An Evaluation of *Closing the Gap*, a systems change programme in the One Northern Devon LCP

Purpose of this evaluation

Devon Community Foundation was commissioned by Darin Halifax, NHS Devon Head of VCSE Partnerships, to assess the impact of NHS / LCP investment in VCSE sector projects and to report on the difference these are making in helping to address health inequalities in communities in Devon. The evaluation explored whether there is social value in delivering these types of interventions (the positive and negative impacts, both anticipated and unforeseen). Our overarching evaluation questions were focused on:

- effectiveness: Has the intervention achieved its intended outcomes? Were the objectives met?
- efficiency: Was the intervention implemented in a cost-effective manner? Did it make optimal use of resources?
- sustainability: Are the positive impacts likely to be sustained over the long term?
- equity: Did the intervention affect all stakeholders fairly? Were there any disproportionate impacts on certain groups?
- relevance: How aligned is the intervention with the needs and priorities of the communities involved?
- impact: What is the nature, magnitude, and scope of the observed impacts (both positive and negative)?

The evaluation was essentially qualitative in design: we reviewed reports relating to the project, attended several partnership meetings, explored the first-hand experiences of selected partners through semi-structured interviews.

Our aim is for the outcomes and recommendations in this evaluation to inform organisational, community and strategic decision-making, including ongoing funding decisions and evaluation and impact measurement frameworks.

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- Closing the Gap brings together a uniquely diverse and enthusiastic partnership, but at this early stage it remains relatively immature and therefore fragile
- There is a very clear, ambitious, and securely led vision for systems change alongside organisational development
- Developing untapped existing peer learning resources would strengthen the partnership alongside individual practice
- A shared outcomes framework that included aspects of cultural change in organisations is more important than a rigid set of metrics
- A coordinator role would support the development of the partnership and leave the leaders more freedom to consider the strategic significance of the work in the wider context

Context

Closing the Gap (CtG) is described in programme documents as a systemic ambition to reduce health, economic and social inequalities in the one Northern Devon (OND) footprint, especially in the most deprived 30% of communities. It is conceived as a conscious alternative to less radical, project-based work:

> *"We'll all be retiring in fifteen years – we wanted to be able to look back and see that we'd made a difference."*

CtG sets out to embed a focus on improving access, experience and outcomes for the most disadvantaged cohorts accessing individual services, and to drive transformational change through partnership work across public, VCSE and private sectors (including NHS organisations, local councils, police, education, the private sector, housing and VCSE infrastructure bodies). The emphasis is on collaboration, prevention and fairness, acknowledging that fundamental disruption to the status quo is needed. It is also a long-term vision: CtG is seen as a ten-year journey toward system-wide cultural transformation, moving from top-down, risk-averse systems to co-production and community-led solutions.

