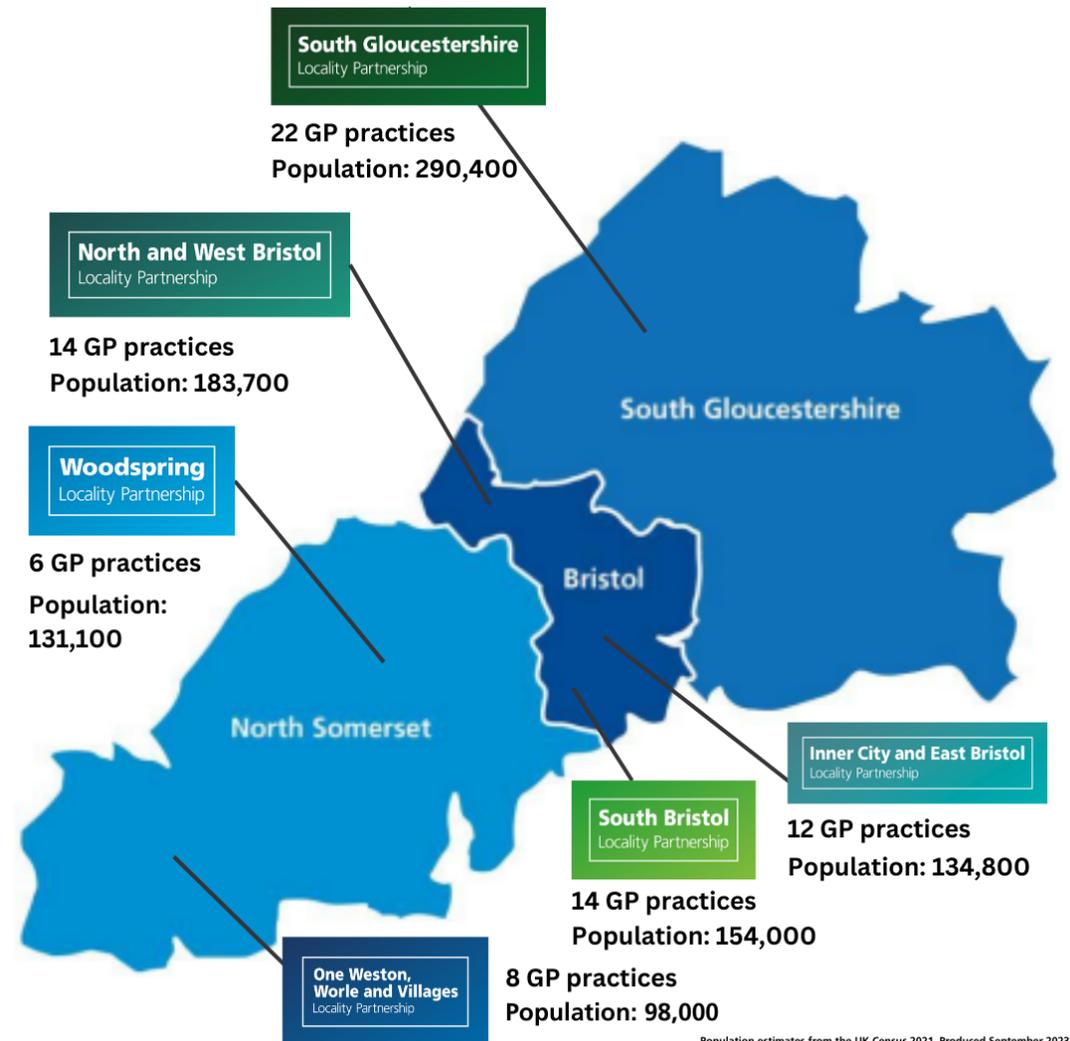


Developing an evaluation framework for Locality Partnerships

Project report and guidance

February 2024



Glossary

BNSSG ICB: Bristol, North Somerset and South Gloucestershire Integrated Care Board.

BNSSG ICS: Bristol, North Somerset and South Gloucestershire Integrated Care System.

Locality Partnerships: Place-based partnerships made up of local health, social care, and voluntary sector organisations. They work at a local level with their communities to improve health and wellbeing. There are six in BNSSG: South Gloucestershire, North and West Bristol, Inner City and East Bristol, South Bristol, Woodspring, and Weston, Worle and Villages.

VCSE: Voluntary, Community and Social Enterprises.

Theory of change: A tool to help an organisation/project describe the problem(s) it is trying to address and a strategy to do this. A theory of change can be used as the foundation of organisation/project strategy, evaluation, and communication. Evaluation can involve the testing of a theory of change.

