including the VCSE review[2] being co-produced by the Department of Health, Public Health England, NHS England and voluntary sector partners; and the Realising the Value programme[3] led by Nesta and the Health Foundation.

Health & wellbeing

Productivity & efficiency

Resilience & cohesion

Research approach

Creating a shared language

This research developed a series of 'frameworks' for understanding how charities work in the health and care system. These were co-designed with charities and health and care system partners:

- **Areas of work:** What charities do—from helplines to pathway design.
- **The system pathway:** Where charities work in the statutory system.
- **The patient pathway:** Where charities help in the patient journey.
- **Ways of working:** How charities approach the interventions they deliver.
- **Additional value:** The difference between charities and other providers.

Assessment of evidence

We reviewed the evidence that was selected by project partners and categorised it against these frameworks alongside additional variables for analysis. In total 72 documents were included in this review. These documents related to 60 distinct projects, interventions or programmes that had been evaluated (referred to as 'cases' in this analysis).

Aggregation of findings

The objective of this research was to assess what the evidence submitted by project partners could tell us *collectively* rather than individually. We have therefore combined evidence to provide an indication of where and how the activities of project partners add greatest value for patients and the system in relation to the three priority outcomes above.

Integrating the VCS offer

This assessment of evidence was carried out in parallel to qualitative research—including interviews and workshops with charities, frontline commissioners and system leaders. While the evidence review provides a sense of *whether*, and in what areas, there is a foundation for increasing engagement between the VCS and the statutory health and care system; the qualitative research has allowed us to make recommendations for *how* this could be achieved in practice.

General definitions

Health and care system: is used in a broad sense, primarily to refer to the statutory system into which the voluntary and community sector seeks to make its contribution—that is the NHS and CCGs, in addition to local authority health and social care and public health. We recognise that the health and care system is not a single entity, but the drive to greater integration makes it important that all parts are included in the conversation about working with the charity sector. The research has been informed by perspectives from all parts of the health and care system, but it has not been practical to distinguish differing implications for different audiences within this report.

Voluntary and community sector (VCS): the evidence review specifically covers evidence from the project partners— ie, a group of large health and care charities. But a much broader coalition of VCS organisations have an interest in health, and there is an increasing recognition that promoting good health means taking action beyond the medical, and addressing the social determinants of health. For this reason, in most cases, we discuss charities or the VCS without specifying the narrower 'health and care charities.' However, some messages do have particular resonance for charities with an exclusive focus on health and care, or a particular condition. In this case we use the terminology 'health and care charities.'

This research has not specifically addressed the role of social enterprises and community interest companies in the health and social care system. We therefore refer specifically to the role of charities in our recommendations. However, based on NPC's broader research we believe that there is considerable overlap in recommendations for these two groups.

Outcome area definitions

Health & wellbeing: health is a positive concept, not merely the absence of illness, and wellbeing covers physical, mental and social state of being comfortable, healthy and happy. Health and wellbeing is one of the three 'gaps' defined in the Five Year Forward View, which states that *'if the nation fails to get serious about prevention then healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions on wholly avoidable illness.'*[4]

Productivity & efficiency: this outcome covers a range of different types of findings related to the efficient use of resources or cost savings (although not always cashable savings). 'Funding and efficiency' is one of the key gaps identified in the Five Year Forward View, which states that if efficiencies can't be found, *'the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.'*[5]

Individual and community resilience & cohesion: this research has also focused on the broader value of charities, in their ability to unlock community assets, engage people and bring communities closer together ('resilience & cohesion'). This outcome could be seen at an individual level (for example a person becoming more resilient in the face of setbacks), or at a community level (for example, a community responding collectively to challenges). The focus of the Five Year Forward View on prevention indicates that this outcome will become increasingly important to the health and care system.

What is the voluntary and community sector's offer to the health and care system?

A SHARED LANGUAGE

This research revealed striking differences in people's perceptions of the role the VCS can play and the value it can add to the health and care system. To address this we developed the frameworks below through consultation with VCS and health and care system partners (see Appendix B).

These frameworks are designed to provide a shared language for charities to describe their work and its value—facilitating consistent messaging using language that resonates with both charities and system partners—and to give commissioners and policymakers a way to identify the aspects of charities' work that most clearly match their needs and priorities.

Each of the frameworks is analysed in further detail on pp. 22–34.

What do charities do?

| Direct treatment and support | Engaging people in keeping healthy | Supported self-management | Involving families and carers | Integrating and coordinating care | System redesign | Support for health and care professionals |

Where in the care pathway do charities help?

System
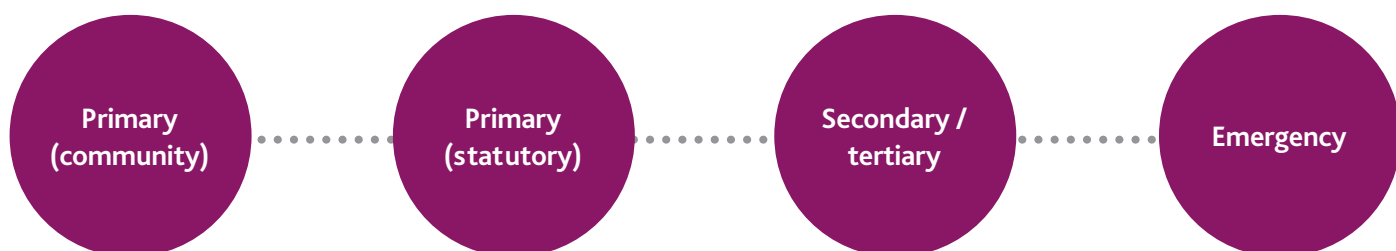
| Primary (community) | Primary (statutory) | Secondary / tertiary | Emergency |
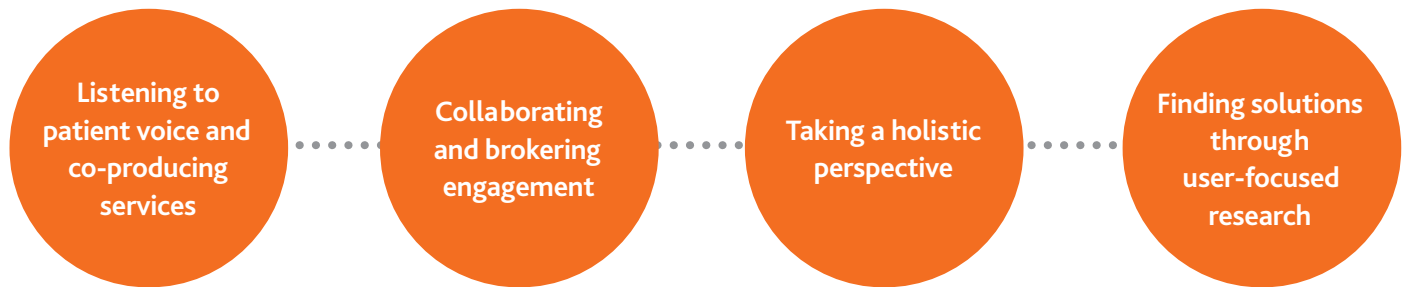
Patient

| Diagnosis | Living with a condition | Escalation | Crisis | End of life |

How do charities work?

Listening to patient voice and co-producing services

Collaborating and brokering engagement

Taking a holistic perspective

Finding solutions through user-focused research

What additional value do charities bring to the system?

Brand and credibility

Positioning and reputation

Flexibility and innovation

Access and reach

Leveraging additional resources

Is there evidence to support increased engagement by the health and care system with the VCS offer?

THE EVIDENCE REVIEW

The primary purpose of this evidence assessment was to determine whether the frameworks effectively reflect the activities of project partners, and to assess the strength of evidence to show that charities are able to deliver effectively on the offer they make to the health and care system.

Aggregate figures summarise evidence across a broad range of organisations, activities, issue areas and evaluation approaches. Though some of the fine detail is lost in this process, the benefit comes in providing a single, coherent articulation of where these activities add value—providing a stronger footing from which to approach conversations about the role of charities within the future health and social care system.

In part, the evidence review was designed to map the body of evidence submitted, by categorising that evidence according to the type of work undertaken and the outcomes being achieved. In parallel, evidence was also assessed based on its quality, to give a picture of the strength of evidence relating to the VCS's contribution in particular areas of work, for particular outcome areas and at particular points in the care pathway.

The limitations of this evidence review

- Findings are presented numerically to create an accessible, aggregated picture of a large pool of evidence. However, the classification of evidence submitted is based on the opinion of researchers at NPC and is inferred from large amounts of text.

- The classification of evidence is based only on the information contained in documents submitted.

- The documents submitted were chosen by project partners, meaning that there is likely to be a selection bias (though it should be noted that the stated aim of the project was to identify the strong available evidence for the value of VCS activities).

- Each partner was restricted in the amount of evidence they submitted, so the evidence reviewed does not necessarily reflect the full evidence of impact held by project partners

- There is a rich level of detail in the evaluations that is necessarily lost in the process of aggregation. Further detail about the interventions that were evaluated is included in the online case study collection.

- Categories for analysis were defined *before* the evidence review took place to ensure that they were recognisable and practically useful to key stakeholders. However, this means that in some cases evidence did not neatly fit the categories for analysis and some compromise was necessary.

- The partners involved in the project are large, national charities—meaning that quantitative findings are not representative of the experiences and capabilities of the sector as a whole.

What this evidence review CAN tell you

- **Where there are examples of strong evidence for the impact of charity activities** on health & wellbeing, productivity & efficiency, and resilience & cohesion.

- **Where these activities are taking place within the system** and at which point in the patient journey charities help.

- **How the frameworks developed can be practically applied** and used to support targeted engagement with the VCS.

What this evidence review CANNOT tell you

- **Where there are gaps in the evidence base.** The gaps shown in these findings may only be gaps in the evidence that was submitted to us, not in the evidence base across the sector.

- **The shape and nature of charity activities in their entirety.** Given that the project partners are large, national charities, the nature of their work is likely to differ from others in the sector.

HIGH-LEVEL RESULTS

Throughout this report we refer to 'findings' and 'cases'. **Findings** refer to a finding (or set of findings) from a submitted evaluation, which tests the link between an 'area of work' and an 'outcome area'. **Cases** refer to a project, programme or intervention being evaluated. Some of the figures quoted were analysed at the findings level (n=175), while others were analysed at the case level (n=60). There were more findings than cases because evaluations could test multiple outcome areas against multiple activities (see Appendix A).

Where we discuss 'strength of evidence' we are referring to a combination of the number of findings, the evaluation methods used and the quality of the evaluation itself (see Appendix A).

The characteristics of the evidence reviewed

Throughout the documents reviewed we found evidence that charities can improve health & wellbeing outcomes for patients and do so in a cost effective way for the system. The evidence reviewed was not comprehensive, but the story it tells is compelling. It shows that charities can add value to the health and care system in a range of ways and shows that charities have a legitimate role in the transformation of the NHS and the wider health and care system in the coming years.

The majority (62%) of findings related to health & wellbeing outcomes and 22% related to productivity & efficiency, while only 16% related to individual and community resilience & cohesion (Figure 1).*

For further findings in relation to specific outcome areas, see pp. 18–21.

Charities can improve health & wellbeing outcomes for patients and do so in a cost effective way for the system.

Figure 1: The outcomes tested in the documents reviewed (n=175)

62% Health & wellbeing	**22%** Productivity & efficiency
	16% Resilience & cohesion

A total of 72 documents chosen by project partners were included in analysis.
These documents evaluated 60 projects ('cases')

* We cannot say within the context of this research whether these proportions represent the evidence base as a whole, as they may simply reflect the evaluations chosen for submission to this review and be driven by the types of organisations involved in the project at this stage.

Evaluation approaches

For this analysis a classification for evaluation approaches was developed by adapting and updating the Nesta standards of evidence. This scale is shown in Figure 2 (for further explanation of how this was developed, see Appendix A).

Overall 44% of the findings we reviewed demonstrated outcomes using a high standard of evaluation (ie, mixed methods, a comparative evaluation or an RCT, see Figure 2).