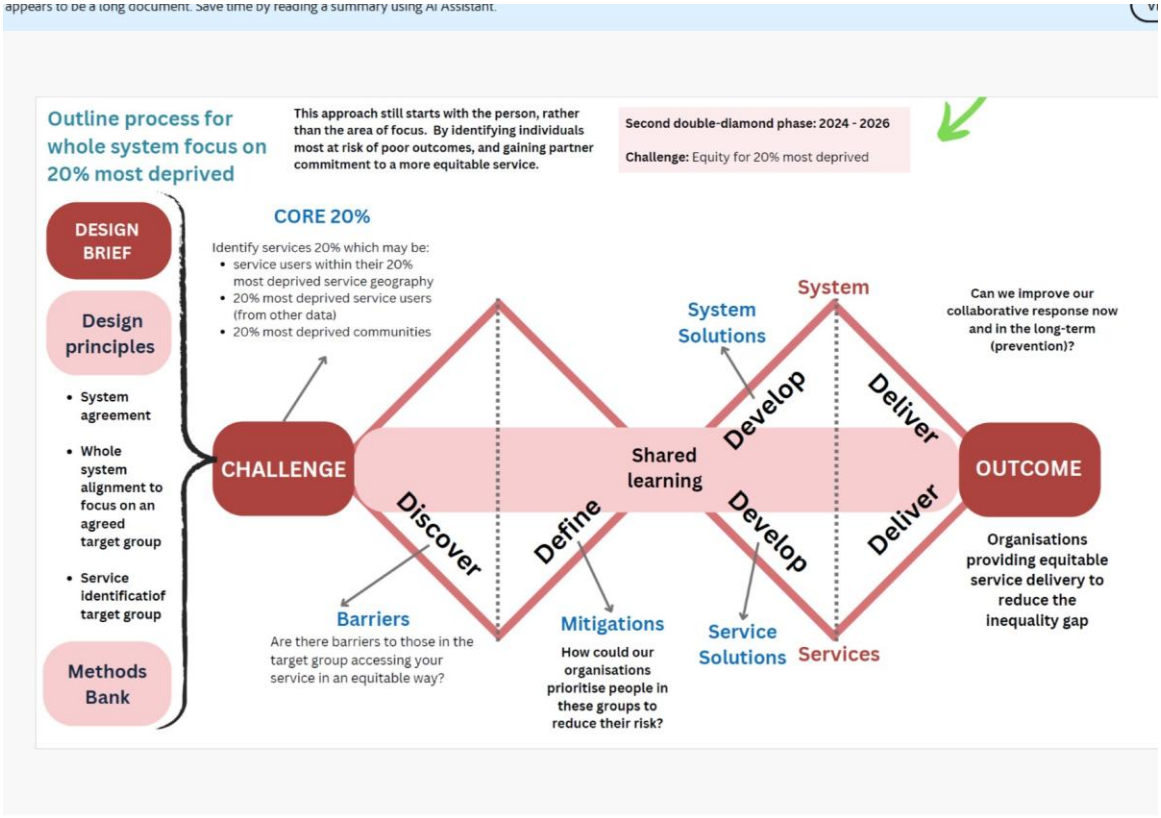
> *"Closing the Gap means that all of the partners that are involved in providing health and social care, broadly defined in the locality, are aware of the impact of inequality in their areas of concern. You know, the impact on employment, the impact on educational attainment, the impact on health outcomes, the impact on criminality and so on, and the impact on systems change and then giving them the tools to be able to do things*

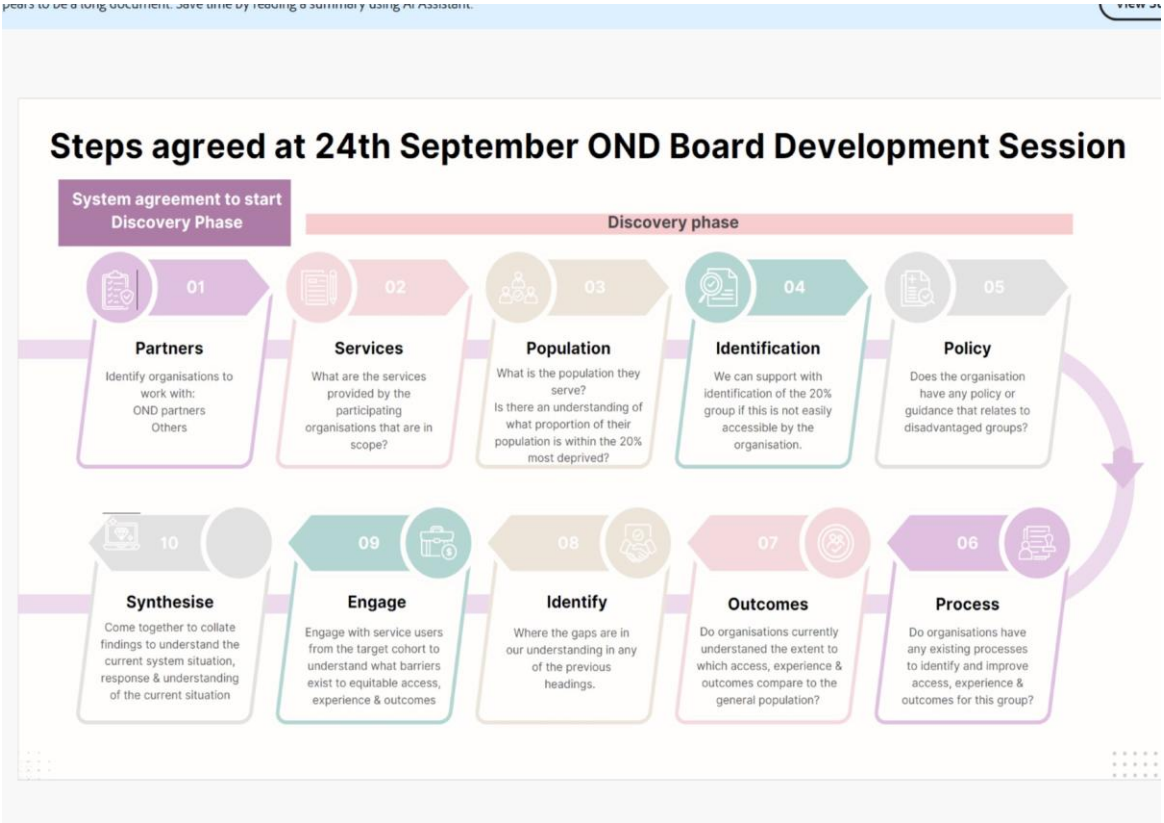
within their sphere of influence as well as specific activities that might be looking at the core 25 plus."