Problem statement: The problem(s) the organisation/project is aiming to solve.

Resources (what you invest): The resources that go into the project that an organisation/project team needs to be able to carry out its activities and achieve outcomes.

Activities (what you do): The actions that an organisation/project team does to deliver a project day-to-day. Activities are within an organisation/project control. Actions should be supported by resources.

Reach: Target group(s) for organisation/project activities.

Outputs (what your activities produce): Products, services or facilities that result from activities. These are often expressed quantitatively; for example, number of users, how many sessions they receive and the amount of contact they had with a project.

Mechanisms (how you deliver your activities): The ways by which an organisation/project team delivers its work (such as the quality of services, relationships and the values and attitudes of staff).

Enablers (what can help or hinder): Internal and external conditions/factors that need to be present or absent to allow an organisation/project work to succeed. The presence or absence of enablers can help or hinder a project.

Short-term outcomes (goals to attain in short term): Changes, benefits, learning or other effects that result from activities and outputs. These short-term outcomes usually include changes in knowledge, attitudes, skills, relationships within target groups which an organisation/project can achieve on its own (directly influence).

Intermediate outcomes (goals to attain in medium term): Changes in behaviour, practices, policies, allocations to which short-term outcomes can contribute (indirectly support).

Long-term outcomes (goals to attain in long term): Changes in health and social outcomes that an organisation/project is trying to achieve and to which your short and intermediate outcomes can contribute (indirectly support).

Introduction

This report summarises the work and outputs from a project that aimed to develop an evaluation framework for the two Locality Partnerships in North Somerset: Woodspring, and Weston, Worle and Villages (December 2022-March 2024). This is a working document targeted at people who plan, fund, deliver and evaluate organisations, services, and projects. You can refine and adapt the theories of change and evaluation examples to meet your needs.

Methods

The project included five stages:

1. Scoping research to understand Locality Partnerships context and potential evaluation approaches (December 2022-January 2023)
2. Decision on a theory of change approach (January-February 2023)
3. Co-development and refinement of the theory of change (March-December 2023)
4. Application of the theory of change for evaluation purposes (January-February 2024)
5. Preparation of report and guidance (January-March 2024).

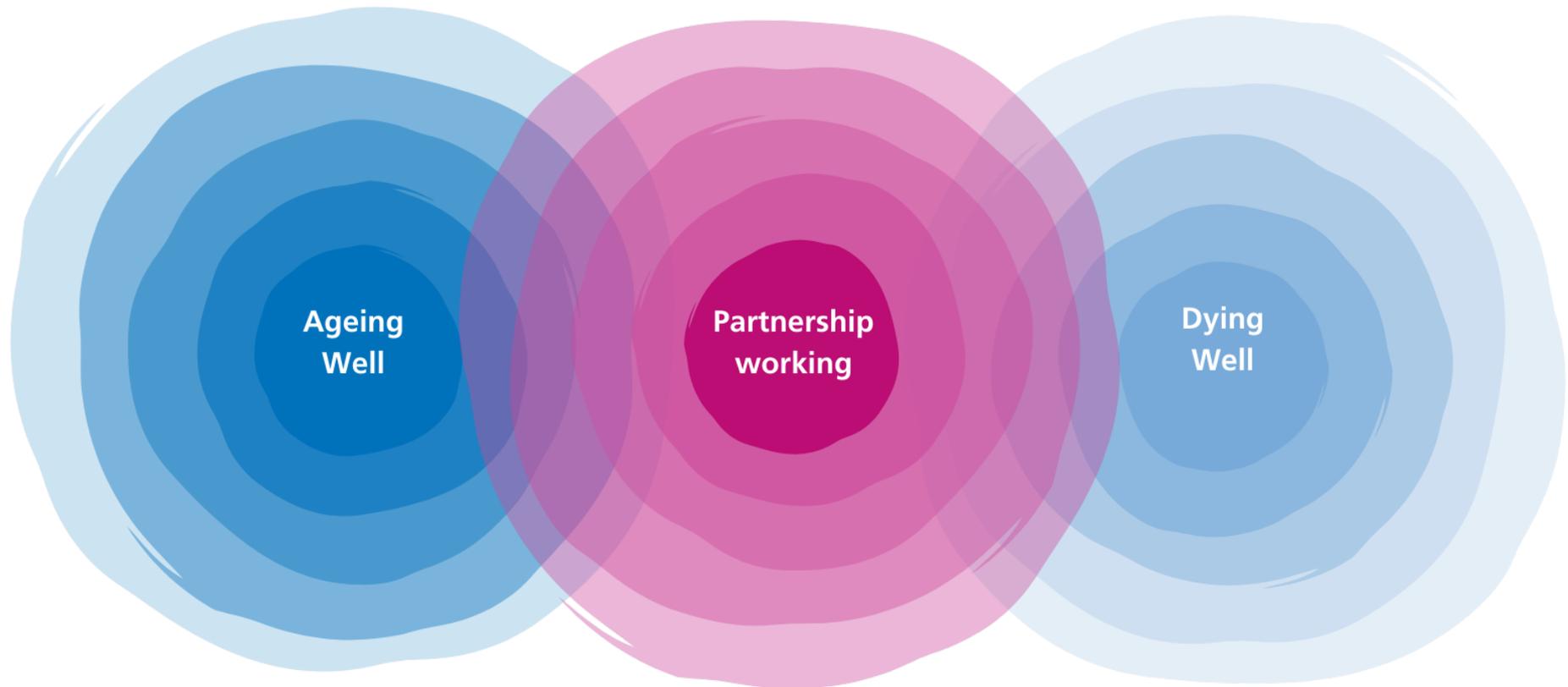
A theory of change is a tool that sets out how an organisation, service or project can deliver intended change by describing relationships between resources, activities, and outcomes. Then an evaluation plan is built around the theory of change. This evaluation can measure success step-by-step - at each level of the theory of change (if needed), helping you know that you are on track.