For productivity & efficiency outcomes, 45% of findings (17 out of 38) were at this standard; for health & wellbeing outcomes, 46% of findings (50 out of 109) were at this standard and for resilience & cohesion outcomes, 32% (9 out of 28) were at this standard.*

Figure 2: The evaluation approaches used in the documents reviewed (n=175)
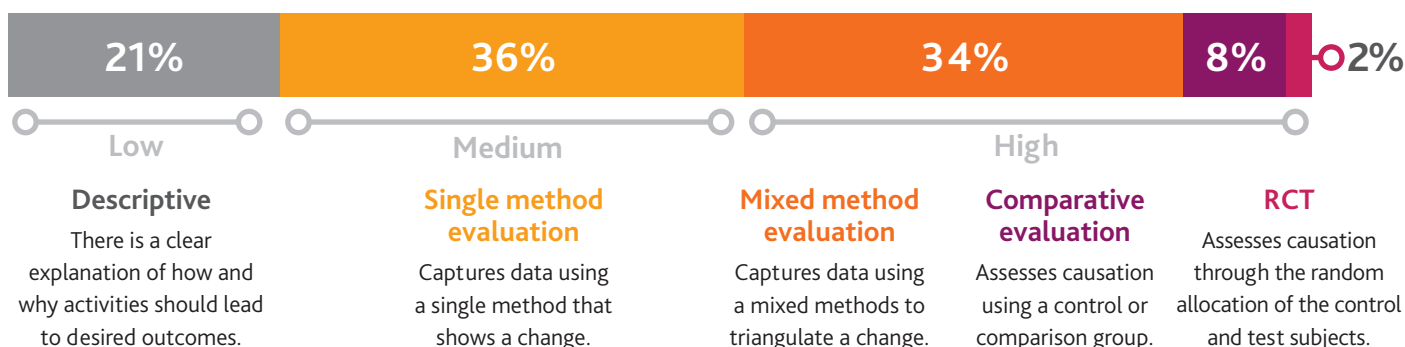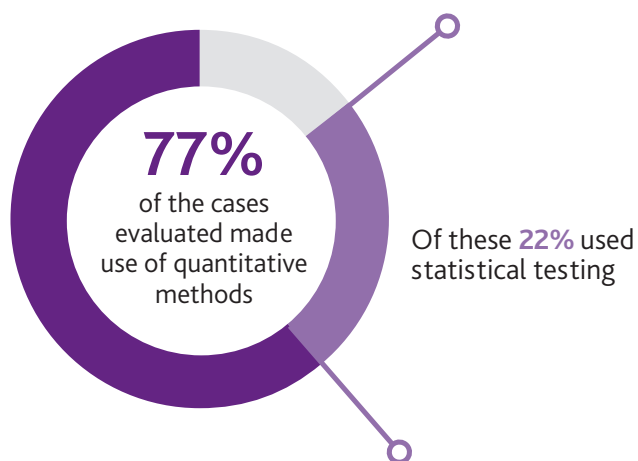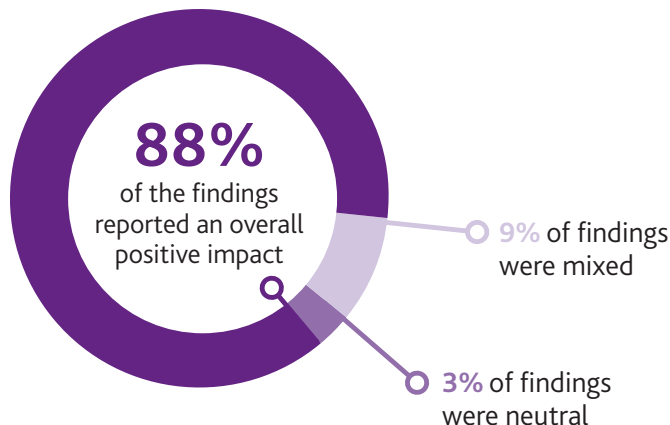
21%	36%	34%	8%	2%
Low	Medium	High		

Descriptive	**Single method evaluation**	**Mixed method evaluation**	**Comparative evaluation**	**RCT**
There is a clear explanation of how and why activities should lead to desired outcomes.	Captures data using a single method that shows a change.	Captures data using a mixed methods to triangulate a change.	Assesses causation using a control or comparison group.	Assesses causation through the random allocation of the control and test subjects.

Figure 3: Quantitative methodologies and statistical testing (n=60)

77% of the cases evaluated made use of quantitative methods

Of these **22%** used statistical testing

More than three quarters of the evaluations used a quantitative methodology such as a survey, data analysis, economic analysis or standardised scale—either alone or in conjunction with another method (Figure 3). Of these, around a fifth used some form of statistical testing (eg, reporting statistical significance). Though not always applicable, this kind of testing gives an indication of whether evaluations have considered how illustrative findings are (eg, whether findings are representative of a broader population, or whether the method used offers a high level of certainty in the results found).

Figure 4 Positive findings in the documents reviewed (n=175)

88% of the findings reported an overall positive impact

9% of findings were mixed

3% of findings were neutral

The vast majority of findings (88%) reported positive impacts (Figure 4). None reported a negative impact (ie, making health worse, or increasing costs). Some findings (3%), particularly in the case of productivity & efficiency, were neutral—in that they had no impact, either negative or positive. Others (9%) were mixed—finding either that positive impacts were felt by some groups but not others, or that positive impacts were very marginal.

* Note that in the case of resilience & cohesion none of the evaluations submitted used a comparative methodology or an RCT.

Focus on health & wellbeing

Health & wellbeing outcomes made up 62% of the findings reviewed and were the most commonly evaluated—in 90% of the cases reviewed. Of the health & wellbeing outcomes evaluated, 46% used mixed methods, a comparative evaluation or an RCT (Figure 5).

Health & wellbeing findings

Examples of findings in relation to health & wellbeing outcomes are listed below:

- Through projects led by local **Age UK** branches throughout England, the *Fit as a Fiddle* programme encouraged good health behaviours such as healthy eating and physical exercise. The final evaluation—based on interviews and before and after surveys of more than 800 beneficiaries—reports on a range of outcomes including statistically significant improvements in participants' wellbeing (as measured on the Warwick-Edinburgh Mental Wellbeing Scale) and the amount of strength and endurance activities participants undertook per week.

- **The British Heart Foundation** piloted the home administration of intravenous diuretics to heart failure patients. They found that 79% of interventions did not involve any hospital admission, whilst 63% achieved their target reduction in oedema (fluid retention), weight loss and/or other symptoms.

- **The British Red Cross** *Support at Home* service offers short-term practical and emotional support at home aiming to help build people's confidence and regain their independence. Self-reported outcomes were measured before and after the intervention using a 5-point scale (based on 90 interviews with service users before their use of the service, 61 interviews at the end and 35 'retrospective' follow-up interviews). There were statistically significant increases in: wellbeing, ability to manage daily activities, participation in leisure activities and coping skills.

- The National Cancer Survivorship Initiative (NCSI) was a partnership between the Department of Health, NHS England and **Macmillan Cancer Support**. The NCSI comprised a number of pilots including assessment and care planning, stratified pathways and providing specialist services across seven pilot sites to support people living with and beyond cancer to return to work. An evaluation of the programme found that 38% of 320 participants went from 'not working to working' or from 'sick leave to full work or modified work'. In light of this success, the Living With and Beyond Cancer (LWBC) Programme was set up in June 2014.

- An evaluation of **Rethink Mental Illness'** Crisis and Recovery Houses in Doncaster, Rotherham and North East Lincolnshire based on Outcomes Star data from 722 service users found statistically significant improvements in managing mental health, self-care, living skills, addictive behaviours, and self-esteem.

Figure 5: Approaches used to evaluate health & wellbeing outcomes (n=109)

Descriptive 17%

Single method 37%

Mixed method 40%

Comparative 4%

RCT 2%

Focus on productivity & efficiency

Productivity & efficiency outcomes made up 22% of the findings reviewed. These findings saw a proportionally higher use of comparative evaluations compared to other outcome areas, with more than a quarter taking this approach (Figure 6). This seems to reflect the need to have a basis of comparison from which 'savings' can be made—more often than not, this comparator was the system as it currently operates.

It should be noted that few of the evaluations we examined included evidence of cashable savings—which are often the focus in the current economic climate. However, it is clear that cashable savings are not the only form of efficiency in the system, and these evaluations demonstrate a range of other ways in which the health and care system can be rendered more productive and effective.

Productivity & efficiency findings

The evidence submitted demonstrated a range of productivity & efficiency outcomes, some examples of which are below:

Redistributed spending

Shifting spending towards treatment at a community level is a key goal for the future health service given that these redistributions can be significant in the context of a drive towards preventing avoidable illnesses and freeing up capacity in secondary care.

- An evaluation of **Macmillan Cancer Support's** South Yorkshire, Bassetlaw and North Derbyshire Survivorship Programme piloted a new 'risk stratified pathway'. This entailed assessing (risk stratified) patients at the end of treatment and changing the follow-up regime so that most patients were supported to self-manage and monitor for cancer recurrence remotely. The evaluation showed a neutral overall effect on costs of a new risk stratified pathway and a new package of interventions for supporting self-management in Sheffield. However, it also showed that these approaches delivered improved outcomes and experiences, at the same time as shifting a portion of spending from secondary to primary and community settings. For example, from the third year onwards, the healthcare costs were estimated to be less on the new care pathway, as patients were required to attend hospital less frequently.

Cost effects in conjunction with health effects

Improving health outcomes without increasing costs should be a key priority for the health and care system, given the practical difficulties involved in making genuine cashable savings. In our review it was often the case that neutral or negligible productivity findings were accompanied by improvements in health & wellbeing outcomes. Of the 60 cases we reviewed, 27 (45%) found both health & wellbeing outcomes and productivity & efficiency outcomes resulting from the same activities, suggesting that the VCS activities with limited or no effect on overall cost can actually be important examples of improving health & wellbeing outcomes *without* increasing costs.

Making processes more robust and reducing time pressures on clinical staff

Qualitative evaluations were particularly good at capturing cases in which new approaches, or additional support, had made processes in statutory settings more efficient (in the sense of becoming better targeted, or less at risk of error) or less burdensome for clinical staff.

- Of the **Stroke Association's** *Life After Stroke service*, one Family and Carer Support Coordinator commented that *'as all patients are now going through the Stroke unit, we're actually getting more referrals. Whereas before you'd get some of them filtering to other wards, and you wouldn't necessarily pick them up'*.

Figure 6: Approaches used to evaluate productivity & efficiency outcomes (n=38)

Descriptive
18%

Single method
37%

Mixed method
16%

Comparative
26%

RCT
3%

Projected costs savings from services delivered at scale

In many cases charities were able to demonstrate efficiencies in the context of a pilot. Evaluation of **Age UK's** integrated care programme in Cornwall, for example, found that the pilot contributed to a 30% reduction in non-elective hospital admissions, alongside a 23% average improvement in the wellbeing of older people (measured on the Warwick-Edinburgh Mental Wellbeing scale). Early calculations estimate a cost benefit ratio of 1:4 for the implementation of this approach.

It is not always the aim of charities to test models at scale and nor are they always best placed to do so. Once charities have sufficiently 'proven the concept', often it is the statutory sector alone that has the necessary size and resources to test the efficiency of models at scale.[6]

Reducing demand pressures and making services more cost effective

In some cases, evaluations were able to report large scale savings. For example:

- **The British Heart Foundation** found that after funding a three-year trial of Arrhythmia Care Coordinator positions in a number of hospitals, evidence of a reduction in readmissions and outpatient appointments was sufficient that 19 NHS Trusts have taken on the role permanently.

- The evaluation of **Mind** in Croydon's service for welfare benefits advice found significant improvement in participants' wellbeing which were associated with reductions in the stress associated with income loss, as well as a significantly lower cost for the intervention group (mean = £1,565) compared to the control group (mean = £5,014) explained by a reduction in the use of public services by the intervention group.

- **Arthritis Research UK** found, through an RCT to assess the introduction of a stratified care pathway for low back pain (the 'IMPaCT Back' study), that this approach led to a mean cost saving of £34 per person in comparison to a control group, as well as indirect savings to the community including a mean saving of £675 over 12 months from days worked compared to the control group.

Improving health outcomes without increasing costs should be a key priority for the health and care system, given the practical difficulties involved in making genuine cashable savings.

Focus on resilience & cohesion

Resilience & cohesion outcomes made up 16% of the findings reviewed, with this outcome area being addressed in 20 of the 60 cases reviewed.

Resilience & cohesion outcomes were therefore the least frequently evaluated in the pool of evidence reviewed. There were also no resilience & cohesion findings at a comparative or RCT level of evidence. (Figure 7).

This may because resilience & cohesion outcomes relate to upstream, preventative interventions which can reduce the number of people needing higher intensity health and wellbeing interventions. They are therefore often less targeted, broad interventions with diffuse effects, and evaluation may not lend itself to research designs that use a control group. As with productivity & efficiency outcomes, however, we cannot be sure whether there are further evaluations of this outcome which were not submitted to this review.

Resilience & cohesion findings

Examples of findings classified under resilience & cohesion are listed below:

- **The Alzheimer's Society's** evaluation of its operational services in 2014–15 found, of 793 people with dementia and 880 carers surveyed, 92% of people with dementia felt they enjoyed increased social contact, while 96% of carers felt part of a supportive community.

- **Mind's** evaluation of its resilience programme for people with long-term conditions found a statistically significant increase in participants' perceived levels of social support before and after the programme, which was corroborated through qualitative interviews.

Exploring the lower level of resilience & cohesion findings in this review

In many cases, resilience & cohesion is an intermediate outcome on the journey to health & wellbeing or productivity & efficiency outcomes. Helping people to feel supported and accepted in their communities is likely to contribute to health and wellbeing improvements, and making use of community assets and equipping people to manage their conditions may lead to reduced demand on statutory services. The extent to which findings fall into this category is sensitive to whether evaluations have focused on these contributory factors, or whether they have focused on the resulting improvements in health & wellbeing / productivity & efficiency.

Evaluation is also responsive to the interests of the public sector, and it may also be the case that a focus on health & wellbeing / productivity & efficiency outcomes results from the focus placed on these areas by decision-makers.

Given that evaluation cycles can be three or more years, accounting for programme design and setup, delivery, and follow up, it is possible that evaluation has simply not caught up with current priorities. There has been an increasing focus on the outcomes of resilience & cohesion in public policy discourse since the publication of *Fair Society, Healthy Lives*[7] in 2010. As this language has percolated through national and local health conversations, there is an instinctive recognition that this is an outcome charities are well placed to support, and an increasing demand for evidence that this is achieved. We therefore expect that we may see an increase in evidence of resilience & cohesion outcomes in the coming years.