"Little bits of funding can help with project work between partners to try and embed Closing the Gap, but I would like to think that, even if that couldn't happen, Closing the Gap as an ethos is embedded in all our partners, so it would happen, should happen anyway."

We were invited to understand how ICB funding for the CtG initiative has been impactful in supporting its effectiveness, efficiency, sustainability and relevance, and how the LCP operates as a delivery mechanism for such programmes. In order to do this, we reviewed reports and minutes, interviewed eleven individuals associated with the partnership, attended regular CtG partnership meetings and staff consultation events, and met with Andrea Beacham and Ollie Hassall a number of times.

Early Progress A detailed plan has been developed by the OND board, identifying three key phases for the work. The Discovery phase focused on understanding the population and assessing partner organisations' current work and gaps. While many partner organisations we spoke to had completed many of the steps specified in the Discovery phase, for example, it is not clear whether everyone had, or whether this process was intended more as a guide.





There has been extensive discussion about how exactly the target segment of the population should be defined, and whether this needs to be standardised across the partnership. This concern was apparently driven by a sense that evaluation of CtG would require the identification of universal metrics and indicators relating to population health or service use data. Individual partners describe slightly varying understandings of the least-heard or most deprived cohort, depending on the work that they do. The conclusion has been to consider a cohort broadly corresponding to the most deprived 30% of Northern Devon LSOAs (deciles 1-3 of the national IMD), while recognising that deprivation in rural areas is not accurately represented by the IMD, and that specific partner insight may identify individuals in ways other than by geography, placing an emphasis on person-centred care (the most deprived 30% was chosen in order to reach the 20% most deprived neighbourhoods as ranked nationally). There is, therefore, space for partners to delineate and justify their own parameters, benchmarking this against the common core, but not constrained by a completely standardised measure. This feels like a very sensible approach, given the particularly localised nature of coastal, or deeply rural parts of the area. The complexity of deprivation measurements risks being a distraction that stalls progress unless this flexibility is retained (as Richard Blackwell explained to the Partnership Group in October).

CtG has completed the 'Discover' and 'Define' phases of the 'double diamond' model above, but it is not yet fully within its 'implementation' phase. This does not mean there has not been significant progress towards organisational change at a cultural level. It is important to understand that, with a vision that prioritises cultural change, many of the early outcomes are rightly focused on establishing the challenge ahead, on processes and developing a

shared understanding. As this report seeks to show, work to build a partnership *is* impactful, valuable action, but it looks very different from the way impact is understood within a project mindset, and it is not expressible in terms of more conventional 'health' indicators. Good progress has been made on:

- building a diverse cross-sectoral partnership and developing a shared vision for addressing health inequalities
- establishing a broad theoretical approach (the double-diamond) and initiating wider conversations within organisations about all the above, as well as what might need to change
- developing partners' understanding of the importance of a focus on equity in access, experience and outcomes, and recognising their responsibility in working to improve this
- considering what understanding partners have (or do not have) of their most deprived service users, and of what their barriers to access might be
- partners considering the experiences of their own staff and volunteers with regard to disadvantage
- noting existing local work, datasets and expertise to help build this picture further
- identification of a range of markers of disadvantage (eg children eligible for free school meals, unpaid carers, NEETs or those with a learning disability), which could suggest relevant indicators for tracking future progress

Early signs suggest some progress on:

- a shift from narratives of risk to ones of trust
- beginning to share learning from existing work to improve focus on disadvantage
- regular meetings to share challenges and ideas between the partners

Obviously, the institutional context within which this work is happening has changed significantly since CtG began and will continue to do so. The team is adamant that this instability should not impact their work excessively:

