Making better use of voluntary sector data and intelligence in health service planning

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A report by members of the Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance

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Executive summary

Members of the VCSE Health and Wellbeing Alliance engaged their networks in a study of how **data and intelligence** held by the voluntary, community and social enterprise (VCSE) sector is currently used in service planning and development, and the barriers and enablers to it being more systematically and widely utilised.

This work comes at an **opportune time** because of current **health and care reform**. The development of integrated care systems (ICS) with their increased focus on population health management and prevention, and specifically the publication of the ICS Design Framework, highlights a significant role for the VCSE sector. Government policy more broadly has intentions to open up and simplify public procurement.

Our findings show a **desire for more effective data sharing by both sectors**, and a recognition of the value of doing so. We identified a range of **barriers** that are often difficult to overcome. These include technical barriers, cultural barriers, financial and economic barriers, and legal and regulatory barriers. Our research also revealed **enablers** of good practice.

We found examples where **good practice** is being developed and identified the component contributing factors.

Based on the findings of the research we make a set of **recommendations** for **integrated care systems** and **local commissioners** that will support more effective sharing of data and intelligence between sectors as the reforms take shape. In summary, these are:

1. to **facilitate** and **resource** data sharing
2. to lead the **codesign** of a **data template**
3. to **maximise** existing data sources before developing new ones
4. to build local VCSE **infrastructure** networks to facilitate the **capture and the utilisation of qualitative and anecdotal data**.

We also recommend that **NHS England** and **NHS Improvement**:

1. ensures that **future iterations of guidance** to local systems includes information on the **benefits** and **enablers** of sharing VCSE data and intelligence
2. considers creating specific guidance for ICS on the recommendations above, such as developing a **data template**
3. establishes and resources a time-limited **action learning programme** that builds on this research, develops further case studies of good practice in data and intelligence sharing that has led to positive outcomes, and disseminates learning nationally
4. **raises awareness** internally with policy leads to understand the impact VCSE data and intelligence sharing could have on their specific work areas, to help inform future NHS policy development.

Contents

Introduction

The purpose of the work was to explore how to **increase the use of data and intelligence held within the voluntary, community and social enterprise (VCSE) sector in health and social care planning**, which in turn will lead to:

- improved health and wellbeing of communities
- improved services
- better partnership working to tackle health inequalities and prevent avoidable ill health.

This report sets out the findings of research conducted by the VCSE Health and Wellbeing Alliance, commissioned by NHS England and NHS Improvement, Public Health England and the Department for Health and Social Care. Six Alliance member organisations[1] worked in partnership to deliver the project, in collaboration with some of their own constituent organisations. It involved a survey, desk research, case study development, interviews with policymakers and the iterative development of findings and recommendations between partners.

This work comes at an opportune time because of current health and care reform, namely the development of integrated care systems (ICS) with their increased focus on population health management and prevention, and specifically the publication of the ICS Design Framework, which highlights a significant role for the VCSE sector. The voluntary, community and social enterprise (VCSE) sector is a key partner in system transformation, so now is a good time to consider how the wealth of data and intelligence that it holds can be better used.

Why share data?

Health and care services do not operate in isolation, they are part of whole system. It is widely acknowledged by planners and practitioners of services that sharing data across sectors and between organisations is in principle a good idea. If we get these processes right, they enable:

- better identification of need
- more effective and efficient planning
- more robust impact measurement
- greater inclusion, particularly for marginalised groups.

Better identification of need

Sharing data across a whole system can provide a more robust understanding of need and help all services, including the NHS respond in a more timely and effective manner.

> **EXAMPLE:** Bromley Well, a cross-sector mental health service partnership in Bromley (southwest London), built a **bespoke database** that was used by all partners. This enabled data to be captured and analysed holistically. Teams were able to collaborate across organisational boundaries, and wider intelligence on the client population could be captured. Through this process it was identified that there was a need for additional mental health support. The system

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[1] Association of Mental Health Providers, Citizens Advice, Friends Families & Travellers, Men's Health Forum, National Association for Voluntary & Community Action (NAVCA) and the National Council for Voluntary Organisations (NCVO), which also took the role as project coordinator.

enabled early identification and a timely response; in this instance a mental health specialist advisor was recruited to deliver a triage system. Without this, delays in detection and response would almost certainly have led to greater demand, and increased cost, at higher tiers of mental health service provision. (More detail Appendix 2)

EXAMPLE: Imperial College Healthcare NHS Trust codesigned a grant scheme together with local stakeholders that would address the social determinants of health in relation to the Covid-19 crisis. This process led to a better understanding of the role of local community organisations in addressing the social determinants of health, which had a direct impact on clinical factors. (More detail Appendix 2)

More effective and efficient planning

The number of people attending NHS services, and in what way, is influenced by people's lives, personal choices, support frameworks and access to and use of other services. These wider factors therefore need to be taken into account to ensure people reach the most appropriate service for them at right time. It can also support planning at system level, in terms of

- mapping current and potential demand
- ensuring services are designed with patients and people with lived experience at the centre
- thereby enabling the best outcomes and value for money.

EXAMPLE: In Somerset Rethink Mental Illness led the development of a partnership to deliver a new model of integrated care. They designed a **bespoke data capture system** which was accessible across partners and across sectors. It used a blend of national metrics and coproduced patient-focused measures, and integrates with NHS software. It enabled a single plan for patients, across all providers, and one single source of data for all stakeholders. (More detail Appendix 2)

EXAMPLE: Citizens Advice Wirral developed a **social prescribing pilot**. Data showed positive outcomes for service users and these data provided the evidence needed for commissioners to expand the service after the pilot. The service highlighted that a reliance on digital delivery can be an excluding factor for patient groups. It also highlighted the need for strategic mapping and planning around how data is collected and interpreted across stakeholders and the fact that not all providers are resourced to set up and manage data and processing systems. (More detail Appendix 2)

More robust impact measurement

Having one well-managed data capture system can be hugely beneficial, not just in facilitating a better understanding of an individual's needs and progress (for example, when receiving service from multiple providers), but also in being able to aggregate wider impact. This in turn facilitates planning.