We ran five workshops with stakeholders representing NHS organisations in BNSSG, North Somerset Council, VCSE organisations and services across the two Locality Partnerships. The stakeholders agreed to produce theories of change for three workstreams: Partnership Working, Ageing Well and Dying Well. The project team analysed outputs from the workshops, drafted narrative and infographic theories of change, and sense checked them with the stakeholders.

The theory of change approach recommends working with stakeholders to agree and prioritise the resources, activities, outputs, mechanisms of change and outcomes. ICB Researcher in Residence Natalia Lewis collaborated with Dartington Service Design Lab, experts in complex systems, Head of One Weston Locality David Moss, and ICB Clinical Effectiveness Programme Managers Ruth Whateley and Kate Strong to prepare and facilitate five workshops in May-December 2023. Service leads and managers from the NHS, North Somerset Council, VCSE organisations attended the workshops. The stakeholders agreed to produce theories of change for three workstreams: Partnership Working, Ageing Well and Dying Well. Workshop 1 focused on the practices of the two Partnerships, local system dynamics and resources which enable and constrain the pathway to change. Workshop 2 targeted outcomes at individual, service, locality, and ICB levels. Workshop 3 focused on mechanisms of change that connect the resources and practices of partners (as defined in workshop 1) with the different levels of outcomes (defined in workshop 2). Workshop 4 aimed to test the logic of the three theories of change. Workshop 5 focused on the application of the theories of change to evaluation, planning, and reporting. The project team analysed outputs from the workshops, drafted narrative and infographic theories of change, and sense checked them with the stakeholders.

Theories of change for Locality Partnerships

We present the relationships between the three theories of change and describe each one in detail. The visual metaphor of ripple demonstrates the day-to-day work of the Locality Partnerships and the systemic way in which the activities produce outcomes through mechanisms of change. We have included five ripples – the inner part marks the activities for each workstream, followed by mechanisms for change. The three outer rings signify the short, intermediate and long-term outcomes for the programme. A ripple metaphor also reflects the importance of partnership working for enabling the pathways to outcomes for the Ageing Well and Dying Well workstreams.



Partnership working Theory of Change

Problem statement:

- Fragmentation and complexity within the system, creating a duplication of efforts, different cultures and paradigms, different terms and conditions for staff and a lack of joined-up services.
- Power-differentials and an over-reliance on the clinical model of health, elevating hierarchies based on profession, training, level of resourcing.
- A narrow focus on outcomes, missing the importance of the quality of processes, relationships and organisational development to drive innovation and improvement.
- Resulting in a lack of trust between different parts of the system and pessimism around how improvements might be meaningful and effective.

Ultimately, the Integrated Care System's (ICS) commitment to partnership working is in recognition of the degrees of complexity involved and the need to work together to respond to the tensions inherent within the system and better meet population health needs.

Resources

Time, resources, knowledge and skills are utilised by the partnership to tackle these tensions in three main ways:

- Resourcing of time to support collaborative working and the development of more integrated approaches.
- Governance and infrastructure within the integrated care system to support meaningful and accountable partnership working.
- Knowledge and skills to support specialist expertise and leadership within the ICS.
- Clear purpose for the partnership and how it services the needs of the population.