> *"I'm hoping that they'll still be absolutely purpose driven in this work and I'm hopeful that, regardless of some of the huge structural changes, that these individuals will say, 'Well, let's just, this is a Northern thing, this needs to be part of our DNA going forward. It doesn't really matter how much change goes on around us. It does feel like there's a real commitment to that."*

The Closing the Gap partnership

The partnership is an exceptionally diverse coalition, backed with a huge amount of goodwill and ambition to work together effectively. No other Devon LCP draws such wholehearted participation from such a range of sectors. In addition, it has a good balance of perspectives, including those with frontline experience, those with helpful strategic oversight, and some excellent data analytics support. This is a significant strength, capable of sustaining a

complex and long-term programme. It is securely led and coordinated, and has a clear rationale for the shift from traditional project-based work. It is, nevertheless, a relatively young partnership, and as such, there are some areas for future development.

Several of our interviewees however observed that, while committed to the principles of the work, they felt 'out of the loop' with the details of the partnership or not quite up to speed in some way. People said things like 'I ought to know more about this than I do', or 'I'm probably not the best person to ask'. It is our impression that this sense of not being as fully engaged as one might reflects both the complexity of the ambition and the relative immaturity of the partnership. It has not yet progressed past a 'hub and spokes' stage, where partners are heavily reliant on leadership and coordination from the centre. While this leadership is skilled and energetic, there are inevitable implications for power dynamics in a centralised model led by a large statutory body. Without attention paid to this, there could be a default assumption that the solutions to problems identified by heath agencies lie within health, while VCSE organisations may already have knowledge and experience of successful approaches (see for example Libraries Unlimited's Afghan women's project in Braunton).

Another symptom of CtG's relative youth is the reliance in several cases on single individuals within organisations. This is starting to change as organisations involve their staff in conversations about CtG but at present it represents a challenge to sustainability.

> *"**Ian:** Do you think you've got that buy-in then, is that starting to happen in North Devon?*
> ***Interviewee:** Some people, a few individuals, will recognise it, but broadly I don't think there's the buy-in yet. When initiatives emerge, unless there are particular individuals, I don't think the buy-in is there. I think there's a question of how you communicate to my sector and having a more structured approach to that, rather than relying on individuals like myself who happen to be involved, and therefore we're getting ad hoc messages and we can have ad hoc conversations, but there isn't yet a structured approach where you can try and sell it."*

There is potential to facilitate wider use of bilateral and multilateral connections, to share learning and value a wider range of knowledge (see below), while simultaneously building the resilience of the partnership. There is also potential to engage with a wider group of stakeholders, for example local Elected Members, business leaders and civic leaders, or those active on specific themes, such as environmental sector organisations concerned with public health and wellbeing.

Different partners are at different points in their journey with regard to systemic change, or in their experience of listening with care to traditionally unheard voices. We do not see this as a problem, but rather as an opportunity for productive collaborative exchange and learning, with vanguard initiatives taking early opportunities to move forward.

"I think being part of that network and being able to learn what other people are doing is really helpful".

It is vital that the partnership moves over time from a group of organisations working largely independently towards a collective goal, to a true coalition, which understands its interdependence and how to leverage that understanding to effect significant change.

System Change vs. Projects

While there is clearly an impressive, unified ambition to embed inequality reduction across organisations, there is also anxiety within the partnership about how to move towards this, and how to measure that progress. Much of this concern stems from the unfamiliarity of a shift towards less tangible systems thinking, and away from activity being centred around shorter-term projects with clearly defined outcomes. Partners express uncertainty about what this means in practice, and this might have the effect of hindering action; they 'get it' as an idea but were struggling to see where they fitted into the jigsaw and what they should be doing. This was especially noticeable in the non-statutory organisations.

"Mostly, when I attend the meetings, I feel energised but I still don't necessarily feel like I fully understand the long term intentions and my place in it, that really important part [we might] play in it. But on the flip side, my understanding of the overall goals of Closing the Gap and how we're trying to embed those into projects and future work and how we train staff and things, I feel like, whilst I'm not necessarily referring to that as Closing the Gap to staff, it still aligns with the values and the kind of work that we're pulling together".

The essential conundrum for CtG is whether it is necessary for partners to engage conceptually with a collective understand of 'systems change' in Northern Devon *in order to* effect meaningful reform, or whether CtG as a descriptive 'banner', under which multiple interventions, with achievable outcomes, can be facilitated, connected and learnt from, is a more realistic means to the same end, at least at this early stage.