> **EXAMPLE:** Torbay Community Development Trust commissioned a specialist **customer relationship management (CRM) system** to support a partnership of 15 organisations. The new system improved processes, which both supported patients and improved efficiency. The CRM system allows different partners to capture, report and cross-refer information about individuals and share information. It also helped overcome some of the challenges that statutory partners have around data sharing through a third-party system. The CRM enables easier analysis and demonstration of the impact and value of the approach, and this has helped the partners secure funding for future work. (More detail Appendix 2)

Greater inclusion for socially excluded groups

It is particularly important to utilise data and intelligence held by **inclusion health** organisations. 'Inclusion Health' is a field which seeks to prevent and address the health and social inequalities experienced by groups of people at risk of or living with extremely poor health as a result of factors such as poverty, marginalisation, multimorbidity and social exclusion. The reasons vary by group, but include the effects of stigmatisation and discrimination, the complex nature of the healthcare system and the effects of the wider determinants of health. The four groups originally defined under the term 'Inclusion Health' were Gypsies and Travellers, people experiencing homelessness, migrants in vulnerable circumstances and sex workers. However, the term is widely used to refer to populations at the sharp edge of health inequalities due to social exclusion and stigmatisation.

These groups are often excluded from mainstream datasets and may also be reluctant to engage with routine data collection as a result of fear of, or experience of, stigmatisation or discrimination. As such, the needs of these populations are frequently overlooked in service planning and delivery.

> **EXAMPLE:** Working with Everyone created a mechanism for public authorities to engage with people with lived experience, and those whom datasets often miss. They engaged people experiencing homelessness and substance use in digital inclusion workshops. This created a cohort of people with lived experience that are now skilled in engaging in service design, bringing their life experience as insight. Working with Everyone developed thematic documents for NHS England and others, that can be utilised to drive forward change and inform decision-making across the health and care system to address inequalities in access and outcomes. They also developed a series of data summary sheets which can be used as soft intelligence to help inform policy and practice. (More detail Appendix 2)

Data and intelligence held by the VCSE

The VCSE sector, through its work with individuals and in communities, is often a holder of a wide array of qualitative and quantitative data and insight on people, their lives and community health and wellbeing.

This data and insight can take different forms:

- facts and figures on individuals involved
- the measurement of impact on individuals after different interventions
- wider intelligence about populations (geographical, theme and communities of interest)
- the impact of the wider environment and/or policy decisions on people and communities

- knowledge about people's use of, and issues with, statutory sector services, how changes to local service offers may affect local communities and how individuals can be best supported within communities.

It can be presented as:

- datasets
- summary reporting
- survey responses
- outcome measures
- case studies
- anecdotal stories and insight.

VCSE organisations gather and collect this data and insight with permission of people and communities. They do this for different reasons, including:

- as management information to refine and develop their own support and services
- for funders, to demonstrate the impact and cost-benefit of their work
- to create evidence to raise issues of concern with regulators, policymakers and commissioners
- as evidence for funding bids
- for business development purposes.

Some data are collected as part of the terms of a specific commissioned contract, but often the requested data do not cover the breadth of knowledge and intelligence the sector has.

The policy context

To understand the policy context, we undertook a literature review. We found that there is extremely limited literature available on how VCSE data and intelligence is being used in the design and development of health services. The few references that we found in our research were from the years immediately after the 2012 health and care reorganisation and predate the current operational environment. In addition, most of the literature examining the role of the VCSE in designing and commissioning of public services tends to focus on giving voice to communities, particularly the most marginalised, rather than as a source of data and intelligence through service delivery or collection of evidence.

Several NHS guidance documents relating to integrated care, **detailed in Appendix 1**, reference the need for systems to use data and intelligence effectively, particularly regarding population health management and tackling health inequalities. However, none are explicit about this data and intelligence, and there is only oblique reference to the VCSE as an important source.

A recent inquiry by the House of Lords into lessons learnt from the Covid-19 crisis[2] argues that five fundamental weaknesses must be addressed in order to make public services resilient enough to withstand future crises and to improve outcomes for the people who need and use public services:

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[2] A Critical Juncture for Public Services: lessons from Covid-19, House of Lords public services committee, November 2020

1. insufficient support for prevention and early intervention services
2. over-centralised delivery of public services, poor communication from the centre, and a tendency for service providers to work in silos rather than integrate service provision (Chapter 6)
3. a lack of integration, especially between services working with vulnerable children and between health care and adult social care
4. an inability and unwillingness to share data between services
5. inequality of access to public services and a lack of user voice (Chapters 3 and 4);

With forthcoming structural reforms and shifts in government policy, now is a good time to see how we can turn limited use of VCSE data into an approach that is more widespread and becomes the norm.

Integrated care systems

With the development of 42 integrated care systems (ICS) across England, players across all sectors (NHS commissioners and providers, local government, private and voluntary sectors) are expected to forge new relationships to improve health and care outcomes. This creates the relationships across a system that are required to address a complex issue such as data sharing.

Specifically, the recently published ICS Design Framework (June 2021) highlights the importance of embedding the VCSE sector in ICS structures. Constituted ICSs will be required to *"have a renewed digital and data transformation plan that is embedded within the ICS NHS body plan and details the roadmap to achieve 'What Good Looks Like'; and enables a cross-system approach to transformation, so that changes to models of care and service redesign involve digital and data experts working with partners from all relevant sectors."* (See also Appendix 1)

Opening up public procurement

"The Government wants to open up public procurement to a more diverse supply base, making it easier for new entrants such as small businesses and voluntary, charitable and social enterprises to compete and win public contracts. We want bidding for public sector contracts to be simpler, with procedures that are quicker and cheaper to participate in and information on contracts easier to find." [3]

This will necessitate a shift away from competitive tendering as the default process for commissioning services. If there is a drive from government to widen procurement opportunities to VCSEs, and more VCSEs are included in supply chains, that will expose systems to the data VCSEs collect. If ICSs want to work more closely with VCSEs, then sharing and valuing data will be important.

With competitive tendering there tends to be a focus on collecting data to monitor delivery and contract compliance. If we move to a more collaborative approach to service delivery then there is an opportunity to collect data for longer-term learning and improvement, rather than to demonstrate provider performance on one- or two-year cycles. The proposed provider selection regime might support a more collaborative approach, but this is still to be tested.

Central government has issued guidance to encourage contracting authorities, including health bodies, to achieve certain social value outcomes such as creating new jobs and skills[4].

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[3] Transforming Public Procurement, Cabinet Office, December 2020

[4] Procurement Policy Note – National Procurement Policy Statement, Cabinet Office, June 2021

Embedding social value in spending decisions also encourages commissioners to collect data that demonstrates additional social value from contract delivery.