Figure 7: Approaches used to evaluate resilience & cohesion outcomes (n=28)

Descriptive 36%

Single method 32%

Mixed method 32%
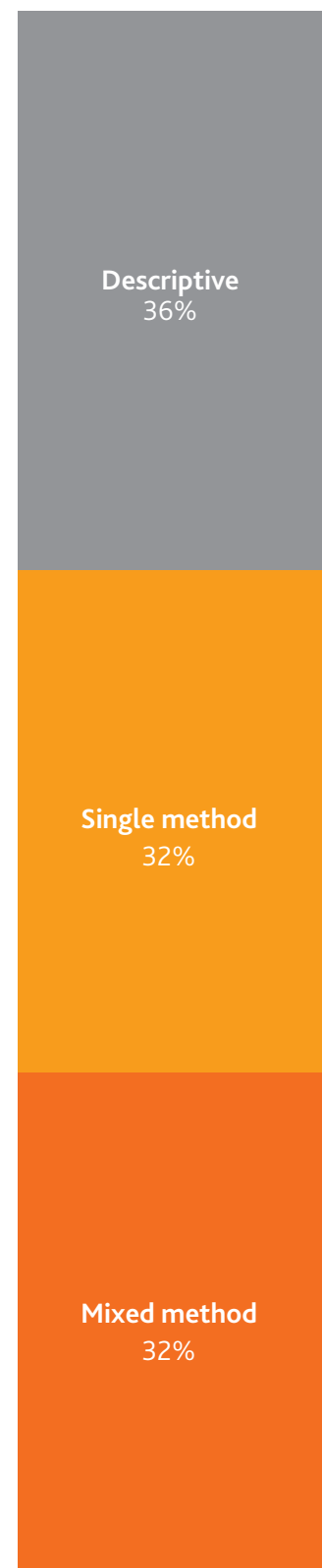
FRAMEWORK 1: WHAT DO CHARITIES DO?

For the purposes of high-level analysis, the specific activities described in evaluations were aggregated under a framework of seven 'areas of work' which was devised at the outset of research based on existing work by the Richmond Group, NPC, the King's Fund and National Voices, and refined through a focus group and workshops held as part of research for the *Doing the Right Thing* project.[8] These are intentionally broad categories which are designed to simplify communication.

Area of work	Associated concepts	Definition
Direct treatment and support	• Emotional support • Psychological support • Practical support	Health and care treatment / support delivered directly to people (includes wider non-medical support services such as financial and employment support).
Engaging people in keeping healthy	• Prevention • Addressing the social determinants of health	Activities that are designed to reduce the likelihood of people becoming unwell. This includes, for example, behaviour change campaigns, information services, outreach work with specific at-risk communities.
Supporting self-management	• Helping people understand their condition • Signposting available support	Activities that are designed to help manage an existing condition appropriately. This includes, for example, information services, signposting available support, health coaching.
Involving families and carers	• Support for families and carers • Involving families and carers in service delivery and design	Services that provide support to families and carers to improve their health and wellbeing, that provide information to families and carers, or work to integrate families and carers into treatment processes and decisions.
Integrating and coordinating care	• Helping patients navigate the system • Convening agencies and individuals	Coordinating care through statutory actors and organisations (eg, relaying information along the patient pathway or conducting research) as well as through patients (eg, equipping patients with knowledge and advice about available services).
System redesign	• Piloting and mainstreaming innovative approaches • Contributing to service design	Activities that work to inform the way that services and whole pathways are designed and delivered—through research, pilots and relaying the views of beneficiaries to commissioners and policymakers.
Support for health and care professionals	• Training • Knowledge sharing	Activities designed to train health professionals in specific areas, to bring them together with patients and other interested actors, to provide capacity relief.

Analysis of this framework draws on *both* the quantitative findings from the evidence review and qualitative findings from interviews and workshops with stakeholders.

System vs. individual level activities

The areas of work cover two broad categories: roles which charities can play in supporting individuals, and roles they play in supporting the health and care system as a whole.

Supporting the individual

| Direct treatment and support | Engaging people in keeping healthy | Supported self-management | Involving families and carers | Integrating and coordinating care | System redesign | Support for health and care professionals |

Supporting the system

Attendees at focus groups for framework design observed that the work of the charity sector is often thought of solely in terms of the value it brings to individuals (ie, 'direct treatment and support', 'engaging people in keeping healthy', 'supported self-management', 'involving families and carers' and 'coordinating care' for individuals). Often the only context in which charities are thought of as bringing value to 'the system' as opposed to the people within it, is in supplementing the resources of the statutory system—for example through providing volunteers to assist in winter crises at A&E.

However, interviewees and workshop attendees made it clear that much of the value the charity sector can add at the 'system level' is complementary and additional. Charities contribute to the way that individual services are designed and the way that whole pathways are structured through research, pilots and a close familiarity with the needs of beneficiaries ('system redesign').

By taking a holistic approach charities are also able to coordinate different aspects of the system—whether by making people aware of other services available, providing guidance on the most appropriate services, assisting professionals with information and referrals or helping patients to navigate between different parts of the system ('integrating and coordinating care' and 'support for health and care professionals').

Diabetes UK, for example, have been involved in the Year of Care programme—a pilot programme across three health communities which provides support to introduce and embed personal care planning into routine care for people with long-term conditions, using Diabetes as a test case. With services being mostly run by the NHS, Diabetes UK has been involved in designing and coordinating the project as a whole.

In the evidence reviewed, we found that more than a third of the outcomes evidenced related to activities that took this system level approach (Figure 8).

Figure 8: The proportion of evidence relating to system-level activities (n=175)

35% of findings related to improvements in the way the system functions

Contributing ideas vs. delivering activity

An additional issue which is central to understanding the roles which charities can play, is the distinction between **contributing ideas** to the health and care system, and **delivering service**s within the health and care system.

Some charities play both roles—either at different times or simultaneously—and they can operate in these roles either at the system level, or in relation to services for individual. For example, charities may be involved in:

- **Contributing ideas:** Undertaking research to develop and pilot a new service or tool to be delivered by the statutory sector.

- **Delivering activity:** Providing an information and signposting service for individuals with a particular condition.

- **Both ideas and delivery:** Redesigning patient pathways and playing a role in their implementation.

Charities vary in their desire and their capacity to play either role. Some charities are able to fund research and pilots of new ideas which they hope wider health and care system partners will adopt as their own over time. Other charities rely on being paid to deliver services for their own financial sustainability, and often they use their delivery roles to inform and develop new ideas for improving services.

This dual role is not well understood by the health and care system, and charities themselves can often blur the distinction between these roles. As a result commissioners and system leaders may struggle to work with charities in both ways. In particular commissioners' nervousness about the risk of showing preference to potential providers can act as a barrier to charity involvement in strategic discussions (see discussion of Integrating the VCS offer on pp. 43–45).

'The voluntary sector tends to be pigeonholed into one of two categories either providers of services who therefore shouldn't be trying to influence things, or lumped into a soft relationship group that engage their beneficiaries but cuts them off from attempts at service redesign and a great deal of innovation.'

Pam Creaven, Director of Services, and Jo-Anna Holmes, Head of Integrated Care, Age UK

The most common activities in the evidence reviewed

The evaluations we reviewed demonstrated outcomes across all seven areas of work (Figure 9). Findings were relatively evenly distributed, with particular emphasis on direct treatment and support, supported self-management, system redesign and integrating care. What this shows is that, in the body of evidence that we reviewed, charities are able to demonstrate outcomes across all the areas of work—in practice rather than just in theory. While project partners tend to focus in some areas more than others, the range of activities carried out is nonetheless very broad—touching on preventative activities and remedying social determinants of health through 'engaging people in keeping healthy', equipping people with the support and resources to manage their condition effectively ('supported self-management') or contributing to the way the system itself is designed and orchestrated, through 'system redesign'. Figure 9 shows that these activities equally encompass system and individual-level activities as well as delivering activity and contributing ideas, as discussed previously on pp. 20–21.

Figure 9: The proportion of findings relating to different 'areas of work' in the evidence reviewed (n=175)*

9%	Support for health and care professionals
10%	Involving families and carers
10%	Engaging people in keeping healthy
15%	Integrating and coordinating care
15%	System redesign
16%	Supported self-management
25%	Direct treatment and support

* In this evidence review we took a 'data point' to be any finding, or set of findings, which tested the link between one of these seven areas of work and one of the three priority outcome areas identified (see Appendix A). Given that each data point was based on an 'area of work' categorisation, the proportion of findings in Figure 9 totals 100%. However, many evaluations covered multiple areas of work and multiple outcomes, and are therefore categorised under more than one 'area of work'.

We assessed the evaluations submitted based on their ability to demonstrate how these seven areas of work led to outcomes in three priority areas: health & wellbeing, productivity & efficiency and resilience & cohesion.

Figure 10 shows that the evidence is particularly strong for health & wellbeing outcomes across the board. We found good evidence that the charity activities submitted led to improved health & wellbeing

across all areas of work, particularly in cases where charities delivered direct treatment and support services, or supported people to manage their condition. The charity activities reviewed also demonstrated strong productivity & efficiency outcomes in relation to direct treatment and support, as well as system redesign activities.

Figure 10: A heat map showing where evidence submitted was strongest
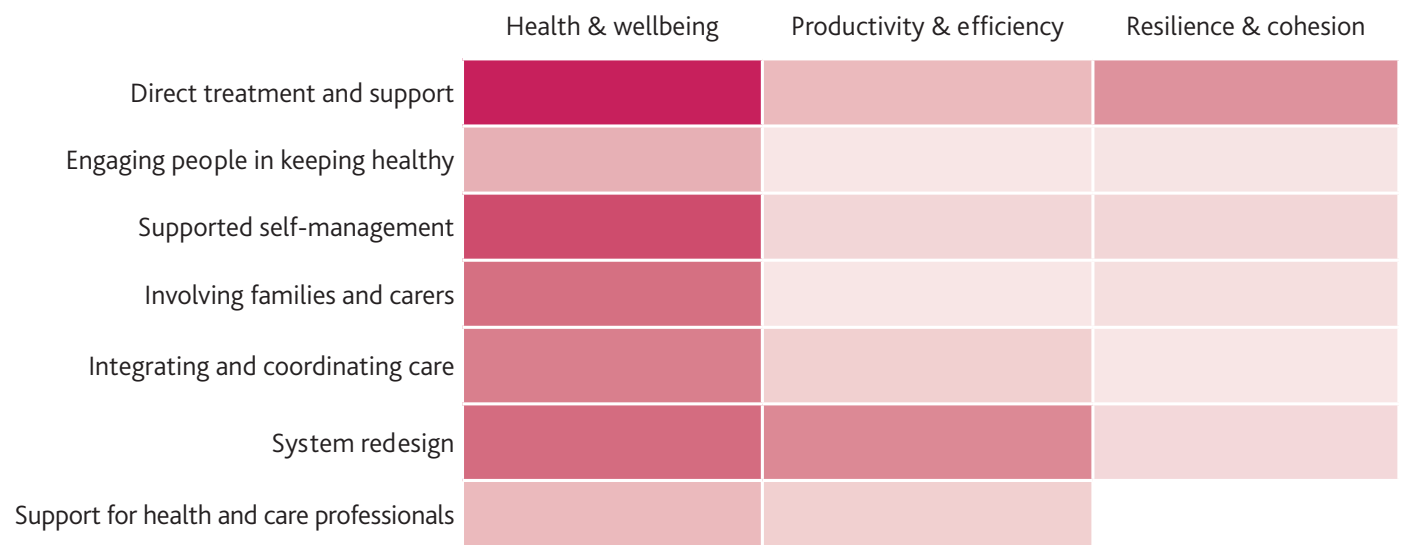
Note: Strength of evidence was determined based on: the number of findings, the evaluation methods used, and the quality of evaluation (see Appendix A for the weightings and methodology used). The heat map shown is designed to highlight strengths, it cannot identify evidence gaps given that the evidence review was not comprehensive.

We found good evidence that the charity activities submitted led to improved health & wellbeing across all areas of work.

The charity activities reviewed also demonstrated strong productivity & efficiency outcomes in relation to direct treatment and support, as well as system redesign activities.

FRAMEWORK 2: THE SYSTEM PATHWAY

Interviewees and workshop attendees told us that it was important to communicate the impact of charity activities in terms of where they can relieve the most pressure in the system. To that end, we categorised the evidence submitted according to where the benefit of activities were felt within the health and care system, in line with the definitions below:

Pathway point *	Definition
Primary (statutory)	Charity activities in a statutory setting or with a statutory partner (eg, GP / Pharmacy / Dentist / Optometrist).
Primary (community)	All other community care outside a statutory setting and without direct statutory partners (eg, charities, youth centres, homeless shelters).
Secondary / tertiary	Includes secondary care (health care services provided by medical specialists and other health professionals who generally don't have first contact with patients, eg, cardiologists, urologists and dermatologists); acute care (medical and surgical treatment usually provided by a hospital—short-term needs), and tertiary care (care for people requiring complex treatments, usually in a specialist centre).
Emergency	Includes emergency, urgent and unscheduled services (A&E, walk-in clinics and out-of-hours services).

Analysis of this framework draws on *both* the quantitative findings from the evidence review and qualitative findings from interviews and workshops with stakeholders.

As was to be expected, a substantial majority of charity activities were in primary care in a community setting (Figure 11). Activities such as **Rethink Mental Illness'** helplines and recovery houses were clearly designed to provide support within communities, and to address the link between people's social circumstances and their health.

A large proportion of the findings identified also related to activities taking place in a statutory setting in the primary (statutory) and secondary / tertiary categories (in practice, there were very few findings relating to tertiary care, given its clinical nature).

Activities in a secondary care setting ranged from projects such as the **Royal Voluntary Service's** hospital transport and 'meet and greet' services, to funding clinical and administrative positions such as the West Berkshire **Neurological Alliances** funding for a two year trial of a rare neurological conditions nurse.

Activities in a primary (statutory) setting included the development and rollout of diagnostic tools, training for nurses and GPs and coordinating local services by creating contact and referral points for patients and services—such as the **Stroke Association's** *Life After Stroke* service in Kent.

* Note that in some evaluations the location of delivery was not the same as the place where benefit was felt. In other cases the place where benefit was felt was not specified; the provision of information, for example, can affect patients at many different stages of the pathway.