Human Learning Systems orthodoxy suggests that, as complexity is itself non-linear, there is no necessity to determine a singular linear process. Change can be initiated at any point: what is important is to ensure that change is communicated, shared and reflected on by the partnership as a whole through the lens of a clear common vision (the 'systems solutions' strand of the double diamond indicates a clear commitment to this). This is the route CtG is following, emphasising an overall aim of integrating a health inequalities lens into service design and decision making, but recognising the challenge of rapidly aligning policies, procedures and funding. As such, the current emphasis for CtG is on individual partner action. As CtG matures, it will be important to begin to shift emphasis towards action initiated collectively. It is likely that a clearer understanding of systems change will emerge organically *through* this collective practice, which could usefully be additionally informed by examples from other contexts nationally.

"I'm always a bit lost because it feels a bit vague... I feel like for me, it's about taking on some of the principles and understanding of Closing the Gap and embedding it in some of the funding bids and projects that we try to do rather than having, like, almost like something that sits in silo, it's that cultural shift that will happen over time".

Structural and institutional constraints

Everyone we spoke to discussed the importance of taking measured risks and challenging traditional systems that perpetuate inequality. However, many felt institutional systems made this difficult.

"We need a strategy or a sentence or people saying 'yes, this is important', but unless their data gathering reflects that, unless the training needs analysis for the organisation reflects that this [CtG] is important, unless we're measuring outcomes in a way that becomes baked into clinicians and others' roles, unless those kind of structures and processes in the organisation change, you're not going to have a culture change beyond the warm words of the individuals that are particularly passionate at the time."

There is caution around some deeply engrained cultural practices, what one person called "organisational inertia":

"There's too much risk aversion in the way we make some decisions and we could be more agile and just trust relationships in order to run with [the] work partners do because they know what they're doing, where they are, they know who they know, and that's as much as we need to know."

"With the NHS we apply the same level of risk appetite at times to everything we do, but... how do we work differently with people and communities to hold risk in a different way? So that is definitely starting to change. Some of it is by necessity because we are resource constrained and we need to focus on those most vulnerable, with the most complex needs, and therefore have to hold risk differently. But that's a real change for clinicians as well, so you know, if communities are saying to us we want to live and experience our lives in a different way to the way that you think clinically is the right way forward, that's a real tension but it is it is starting to change, but it's been cultural change because people have trained in their methodology for many years and we really need to start to challenge that".

Some of this uncertainty was expressed as doubt about whether an LCP-level initiative had sufficient authority to shift the dial:

"I end up in lots of meetings where grand things are talked about and there might be a nice strategy that's produced and there might be a big debate

about the colours that are used and the comms strategy and so on and that might be quite organised and go down to the outcomes that we're trying to measure but whether that gets translated into what the providers do or not do is the question. I don't think it does because the LCP is a body without real bite still, they can't compel providers to do things, and providers are operating in a commissioning environment which doesn't necessarily take into account inequality."

For others, questions were raised about the extent of statutory commitment to equity and prevention:

"The reality though of the funding organisation, so whether it's local authority or the NHS, the Integrated Care Boards particularly, is I'm not seeing the reality of funding shifts to close the gaps because the way in which the priorities are driven just jar with some of that. So there's aspirations and words around prevention, early intervention, addressing some of those health inequalities, population health management, putting our attention and focus for those, you know, children versus adults, pockets of deprivation, economic growth, etcetera. But the reality is the funding then goes to the acute hospitals, the emergency departments, the high end, you know, bed-based care. That's the mismatch, a strategic mismatch that we're challenged with."

Shared language:

Some interviewees noted the need to 'package' CtG messages for staff, stakeholders and volunteers across different sectors, from frontline teams to strategic leaders, to 'sell' CtG and improve engagement. Not everyone sees the challenge of 'translating' abstract language into something meaningful for frontline practice as a marketing exercise, but there is nevertheless concern that its expression can feel 'rather nebulous'.

"I think that the challenge sometimes is the language, the language can be quite complex and it can be difficult to see and translate that into the everyday, which is really important actually. For true impact over a lengthy period of time because, you know, system change isn't always about the institutions, it's system change across a massive diverse group of organisations that cover all aspects of the system, so the transferability of understanding what tackling inequality means is important."

"Because we are feeling really reluctant, I'm afraid, to support things where the payback is nebulous or long drawn out and the connections we have today between state providers and the private sector, in my view, are pretty weak and there's been a reluctance on both sides, I say, to get engaged because we speak slightly different languages and planning horizons tend to be slightly different as well".