New operational approaches

New operational methods require the intelligent use of data and intelligence. For example:

- for social prescribing to work at its best, the data and intelligence that the link workers (or social prescribers) capture should feed into the process of evaluating frontline service provision, identifying gaps and commissioning accordingly.[5]
- NHS operational guidance for mental health provision[6] requires that *"all providers, including in scope third sector and independent sector providers, submit comprehensive data to the Mental Health Services Data Set and IAPT Data Set."*

NHS Digital Transformation Plan

The Digital Transformation Plan[7] sets out an overarching vision for how the NHS will digitise, connect and transform the health and care sector. This data strategy explains in more detail the role that data will play in that transformation and how it can inspire effective collaboration across the NHS, adult social care, and public health, help us care for people in the best possible way, and ensuring that citizens have the best experience possible when using the system.

Three key priorities underpin this strategy:

- to build understanding on how data is used and the potential for data-driven innovation, improving transparency so the public has control over how we are using their data
- to make appropriate data sharing the norm and not the exception across health, adult social care and public health, to provide the best care possible to the citizens we serve, and to support staff throughout the health and care system
- to build the right foundations – technical, legal, regulatory – to make that possible.

Build back better

Build Back Better[8] is a government policy that sets out its plans to support economic growth through significant investment in infrastructure, skills and innovation.

Whilst the national policy is mostly about economic recovery, the term 'build back better' is being commonly used, particularly in the NHS, to harness the better ways of doing things that emerged in the pandemic and build on these to create a better future. This will undoubtedly entail the need for better collaboration, especially across sectors and organisational boundaries, which can provide a platform for better use of data. Experience during the pandemic showed us

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[5] Rolling Out Social Prescribing: Understanding the experience of the voluntary, community and social enterprise sector, National Voices, September 2020

[6] 2021/22 priorities and operational planning guidance, NHS England, March 2021

[7] Data Saves Lives: Reshaping Health and Social Care with Data, Dept. of Health and Social Care, July 2021

[8] Build Back Better: Our Plan for Growth, UK Treasury, March 2021

that removing some of the barriers to sharing data across sectors enabled speedier and more effective responses.

What is the problem?

To help us understand the issues, we conducted a survey among the constituent members of the partner organisations, as well as focus groups and in-depth interviews. This revealed the following:

1. It is not the norm for data and insight to be shared

Whilst it is a national policy ambition, and there are examples of cross-sector data sharing in practice, sharing of data is far from the norm. It is far more common for VCSE data to not be used by health service planners, or for them to not even know about its existence.

2. The benefits of sharing data and insight are not universally understood

Policymakers and commissioners consider the benefits of reaching 'hard to engage' communities but not what the VCSE might already know about people's use of statutory sector services, or how changes to the voluntary sector might affect statutory sector service demand.

3. There are not established processes to allow data sharing

In the main, there are not processes in place that allow data to be consistently fed into public sector decision making. Most data currently collected by the statutory sector from the VCSE relates to contract management. For example, if the NHS or a local authority has commissioned VCSE services locally, then they collect the outcomes and learning, but this is often not shared or mapped across the wider system. The intelligence therefore sits with the commissioner of that service but is not utilised by other strategic decision makers.

4. Insight is not gathered early enough

Public sector engagement with the VCSE to understand more about a particular demographic or issue is often done at a point where most of planning been completed and scope for influence is minimal. This is because a business plan must usually be presented in order to release money for an engagement process or consultation phase. This can lead to the possibility of minimal tweaks, or even inappropriate services, rather than dynamic service redesign.

5. Commissioners sometimes do not fully understand pressures in VCSE capacity

Statutory sector services might be designed on the assumption that certain other services (e.g. early support and intervention) are available within the VCSE, but those services might have reduced significantly or closed, especially at the moment. This could lead to miscalculation of demand for NHS services, causing gaps or duplication in provision.

6. Barriers to data sharing even exist within formal partnerships and collaborations

There are issues with the practical sharing of data across partnerships. In some instances, statutory sector partners do not pay attention to VCSE data. In many cases the VCSE organisations involved are not able to access statutory sector data on service users. This causes

duplication of effort and the need to gather information from the service user multiple times, which is unwelcome and disruptive for the individuals involved.

Findings of this research

Despite the few localised good examples that we found, the researchers could not find examples of VCSE data being used in ways that are systematic, strategic and widespread. In nearly all cases there are significant **BARRIERS** to overcome – technical, cultural, legal and economic. But at the same time there are **ENABLERS** that can help. These are outlined below. **RECOMMENDATIONS** are made as to how good practice can become more widespread.

Barriers

Technical barriers

- **Limited central systems.** The size, scale and diversity of the VCSE sector (which in many ways is a strength) provides a challenge for collecting, collating and analysing data and intelligence across VCSE organisations, and within different localities or topics within the health sphere. There are limited systems that perform these functions and limited access to them.

- **Variance of reporting systems.** There is a lack of consistency in approach for capturing data and intelligence across the VCSE, and even sometimes within one organisation in response to different requirements from funders or commissioners.

- **NHS Number**. There are challenges to tracking one person across different services or VCSE organisations, unless operating within a framework that allows sharing of NHS number, which is very often not the case.

- **Cost**. Software that collects, collates and analyses data effectively is often very expensive, and out of reach for many VCSE organisations. Resource for these systems and the time for utilising them is often not included in grants or service contracts. Equally, VCSE organisations often require staffing resource to manage data, and it is challenging to find this core operating cost from contracts and grants.

- **Relevance**. With the vast array of data, intelligence and insight held by the VCSE and the different ways of describing things, it can be difficult working across sectors to understand what is relevant.

- **Numbers.** When dealing with marginalised groups, on rare issues, or in small communities, there can be low numbers of individuals, which mean data are not statistically significant. There is also the issue that 'anonymised' data collected from very small populations might make the identity of the users too easily identifiable.

- **Exclusion of marginalised communities.** Mainstream datasets (such as EMIS and Hospital Episodes Statistics) do not routinely collect data on inclusion health groups and therefore do not pick up on the significant inequalities and barriers to primary healthcare for marginalised communities.

- **Digital exclusion.** Many inclusion health groups experience disproportionately high levels of digital exclusion, with lack of access to data and devices. It can be challenging to ensure that

the voice of particularly excluded communities is amplified in health policy decision-making, which has become more difficult during the Covid-19 pandemic.