Figure 11: The points at which charity services were targeted in the system pathway (n=60)
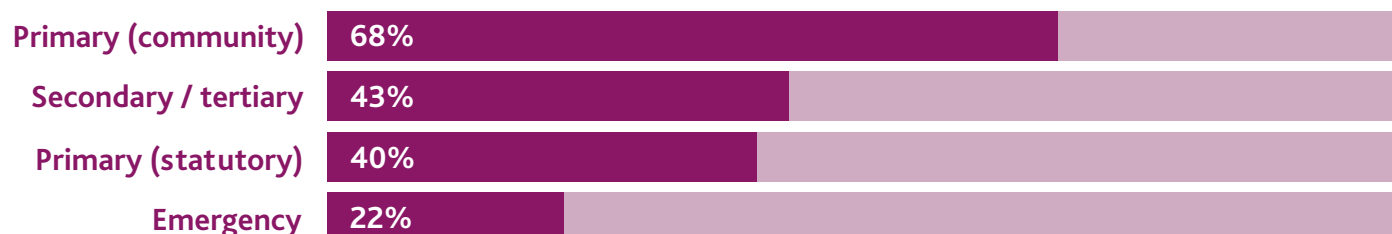
Primary (community) **68%**

Secondary / tertiary **43%**

Primary (statutory) **40%**

Emergency **22%**

Note: Given that many activities targeted multiple points in the pathway simultaneously, bars sum to more than 100%

We found that 48% of cases reviewed were working across multiple points in the system pathway. **Macmillan Cancer Support's** pilot of new approaches to providing one-to-one support for people with cancer, for example, introduced four new roles across different points in the health and care system, including a Macmillan cancer support worker, a Macmillan complex case manager and Macmillan nurses in primary care and community care settings.

Charity activities often operate across system boundaries—working with people living with a particular condition as they move between different parts of the system; for example supporting people with cancer both when they are undergoing treatment, when they are 'living with and beyond' cancer or moving into end of life care.

A considerable number of 'system level' activities (see p. 21) also focused on the coordination of community and statutory services, and therefore, by their nature, involved working at multiple points in the pathway.

Figure 12: Cases which targeted multiple points in the system pathway (n=60)

48%
of cases targeted multiple points in the system pathway
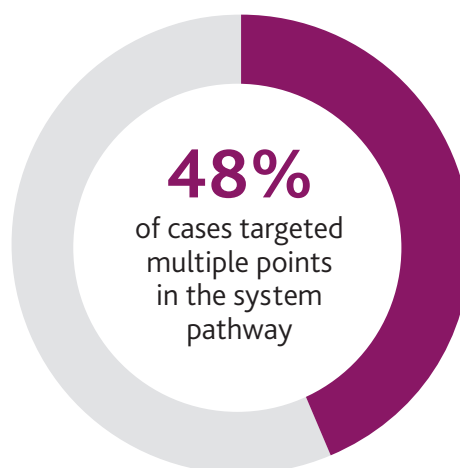
The strength of evidence in relation to the system pathway

Figure 13 shows that strong evidence for health & wellbeing outcomes resulting from charity activities was found throughout the system pathway, particularly in a community setting. Productivity & efficiency evidence was less strong, but nonetheless present for activities working at all points in the pathway. As would be expected, evidence for improvements in resilience & cohesion were mostly seen at the community level. This is because community outcomes are usually—by their nature—achieved by focusing on community-level activities.

Note: Strength of evidence was determined based on: the number of findings, the evaluation methods used, and the quality of evaluation (see Appendix A for the weightings and methodology used). The heat map shown is designed to highlight strengths, it cannot identify evidence gaps given that the evidence review was not comprehensive.

Figure 13: A heat map showing the points in the system pathway at which evidence for achieving priority outcomes was strongest
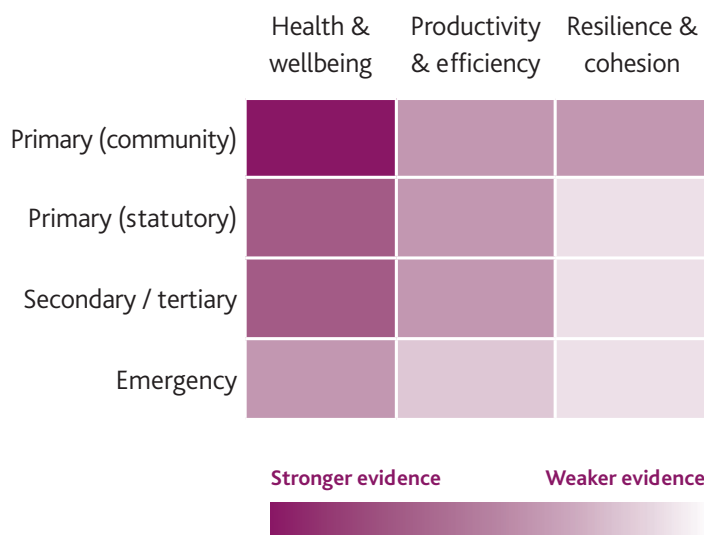
FRAMEWORK 3: THE PATIENT PATHWAY

As well as considering how charity activities fit into the statutory system, we also assessed where charity activities took place from a patient perspective, to help understand what these activities achieve for people, as well as the system. This analysis was based on the following categories:

| Category used in analysis*	Definition
Diagnosis	Help for those who have been recently diagnosed with a condition or are at the point of diagnosis.
Living with a condition	Help for those with long-term conditions, or circumstances, to manage their condition and to 'live well'.
Escalation	Help for those with symptoms increasing in severity (eg, moving to co-morbidity or from secondary to tertiary care) or whose circumstances are becoming worse.
Crisis	Help for those experiencing the sudden onset of symptoms or circumstances requiring immediate response.
Recovery	Help for those no longer receiving treatment, but in need of support, or whose circumstances are improving.
End of life	Treatment and care for those with incurable disease. Palliative care in hospitals, in the home and in hospices.

Analysis of this framework draws on *both* the quantitative findings from the evidence review and qualitative findings from interviews and workshops with stakeholders.

A large majority of interventions submitted worked, in some way, to help people to manage a condition or to enjoy a high quality of life (Figure 14). This was particularly achieved through direct support, the provision of group activities (such as **Alzheimer's Society's** *Singing for the Brain* groups), or through the provision of information to help understand a condition or treatment options.

Half of the interventions assessed also worked with patients after illness or treatment to aid recovery. Activities here included the supply of equipment (eg, short-term wheelchair loans by the **British Red Cross**), direct care and support at home, advice on non-medical aspects of life after illness (eg, **Macmillan Cancer Support's** welfare rights advisors) and respite care (eg, the provision of respite care by the **Stroke Association** for the families of stroke survivors).

* Note that actual 'treatment' spans multiple categories, in that people can receive treatment in response to crisis, to aid recovery, to deal with an escalating condition or to keep it stable.

Figure 14: The proportion of cases reviewed working at different points in the patient pathway (n=60)
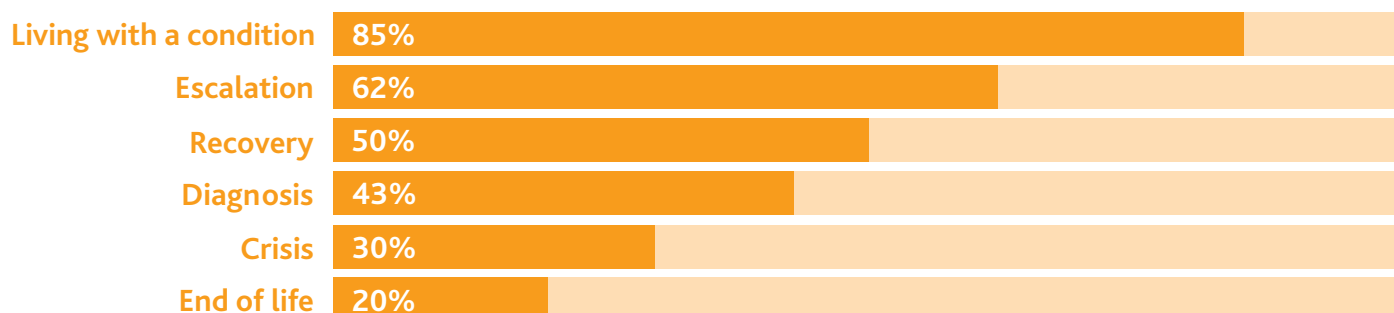
Living with a condition	85%
Escalation	62%
Recovery	50%
Diagnosis	43%
Crisis	30%
End of life	20%

Note: Given that many activities targeted multiple points in the pathway simultaneously, bars sum to more than 100%

A substantial number of cases (43%) also involved helping people at the point of new or recent diagnosis. In many cases this was achieved through the provision of information to help people understand a condition, while in others charity involvement extended to improving the process of diagnosis itself. **Arthritis Research UK**, for example, funded the development of the STarT Back tool, which helps GPs to identify risk factors and recommend the appropriate treatment for those experiencing back pain. The **British Heart Foundation** have also piloted and rolled out a system for the early diagnosis of Familial Hypercholesterolaemia across England, Northern Ireland, Scotland and Wales.

Working across the patient pathway

As in the case of the system pathway, a large proportion of the evaluations assessed (71%) were of interventions working with people with a variety of health statuses (Figure 15).

The tendency of charity services to work across pathways is an important part of what distinguishes them from clinical services which are, by their nature, specialised. By working with people experiencing problems at different stages, at the same time as working in multiple parts of the system, charities are able to act as a connector between otherwise fragmented parts of the system and a take a holistic perspective of the problems being faced and how to solve them.

Figure 15: Cases which targeted multiple points in the patient pathway (n=60)

71%
of cases
targeted multiple
points in the patient
pathway
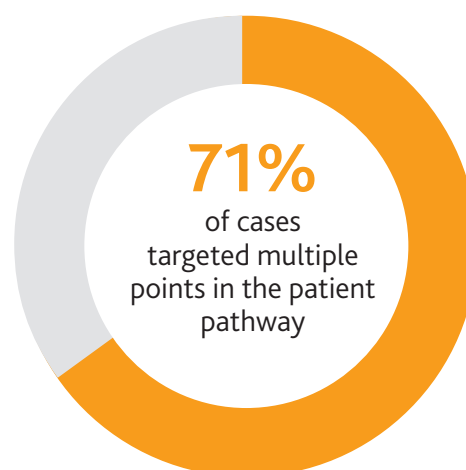
'What the Alzheimer's Society was able to do was to make me and other leaders aware of the issues that are faced when treatment has ended. Our responsibilities don't just stop at the point of transfer or discharge. We can now make services more connected and streamlined than they would otherwise have been.'

Sir David Dalton, Chief Executive, Salford Royal NHS Trust

FRAMEWORK 4:
HOW DO CHARITIES WORK?

Interviewees and workshop attendees were clear that the value offered by charities goes beyond simply the activities that they deliver and the outcomes they achieve. Instead, they felt that much of the charity sector's value comes from *how* charities deliver services. Leaders from the health and care system, in particular, were eager for this to form part of the narrative about the role of charities in health and care.

Based on our research we have identified four broad areas that summarise the way charities approach their work.

Ways of working	Associated concepts	Definition
Listening to patient voice and co-producing services	• Understanding patient experience • Working 'bottom-up' • Recognising people as assets • Building on existing capabilities • Shared decision making • Facilitating rather than delivering[9]	Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.[10]
Collaborating and brokering engagement	• Partnership • Consortia • Cross-sector collaboration	Organisations working with other *organisations* to develop and deliver services (either a public, private or voluntary partner).
Taking a holistic perspective	• Whole person care • Building relationships • Psychosocial approaches • Wellbeing • The social determinants of health	Taking an approach that takes account of more than a single, immediate condition (ie, non-specialist approach). This may mean both taking account of other conditions and/or personal circumstances.
Finding solutions through user-focused research	• Piloting • Challenging the status quo	Sitting outside of the system allows charities to operate in a less rigid and constrained environment and allows them to be innovative. Charities sit between beneficiaries and the system, and are able to design and test services that respond to the needs of their beneficiaries.

Analysis of this framework draws only on findings from qualitative research based on interviews and workshops with stakeholders (in contrast to frameworks 1–3 which also draw on quantitative findings from the evidence review).

Perceptions of charities' ways of working: insights from interviews

Frontline commissioners and health and care system leaders articulated a wide range of concepts that they associated with the ways charities work and the reasons this is valuable.

Listening to patient voice and co-producing services

'The voluntary sector don't have the "white coat effect", they don't have the 10 minute appointment, they have a chance to really engage with people and create in-depth relationships.'

Jeremy Bennett, Strategy & Planning Support Officer, Leicester City CCG

Collaborating with other providers

'What makes a third sector project stand out? The ability to coordinate public partners and the wider sector partners.'

Will Cleary Grey, Programme Director, Commissioner Working Together Group

Taking a holistic perspective

'We needed a strategy shift from just treating ill health to helping people control their lives. It was driven by the goal of starting conversations with the patient – that's a key part of third sector expertise.'

Tracey Roose, Director of Transformation, NHS Kernow CCG

Finding innovative solutions through user-focused research

'The voluntary sector can generate more creative and suitable interventions instead of having to meet pathway criteria… They are more "fleet of foot".'

Murray Rose, Director of Commissioning, Darlington Borough Council

Evidencing charities' ways of working

It was not practical to assess the impact of these ways of working in a systematic way from the evidence; it was rarely the subject of the evaluations. These ways of working were often implicit rather than explicitly discussed within charities' evaluation, and few of the evaluations sought to understand specifically whether these ways of working were the reason their services were effective at achieving health & wellbeing or other outcomes. Ultimately, therefore, we have not sought to map the outcomes achieved by the interventions we reviewed against these ways of working, but we note, from our discussions with health and care system leaders, that there is significant interest in these ways of working, and there may be a case for work to develop the evidence base in this area.

FRAMEWORK 5: WHAT ADDITIONAL VALUE DO CHARITIES BRING TO THE HEALTH AND CARE SYSTEM?