On the other hand, concern over consistency in defining key terms ('health inequalities', for example), can be overplayed. We suggest there is space within the model for varying ideas between partners, and that a definitive agreement on the terminology is not necessary at the outset for a robust shared vision, as long as the conversation is maintained.

Capacity and Resourcing

CtG is a long-term undertaking; leaders suggest a 5-10-year timeframe. Across the partnership, there is widespread concern about long-term sustainability and the mismatch between ambition and resources. Resourcing is obviously needed to coordinate and develop the partnership, and relationships between organisations going forward. Not all innovation necessarily requires additional funding, of course, but some additional expenditure is often necessary in the first instance. CtG has only a very small pot for funding innovation activity. Beyond this, partners value sources of flexible funding such as NHS prevention funds, and there are clear opportunities with the new Neighbourhood Teams and on-going support for LCPs to continue to develop Closing the Gap as a partnership for radical change.

There is a dilemma, nonetheless, stemming from uncertain resourcing for CtG. It has been argued that resources should not be withdrawn from certain populations in order to resource the most vulnerable. The current CtG 'levelling up' approach, where the focus (but not resources) are transferred towards tackling the 30% in most need, will be hard to implement if significant new funding, new savings or significant shifts in investment priorities are not forthcoming. How can CtG 'level up' with no new investment or without resources also being transferred from elsewhere in the system? We suggest that more attention is paid to the question of resourcing Closing the Gap and whether this can actually be achieved without redeploying resources from other parts of the system.

> *"We have a really clear idea of what will work and also what will save a lot of money and it's just a question of having those funders believe in that shared vision".*

Lack of long-term, sustainable funding for CtG might undermine partners' sense that CtG is valued and that there is strategic intent and commitment to tackling deep-seated health inequalities. In turn, this can affect their own commitment to the work, making it inevitably less impactful. We agree with leaders who advocate for multi-year commitments to enable learning, stability and measurable progress over the medium term, which can intersect productively with changes in the institutional landscape.

> *"The challenge will be: How do we persevere with this? Almost despite the changes, not because of them. There'll be further landscape changes certainly on a commissioning basis, a Devon and Cornwall footprint. That'd be even bigger scale. So how does that local work fit with wider pieces of work?"*

More broadly, capacity for innovation and learning is affected by overall organisational stability. The precarious situation of especially VCSE partners, including Libraries Unlimited

and the CVS organisations, often dependent on piecemeal, short-term grants, often confirmed at the last minute, leaves no bandwidth for creativity. In the absence of a backfill budget to support attendance at meetings, the engagement of smaller organisations without secure core funding is at risk. This is a loss not only in terms of the contribution their activity could make to tackling health inequalities, but also with regard to their critical insight into barriers faced by vulnerable groups.

> *"Because I work in the voluntary sector and we're so terribly underfunded, my ability to join up the work that I've done with NHS colleagues is really impacted upon by my capacity and the fact that my organisation is not funded for any of my time to take part in those things. So as soon as I was invited to the meetings, my first thought was, 'Oh, I don't really know what I can say' and 'I'm so stretched doing the work that my ability to participate with others that are doing the work is really limited'… My fear is that the voluntary services that would be best placed to support that new way of working won't be here by the time that's worked out, because the funding situation is so dire... It's very, very bleak at the moment".*

> *"Any organisations that has been invited, if their attendance is sporadic, like mine, it will be due to resources rather than them not believing that it's a priority or not believing in the vision".*

The private and education sectors have also struggled to attend and contribute to CtG due to everyday work demands and other priorities. The partnership is on paper much more diverse than most other constellations locally, but these gaps do have the potential to lessen the overall impact of the work. It is also clear that different partners have a wide range of levels of engagement, and motivations for and constraints to participating, which have not been explicitly explored.

Unlocking existing 'assets' for learning and valuing alternative forms of knowledge

There are several examples of work already being led by CtG partners that serve as practical expressions of the CtG ambition, and which have yet to be fully understood as such. One such example is the Ilfracombe Poverty Truth Commission. This latter is a very carefully facilitated (by OND), significantly funded (by the ICB) opportunity to understand how a serious commitment to understanding the perspective and experience of those living in poverty could transform how services are conceived and delivered. It is squarely within the strategic orbit of CtG, and has much transferable learning that could be of value to a range of partners who are considering how to hear the voices of residents more clearly. As such it is both a valuable untapped asset, and a powerful example of CtG in practice.