Enablers:

Staff need protected time to do the invisible work of integration, e.g. attending workshops and meetings which support setting and delivering a shared vision. The governance of the ICS supports can support accountability of partnership working by ensuring that there are well-resourced supports for integrated activities/roles. Leadership in the ICS can emphasise the importance of partnership working by recognising the staff who demonstrate the skills of collaboration, systems leadership and community development alongside their role.

Activities

Within the partnership, resources are directed within the following groups of activities:

- Demonstrating the value of integrated working – articulating and evaluating our work together.
- Connecting with staff teams, across organisations and within our communities - sharing knowledge and understanding of local assets, connecting practitioners and cross-organisational digital investment.
- Dedicating time to work together as strategic leaders to develop trust and a shared vision for more intelligent and joined up care.
- Making best use of resources to support integrated working, including the hyper-local knowledge needed to effectively identify and address inequalities.

Enablers:

Working together on shared activities enables partnership working in a more robust way than setting priorities and specific deliverables. 'Doing' together is what stabilises and strengthens the strategic vision of partnership working. Creating criteria for success in partnership working, or using similar evaluative tools, can help the partnership to demonstrate the value of working together. Leaders can ensure that there are clear processes for valuing local knowledge and relationships as well as work to address inequity through supervision, appraisals and other reviews of team performance.

Reach

These partnership activities reach a wide range of stakeholders, including:

- Commissioners, Health and Wellbeing boards, Integrated Care Partnerships.
- Frontline staff and volunteers.
- Lived Experience Leads.
- Governance Boards, e.g. ICB.
- Strategic leaders and the organisations and communities they work in/for.
- Community leaders.

Enablers:

Partnership working requires a wide reach. It also requires a deliberate choice in terms of reach, so that everyone involved in the partnership has a clear role and set of responsibilities. Partnership working is enabled by a regular review of *who* is involved and *why*, and a questioning of whether the *right* people are in the room to serve the purpose of the partnership.

Mechanisms

The ICS creates impact within partnership working by leveraging the following mechanisms within its activities, which make best use of the resources available.

- Ability to work across different kinds of knowledge and practice, supporting and elevating different forms of expertise with an awareness that no one profession, or organisation will hold all the answers.
- Sharing learning and experience to develop a shared story through opportunities to connect and have fun together.
- Freedom within boundaries defining a leadership and management culture that ensures a tolerance for risk and a culture that prioritises curiosity and enables learning by doing and learning from failure.
- Collaboration including strong communication and information sharing
- Acting on serendipitous opportunities for further collaboration that come from working in partnership.
- Making best use of funding opportunities with resources going to the strategic investment that supports integrated services and more partnership working.
- Ensuring that funding moves directly to communities as well as through traditional NHS channels.

Enablers:

Collaborative working across partnerships is a self-reinforcing practice meaning that effective collaboration further strengthens partnership working. Collaborative working is enabled by

trusting relationships and 'doing' shared work together. Collaboration is also enabled by close proximity of working together so that opportunities for ideas, for debate and for innovation can emerge. Collaboration that enables a focus on equity and inequality ensures that the ideas that emerge serve the whole partnership.

Outputs

These activities and mechanisms create a number of shared outputs:

- Clarity of partnership roles and responsibilities.
- The right tools to help enable partnership working, including better access to information for more informed decision making.
- Clear priorities at the organisational level – and at the partnership level – to support systemic needs of the population.

Enablers:

'Doing' shared activities together can enable partners to develop clarity on their role and responsibilities in the partnership. Similarly, through working together, partners can determine the right tools and information that needs to be shared across the partnership to create change. Assuming the partnership has established a clear purpose for its existence, the activities of partnership working can support further refinement of purpose and alignment between organisational priorities and those that are priorities for the partnership to achieve.

Short-term outcomes

In the short term, we hypothesise partnership working within the ICS creates changes in capacity, knowledge and understanding:

- Improved knowledge and appreciation of other organisations and the challenges they face.
- Strengthened foundations for partnership working including trust and shared values.
- Improved collective capacity and culture for partnership working.
- Improve empathy and compassion for others working in the integrated care system.

Enablers:

The activities of partnership working will enable a greater understanding of the partnership's purpose, and how best to work with the assets of the community to realise changes that are needed and wanted. Working in partnership creates resilience and trust and further embeds the practices of collaboration. These outcomes are enabled by having a clear framework and criteria for success for the partnership, which outlines the problems the partnership is trying to address, its purpose for working together and the roles and responsibilities of each partner in order to realise this purpose.