Interviewees and workshop attendees were clear that there were features of charity providers that set them apart from other types of providers, and which serve to make them an important part of the health and care landscape. To some extent the concepts in the table below seek to answer the question 'what do charities offer, which private and public sector organisations cannot?' And while interviewees noted that these concepts are not the exclusive preserve of the charity sector, it was recognised that organisations with a social mission, which operated outside the confines of the public sector, and which supported their statutory engagement with wider programmes of work, were most often charitable, and that these features underpinned the key characteristics identified.

Area of added value	Associated concepts	Commentary
Brand and credibility	• Credibility of individual organisations with the public and with the health and care sector • Credibility of charities as a whole	The brands of charities are recognised individually, and the brand of the charity sector collectively is recognised as mission driven.
Positioning and reputation	• Independence • Trusted intermediary • Convening	The positioning and reputation of charities is related to their relationships with other players in the system. It is a component and contributing factor to the broader concepts of brand and credibility.
Flexibility and innovation	• Risk taking • Responsiveness • Agility	Charities' position outside the statutory system influences the ideas and solutions which charities can put forward, and gives them freedom from some of the health and care system's bureaucracy.
Access and reach	• Embedded in communities • Understanding of need • Building on community assets	For many people in the health and care system, the relationships which charities have in communities are the root of much of their value to the system.
Leveraging additional resources	• Volunteering • Fundraising • Refer-on services • Research and evidence assets	Charities are often able to leverage resources that the statutory health and care system partners cannot—including funding for research and development, additional services which can be built into referral pathways, volunteers and charitable funds.

Analysis of this framework draws only on findings from qualitative research based on interviews and workshops with stakeholders (in contrast to frameworks 1–3 which also draw on quantitative findings from the evidence review).

Brand and credibility

'It was important to have members from the voluntary sector with a credible platform. Having a voice at national level helped.'

Tim Shields, Head of Business Intelligence, NHS Calderdale CCG

The brand and credibility of charities was a strong theme of the research—both the recognition of the profile and 'household name' status of some large national charities, and the integrity of the sector as a whole. Charity partners tended to use the language of brand, and health and care partners to use the language of credibility. As some research indicates falling trust in the charity sector as a whole,[11] it will be interesting to see whether this affects the relationships which the health and care system seeks with large and small charities.

Positioning and representation

'Charities bring all of the stakeholders together including the patient. They are seen as independent and therefore as a strong partner to guide this process of alignment.'

Bridget Turner, Director of Policy and Care Improvement, Diabetes UK

Charities are well-placed to act as a trusted intermediary between people and public services. Being embedded in communities, and with a holistic perspective on people's problems, charities are in a strong position to gauge the needs and opinions of people in those communities. At the same time, many are engaged in the design and delivery of public services and are therefore able to act as a conduit for people's views within local and national decision-making. For example, through their Service Pledge programme **Breast Cancer Now** work with clinicians to help them shape the design and delivery of services in line with patient feedback.

Charities' deep understanding of the needs of the people they serve, combined with an understanding of how the health system works, allows them to act as trusted intermediaries, and to convene conversations which otherwise would not happen.[12]

Flexibility and innovation

'Charities are stimulants for thinking about alternative approaches. Statutory organisations can be fairly inert and sluggish to change whereas charities are more willing to take risks and be more proactive.'

Sir David Dalton, Chief Executive, Salford Royal NHS Foundation Trust

Charities are seen as more responsive to changes in their external environment and to the views of beneficiaries than organisations in the public sector. Charities operate outside the rigidity and specialism of the statutory system; while health professionals can be constrained by the traditional boundaries of their role, charities can be more imaginative in thinking about what might work for individuals. As smaller organisations, charities can be nimbler and develop ideas quickly. The key to harnessing this innovation is to ensure that there are appropriate outlets by which this innovation can be brought to scale.

Access and reach

'The statutory sector cannot fully meet needs without engaging the voluntary sector. They're absolutely crucial in knowing what people at the grassroots need.'

Helen Walker, Deputy Director for Equity and Communities at the Department of Health

Health and care system leaders interviewed through this research recognised that charities can bring to the fore the needs of neglected segments of the population; and they also encourage a stronger focus on the non-medical outcomes which often matter most to people (for example, being able to walk a dog).

Charities are often embedded in communities, working with individuals in a way that the statutory health and care sector struggles to do. Because charities often engage with people across a whole range of issues, they can be particularly well placed to support the health and wellbeing of people who might be reluctant to access the traditional health and care system. Charities' cross-issue focus is likely to be increasingly valued as growing emphasis is placed on the role of non-medical factors in people's health.[13] And geographical communities are not the only ones which matter in health; condition-specific or beneficiary-specific charities play an important role in supporting people from particular communities of interest.

Leveraging additional resources

Charities can bring additional resources to the health and care system, including volunteers, a research evidence base, charitably funded activity, and even additional funds from charitable sources. However their capacity to do so varies from one charity to the next.

The resources which well-funded, expert and professional voluntary sector organisations bring were recognised by interviewees as often instrumental in getting innovation off the ground. These resources can create a more equal relationship between the charity and its health and care system partners.

'Previously the NHS had all the money and it was by far the dominant partner. Now increasingly the third sector is providing funds and public actors are trying to seek them out. This gives third sector actors much more pull then they had in the past. This shift has led to a much warmer relationship.'

Amy Rylance, Head of Healthcare Professional Engagement, Diabetes UK

Many charities can leverage substantial community assets including, in particular, volunteers, often based on their strong links to communities—whether defined geographically or by shared experience. Volunteers can provide support at lower cost—although volunteering programmes do require financial investment to be well managed and effective. More importantly, volunteers build different kinds of relationships with service users; the feeling that relationships built are voluntary rather than professional creates a different dynamic. Many charity activities, such as **British Lung Foundation's** *Breathe Easy* programme are volunteer led and run. These services use the skills of beneficiaries to deliver services, bringing dual benefits in reducing the costs of delivery, while also improving the wellbeing of those volunteering through building their social networks and reducing isolation.

Some charities are able to bring additional funds to the health and care system, or to 'gift' services to users, beyond the statutory offer (for example in referring users of one service to other charitably funded services offered by the charity). However it is be important to remember that not all charities have the core income to make this kind of financial contribution possible; this is likely to be the preserve of major national charities.

'The real USP of charities is the dedication of volunteers… they build different relationships with people than somebody who's being paid to be there.'

Karl Demian, Director of Strategy and Development, Royal Voluntary Service

Charities can bring additional resources to the health and care system.

SUMMARY OF FINDINGS FROM FRAMEWORKS ANALYSIS

- There is strong and positive evidence for what charity activities can achieve—particularly for health & wellbeing outcomes and for work that focuses on direct treatment and support, supported self-management, system redesign and coordinating and integrating care.

- There is evidence for the 'harder' productivity & efficiency outcomes identified in the NHS Five Year Forward View—and this was an area in which evaluations often used a higher standard of evaluation.

- Charity activities do not only help individuals. More than a third of the findings identified in this review related to activities that help to improve the health and care system—either by piloting new approaches, feeding expertise into the process of service design, or coordinating actors within the system.

- There is evidence to back the assertion that charities tend to adopt an integrated approach. Nearly half the interventions we reviewed worked at multiple points in the system pathway (eg, primary and secondary care), while more than two-thirds worked at multiple points in the patient pathway (eg, treatment and recovery).

Implications for charities

- It is important to articulate how and why approaches work, as well as what they achieve. Commissioners continue to value the ability of charities to talk about their outcomes, but are also enthusiastic about the additional value charities can provide through their ways of working—which enable them to do things that the public sector cannot.

- Therefore charities should consider investing in process evaluations—which focus on areas such as the purpose of an intervention, its essential ingredients, the way it is targeted and the conditions for success—as these are just as important as evaluations of impact.[14]

- Resilience & cohesion will continue to be important concepts, so charities should keep building evidence relating to these outcomes for individuals and communities.

Priority actions for the health and care system

- Use the frameworks developed to structure conversations with the VCS to develop solutions that meet your needs.

- Communicate needs and evidence requirements in a consistent way.

- Identify where charities could be strategic partners in solving the problems you face. This may be particularly relevant in conversations about integrating care.

How do we ensure the voluntary and community sector can play its part in the health and care system?

WORKING EFFECTIVELY TOGETHER

During the course of this research we have sought to maintain an open dialogue not only with project partners, but also with the leaders across the health and care system that the partners ultimately sought to engage. We did this through a series of interviews, focus groups and workshops.

After our initial analysis, which focused on Framework 1, discussions with stakeholders challenged the project partners' initial assumption that the primary barrier to more effective joint working between the VCS and others health and care system partners was a perceived lack of evidence, and demonstrated that the reality of working together is more complicated. In this section we seek to unpack the wider barriers to effective working that were identified by this project, and outline some potential ways forward.

Strengthening the changing relationship between charities and health system partners

The relationship between charities and the health and care system is already changing. Clinicians and managers recognise the need to do things differently and introduce new thinking if they are to maintain or improve patient outcomes within strict efficiency targets.

These changes have been driven in part by the charity sector taking a more strategic role, and learning how to position themselves in relation to the health and care system.

The following section considers the practical factors which could enable this change to pick up pace. These factors can be grouped under three headings:

- **Creating evidence-based solutions:** the availability of, expectations of, and reality of seeking evidence-based solutions.

- **Integrating the VCS offer:** the challenges of two complex and decentralised sectors engaging in effective dialogue.

- **Making progress within austerity:** the reality of undertaking these challenges in a resource-starved environment.

While the previous section reviewed evidence provided by a number of large health and care charities, the following section responds to discussions about the VCS more broadly. Interviewees discussed both condition-specific health and care charities and also those which support specific beneficiary groups; discussions covered charities of all sizes including grassroots community organisations.

'We don't have any choice anymore. Charities are no longer seen as a bunch of do-gooders.'

Jeremy Bennett, Strategy & Planning Support Officer, Leicester City CCG

'Charities used to be completely separate, but they're increasingly seen as more integral and approachable. This has mainly been led by charities learning to communicate better with the health system.'

Jacky Jones, Breast Clinical Nurse Specialist at Barts Health NHS Trust

The relationship between **charities** and the **health and care system** is already changing. Clinicians and managers recognise the need to do things differently and introduce new thinking.

SUMMARY OF RECOMMENDATIONS

Creating evidence based solutions

Principles for change

1. **Expectations for evidence need to be both realistic and proportionate.**

2. **Charities and the health and care system need to agree what data is needed and how to produce it.**

3. **The public sector needs to support charities to develop effective evidence in practical ways.**

Recommendations

The health and care system needs to:

- Only request evidence that is realistic for a project's stage of development.

- Enable and support good evaluation—rather than simply demanding it—through data sharing and investment in scaling effective approaches.

- Make clear what information is required from the VCS, and why.

- Move away from evaluating complex system interventions in the same way as medical treatments.

The charity sector needs to:

- Avoid over-stating the evidence case.

- Communicate evidence of impact and value in a way that aligns with the interests of decision-makers.

- Collect and manage data in a way that is useful to partners.

» Priority actions for the health and care system

- Check that evidence standards are not a barrier to testing new approaches, and be pragmatic about the evidence required—whether for procuring services or mainstreaming new approaches to service delivery.

- Recognise the trade-off between the need for new approaches, and the demand for highly-rigorous evidence standards.

- Once this approach to evidence has been clarified, communicate clearly what is needed to charity partners.

Properly integrating the VCS offer

Principles for change

4. **Mechanisms for VCS input to transformation efforts are needed in all parts of the system.**

5. **Charities need consistent messages and coherent representation.**

6. **The health system needs to look outside itself to implement new approaches.**

Recommendations

The health and care system needs to:

- Draw on the strengths of the VCS in reshaping the NHS around the integrated, person-centre vision of the FYFV and the devolution agenda.

- Make use of existing local infrastructure to coordinate with the VCS in both health and social care. Where this is absent, make long-term investments in infrastructure and capacity building.

- Ensure more consistent representation of charities in bodies leading transformation efforts.

The charity sector needs to:

- Find a set of 'good enough' common messages and coordinate the way these messages are communicated at both a local and national level.

- Be clear where they, as individual organisations, have strengths and where others can add more value.

> **Priority actions for the health and care system**
>
> - Incorporate the VCS perspective into decisions about health and social care at a national and local level.
>
> - Seek out existing forums through which to do so, or create them where they don't exist.
>
> - Where VCS representation is fragmented and overwhelming, take an active role in creating the mechanisms to coordinate these conversations.

Making progress within austerity

Principles for change

7. Charities and the health and care system must work to reduce unnecessary burdens on one another.

8. The public sector's crisis of funding and capacity needs to be the context for most conversations.

Recommendations

The health and care system needs to:

- Ensure funding and contracting arrangements support collaboration between charities and other providers, and minimise bureaucratic burdens.

- Recognise that the charity sector can bring ideas and resources to the system, but some charities will need support to do so effectively.

The charity sector needs to:

- Start to develop the partnerships that will be needed to respond to an increasingly place-based health agenda.

- Be wary of 'asking for more' in a resource-starved system. Frame conversations in terms of added value, not just the resources required.

> **Priority actions for the health and care system**
>
> - Review commissioning and procurement processes to identify areas which create an unnecessary burden on providers, or which disincentivise partnerships and consortia bids and consider how processes could be less adversarial.

CREATING EVIDENCE BASED SOLUTIONS

1. Expectations for evidence need to be both realistic and proportionate

The health and care system is entering uncharted territory as it is tasked with improving health outcomes and the quality of care against a backdrop of demanding efficiency targets. This means exploring new approaches—to reduce demand through prevention, to empower people to take control of their own health, and to better address complex and interrelated needs by providing a fully integrated service.

'We need to recognise where we're leading the evidence and breaking new ground… We can't let that stop us from trying new things.'