> *"So it's been a really broad mix of the civic world, but very importantly for me with the Closing the Gap is really listening to people's experiences that I cannot emphasise. It's fine sat in a room talking to each other about people, but actually to have that real co-production ethos and listening to*

people's experiences, [with the Ilfracombe Poverty Truth Commission] it's been eye opening, really eye opening".

Similarly, *Building a Strong and Vibrant VCSE Sector in North Devon and Torridge,* the joint project between North Devon CVS and TTVS in Torridge, funded by the National Lottery, is also a potentially rich source of relevant insight and learning. The project's emphasis on hearing the 'quiet voices' has had some success in improving the inclusion of young people and those from the Global Majority in this grassroots community development work. Reflecting on the first year of this 2.5 year project, learning partners note that practitioners remain reticent about the value of their knowledge and understanding. More structured opportunities for sharing stories of successful engagement would not only be helpful for others within the partnership, but would help strengthen this project, through enhancing the 'learning loop', as recommended by the learning partners.

There is plenty of potential for some peer learning, given partners' different stages on this journey, and varying range of knowledge and experience. It would require some dedicated facilitation, to spot the opportunities for cross-partnership exchange, but would make very efficient use of internal knowledge. This would contribute to practice through sharing insight (for example into habitual VCSE links with public sector provision, which are seen as novel in more statutory contexts). But it would also strengthen the partnership, through building bilateral links not dependent on leaders, and rebalancing power dynamics in favour of some of the smaller partners. Currently they do not always feel their knowledge and expertise is valued or valuable by others, which is both inaccurate, and a waste of important partnership assets.

CtG is very fortunate in having some highly skilled and experienced health data specialists amongst its cheerleaders. Discerning use of this capability could substantially assist the inevitable necessity to focus and prioritise actions, by having a robust evidence base for so doing. For example, attention to available population segmentation analysis could highlight opportunities to address infrastructural 'cold spots', with unequal spatial distribution of people, projects, need and resources. Areas of infrastructural strength tend towards a virtuous cycle of positive connection, endorsed by successful flows of funding, inadvertently reinforcing inequality. For instance, dissection of the Indices of Deprivation domains makes it easier to discern particular aspects of rural disadvantage, such as access to services, which have often-overlooked health impacts.

Evaluation, Evidence and Indicators

The CtG team has concerned itself closely with the question of how to measure, evaluate and understand the changes it hopes to see. This is a challenging question, given the explicit focus on shifting organisational culture in favour of a centring of equality considerations,

over fixed, tangible outcomes. Add to this the tension between individual initiatives needing to be understood and evaluated on their own terms (and in concert with individual organisational frameworks, indicators and data management systems), and the desire to be able to look across the whole programme, through some consistent metrics. All this is further complicated by the fact that many of the changes now being made could take years to have full effect on the ground.

> *"Most people are trapped in the day-to-day. I'm thinking about the sort of initiative we're talking about here that maybe in two or three years starts to make an impact... but it's not something that you're going to see an immediate impact from. It's a long-term investment".*

Alongside the methodological complexities are significant structural and ideological considerations. To whom is CtG answerable in terms of outcomes, and on what basis? What space is there to flex the traditional parameters of what constitutes evidence in the capturing of the full range of social value? It is clear that close (but not, perhaps, slavish) adherence to the ICB's recently drafted evaluation guidelines will be necessary. There is nevertheless uncertainty and concern about potential incompatibility between the nature of the work and the reporting demands of the (current and future) ICB, especially within a cross-sectoral partnership. Partners feel they have the experience and knowledge to make courageous changes based on trust rather than heavy-handed accountability metrics but there is anxiety about the basis on which success could be measured:

> *"We're arguing with the ICB. We've got a system, we've got a set of individuals that are keen, that are committed. We've got an organisational structure that makes sense. We've got a track record of programmes being delivered... we will take that autonomy. We'll take that control and we will deliver things. But you need to let us know how we're going to be judged so that we know what outcomes we're expecting to deliver."*

> *"So you have to have a conversation that says: 'We're very clear on what we think the outcomes could be, but we need your help to get there'. Rather than talking about it's one conversation, but if we do this, these are the sort of results we can get. And we have seen where this has worked somewhere else, because it really helps. We can say, this is not something we're pulling out of the air. It's an approach that's grounded in what has worked in similar communities elsewhere. And therefore, we can make it work here with a high degree of support".*