Intermediate outcomes

These short-term changes in capacity, knowledge and understanding should create visible changes in behaviour, including:

- Leaders in the system actively connecting and making joint decisions.
- Pooling of resources and joint commissioning practices are more common.
- Precariousness of funding arrangements for partners in the ICS reduces.
- Shared language and vision is expressed by leaders across the ICS.
- Higher quality services and support.

Enablers:

In order to see these changes in behaviour, some of the activities and mechanisms of partnership working will need to be in place. For example, putting in dedicated time to work together, articulating the purpose of working together, developing roles for the partners, establishing strong foundations of trust all enable the outcomes of making joint decisions, pooling resources, developing shared language.

Long-term outcomes

The more longer-term outcomes reflect the way this model addresses the initial problem statements, creating:

- More integrated services that seek to balance clinical and non-clinical offers of support.
- Reduced duplication of processes and less fragmented of services and supports.
- Higher levels of trust between partners and providers of support.
- Improved staff wellbeing.
- Improved patient experience.
- Devolution of authority and increased resources for partnership working.

Enablers:

These long-term outcomes are positive steps forward to address the system problems that have been identified, such as duplication of services and supports, challenging power differentials between different parts of the ICS, fragmentation and a lack of trust. These outcomes of – for example, more integrated services and reduced duplications – are enabled by successful application of the relevant mechanisms, activities and reach outlined in the theory of change.

PARTNERSHIP WORKING THEORY OF CHANGE

ACTIVITIES

Demonstrating the value of integrated working

Connecting with staff teams and with our communities

Dedicating time to work together

Making the best of resources to support integrated working

MECHANISMS

Awareness that no one person is an expert

Resourcing integrated services and partnership working

Strong communication and information sharing

Serendipitous opportunities for further collaboration

Shared learning

Leaders' risk tolerance and continuous learning

Top-down and bottom-up funding

SHORT-TERM OUTCOMES

IMPROVED KNOWLEDGE OF:

Responsibilities in the partnership

What's needed and wanted

Community assets

Local inequalities

STRONG FOUNDATIONS FOR PARTNERSHIP WORKING BY:

Embedded collaboration

Trust between partners

Shared values

IMPROVED COLLECTIVE CAPACITY AND CULTURE FOR PARTNERSHIP WORKING INCLUDING:

Collective capability and confidence

Connectivity

Resilience

INTERMEDIATE OUTCOMES

Joint funding arrangements

Connected system leaders

Shared language and vision

Quality services and supports

LONG-TERM OUTCOMES

Improved patient experience of partnership

Integrated services that balance clinical and non-clinical offers of support

Reduced duplication of processes and reduced fragmentation of services/support

Higher levels of trust between providers of support

Higher trust in the system to devolve authority

Improved staff wellbeing

Ageing Well workstream theory of change

Problem statement

- Increasing ageing ill population, particularly people with multi-morbidity.
- Inequality in the health of our ageing population.
- People at a higher risk of falls and frailty related incidents.
- People at a higher risk of social isolation and loneliness.
- High demand on services from falls and frailty incidents.
- Workforce recruitment and retention challenges.

Resources

Community assets, policy, resources, and staff are needed to address these problems:

- Intelligence and evidence support.
- Funding and business case development.
- Ageing Well boards, groups and governance.
- National policy related to Ageing Well.
- Workforce across service providers (recruiting and training), including primary care, secondary care, community services and VCSE.
- Safe and accessible community spaces, including physical and virtual spaces.
- Digital infrastructure and shared resources.

Activities

These resources are directed within the following groups of activities:

- Identification of population cohorts that would benefit from the different interventions or services, including those not in contact with services.
- Staff and volunteers training and development.
- Reimagining and developing services and offers.
- Proportionate and holistic assessment and care planning, including advanced care planning.
- Proactive and co-ordinated care by a multi-disciplinary team.
- Crisis response in different settings.
- Reducing falls and frailty work in different settings.
- Signposting or referrals into services and offers.
- Refreshing digital assets.

Reach

These activities are targeted at:

- Staff and volunteers across service providers.
- People with multi-morbidity and/or complex health needs, at risk of unwarranted health outcomes.
- Older people living in residential and nursing care homes.
- Older people living in their own homes.
- Unpaid carers supporting people.

Mechanisms

These activities bring change through:

- Sharing learning between staff and services.
- Services operating across boundaries.
- Creating sustainable offers and interventions.
- Creating space and trust between services to try new things.
- Solutions and services are co-designed with communities on an equal basis.
- Using humour and fun in preventative work.
- Using different ways to build relationships.