Warren Heppolette, Strategic Director: Health & Social Care Reform, Greater Manchester CCGs, Local Authorities & NHS England

The evidence base for innovative practice will always be—by definition—emergent, indicative, and incomplete. This means that, for a system which recognises it is in need of new ideas, there a choice between holding onto rigid evidence standards—and finding that nothing meets that standard—or taking a more pragmatic approach. As previously discussed (see Framework 5) the VCS operates in a more flexible environment that allows it to take on the risks in innovation that statutory bodies cannot. It can also bring resources to bear to pilot and test new approaches. Indeed, 35% of the findings of evaluations in this review related to interventions to support redesign and integration in the system (Figure 8).

'Evidence expectations vary by project. If it's a new project and quite innovative it would require relatively little evidence, while if it was something on a larger scale and less innovative I'd want to see something more substantial.'

Will Cleary Grey, Programme Director, Commissioners Working Together Group

'It matters that you have good quality evaluation, but it matters more whether or not you have any information on which to make a decision.'

Sally Burlington, Head of Programmes, Local Government Association

Of course, evidence of a certain quality is necessary for the health and care system to take informed decisions. However the drive towards 'gold standards' of evidence such as RCTs can have costs that considerably outweigh the benefits. Not every organisation is able, or needs, to produce individual evaluations to isolate attributable impacts on every outcome of interest.

'Attribution is near impossible—the system can be too complicated to disentangle. We can encourage voluntary sector organisations to attribute outcomes, but we must also encourage them to understand their evidence base—as well as the assumptions that led them to believe their initiatives will lead to improved outcomes and experience for their clients and the wider system.'

Tim Shields, Head of Business Intelligence, NHS Calderdale CCG

In many cases, evaluation based on a logical model of how change happens is the most appropriate approach in a complex system where attribution is not practical—ie, a *Theory of Change*[15] approach. A justification of the logic that links activities to outcomes can be drawn from the evidence base that already exists, as well as organisations' internal monitoring. This approach helps to demonstrate why a particular intervention is valuable and what it achieves, in a cost-effective way, at the same time as generating monitoring and evaluation that can underpin the constant improvement of services.

Commissioners: Only request evidence that is realistic for a project's stage of development. It is impossible for the charity sector—or for any partner—to be low cost, innovative, and rigorous to the degree demanded in clinical research all at the same time. If the system is to benefit from the innovative strengths of the VCS while keeping costs to a minimum, disproportionate standards for evidence should be avoided.

Charities: Avoid over-stating the evidence case. This is unconvincing and ultimately harmful. If evaluations are to support learning, development and partnership, they should be rooted in what is already known, led by what needs to be known, and upfront about what they can and cannot demonstrate.

All: Move away from evaluating complex system interventions in the same way as medical treatments. People have complex needs and take different pathways through the health and care system; so attempting to develop a meaningful control group is costly and often unrealistic. Furthermore evaluations that put disproportionate emphasis on whether outcomes were achieved by a *particular intervention* may fail to consider *how* and *why* outcomes were achieved, which limits opportunities for replication.

2. Charities and the health and care system need to agree what data is needed and how to produce it

The evidence which charities use to articulate their offer does not always align with the metrics and priorities which health and care system partners need to report on. Both sides may pursue common outcomes, but articulate this in different ways, making it more difficult for those within the health and care system to see a compelling reason to work together. This is not necessarily a case of needing to collect more data, but of using the right data.

Often the challenge arises where charity and health and care system partners do not discuss what metrics or information are needed before designing the intervention. Where partners in the charity and health and care sectors do not understand what data and evidence is important to each other upfront, charities can waste effort collecting data which is no use to anyone.

'You need to understand what kind of datasets we work with and how we present information to our potential referral sources… this can be achieved by involving commissioners at an earlier stage to understand what information they need and how it needs to be presented.'

Jeremy Bennett, Strategy & Planning Support Officer, Leicester City CCG

'The evidence we are looking for needs to have real and practical application to the health and care systems of today to make the experience of people better.'

Duncan Selbie, Chief Executive, Public Health England

Commissioners and decision-makers: Be clear about what information is required from charities, and why. We found throughout our qualitative research that charities often felt an expectation to produce certain information when that expectation did not actually exist among the relevant policymakers or commissioners. In order to avoid the production of unnecessary metrics, specific expectations should be communicated prominently—through formal engagements such as invitations to tender, as well as public material on websites and local forums and infrastructure bodies.

It is also important to recognise that shifting the priorities in what evidence is required will require a period of adjustment from providers, as evaluation takes time. Signals should therefore be given as early as possible, and timescales for evidence demands should take account of the time that providers must take to adjust.

Charities collect evidence for a range of reasons and not only for statutory audiences, but if health and care partners and charities communicate early there is potential for greater efficiency and effectiveness all round—for example if charities collect demographic data in the same way as commissioners record it results will be more directly applicable. If charities want to engage audiences from the health and care systems with the services they evaluate, it will be useful to consider the data those audiences will be interested in during planning stages, and if appropriate, involve them in planning.

Charities: Communicate evidence of impact and value in a way that aligns with the interests of decision-makers. Charities should be able to demonstrate a clear connection between their goals and the priorities of commissioners or policymakers.

3. The public sector needs to support charities to develop effective evidence in practical ways

As the task of demonstrating the effectiveness of interventions becomes more difficult and expensive for both charities and the health and care system, it will become increasingly important for partners to work together and share existing data effectively.

Collecting robust data is time consuming and expensive. It can be particularly challenging when interventions require clinicians to collect data—as many healthcare professionals struggle to add an extra task into their working day. However, much of the data which charities could use to demonstrate the impact of their interventions already exists within the health and care system—collected by hospitals, GPs and through public health programmes.

'Robust evidence is important for successful clinician engagement. Clinicians tend to want clinical data… they are attracted to programmes that use their own data.'

Liz Henderson, Redesigning the System Special Adviser, Macmillan Cancer Support

'We would like to use more clinical impact data but this is very expensive to collect.'

Amy Rylance, Head of Healthcare Professional Engagement, Diabetes UK

There are practical challenges in sharing data, but there is a precedent for navigating these in projects such as the Justice Data Lab, which NPC worked with the Ministry of Justice to set up.[16] And in the area of health, NPC has already supported the Health and Social Care Information Centre (HSCIC) to write a business case for a health analytical service which follows the Justice Data Lab model. This would measure the impact of services on secondary care—A&E, admissions, readmissions, lengths of stay and costs—by using public administrative data to assess the long-term outcomes of cohorts that have been subject to particular interventions compared to a matched comparison group.[17]

Challenges still remain, in securing the necessary investment to support this analytical service, and in overcoming the sensitivity of sharing data in the context of personal health. But these barriers are well worth overcoming, as improving data sharing could significantly lower the cost and streamline the process of producing robust evaluations of the outcomes that are central to delivering effective and efficient health and care services.

National decision-makers: Enable and support good evaluation—rather than simply demanding it—through data sharing and investment in scaling effective approaches. The statutory system is often a significant barrier to evaluating the very outcomes for which it demands evidence. Not only does the public sector hold the information that can support evaluation, it has the necessary size, influence and resources to support the replication and adoption of approaches that have been shown to be effective on a smaller scale.

It is not usually possible for charities to develop evidence at the scale required for replication across the public sector. The public sector is in the process of testing new models for delivering better health and care outcomes and charities should be incorporated into this process if their effective approaches are to take hold.

Charities: Collect and manage data in a way that is useful to partners. Charities' management information should not only aid effective organisational development, but should—in line with data protection legislation—support partnership and joint working. Effective partnership, even outsourcing evaluation, requires a clear picture of who a service is reaching and how it works.

PROPERLY INTEGRATING THE VCS OFFER

4. Mechanisms for VCS input to transformation efforts are needed in all parts of the system

Our interviews and workshops informed the frameworks developed for understanding how charities work and the additional value they bring. They demonstrated that the health and care system is open to involving the charity sector. However if the VCS is not represented within the discussions, it is unlikely that either its perspectives and values will filter into the various transformation agendas, or that its work will align effectively with the needs of commissioners.

'I think it's rare to have that route in and that level of relationship with the local authority…. It's rare to be able to talk to commissioners about what they actually want.'

Karl Demian, Director of Strategy and Development,
Royal Voluntary Service

'Because the VCS is represented at [Vanguard] board level we're seeing the case being made at the strategic level. Eventually this will filter down to provider level.'

Tim Shields, Head of business intelligence, NHS Calderdale CCG

Currently, charities are not consistently represented in the key discussions around transformation taking place around the country. Without representation in these forums, opportunities for health and care services to evolve as envisaged in the Five Year Forward View will be missed.

All local areas are looking for solutions to the same issues. Whether it is under the banner of major transformation programmes such as the NHS Vanguards, in devolution areas, such as Greater Manchester, around the development of Sustainability and Transformation Plans, or in the work of Health and Wellbeing boards, local infrastructure organisations, or other health forums, it is vital that the charity perspective is brought to the table.

Local and national decision-makers: Ensure more consistent representation of charities in bodies leading transformation efforts. Involvement in strategic conversations will help charities understand the framework that decisions are being made in, and help the health and care system to incorporate ideas which the charity sector brings.

Charities: Be clear where you, as an individual organisation, have strengths and where others can add more value and collaborate to create a holistic offer. The commissioners and system leaders consulted in this research valued both the credibility and reach of large, well-known organisations, and the links into communities which local organisations hold. All types of organisation have their roles to play, but claims by any one organisation to be all things to all people are not considered credible and can obstruct constructive joint working.

5. Charities need consistent messages and coherent representation

The health and care sector struggles to hear and respond to the range of priorities from different parts of the charity sector. As each charity seeks to get its voice heard, there may be some isolated wins, but the charity sector will struggle to make a strategic intervention in the fundamentals of how health and care is arranged.

'Charities can be very wedded to a single issue. We need to approach things more strategically, with a broader remit, and then bring specific constituents into that solution.'

Health system leader*

While many charities draw their credibility and support from their very specific focus—for example on a particular condition—and it is this focus which harnesses the enthusiasm of many volunteers and donors, it is clear that the health and care system is not able to engage with issues through these narrow lenses. It is therefore vital that the VCS works together to articulate a common set of asks to the health and care system at the national and local level.

Partnership working is a recognised strength of the sector, and it is demonstrated in the numerous coalitions which exist across the sector to press key areas of shared interest (such as the Care and Support Alliance) and in projects like *Doing the Right Thing.* However it was clear from our discussions that coordinating messages between national and local, large and small, specific and generalist charities in order to bring simple and clear messages to the local health and care system is still proving a challenge.

'We identified 600 different voluntary and community groups. Healthcare professionals tended to not be aware of these groups individually, but the voluntary sector board provided a joint point of contact... The programme's success was in large part to this smooth communication.'

Tracey Roose, Director of Transformation, NHS Kernow CCG

If the VCS is to play the role it wants to within the transformation agenda then urgent action is needed to coordinate its messaging and deliver these coherently. This could mean coordinating high-level policy asks through larger, national organisations; this may mean selecting representatives for local strategic forums such as Health and Wellbeing Boards, or it may mean making better use of local voluntary sector infrastructure organisations.

Statutory partners need to be clear where they engage charities as individual organisations, and where they expect a charity to represent a wider community of interests. Charity trustees also need to support the charities they govern to play this role of representing the sector, clearly signalling their support for the charity to pursue a wider vision of its mission by representing sector wide interests where appropriate—feeding information and opportunities back to a wider community of partners.

Local commissioners: Make use of existing local infrastructure to coordinate with the VCS in both health and social care. Where this infrastructure is absent, make long-term investments in infrastructure and capacity building. The challenge of working with the charity sector is not a new one, and many local authorities have invested in capacity-building (including through CVSs), communications forums, and grant funding to improve engagement with the charity sector. These techniques, channels and resources can be used in public health and social care, but at present are rarely linked into NHS and CCG structures. The NHS and CCGs do not need to replicate these structures but could use existing channels to improve their own communication for relatively little additional cost.

Charities: Find a set of 'good enough' common messages and coordinate the way these messages are communicated at both a local and national level. If the VCS could get behind a small number of common offers to improve patient experience and outcomes across a range of beneficiaries and disease types, it would be difficult for the public sector to ignore this. If charities are to be represented as a sector, nominated organisations or individuals must be trusted to deliver this role beyond their particular interests and must feed back information and opportunities to the wider community.

* This quotation is taken from an NPC interview conducted as part of this research, but has been anonymised at the request of the interviewee.

6. The statutory system needs to look outside itself to implement new approaches

Integration is a watchword for the Five Year Forward View—which targets coordination *'between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment'*.[18] Integration implies a more holistic view of health and of individuals who interact with the health and care system: moving away from a model of medical treatment and cure to incorporating the social factors which keep people well or aid their recovery and to creating a greater coherence between different pathways through the system. The Five Year Forward View's proposal for *'a radical upgrade in prevention and public health'* also indicates that the health and care system will need to extend its reach significantly in the non-medical space.

'We need to change the game in prevention and early intervention… domestic violence, unemployment, housing, low educational attainment—it all becomes part of the scope.'

Warren Heppolette, Strategic Director: Health & Social Care Reform, Greater Manchester CCGs, Local Authorities & NHS England

Among our interviewees, the challenge of implementing the Five Year Forward View was seen as both structural and cultural. The NHS in particular is forced to work at such a pace, and on short time horizons, that stepping outside these immediate pressures and taking a decision to do things differently is very difficult. Budgets and financial incentives remain tied to institutional boundaries, and professional expectations and relationships are firmly established. To overcome these divisions requires the engagement of a huge number of stakeholders across different organisations.

'We need to understand how literal the NHS is. It seeks permission for everything. This is in part because it's so busy getting through the day, next week is another country.'

Duncan Selbie Chief Executive, Public Health England

'We can bring together people from different fields in a way that the public sector is unable to do… If the NHS tried to run something similar it would be done by the position or rank of the professional not by the condition they are trying to support… Charities have the ability to step outside the natural hierarchy of the NHS.'