As CtG has not yet moved fully into implementation mode, there is an opportunity to design a proactive approach to evaluation that rises to these challenges, pushing the boundaries of conventional health metrics, while intersecting closely with the ICB's evaluation framework. Although ultimately it could be desirable to consider some common outcome indicators at the level of service demand or population health, at the current stage it would make more sense to agree some overarching outcomes and leave individual organisations to decide how they each measure them. Some examples:

[service level] **Our organisation is informed by the experience of those with lived experience of disadvantage as a matter of course** [e.g. service co-design/review has input from users from disadvantaged communities; consideration of the most disadvantaged 30% embedded into organisational policy and procedure wherever appropriate; board/advisory representation from those with lived experience]

> *"The natural, seamless inclusion of those who use services, so we design services for people, so the services we design affect people every day. So those individuals are absolutely integrated into the system design approach and feel really a part of that in some way shape or form. So lived experience right at the heart of service design would be something quite strong in terms of systemic change for me and to be able to demonstrate the value that that would be valuable for me".*

[service] **Our service is accessed more easily by disadvantaged users:** [e.g. analysis of users' LSOA of residency; feedback from service users; examples of range of ways users are engaged/barriers removed; ethnographic observation of participants in an activity]

[system] **Disadvantaged users in Northern Devon experience engagement with services as person-centred and integrated** [e.g. range of onward connections/signposting from individual organisations; stories of change from staff and service users; measures of attendance/engagement].

Further down the track it will be appropriate to consider some proxy indicators to understand impact on population health, or the prevention agenda, based on a more granular understanding of specific cohorts within the 'disadvantaged' category, and the nature of the health-related inequality they experience. At this point, further outcomes should be agreed collectively, which should not see these indicators as ends in themselves, but as means to broader ends that remain centred on the person: for example an absence of crisis [e.g. stable accommodation, community inclusion]; or greater independence [e.g. improved strength and balance; access to community transport].

Much of this measurement, especially at an earlier stage, will be through qualitative means. It is not necessary to be able to count something for it to be valuable, nor does being able to count more of something make it inherently better. There is no need to reinvent wheels here – evaluation toolkits do exist to support partners (such as the Advancing Mental Health Advocacy from the Royal College of Psychiatrists), but there is a need for further support and scaffolding, especially for smaller organisations, in deciding how best to understand the value of their work. None of this will be effective, however without a shared outcomes framework that everyone understands and considers relevant and proportionate.

Final Thoughts

Closing the Gap is at once a descriptive umbrella under which existing work can be shared and scrutinised, and an initiating force to drive collective action at both service and system

levels. There is much to celebrate, and also much of value that is currently under-recognised. It is widely valued as ambitious and necessary, but it is fragile. While it has had some significant success thus far, without sustained funding, clarity about priorities for action and evaluation, and engagement with current policy shifts, it risks becoming another well-intentioned but short-lived initiative.

The strength of a partnership is not measured by the degree of operational alignment required between partners, and especially not where such alignment involves smaller partners aligning themselves with larger ones. CtG has made some important decisions that ought to avoid these traps. While there is an obvious need to ensure legal compliance and financial probity, these issues need not interfere with the freedom people require to innovate, take risks, be responsive and be creative. There remains more potential for the CtG partnership *as a partnership* to add value and become more than the sum of its parts.

Here are some suggestions that we feel might help the partnership take forward our observations:

- Improve the integration of initiatives within the CtG footprint that already meaningfully involve people facing disadvantage (especially the Ilfracombe Poverty Truth Commission and the Lottery-funded VCSE project), and wider application of this learning, to enable positive action for health and wellbeing to be more defined by people and place, rather than by systems.
- Consider how to feed the insight already developed pro-actively into conversations about Integrated Neighbourhood Teams, in order to develop community capacity for action on tackling health inequalities. Linking CtG insight with, for example, the Eastern LCP's Social Health model could prove powerful in this respect.
- Build a shared outcomes framework to guide measurement, evaluation and reflection, but do not rigidly predetermine standardised indicators for the whole partnership. This is not a project, it is a movement.
- Consider investment in a medium-term co-ordination role for CtG, to maintain and develop the partnership and have oversight of evidence collation and iterative peer learning. This would allow the CtG senior leadership to focus on systemic change at the macro/policy/political level.