Outputs

These activities and mechanisms should create the following outputs:

- Increased number of patients with high-quality care plans.
- Improved digital connectivity, linking and reporting, for care plans or shared digital resources like the carers register.
- Timely action or escalation to non-acute services.
- Enhanced Ageing Well workforce and services in place.
- Upskilled Ageing Well staff and volunteers.
- People are connected with services and offers.

Short-term outcomes

In the short-term, communities and individuals should improve their attitudes, knowledge, and confidence:

- Staff are better able to access relevant information about patients/clients.
- Reduced patient contact with crisis or acute services.
- Improved staff knowledge, for example around managing falls in peoples' homes and care homes, and knowledge of the services and offers available.
- People feel supported by other people, including with different kinds of grief and trauma.
- Improved awareness of services and offers.

Intermediate outcomes

These short-term changes should create visible changes in behaviour and practices by:

- Early identification by staff of health and care issues and action implemented, for example chronic wound identification, delirium.
- Better collaboration between services and partners.
- Reduction in falls and frailty incidents for people living in different settings.
- People are more active for longer, including reduced deterioration or decompensation if hospital admission is avoided.
- People access and engage with services or offers.
- Improved ability to navigate services and offers.

Long-term outcomes

The intermediate changes in behaviour and practices lead to changes in long-term health and social outcomes:

Human outcomes

- Improved patient and carer experience of Ageing Well services.
- People live at home for as long as possible with care and support around them.
- Improved wellbeing and health.
- Reduction in isolation and loneliness.
- Reduced burden on unpaid carers.

Service utilisation

- Reduced waiting times for health and care services, such as urgent and emergency care and social care.
- Reduced avoidable health service resource use particularly for:
 - Unplanned care.
 - Avoidable admissions to secondary care.
 - Shortened length of stay for unavoidable admissions.
- Reduced number of avoidable attendances to Emergency Departments from care homes.
- Reduction in primary care use for people who frequently access services.

AGEING WELL THEORY OF CHANGE

ACTIVITIES

Developing patient-facing areas such as:

- Proportionate, holistic and advanced care planning by multi-disciplinary team
- Crisis response in different settings
- Reducing falls and frailty in different settings
- Sign-posting or referring into services and offers

Refreshing digital assets

Reimagining and developing services and offers

Training and developing staff and volunteers

Identification of cohorts that would benefit

MECHANISMS

Sharing learning between staff and services

Services operating across boundaries

Creating sustainable offers and interventions

Creating space and trust between services to try new things

Solutions and services are co-designed with communities

Using humour and fun in preventative work

Improved awareness of services and offers

Using different ways to build relationships

SHORT-TERM OUTCOMES

Staff better able to access relevant information about patients and clients

Reduced patient contact with crisis or acute services

Improved staff knowledge e.g. managing falls, services and offers available

People feel supported by other people

INTERMEDIATE OUTCOMES

Early identification of health and care issues and action implemented

Better collaboration between services and partners

Reduction in falls and frailty incidents for people living in different settings

People are more active, for longer

People access and engage with services or community offers

Improved ability to navigate services and offers

LONG-TERM OUTCOMES

Reduced avoidable use of health services' resource

Reduced waiting times for care services

Reduced burden on unpaid carers

Improved patient and carer experience

People live at home for as long as possible with support around them

Improved health and wellbeing

Reduction in isolation and loneliness

Dying well workstream theory of change

Problem statement

- Specific cohorts of people die without receiving good quality end of life care.
- People with palliative needs have poor quality of dying.
- Practitioners responsible for identifying palliative needs do it too late.

Resources

Community assets, policy, resources, and staff are needed to address these problems:

- Funding.
- Safe and accessible community spaces.
- Pragmatic policy.
- Standards for palliative care.
- Shared resources including tools to recognise frailty, shared health and social care records.
- Packs for preparing for dying.
- Practitioners providing palliative care (i.e., nursing staff).

Activities

These resources are directed within the following groups of activities regarding death, informed choices about place for death, and symptom control:

- Educating.

- Equipping with skills and tools.
- Linking with relevant practitioners and resources.
- Supporting.
- Facilitating.

Reach

These activities are targeted at:

- Communities.
- People of any age with palliative needs in their last year of life.
- Informal carers.
- Practitioners.