Cultural barriers

- **Competition.** Competitive commissioning practices put VCSE organisations in competition with each other instead of enabling collaborative working. They often gather data and intelligence that is commercially confidential or supports their business development, so they would be reluctant to share this information to competitors.

- **Perceived value.** Different sectors can have different perspectives on what constitutes 'valuable' evidence. The NHS is grounded in randomised-control trials, academic and scientific approaches, and can often be less open to considering other types of data, especially anecdotal data.

- **Different ways of collecting and processing data.** Due to the different ways of collecting and processing data and intelligence, the statutory sector can sometimes be concerned that VCSE data is not robust enough.

- **Lack of shared understanding.** There appears to be a lack of in-depth exploration of what data and intelligence from sources outside of the statutory health sector tells us, despite its potential benefits, particularly in areas such as population health. There is not yet a common understanding.

- **Misconceptions.** There is often a lack of understanding about the breadth and depth of the VCSE sector itself. There is still sometimes a belief that it is 'volunteers in church halls', rather than a recognition that VCSE organisations are everything from volunteer-led to providers of clinical services. In fact, the VCSE sector has a combined contribution of £18.2 billion to the UK economy, 0.9% of national GDP, and employs a paid workforce of more than 909,000.[9] A better understanding of the depth and breadth of the sector will lead to a better appreciation of the data and intelligence that the sector might be able to produce.

- **Lack of clarity on what to ask for.** Due to capacity challenges, commissioners sometimes find it difficult to have detailed knowledge of all services that they commission, making it more difficult to make informed choices about what data to collect.

- **Language.** Language and terminology are often different across statutory and VCSE sectors, with different terms used including in the field of data and intelligence. This can lead to misunderstandings and things getting 'lost in translation'.

- **Influence.** VCSE organisations reported that it is often difficult to find the right person to talk to in the system that has the authority to act and make decisions to overcome barriers to data sharing.

Financial and economic barriers

- **Resources.** VCSE organisations are often not funded sufficiently to collate and analyse the data they collect. Having multiple funding streams, each with varying requirements, can add

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[9] Data captured by NCVO Civil Society Almanac for the year 2017/18 (estimation method designed by NCVO with Office for National Statistics)

to the difficulties in collating data that spans across commissions. Also it would be difficult to include this cost in contract bids.

- **Value of data.** Data and intelligence can be commercially valuable assets that organisations can be reluctant to share for free. Many VCSE organisations gather insights at great cost to their organisation, often not covered by grants or commissions, so can be reluctant to share this information.

- **Expense.** Software programmes are generally expensive and often incur additional costs for each new geography or new partner added. This kind of expense can be very difficult for VCSE organisations to meet, especially given the difficulty of funding such infrastructure costs through contracts.

- **Inclusion health populations**. Limited capacity and funding mean that VCSE organisations working on behalf of inclusion health populations have to respond strategically to the needs of communities, often developing projects that maximise output in order to best use limited resources.

Legal and regulatory barriers

- **Protocols.** There is generally a lack of a recognised protocols and processes around sharing data, either at national or system level. Even within one system area, different funders and commissioners might ask for different data sets for different purposes, which leads to a lack of shared vision of what data is needed, what data might be valuable and how to develop processes to collect and share data. Sometimes there are protocols that actively inhibit data sharing.

- **UK General Data Protection Regulation (GDPR).** This is causing additional challenges when data has been gathered previously for a specific purpose and permission was not sought at the time to share data more widely.

- **National policies and processes.** Sometimes policies written at national level can unintentionally hit the ground in a way that leads to unintended barriers, or misinterpretation by local decision makers. This is sometimes because national guidance naturally must be broad and high-level, or due to the speed with which national policy needs to be implemented.

Enablers

Through the research, we identified several ways of working that could enable better use of VCSE data and intelligence:

- **Value.** A willingness to accept that VCSE data and intelligence is a valuable and necessary part of a whole system approach to effective person-centred health and social care.

- **Relationships.** Strong links with grassroots organisations and working with trusted intermediaries (such as local infrastructure organisations or VCSE prime contractors) are key to developing networks that can support meaningful engagement and gather key intelligence and insights that may otherwise go unheard by health policy decision-makers.

- **Funding.** In order to address the stark and longstanding inequalities in healthcare access and outcomes experienced by excluded communities, there is need for greater funding to the sector to ensure the needs of inclusion health groups are consistently included in policy and planning.

- **Regular communication.** During the Covid pandemic, heightened communication enabled cross-sector partnerships to respond faster and more effectively to meet the needs of the whole population whilst targeting those with the greatest needs. We need to ensure these examples are remembered and built on as we move forward and "build back better".

> **EXAMPLE:** During the pandemic Doctors of the World translated Covid-19 guidance into 60 different languages, to ensure that messaging around Covid, and entitlements to healthcare, were reaching communities who needed this vital information, and may otherwise be unaware of key developments during the pandemic. (More detail Appendix 2)

- **Different types of intelligence.** A willingness to consider qualitative and anecdotal intelligence where there might not be robust quantitative data.

- **Understanding.** A joint understanding among both sectors of what data and intelligence is useful.

- **Technology.** Shared access to a data capture system.

> **EXAMPLE:** Community Action: MK built an online data collection tool that can easily provide real-time intelligence on community needs and feed into strategic planning. (More detail Appendix 2.)

- **VCSE infrastructure.** VCSE infrastructure organisations have a strong role to play in helping to coordinate, facilitate and administer systems and data sharing within and on behalf of providers.

> **EXAMPLE:** Community Action: MK, in developing the data collection tool (above), provided strong local leadership and secured the resources that enabled the tool to be developed.

- **Openness.** A willingness for all parties to explore new ways of working.

> **EXAMPLE:** Imperial College Healthcare NHS Trust codesigned a grant scheme together with local stakeholders that would address the social determinants of health in relation to the Covid crisis. This was the first time that the trust's financial resources had been used at this scale to engage the community in addressing a health concern.

- **Partnerships.** Specifically in relation to inclusion health groups, developing strong networks with leading academics and experts on inclusion health, as well as people with lived experience and other VCSE organisations, could help to ensure joined up working and build a strong lobby for influencing change.