Amy Rylance, Head of Healthcare Professional Engagement, Diabetes UK

Devolution may provide an opportunity here—where health and social care are part of devolution plans, the focus is often on integration of care and more effective care pathways between the different health bodies in a geographical area. Greater integration can happen without formal devolution, but devolution can provide a catalyst to discussions about transforming health services. As the practices of devolution are emerging, it is clear that the health and care system will remain accountable to much of the existing national regulation, and it remains to be seen how far accountability within health and care will change.

'One of our key strengths is the ability to transfer knowledge across geographical areas or parts of the health and care.'

Pam Creaven, Director of Services, and Jo-Anna Holmes, Head of Integrated Care, Age UK

> **Local and national decision-makers: Draw on the strengths of the VCS in reshaping the NHS around the integrated, person-centre vision of the Five Year Forward View.** It is very difficult for time-poor public servants—with responsibility for delivering health outcomes while finding financial savings—to undertake innovative or risky activity. Charities have an opportunity to use their freedom from institutional structures to push approaches which do not fit neatly within the health and care system's structures and expectations, and statutory partners should capitalise on this to generate momentum.

MAKING PROGRESS WITHIN AUSTERITY

7. Charities and the system must work to reduce unnecessary burdens on one another

The charity sector constantly struggles with capacity; its resources are very limited in comparison to public spending on health. Earlier in this report (see p. 25) we discussed the dual role which charities play in both delivering services within the health and care system (whether contracted or charitably funded) and bringing ideas to the health and care system. The capacity challenges charities face differ depending on the role they are seeking to play.

The charity sector can struggle to respond to the kinds of contract opportunities that health and care commissioners tend to offer. Charities are often too small or specialist to deliver a contract for an entire locality, or across a whole range of services. Collaboration and consortium approaches can be effective, but are time-consuming to establish.*

'Delivering at scale is a challenge for charities, but incredibly important for the public sector.'

Hardev Virdee, Chief Finance Officer, Wandsworth Clinical Commissioning Group

'There isn't a single charitable provider who could provide all the things we need, which makes things very hard… Consortia often get bogged down in the business of how to work together as providers and as a result don't focus on engaging well with commissioners, or on articulating what they will deliver.'

Innes Richens, Chief Operating Officer, NHS Portsmouth Clinical Commissioning Group

The capacity challenges the VCS faces in ensuring it is able to feed in its ideas are different. This is primarily a product of the significant time and resource needed to build the relationships necessary to get traction for new ideas in a system which lacks mechanisms for replication. Charities must exert influence wherever decisions are being made, and even large charities with dedicated national policy teams, and those with a decentralised (eg, federated) structure will struggle to engage everywhere. Smaller charities with no route to national influencing, and little capacity to engage locally will struggle most. Charities can't resolve this problem individually—instead they will need to share the burden of engaging and grapple with the challenges of doing so effectively (as discussed on p. 44).

Commissioners: Ensure funding and contracting arrangements support collaboration between charities and other providers, and minimise the bureaucratic and other burdens on providers. Health and care commissioners should look for approaches which foster the collaborative links that charities have worked to develop rather than undermining them through open competition—for example through careful market engagement, continuing work to make standard contracts less burdensome, introducing alliance contracting, incentivising partnerships or through the greater use of grants as an alternative to contracting.

Charities: Start to develop the partnerships that will be needed to respond to an increasingly place-based health agenda. The drive towards increased integration of health and care within localities, implies that very few organisations will be able to address problems independently. Commissioners cannot maintain relationships with a large and varied body of providers and influencers. Charities need to start building relationships and habits of joint working with partners of different sizes and specialisms, so that collaborative approaches can emerge based on the respective strengths of partners. This will provide a stronger foundation for joint contract delivery than a partnership built in response to a specific tender.

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* The review of VCSE engagement with the health and care system, commissioned by the Department of Health and its Arms Length Bodies, will shortly make its final recommendations on how contracting arrangements between the VCS and statutory health and care system partners can be improved. These, along with current work to review the NHS standard contract, are likely to provide strong foundations to make improvements in this area.

8. The public sector's crisis of funding and capacity sets the context for all conversations

Local authorities are facing budget cuts which put extreme pressure on public health and on social care, CCGs are equally being encouraged to make dramatic savings while integrating care and improving patient outcomes, and many hospitals are running deficits and facing a level of demand which forces them to cancel routine operations. This means that, while the health and care system seems to have a shared understanding of the necessary direction of travel, it is incredibly difficult to get any real movement on the frontline—commissioners simply don't have the capacity to respond to the offer which the VCS can make.

'It's not that there is an absence of evidence or professionalism, it's that there is no purchaser. Charities are ahead of the market… Commissioners don't have the headspace to work at this pace of change.'

Guy Boersma, Managing Director, Academic Health Science Network

'As a CCG a lot of our energy in terms of finance, clinical and management capacity is focused on traditional [public sector] providers—this transactional stuff can consume a lot of our resource.'

Tim Shields, Head of Business Intelligence, NHS Calderdale CCG

Charities get traction where they offer solutions to a problem the health and care sector is grappling with. Aligning with health and care decision-makers' language and timing will make it easier to get traction—and for most health and care decision-makers, doing more with diminishing resources is at the forefront of their concerns.

Some commissioners reported finding it difficult to work with charities who did not understand the system or were perceived as arrogant in their communications—suggesting that they 'know better' than statutory providers. There was a sense that charities asking for additional resources for improved services were being unrealistic—and this made their requests low priority.

'The relationship can easily break down if the third sector is seen as dictating terms to the NHS… Instead the third sector needs to be seen as an enabler that knows when to step back.'

Liz Henderson, Redesigning the System Special Adviser, Macmillan Cancer Support

'The system increasingly needs to safeguard standards of care at a lower cost. This often isn't the pitch of the charity sector… charities need to be prepared to talk about substitution and not just additionality—and to recognise the need for greater efficiency.'

Sir David Dalton, Chief Executive, Salford Royal NHS Foundation Trust

Our research indicates that charities are becoming increasingly adept at positioning their asks in this environment, but there is a trade-off in the way these conversations are approached. As mission driven organisations, charities must hold the statutory system to account when they see it failing to deliver suitable care for the beneficiaries they care about. But the more they are able to do so in recognition of the financial constraints the system faces—and where possible to suggest practical improvements—the more likely this will be to gain traction.

Charities: Be wary of 'asking for more' in a resource-starved system. Frame conversations in terms of added value, not just the resources required. Charities have a role in speaking out when services are not doing the best by beneficiaries, but they also have a role in supporting health professionals to achieve the best results possible within resources available. Charities need to start their conversations with health and care partners from the position of understanding the financial reality and continue to look for ways to do things better within resources available. These conversations are best framed in terms of what can be offered, rather than the support required (see Section 1: What is the VCS offer to the health and care system?).

Local and national decision-makers: Recognise that the charity sector can bring ideas and resources to the system, but some charities will need support to do so effectively. The resources of the VCS are often called upon to plug the gaps in funding or human resources for statutory provision. This is an important role for the sector to play in the current climate, but this needs to be balanced by some investment in supporting the capacity of the sector and engagement on equal terms if these benefits are to be felt as part of a more coherent and sustainable health and care system.

CONCLUSION

The harsh realities of the current economic climate have the potential to accelerate transformation in the health and care system—towards a new understanding of health and care which most partners agree is essential, but which has yet to be realised.

Making holistic, integrated, preventative and person-centred care a reality will require a shift away from the narrow focus of the current health and care system, constructed around a highly centralised statutory system—to one which capitalises on the expertise and resources of all sectors, including the voluntary and community sector. But, as this research has laid bare, we are only just out of the starting blocks in terms of establishing the kind of relationships and ways of working between the statutory and voluntary sector actors that will be necessary to achieve this change at the pace and scale required.

This research shows that charities can add value to the health and care system in a range of ways and that charities have a legitimate role in the transformation of the NHS and the wider health and care system in the coming years. It has attempted to start the process of breaking down the barriers between the VCS and its statutory health and care system partners. In doing so, the research has contributed three things:

• It has **developed a shared language** to make clear what charities do, how they do it, what they achieve—and for whom—and the features of charities that mean they have a unique contribution to make to the health and care system.

• It has brought together the evidence from a partnership of national UK health and care charities and from consultation with a wide range of stakeholders which has **confirmed that charities can deliver on the offer laid out in these frameworks**. The evidence reviewed is not comprehensive, but the story it tells is compelling:

– Charities can deliver strong health & wellbeing outcomes for patients and do so in a way that is either more cost-effective to the system, incurs no additional cost or which helps the health and care system to run more smoothly.

– Charities are not just a mechanism for delivery, they can also make a powerful contribution to the way services and systems are designed.

– Charities not only help individuals through one-to-one relationships, but they also help systems to function more effectively by innovating and gifting new models and approaches, and integrating actors from across institutions, sectors and pathways.

– Charities live up to the promise of operating across institutional boundaries—helping people in settings ranging from village halls to hospitals, tackling a wide range of needs, and offering support to help people stay safe and healthy after discharge from hospital, to enabling people to stay out of hospital in the first place, to caring for people in a place of their choosing at the end of their lives.

• And finally, it has established—through qualitative research involving charities, commissioners and senior policymakers—a set of **recommendations** for charities, commissioners and policymakers to take practical action to integrate this offer into the future health and care system.

There is increasing recognition that our current model of health and care is unsustainable and that we are at risk of providing care and treatment of poorer and poorer quality. This reality presents an unprecedented opportunity to redesign healthcare systems to focus on holistic, integrated, preventative and person-centred care.

To achieve this, both the VCS and the statutory system must change their behaviour; not always in substantial ways, but with a sense of urgency. By fully understanding each other's needs and priorities, and by making small compromises and concessions, partnership between charities and statutory organisations can build a truly integrated health and social care system which is sustainable and fit for purpose.

Charities have a legitimate role the transformation of the NHS and the wider health and care system in the coming years.

Appendices

APPENDIX A: METHODOLOGY

Overall methodology

Developed 'areas of work' (Framework 1) and defined priority outcome areas	Reviewed project partner evidence against initial framework	Shared initial findings with project partners and health and care leaders	Refined and extended frameworks	Reviewed evidence against system pathway (Framework 2) and patient pathway (Framework 3)

Interviews with charities, commissioners and health and care leaders to explore success factors and barriers to joint working	Interviews to interrogate Phase 1 findings and explore charities' ways of working (Framework 4) and 'additional value (Framework 5)

This research was carried out in two phases. The nature of the second phase of work was determined by what we found in the first phase, and the comments of project partners and stakeholders consulted at the midpoint of the research. The initial phase of work responded to the brief set out by project partners which sought a synthesis and analysis of the evidence *'that arises from service redesign and / or delivery work, undertaken by VCS organisations, which credibly and demonstrably improves patient and user experience, outcomes and the efficiency of resource use'*. In response to this brief, the first framework ('areas of work') was created based on existing research and a focus group with charity partners. Submitted evidence was then assessed based on it's ability to demonstrate the connection between these areas of work and priority outcome areas (which were defined by project partners).

In parallel to this first review of the evidence, interviews were conducted with charity representatives, commissioners and health and care leaders, in order to determine the conditions under which projects such as those in the evaluations submitted came into being.

At the conclusion of this first phase of work, a number of workshops were held with project partners, and representatives from across the health and care system (see acknowledgements, Appendix B). Attendees suggested that whilst evidence for the outcomes achieved by charity activities were a necessary precursor to engagement, this evidence was not sufficient to support meaningful engagement. Attendees at these workshops suggested that it would be valuable for this research to provide a sense of where in the system charity activities were achieving positive outcomes, and also how charities offer a unique approach.

In response to this feedback, we developed additional frameworks (Frameworks 2, 3, 4 and 5) and conducted another review of the evidence as well as further interviews. The second review of the evidence focused on the points at which charity activities intervened in the system and patient pathway (Frameworks 2 and 3) whilst qualitative research aimed to draw out the unique elements of charities' approaches to service design and provision (Frameworks 4 and 5).

Methodology for quantitative assessment of evidence (Frameworks 1, 2 and 3)

Approach

The evidence assessment used a deductive content analysis methodology.[19] That is to say, frameworks for analysis were defined before assessment of documents (as opposed to defining categories based on the evidence submitted). This was partly due to time available (as an inductive methodology requires reading all the submissions once through before analysis can begin), but it is also because frameworks are designed for communication as well as analysis—that is, the findings need to resonate in the context of ongoing discourse, and categories for analysis should therefore match up to ongoing discussions, as well as pre-existing research and definitions.

Assessment is limited to the *information contained in the documents only*. At various points in analysis we have used a 'concerns' flag. This includes cases in which there are clear methodological concerns (eg, very small or unrepresentative samples) but also those where documents provide insufficient information to make a judgement.

Time and resources available for the assessment were limited. As such this work should be treated as a 'rapid evidence assessment', designed to create a summary picture of the landscape of evidence and activity, rather than rigorous interrogation of individual documents.

Documents were assessed twice—once after the development of Framework 1, and again after the development of Frameworks 2 and 3 which were developed based on initial feedback to Framework 1 analysis from stakeholder workshops.

Terms for analysis

'Document': Individual documents submitted by organisations. Multiple documents may relate to a single activity or intervention.

'Case': A project, intervention or programme that has been evaluated. Cases may be made up of a single document, or multiple documents.

'Finding': A (set of) finding(s) that relates to the delivery of outcomes within a specified area of work (3 outcome categories and 7 'areas of work' were defined for analysis, meaning that each individual case could return up to 21 data points)—see below for a full explanation.

Assessment of evidence quality

We classified evaluations into 5 categories based on the way they had tested the outcomes achieved. For the purposes of this review we created an adapted version of the Nesta standards of evidence.[20]

The distinction in our approach was to focus on the first three levels of the Nesta scale. This is because it is rare to see evaluations of level 4 or 5, given that these levels of evidence cannot often be achieved by the charity sector alone.* The public sector is often the only one with the size and resources to genuinely take concepts to scale and test their effectiveness at that level.[21] On that basis it would be unreasonable to expect this level of evidence to be a precursor to engagement with the sector.