Mechanisms

These activities bring change through:

- Building trust in communities.
- Creating safe environments for people to be able to speak honestly.
- Knowledge sharing which involves managing good communications and understanding existing culture and practices around death.
- Normalisation of conversations around death.
- Implementing principles of empowerment, respect, and positivity through celebrating lives, using art, humour and creative space.

Outputs

These activities and mechanisms create outputs:

- Community expertise and power.
- Conversations about death and dying during last year of life.
- Everyone encouraged to have a dying box.
- Completed End of Life care plan.
- Community-based services for dying.

Short-term outcomes

In the short-term, communities and individuals improve their attitudes, knowledge, and confidence to empower patients and carers to talk about death:

- Community members increase knowledge about where to go for support and better appreciate individual's choices about their death.
- Individuals and community increase confidence in speaking about death.
- Informal carers increase knowledge about loved ones wishes.
- People with palliative needs increase knowledge about choices on how to communicate their needs.
- Professionals, carers, and people with palliative needs improve death and bereavement literacy.
- Professionals increase knowledge about what Advanced Care Planning is and how to access it.

Intermediate outcomes

These short-term changes should create visible changes in behaviour and practices by:

- Increasing proportion of people who can find information about health and care services regarding palliative care.
- People have better quality of dying and death.

Long-term outcomes

The intermediate changes in behaviour and practices should lead to changes in long-term health and social outcomes by:

- Reduced service utilisation:
 - Reduced avoidable hospital admissions.
 - Increased use of community-based alternative services.
- Improved quality of life.
- Improved symptom control.

DYING WELL THEORY OF CHANGE

ACTIVITIES

PROVIDING TARGETED GROUPS WITH:

- Education
- Skills and tools
- Connections with relevant practitioners and resources
- Support
- Facilitation
- Training

MECHANISMS

- Trust in communities
- Safe environments for people to be able to speak honestly
- Good communications and shared understanding of existing culture and practices around death
- Conversations around death normalised
- Principles of empowerment, respect, and positivity implemented

SHORT-TERM OUTCOMES

- Community members increase knowledge about where to go for support and better appreciate individual's choices about their death
- Increased confidence for individuals and community to speak about death
- Informal carers have increased knowledge about loved ones wishes
- People with palliative needs have increase knowledge about choices on how to communicate their needs
- Professionals, carers, and people with palliative needs improve death and bereavement literacy
- Professionals increase knowledge about what Advanced Care Planning is and how to access it.

INTERMEDIATE OUTCOMES

- People have better quality of dying and death
- Increased proportion of people can find information about health and care services regarding palliative care

LONG-TERM OUTCOMES

- Reduced service utilisation by reduced avoidable hospital admissions and increased use of community-based alternative services
- Improved quality of life
- Improved symptom control

How to build an evaluation framework around your theory of change

An evaluation framework built around your theory of change will ensure you collect information that tells you what difference you are making. It will give you a coherent framework on which to base your measurement efforts and ensures your data collection is structured, rather than ad hoc and opportunist. Designing this framework with your stakeholders will involve deciding what data to collect, the level of rigour of evidence you need, and how to go about collecting this data. This process requires buy-in from leadership, a strong commitment to the value of evaluation, and the investment of time and skills.

For detailed guidance on using your theory of change to develop an evaluation framework read:

1. Ellen Harries, Lindsay Hodgson and James Noble. Creating your theory of change. 2014: <https://www.thinknpc.org/wp-content/uploads/2018/07/Creating-your-theory-of-change1.pdf>
2. James Noble, Peter O'Flynn, Anne Kazimirski. Understanding impact. Using your theory of change to develop a measurement and evaluation framework. 2020: <https://www.thinknpc.org/wp-content/uploads/2020/02/Understanding-Impact.pdf>

In brief, follow the four steps:

Step 1. Map your theory of change

You don't have to start from scratch, use our theories of change as a starting point. From the three theories of change, choose one or two that are relevant to your service/project. Look at commonalities with your service/project. Keep the commonalities and add service/project-specific problem statement, resources, activities, target groups, outputs, enablers, mechanisms of change and outcomes. You can do it at workshops or consultations with your stakeholders.

Step 2. Prioritise what you measure

Prioritise the most important elements in your theory of change and focus on measuring those. These will need to reflect what your stakeholders, especially funders, see as important. Nevertheless, they should also be things that: you directly influence (rather than indirectly support); are important or material to your mission; are not too costly to measure; and will produce credible data. These elements (e.g. activities, outputs, outcomes) form the basis of your evaluation framework.