> **EXAMPLE:** Working with Everyone created a mechanism for public authorities to engage with people with lived experience, and those whom datasets often miss. From this, they **developed thematic documents**[10] for NHS England and others, that can be utilised to drive forward change and to inform decision-making across the health and care system to address inequalities in access and outcomes. They developed a series of 'Data Summary Sheets', following research (in partnership with a university) with socially excluded patient groups. These can be used as soft intelligence to help inform policy and practice.

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[10] An example document produced in this way is Moving Forward with the NHS Long Term Plan – No-one Left Behind

EXAMPLE: Doctors of the World identified that there was a barrier to people from marginalised groups accessing mainstream healthcare. They identified a significant gap between policy and practice in access to primary healthcare, and therefore developed the Safe Surgeries Initiative which contains seven practical steps for surgeries to implement to overcome these key barriers, including not asking for photo ID and proof of address.

Recommendations for integrated care systems and local commissioners

1. Integrated care systems and commissioners should facilitate and resource data sharing

ICSs should adopt a new approach that **facilitates and resources the effective sharing of appropriate data** between the VCSE and other stakeholders. This can be done within the context of the **ICS maturity matrix**, which talks about:

- increasing the effective involvement of voluntary and community partners, service users and the public in decision-making at system, place and neighbourhood
- collaborative and inclusive multi-professional system leadership and governance, including local government and the voluntary sector
- implementing priorities in prevention and reducing health inequalities as part of care model design and delivery.

Critical to implementing this will be **codesigning** the policy with the VCSE sector, including people with lived experience, and working with local partners to ensure that commissioning and grant arrangements allow for the infrastructure cost of data collection, management and secure sharing. This is of particular importance for small organisations, particularly those working with groups experiencing inequality or exclusion.

2. ICSs should lead codesign of a data template

Each bit of the structure, be it geographic (system, place, neighbourhood) or thematic (e.g. mental health) should **codesign** with the VCSE the nature of data required, how it is captured and how it could be shared.

This should be supported by the development of an **ICS data template**, developed in partnership with all stakeholders. This process will identify the type and depth of the data, including quantitative, qualitative and anecdotal, that would be useful. A broad framework should also be developed to illustrate the reporting format, the resources required and how each activity in each element fits together and adds value. The template should be customised to meet the requirements of each system.

People with lived experience and VCSE experts should be remunerated for their time.

3. ICSs should maximise existing data sources before developing new ones

The option of whether or not to develop new databases should be a matter for discussion with stakeholders. The **value** and **purpose** of existing databases must be taken into account, along with the challenges of sharing data across partners. The type and purpose of any new database or data source must be clearly established. Is it to develop and monitor the impact of services, or secure data on health and wellbeing, or develop partnerships to tackle health inequalities and prevent ill-health, or a combination of all of these?

4. ICSs should resource the software required

The **costs** and **consequent accessibility, implementation** and **maintenance** of software for VCSE organisations should be established and properly resourced, as part of a place-wide or system-wide data strategy.

5. ICS should build networks through local VCSE infrastructure

ICS structures should build effective **relationships** with VCSE via **local infrastructure organisations**,[11] as a gateway to the wider VCSE. This will support the building of networks and dialogue between VCSE and the ICS that will in turn facilitate the **capture and the utilisation of qualitative and anecdotal data**. VCSE infrastructure organisations have extensive data sources that can provide information and contacts within the areas covered by each neighbourhood, place, and system, including that regarding the experiences of socially excluded communities, such as Gypsies and Travellers, people experiencing homelessness, and migrants in vulnerable circumstances.

This approach will enable targeted dialogue through which health needs, inequalities and opportunities for prevention can be identified. It can also be a vehicle through which those at risk of unnecessary hospital admission can be better identified and supported, and social prescribing can be strengthened.

At 'place' level, access to such networks could strengthen the understanding of local need and the ability to plan the use of collective resources, including beyond traditional health and social care services, to make the best use of overall public and community resources. The detail and the **resources** to develop and sustain this work will need to be considered at the planning stage.

Recommendations for NHS England

NHS England and NHS Improvement can play a key role in supporting the developments suggested herein. Specifically, it can:

1. ensure that **future iterations of guidance** to local systems includes information on the **benefits** and **enablers** of sharing VCSE data and intelligence
2. consider creating specific guidance for ICS on the recommendations above, such as developing a **data template**
3. establish and resource a time-limited **action learning programme** that builds on this research, develops further case studies of good practice in data and intelligence sharing that has led to positive outcomes, and disseminates learning nationally
4. **raise awareness** internally with policy leads to understand the impact VCSE data and intelligence sharing could have on their specific work areas, to help inform future NHS policy development.

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[11] A list of local VCSE infrastructure organisations across England can found on NAVCA's website.

Appendix 1: Public sector guidance

1. Guidance on designing integrated care systems – system, place and neighbourhood levels

[Designing integrated care systems (ICSs) in England](#) (NHS, 2019) includes an 'ICS maturity matrix' covering five domains of system maturity with four stages in each. The guidance notes that mature ICSs will be *"effectively utilising national and local data"* to *"deliver a full population health management capability embedded at neighbourhood, place and system levels which supports the ongoing design and delivery of proactive care."*

The same guidance makes reference to the benefits of utilising local data at the place level:

"Two crucial pieces of work are driven at 'place' level, both relying on collaboration and joint decision-making. These are clinical care redesign (simplifying and standardising care pathways across a whole area) and population health management (making better use of data to improve how health and care services address wider health determinants such as housing, environmental quality and access to good employment and training)".

And at a neighbourhood level:

"More mature PCNs will use increasingly sophisticated data to identify and give more proactive care to those at risk of unnecessary hospital admission and will use new technology and tools such as social prescribing to help people to care for themselves where appropriate."

However, the guidance does not go on to suggest what 'national and local data' should include and, without being explicit, it may be that VCSE sources are not considered.

2. Link to population health

Guidance to primary care networks (PCNs) cites the example of population health in Lancashire:

Lancashire neighbourhoods including Chorley and Skelmersdale are developing 'population health management' approaches, to improve local people's health results, reduce inequalities and address the broad range of individual, social and environmental factors that affect these. To do this, GPs, councils, community organisations and others are building shared information and understanding about how different groups of residents live their lives. For example, bringing different data sources together to identify how those with two or more long-term conditions can best be supported to prevent complications and live independently.

Healthier Lancashire and South Cumbria (ICS) [describes](#) how they have used data on long term conditions to do this but does not explicitly reference working with VCSE data.