We also added additional layers to levels 2 and 3 of the Nesta scale to improve our ability to differentiate approaches. This was on the basis that 'capturing data to show a positive change' (Nesta level 2) can either be done through a single methodology, or by using multiple methodologies in order to test and triangulate the change being observed. Similarly, 'demonstrating causality through a control or comparison group' (Nesta level 3) can be achieved either by using a comparison group, or by randomising the allocation of subjects between a test and control group (an RCT).

The method used for evaluation is distinct from the quality of that evaluation. It is, for example, possible to have high quality survey and a poor quality survey. To that end, we also assessed findings on the quality of evaluation. Quality was assessed on binary scale—ie, findings were either marked as having concerns about quality, or they were not.

Given that assessment was based on the evidence presented in the documents submitted, the 'concerns' flag was also used where there was insufficient information in the document to make a judgement about evaluation quality, or where the information given indicated that findings may not support the claims being made (ie, very small or unrepresentative samples).

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* Level 4: 'one or more independent replication evaluations that confirm your conclusions' and Level 5: 'you have manuals, systems and procedures to ensure consistent replication and positive impact.'

Category name	Definition
Descriptive	There is a clear explanation of how and why activities should lead to desired outcomes.
Single method evaluation	Captures data using a single method that shows a change (does not use a control / comparison group).
Mixed method evaluation	Captures data using mixed methods to triangulate a change (does not use a control / comparison group).
Comparative evaluation	Assesses causation using a control or comparison group.
RCT	Assesses causation through the random allocation of control and test subjects.

In total 30% of findings were marked as having concerns about evaluation quality.

Heat map scoring

To create the heat maps to show evidence quality, each segment was scored on the basis of the following formula:

Quantity of evidence x evaluation approach x quality of evaluation

Levels of evidence were weighted on a three point scale:

Level of evidence	Weighting (no quality concerns)	Weighting (quality concerns)
Descriptive	x1	x0.5
Single method	x2	x1
Mixed method OR comparative evaluation OR RCT	x3	x1.5

The highest category of evidence includes mixed methods evaluations, comparative evaluations and RCTs—a departure from the approach put forward by Nesta. This is in recognition of the fact that evidence standards need to be proportionate to the scale of a project and the resources available, and that different methods are appropriate depending on the goals of an evaluation.

Methods like RCTs can be a very effective methodology for determining what effect activities have on their beneficiaries, but the evidence provided is specific to the context in which the RCT was applied. Where the goal of evaluation is to discover *why* certain approaches work, *how* they work, and *for whom*, other evaluation methods may be more appropriate within the resources available.

Raw heat map scores

	Outcomes		
Area of work	Health & wellbeing	Productivity & efficiency	Resilience & cohesion
Direct treatment and support	54.5	18	23
Engaging people in keeping healthy	19	4	4.5
Supported self-management	40	7	7
Involving families and carers	29	3	5.5
Integrating and coordinating care	27	8.5	4
System redesign	30	25	6
Support for health and care professionals	15	9	0

| **System pathway point**	Health & wellbeing	Productivity & efficiency	Resilience & cohesion
Primary (community)	148.5	47.5	47.5
Primary (statutory)	95.5	39	8
Secondary / tertiary	99	42	7.5
Emergency	47	25	7.5

Note: Total scores are higher in the 'system pathway' heat map than in the 'areas of work' heat map because the impact of interventions can be felt at multiple points in the system pathway. Often evaluations dealt with a range of beneficiaries at different points in the pathway. A single set of findings may therefore demonstrate outcomes that are felt at multiple points in the system pathway.

By contrast, a data point was defined by an area of work (see pp. 54–55). The areas of work framework (as the first framework) was designed on the basis that categories would be mutually exclusive. This was most often the case—but in a very small number of cases findings were duplicated where they applied equally to more than one area of work, and where findings were not provided in any greater granularity.

Defining a 'finding'

In the evidence submitted for *Doing the Right Thing* **research, it was often the case that multiple findings relating to multiple outcome areas were found in single evaluations. The text below gives the definition we used to identify individual 'findings' within this information.**

Generally, a finding is any situation in which an activity (categorised under one of seven 'areas of work') is reported alongside a corresponding outcome.

Area of work ⟶ Outcome = Finding

Assessment of evaluation quality
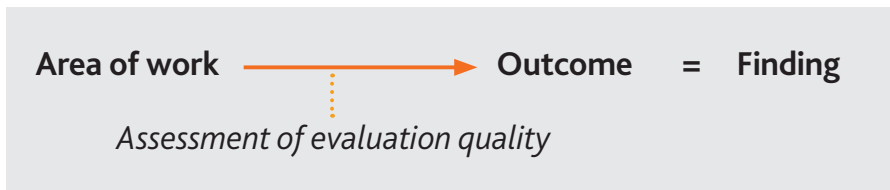
The relationship between an area of work and an outcome is determined by an assessment of the methods used to evaluate their connection (eg, an activity may be 'correlated' to a particular outcome, or it may 'cause' a particular outcome, or the connection may be unclear from the evidence presented).

Though in the simplest cases areas of work are evaluated on their ability to achieve single outcomes, the evidence submitted also presented a number of more complex scenarios, namely:

Areas of work leading to multiple outcomes

In many cases particular areas of work are associated with multiple outcomes.

On the basis that the purpose of our research was to assess the level of evidence for charities' ability to achieve outcomes in three specific areas (1. Health & wellbeing, 2. Productivity & efficiency, and 3. Resilience & cohesion), we applied the following rules to cases with multiple outcomes attached to a single area of work:

Area of work ⟶ Health & Wellbeing Outcome 1 = Finding 1

⟶ Health & Wellbeing Outcome 2

⟶ Productivity & Efficiency Outcome 1 = Finding 2

This method was used to avoid skewing results based on the granularity of reporting and to ensure that the assessment of evidence was not excessively time intensive.

In theory it would be possible, for example, to take the results from each individual survey question as a separate finding. However, it is not necessarily true that a 36 question survey designed to determine a person's wellbeing demonstrates more improvement in wellbeing, or even better evidence, than a 25 question survey designed to do the same thing. Equally, while some evaluations would report the findings of comparable studies across multiple sites as separate findings, others would report an aggregate figure across all pilot sites. In the same way, annual data collected over 20 years and published in different reports may be reported as 20 findings, or it may be aggregated into a single coefficient.

By limiting each area of work to a maximum of three 'findings' (ie, a health & wellbeing 'finding', a productivity & efficiency 'finding' and an individual and community resilience & cohesion 'finding') we aimed to ensure that results were not skewed by the granularity of reporting.

A finding, in the context of this project, may therefore refer either to a single finding, or to a set of findings, relating to a priority outcome area.

There are clear limitations to this methodology, namely in that it does not differentiate activities that achieve multiple benefits from those that achieve single benefits. However, given the need to aggregate findings across a large range of activities and a large range of methods and reporting styles, this was judged to be the best approach available.

This means that for any 'case' there are 21 possible sets of findings:

	Outcomes		
Areas of work	Health & wellbeing	Productivity & efficiency	Resilience & cohesion
Direct treatment and support	1	2	3
Engaging people in keeping healthy	4	5	6
Supported self-management	7	8	9
Involving families and carers	10	11	12
System redesign	13	14	15
Support for health and care professionals	16	17	18
Integrating and coordinating care	19	20	21

APPENDIX B: ACKNOWLEDGEMENTS

The research underpinning this report has been made possible through the contributions of a wide range of individuals and organisations who have given time and expertise. NPC would like to thank all those who have supported the research and production of this report.

Project partners

Doing the Right Thing **project chairs:** Charles Alessi, Senior Advisor at Public Health England and Tom Wright CBE, Chief Executive, Age UK.

Doing the Right Thing **project team:** Charlotte Augst, Richmond Group Partnership Director; Kate Jopling, *Doing the Right Thing* project manager and Ruthe Isden, Health Influencing Programme Director at Age UK.

A number of individuals from the below partner organisations also dedicated time to the design, conduct and review of this research:

- Age UK
- Alzheimer's Society
- Arthritis Research UK
- Asthma UK
- Breast Cancer Now
- British Heart Foundation
- British Lung Foundation
- British Red Cross
- Diabetes UK
- Macmillan Cancer Support
- Mind
- The Neurological Alliance / MS Society
- Public Health England
- Rethink Mental Illness
- Royal Voluntary Service
- Stroke Association

Research participants

The following individuals offered their support in the development of the research through attending workshops, focus groups, or participating as interviewees:

- Amy Rylance, Head of Healthcare Professional Engagement, Diabetes UK
- Amy Sinclair, Partnerships and Policy Manager, Public Health England
- Andrew Proctor, Director of Advice and Support, Asthma UK
- Bridget Turner, Director of Policy and Care Improvement, Diabetes UK
- Catherine Davies, Executive Director, Monitor
- Catherine Foot, Deputy Director of Policy, The King's Fund
- Catherine Pollard, Pricing Development Director, Monitor
- Cathy Morgan, Deputy Director, Performance, Partnership and Accountability Strategy Directorate, Public Health England
- Charlotte Williams, Programme Manager – New Care Models Team, NHS England
- Sir David Dalton , Chief Executive, Salford Royal NHS Trust
- David Bramley, Domain Team Lead, NHS England
- David Paynton, National Clinical Lead, RCGP Centre for Commissioning
- Deborah Kirkham, Clinical Fellow, NHS England
- Don Redding, Policy Director, National Voices
- Duncan Selbie Chief Executive, Public Health England
- Edward Davies, Policy Fellow, The Health Foundation
- Elaine Tanner, Head of Influencing and Engaging, British Heart Foundation
- Emma Easton, Patient and Public Partnerships Lead, NHS Patients and Information Directorate
- Felicity Dormon, Senior Policy Fellow, The Health Foundation
- Fiona Russell, Advisor, Local Government Association
- Gavin Terry, Policy Manager, Alzheimer's Society
- Guy Boersma, Managing Director, Academic Health Science Network
- Hardev Virdee, Chief Finance Officer, Wandsworth Clinical Commissioning Group
- Helen Walker, Deputy Director for Equity and Communities, The Department of Health

- Innes Richens, Chief Operating Officer, NHS Portsmouth Clinical Commissioning Group
- Jacky Jones, Barts Health NHS Trust, Breast Clinical Nurse Specialist
- Jeremy Bennett, Strategy & Planning Support Officer, Leicester City CCG
- Joanna Goodrich, Head of evidence and learning, Point of Care Foundation
- Jo-Anna Holmes, Head of Integrated Care, Age UK
- Johanna Ejbye, Senior Programme Manager, Health Innovation, NESTA
- Julie Wood, Chief Executive, NHS Clinical Commissioners
- Karl Demian, Director of Strategy and Development, Royal Voluntary Service
- Katie Robinson, Deputy Director in the Strategy Group, NHS England
- Linda Patterson, Clinical Vice President, Royal College of Physicians
- Lindsay Marsden, Policy & Learning Manager, Big Lottery Fund
- Liz Henderson, Redesigning the System Special Adviser, Macmillan Cancer Support
- Lynda Blue, Healthcare Innovation Programme Manager, British Heart Foundation
- Mark Hill, Policy & Analysis Officer at Association of Directors, Adult Social Services
- Martin McShane, Medical Director for Long Term Conditions, NHS England
- Murray Rose, Director of Commissioning, Darlington Borough Council
- Pam Creaven, Director of Services, Age UK
- Patricia Conboy, Policy Manager, British Geriatrics Society
- Paul Carey-Kent, Policy Manager (Health, Social Care & Welfare Reform), CIPFA
- Paul Corrigan, Health commentator and independent consultant
- Paul Streets, Chief Executive, Lloyds Bank Foundation for England and Wales
- Phil McCarvill, Deputy Director of Policy, NHS Confederation
- Polyanna Jones, Collaboration Lead, New Care Models Team, NHS England
- Ruth Thorlby, Acting Policy Director, Nuffield Trust

- Sally Burlington, Head of Programmes, Local Government Association
- Steven Laitner, National Clinical Lead for Shared Decision Making, Department of Health
- Tim Shields, Head of Business Intelligence, NHS Calderdale CCG
- Tracey Roose, Director of Transformation, NHS Kernow CCG
- Warren Heppolette, Strategic Director: Health & Social Care Reform, Greater Manchester CCGs, Local Authorities & NHS England
- Will Cleary Grey, Programme Director, Commissioner Working Together Group

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TRANSFORMING THE CHARITY SECTOR

NPC is a charity think tank and consultancy which occupies a unique position at the nexus between charities and funders, helping them achieve the greatest impact. We are driven by the values and mission of the charity sector, to which we bring the rigour, clarity and analysis needed to better achieve the outcomes we all seek. We also share the motivations and passion of funders, to which we bring our expertise, experience and track record of success.

Increasing the impact of charities: NPC exists to make charities and social enterprises more successful in achieving their missions. Through rigorous analysis, practical advice and innovative thinking, we make charities' money and energy go further, and help them to achieve the greatest impact.

Increasing the impact of funders: NPC's role is to make funders more successful too. We share the passion funders have for helping charities and changing people's lives. We understand their motivations and their objectives, and we know that giving is more rewarding if it achieves the greatest impact it can.

Strengthening the partnership between charities and funders: NPC's mission is also to bring the two sides of the funding equation together, improving understanding and enhancing their combined impact. We can help funders and those they fund to connect and transform the way they work together to achieve their vision.

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This report is based on the work NPC undertook with and for the *Doing the Right Thing* partnership, bringing together the Richmond Group of Charities and other charity and statutory partners.

The
Richmond
Group
of Charities

In partnership with