Step 3. Choose your level of evidence

Basing your evaluation framework on your theory of change can help steer you in the right direction and avoid either under-investing or over-investing in measuring the change. There are four main ways to make a credible case that what you do really makes a difference:

1. **Statistical** approaches look for patterns in quantitative data to see if the effect (i.e., the expected outcomes) frequently follows the cause (i.e., the service). Such approaches include before and after comparisons, correlation, regression analysis, and other statistical models.
2. **Experimental** approaches compare differences in outcomes between people who receive a service (the intervention group) and those who do not (the control group).
3. **Case-based** approaches compare cases (e.g., individuals, groups of people, or places) *within* a service or project or *across* services or projects, to draw conclusions about causes of the effects and the impact of service/project. This approach recognises that there is rarely a single cause to any health/social outcome and that it is hard to unpick all the various influences.
4. **Theory-based** approaches describe in detail how a service or project influences different people at different times and places using observations by staff, evaluators, and other stakeholders, as well as the views of beneficiaries, rather than by analysing lots of cases or using a control or comparison group

Step. 4. Select your sources and tools

You may find an existing tool or data source, or you may need to develop one. Do not feel the need to reinvent the wheel: consider what tools are already available and think about existing evidence for the causal links in your theory of change. This [Evaluation Toolkit](#) has a link to validated outcome measures inventory. Consider the following questions (on the next page) and solutions when selecting the tools.

Step. 4. Select your sources and tools

Table: Selecting sources and tools

Area	What to consider	Tips
Outcomes	What is the mix of 'soft' or 'hard' outcomes in your work? Does the tool fit the outcomes you want to measure? Can you both measure change and understand why change has happened?	Choose standardised and validated tools from this Evaluation Toolkit . Try to get hold of existing administrative/ statutory data for hard outcomes. Use quantitative tools to measure change and qualitative tools to explore how change happens.
Activities	Do you work with people over a long period of time? Is your service/project innovative or established? Are you trying to scale up your service/project?	Consider how you might follow up with people in the long term, such as contacting a random sample or using statutory data. Resource-intensive tools may not be appropriate for light-touch services/projects. If you are delivering a new service/project or trying to scale up, you should invest in a robust evaluation.
Stakeholders/ beneficiaries	How accessible are your users/beneficiaries/stakeholders? How easy is it to get a representative sample? How easy is it for respondents to take part in evaluation?	Consider secondary data sources for beneficiaries/stakeholders who are not accessible. Ensure tools are tested for the population you work with—e.g., older people, people with learning difficulties.
Time and resources	How can you minimise the collection of new data (i.e., using existing evidence and data collected by others)? What resources are available to collect, use, and analyse data?	Identify a lead in your organisation, service or project to drive evaluation. Involve someone with relevant skills and experience as needed. Use research tools that others in health and care use rather than reinventing the wheel. Make use of training, free tools and guidance. Consider sharing measurement with other organisations, services, projects to reduce costs.
Need for rigour	What is widely accepted in your area of health and care? What is your appetite for rigour? Are tested tools available for outcomes you seek?	Look for shared measurement and common tools to increase rigour. Explore tools already available on the Evaluation Toolkit before developing your own.
Funders/ senior stakeholders	What is the appetite for evidence? Are your priorities for measurement aligned with your funders/senior stakeholders? Are they asking you for different information?	Talk to people to understand their priorities. Talk to people who ask for information that is not a priority for you. Work with different people to reduce duplication in reporting. Consider developing a shared measurement approach with other organisations, services or projects to streamline reporting.

How to use your theory of change for developing a business case/funding proposal: worked examples (Nathalie Willmott, Locality Development Manager, Woodspring)

Developing the business case for Complex Care Teams in Woodspring Locality Partnership

- The initial idea for Complex Care Teams was developed as part of the Ageing Well Target Operating and Quality Model (finalised in January 2023) which was developed by the Woodspring Locality Partnership.
- Extensive work has been undertaken by a small group to develop the concept and produce a comprehensive business case.
- I reviewed the Ageing Well theory of change and identified the common elements, of which there are many, and used the theory of change narrative to articulate the aims, objectives and benefits in the business case and to support the case for change, and I am now working with partners to identify ways to measure elements of the theory of change in order to provide case for change, baseline data and form measurable goals. I also used it to explain how the proposal fits with the Locality Partnership's strategic objectives.

Producing a funding proposal for Power to Pill

- The Power to Pill project was developed and summarised by the project group.
- I identified the commonalities between the proposal and the Ageing Well theory of change, and used the theory of change narrative to complete the intended outcomes section of the proposal and expand on how the proposal fits with the partnership's strategic objectives.

Acknowledgements

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