3. Primary care maturity matrix

"Use of data and population health management" is one of the five components of the *Primary Care Network Maturity Matrix* (NHS, 2019) with the use of data in the most mature PCNs described as:

"Systematic population health analysis allows the PCN to understand in depth their population's needs, including the wider determinants of health, and design interventions to meet them, acting as early as possible to keep people well and address health inequalities. The PCN's population health model is fully functioning for all patient cohorts. Ongoing systematic analysis and use of data in care design, case management and direct care interactions support proactive and personalised care."

Appendix 2: Examples of good use of VCSE data and intelligence

1. Community Action: MK developed digital tools to capture community intelligence more systematically

Challenge

A team of 12 community mobilisers working across housing estates in Milton Keynes were picking up valuable intelligence on community needs, but it felt like this was only "by chance", through team meetings and ad hoc conversations. No one organisation had the full picture. They saw a need to capture intelligence in a more systematic way. To address this, Community Action: MK (CAMK) asked the mobilisers to record intelligence in manual records, which were then collated manually and shared at team meetings.

With funding towards a citizen innovation project, MK: Smart, they had developed a prototype technical solution for capturing data called Quick Chat App (a mobile and desktop app), but technology moved on quickly, and became costly. This all happened at a time of drastic funding cuts due to austerity, so they were unable to seek local statutory funding to support the development. So, for several years there was not a good solution for collating and sharing the intelligence they were picking up. They tried various simple solutions such as Google Forms, but this was not effective.

Then the Covid pandemic hit, and CAMK started hearing anecdotal stories of people 'slipping through the net' of support. They were also hearing from their member organisations that charities were finding it difficult to voice the concerns of their communities, could not access decision makers, and so on. So, the need for systematic data capture became even more imperative.

Action

CAMK applied for a development grant from Catalyst, an organisation that promotes the use of technology in the VCSE sector. This enabled them to develop a digital tool, which they codesigned with their digital partner and local community groups, to gather on-the-ground data and intelligence.

The technical infrastructure is 'open source', which means that organisations across the country can adopt and customise the solution.

Outcomes

The tool has been launched and tested within the local VCSE sector in Milton Keynes and is receiving real time data. The CAMK team will be engaging with the VCSE organisations to explore ways of presenting and sharing the data in the most effective way.

The tool is available to any voluntary groups and organisations in Milton Keynes of any type and size, not just to the CAMK team, allowing them to share insights from their work, including what

they are hearing from their beneficiaries or services users, or the communities they support or represent. This offers a sector-wide approach to collecting data.

Based on the 'open code' principle, the tool is also available to any organisations, not just those based in Milton Keynes, to re-use and adapt to their individual and local needs.

The tool's data methodology focuses on capturing the vast and varied grassroots intelligence within the VCSE sector and is designed to collect information on ideas, interests, impacts and issues (it is not only issue-focused).

Cost-effectiveness and sustainability have been at the heart of developing this solution, meaning that the tool can be used long-term and will not be affected by funding shortages and needs for updates, which can be very costly.

Impact

The MK Community Data tool was codesigned, reflecting the needs of the CAMK team and the main user group - the local VCSE groups and organisations in Milton Keynes. Some of the key needs that have been identified as part of the user-research that underpinned the development of the tool are:

- Manager of a local charity: *"I need to see who else is recording and supporting similar issues so that we can find ways to work together to address the issues more effectively"*
- Service provider: *"I need to understand and categorise my clients' issues, so that I can easily record and share this in a secure and structured way to make sure my clients' needs are being met and to create evidence that our work is vital and needed"*
- Small local charity: *"I need to find ways for the needs of my beneficiaries to be heard and understood by decision makers"*
- Someone designing local services: *"I need to understand the real lived experiences of people that services support, and the broad issues that are impacting their lives, so that solutions are properly informed and effective"*

The tool facilitates a fuller representation and picture of needs within communities across Milton Keynes, which can be used to influence how decisions are being made and to ensure that the local services are designed to reflect those needs.

Thanks to the themes and keywords methodology the tool uses, it helps to identify commonalities and opportunities for collaboration within the VCSE and across the sectors to address service user needs.

It has the potential to create a strong, collective voice of the local VCSE sector that will have more influence with service users and decision makers. It could also act as a powerful bank of evidence, helping the VCSE to prove the need for their services.

Enablers

- Local VCSE partners can directly input data. There is no 'gatekeeper'.
- Good tagging of the data, using themes and keywords, etc.
- The solution is cheap to maintain, currently under £100 per year for the hosting.
- Data is anonymised, which is compliant with GDPR. This avoids the time-consuming and costly requirement for service users to give permission for their data to be used and shared, and the data to be managed according to legislation.

- External development funding enabled the solution to be designed.
- There was initial interest from the statutory health sector, which gave CAMK confidence that the solution would have a wider strategic use.

Lessons learnt

Consideration should be given to the sustainability of the solution, principally how it is funded. Ideally local public bodies such as the council or integrated care system should pick this up, as there are clear advantages for them to accessing this data.

The success of the tool will depend on a range of VCSEs across Milton Keynes inputting their information, so engagement is a key priority going forward. This necessitates staff time dedicated to rolling out the tool and engaging with the local VCSE to encourage its use.

The CAMK team have been encouraged by the conversations they have had with stakeholders both within the VCSE and in other sectors. They are, however, also aware of the challenges around continuing to encourage and enable very busy VCSE groups to continue to feed data into the tool on a regular basis; and they are exploring options, including regular workshops with users, that will give the sector ownership around how the data can best be used, and what the focuses should be going forward.

Following user input, it has been identified that the tool should be developed in a way that strikes a practical balance between capturing detailed data from the huge range of issues covered by the VCSE and remaining a quick and easy tool for users to engage with.

As the range of information to capture is so vast, and changes at pace, flexibility must be built into the tool so that it can continuously adapt and improve when needed. CAMK realised that creating a perfect, complete and static iteration was not practical.

Discussions with health bodies and VCSE infrastructure organisations nationwide has shown wider interest in the tool. For example, health sector colleagues have been interested in using it to map and monitor health inequalities.

Recommendations

The urgency for the development of this community intelligence tool was born out of the Covid-19 pandemic. The vital grassroots intelligence that VCSE groups hold was not being used to understand urgent community issues, and no-one (including service providers and decision makers) had a full picture of the new and emerging needs across a range of people in Milton Keynes. We believe that this 'lived experience' data is key in addressing those needs, particularly in understanding the impacts being felt by groups disproportionately impacted by Covid-19.

Co-design has been key, so we recommend using this approach as much as possible when developing solutions that are designed to be used by a range of users, representing a wide range of perspectives and needs. This should include practical accessibility needs, such as users with visual impairments.

2. A bespoke database designed by a consortium in Bromley

A partnership of VCSE organisations was set up in Bromley to work together to enable Bromley residents to stay emotionally and physically well, avoid or delay the use of health and social care services and remain independent. The Bromley Well service is jointly commissioned by the local CCG and council.

Clients access the service through a **single point of contact** hosted by one of the partners. This delivers a much clearer pathway for clients and referrers.

A **shared database**, 'Charity Log', holds and processes all client data and enables reporting against agreed KPIs. This means:

- Client outcomes of the service as a whole can be captured (rather than having to be collated from multiple providers).
- Teams can collaborate across organisational boundaries.
- Wider intelligence on the client population can be captured and acted upon.
- Providers can be performance-managed among the partnership, and supportive action to address delivery issues can be taken.

The consortium has a **direct line of input** to the health and wellbeing board, which facilitates the data and intelligence harnessed by the service to influence planning.

Example of benefit of this approach

The need for mental health support was higher than anticipated. This need was picked up and a mental health specialist advisor was recruited to deliver a triage system.

Recommendation

Commissioners should invest in single points of access and shared data storage across providers. This makes it easier to pick up and act upon service user needs, as well as enabling more efficient provider performance management and greater agility to notice and act on issues that need support.

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3. A bespoke data capture system in Somerset

Rethink Mental Illness led a partnership developing a new integrated model of care for people with moderate to severe mental illnesses. They designed a bespoke data capture system that integrates with mainstream NHS data systems and was coproduced with service users. The benefits included a single plan for service users and the provision of one single data source across sectors and organisations.

Their service model breaks down barriers between primary and secondary care and creates partnerships between statutory services and the VCSE sector to provide a wide scope of clinical and social support.

The approach involved the **blending** of **national metrics** required centrally by NHS England and Improvement with **co-produced, patient-focused measures** that are meaningful for service users in Somerset.

The partnership **worked with experts by experience to co-produce a longlist of possible outcomes** based on the experiences and priorities of those living with mental illness.

Giving access to partners to EMIS, the NHS data system, was not desirable, as it was deemed to entrench traditional power dynamics and hierarchies. So, they **designed a new** care and support planning and outcomes recording digital system that **integrates** with popular healthcare records software.

Benefits

- Service users only have one plan that crosses all the agencies involved in their care.
- There is one source of client data that everyone has access to.

Enablers

- Buy-in of STP performance and finance departments
- Dedicated investment in service transformation
- "Record light and report once" approach, and simple recording measures for small organisations
- Co-production with experts by experience. This ensured meaningful person-centred measurement of the service's impact, without creating a data burden.

Still to do

- The partnership is still considering how they can capture the impact of the full mental health ecosystem – from large NHS providers to micro-organisations and peer support groups.
- Development of a patient portal, which will give individuals the ability to meaningfully own their own personal plan.

4. Data capture from Wirral social prescribing pilot

A social prescribing pilot was set up in the Wirral with five link workers being employed by the local Citizens Advice or Age UK.

The challenge

The challenges were to

- improve proactive identification of adults whose health and wellbeing is likely to improve following a social prescription
- provide a person-centred, community-based health and support programme
- support people to better manage their own health and make informed choices
- reduce financial pressure on the health and social care system
- embed social prescribing at the heart of local primary care structures
- provide evidence to secure future funding.

What we did

The link workers engaged people with COPD and low mood, anxiety or depression, and provided structured support conversations to understand the underlying causes of their problems. They used EMIS and Casebook for the storage of client data. This enabled them to capture a wider range of data than EMIS would allow.

Outcomes

Through shared data, the project was able to show the positive impact on health and wellbeing in Wirral. This success led to a significant upscaling, and the project expanding from primary care into secondary care, through a contract with a mental health provider. This provided access to an additional beneficiary group: clients of Citizens Advice Wirral with mental health issues.

Barriers still to be addressed

A range of barriers still need to be addressed:

1. Reliance on digital delivery is an excluding factor for some patient groups
2. There is a disconnect at system level, meaning that the value of social prescribing in addressing the wider determinants of health are not being recognised.
3. There is no strategic mapping and planning around how the data is collected and interpreted across the service stakeholders, so potentially useful data is not being captured or used to inform planning.
4. Providers are not resourced to set up and manage data storage and processing systems, and therefore providers do not have data specialists, which means that data is not able to be used in the most intelligent way.
5. The lead provider does not have a direct line of contact into the health and wellbeing board, which inhibits their ability to use any data or intelligence that they do capture to have wider influence.

5. A CRM system in Torbay

Torbay Community Development Trust works in partnership with others to reduce loneliness and isolation in its community and improve health and wellbeing. They follow an approach grounded in asset-based community development, with community builders that support people in communities to work together to build the connections, activities and support they want to improve their community. A team of 15 community builders work in partnership with local citizens and wellbeing coordinators from Age UK Torbay and Brixham Does Care to deliver social prescribing.

Early on, the Trust recognised that capturing and sharing data across partners would be a challenge so they bought in a specialist customer relationship management (CRM) system to support the partnership. This has inbuilt security for the storage of data but also allows different partners to capture, report and cross-refer information about individuals and share information. The Torbay Community Development Trust administers the CRM system in the middle.

Benefits

Partners have found that having this robust CRM system in place has been one of the reasons for the success of their whole approach. In terms of the data challenge, it helped partners to overcome challenges related to data confidentiality and privacy. It has also helped overcome some of the challenges that statutory partners have around data sharing through the use of a third-party system.

Another benefit is that the system enables easier analysis and demonstration of the impact and value of the approach. This has helped the partners build on the success of the programme by securing funding for future work.

6. A mechanism for engaging people with lived experience

Working with Everyone created a mechanism for public authorities to engage with people with lived experience, and those whom datasets often miss. This highlights the benefit of gathering **soft intelligence** from community members from excluded or marginalised groups.

Taking an 'asset' approach, they built a network of 'experts by experience' keen to influence health and care policy and planning, initially by working through known advocacy and support organisations.

They ran a programme of **digital inclusion workshops** with people experiencing homelessness and substance misuse who are digitally excluded. They provided coaching to participants and support to trainers to ensure maximum inclusivity.

From this, they **developed thematic documents**[12] for NHS England and others, that can be utilised to drive forward change and to inform decision-making across the health and care system to address inequalities in access and outcomes.

(They are now working with an analyst from Bradford University to develop published peer-research that can help to build a stronger evidence base on the needs of particularly socially excluded communities.)

They developed a series of Data Summary Sheets, following research with the University of Bradford with particularly socially excluded patient groups. These can be used as soft intelligence to help inform policy and practice.

Enablers and lessons

- Remunerate "Experts by Experience" for involvement. This enables meaningful engagement.
- Work through grassroots organisations and work with trusted intermediaries.
- Buddying and peer-support helps to safeguard people and protect from some of the emotional impact of discussing personal experiences in public forums.
- Ensuring that care and childcare are paid for is vital so that people with caring responsibilities are able to participate.
- Remuneration must be paid in a form suited to personal circumstances, for example, vouchers rather than payment for those claiming benefits or asylum payments.

Recommendations

Invest time and effort in work to establish meaningful engagement, to ensure that communities can speak up on their own behalf.

For people who have experienced social exclusion, recognise the emotional investment placed in engagement meetings and be mindful of the emotional impacts of disclosing personal experience.

Ensure that engagement is practical and accessible; deliver information in an accessible way, support digital inclusion, and offer financial incentive in a practical format.

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[12] An example document they produced in this way is Moving Forward with the NHS Long Term Plan – No-one Left Behind

7. A co-designed grant scheme with community stakeholders

Imperial College Healthcare NHS Trust worked with its hospital charity and academic partner to create a £450,000 grant programme to support local organisations working with those worst affected by Covid-19.

They **co-designed the grant programme**, including the grant criteria, application process and evaluation process, with local stakeholders. This meant that 90 local community organisations were able to bring their data and intelligence on their populations to a collaborative process that led to appropriate targeting of resources to address health inequalities and the social determinants of health.

This was the first time that Imperial funds had been used to support external community partners at this scale. This was done because senior decision-makers in the trust had seen anecdotally a direct link between the wider social determinants of health and the clinical issues presenting through Covid.

The co-design approach led to:

- a more impactful programme which accurately reflected local needs
- the building and strengthening of relationships between statutory and VCSE partners and a way of working for future programmes
- the identification of individuals and groups with additional needs that could be supported outside of the grant programme
- better understanding of how VCSE intelligence can shape a programme development from the outset.

Enablers

- Flexible and open approach of the funding partner
- Commitment to addressing wider determinants of health
- Collaborative, multidisciplinary steering group
- Willingness of communities to engage and commit time
- Use of interactive online tools to help engage workshop attendees
- Honest and open dialogue – this allowed the communities to act as a critical friend to the programme, providing constructive critique and identifying areas for improvement
- Expertise in community engagement, communication and quality improvement
- Partnership with a research organisation with experience in applied research and mixed methods evaluations
- Buy-in from the steering group and communities to try something new and accept that not everything would work but wanted to try!

Recommendations

See the big picture, beyond one's own organisation.

Be comfortable with change and the process throwing up some difficult challenges to attitudes and ways of working.

Allow lots of time for thorough and genuine process, which has the ultimate benefit of strengthening relationships and building sustainable ways of working for the future.

8. Collecting data routinely from marginalised groups

Doctors of the World undertook two initiatives to address systemic barriers for people from marginalised groups to access mainstream healthcare or information. They run specialist health clinics in London and Birmingham for people from marginalised or excluded groups as well as a national advice line. Clients' barriers to accessing healthcare relate to factors such as refused registration due to lack of ID and fixed address in primary healthcare, unstable housing circumstances, immigration status, lack of access to translation services, digital exclusion, etc.

One of the main challenges for mobilising action to address these barriers is a **lack of routine data collection** within health and care services for many vulnerable migrant groups. The needs of these communities therefore remain largely invisible in datasets.

Routine data collection at the point of contact with Doctors of the World's services, alongside meaningful engagement with community members, was used to inform the development and delivery of two specialist services, as well as to influence change:

1. Safe Surgeries Initiative

Doctors of the World identified a significant gap between policy and practice in access to primary healthcare. Whilst there is no regulatory requirement to provide ID, a fixed address, or details of immigration status in order to register, many GP surgeries refuse patients on this basis. In addition, the information collected highlights additional barriers to accessing a GP practice, relating to inaccessible communication, such as lack of access to interpreters, and digital exclusion.

In response to this, Doctors of the World developed the Safe Surgeries Initiative which contains seven practical steps for surgeries to implement to overcome these key barriers in primary healthcare, including not asking for photo ID and proof of address.

2. COVID-19 Translated project

Doctors of the World developed a translated information project to ensure key guidance and updates reached underrepresented communities.

They reviewed available translated information from the government and health and social care services and identified that a number of communities would not be picked up. They then analysed data from their clinics and surveyed communities to gain insight into key languages spoken. Resultantly, Doctors of the World translated Covid-19 guidance into 60 different languages, to ensure that messaging around Covid-19, and entitlements to healthcare, are reaching communities who need this vital information, and may otherwise be unaware of key developments during the pandemic.

Outcomes and impact

- 400+ surgeries signed up as 'safe surgeries'.
- Endorsement of 'safe surgeries' initiative by NHS England, Royal College of General Practitioners and Royal College of Nursing.
- Extremely positive feedback from participating GP surgeries.
- 60,000+ downloads of Covid-19 information.

Lessons learnt

Doctors of the World had to evolve and adapt to new ways of working, to strategically respond to the needs of migrants in vulnerable circumstances despite limited capacity.

During the pandemic, a strategic approach to working was key; both recognising limitations in terms of capacity and directing attention towards areas where the most progress could be made. Despite this, they continued to establish meaningful engagement with communities in health policy decision-making. To support this, they established a network of migrants with lived experience to co-produce solutions to barriers to health and care. The value of this network was brought into focus during the pandemic, during which time the network provided key intelligence on barriers to testing, vaccination and more, which can be used to directly influence policy.

Recommendations

Developing good systems for data collection is key to building a strong evidence-base on barriers to services and influencing change.

Meaningful engagement and co-production with communities is vital for identifying insights on how to improve access and uptake to health and care services.

Work strategically and collaboratively towards key planned strategic objectives and develop "concept notes" of possible projects to support these, so that fundraising staff can proactively apply for relevant funds.

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