VCSE Review

Investing in partnerships for health and wellbeing

Joint review of investment in Voluntary, Community and Social Enterprise organisations in health and care sector

Interim report co-produced by representatives of the VCSE sector and the Department of Health, NHS England, and Public Health England.

March 2015

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Executive summary

We have made incredible advances in medicine and lifespan, and developed more enlightened approaches to inclusion for people with long term conditions and disabilities in this country, and yet, we have not created fair and sustainable health and wellbeing outcomes for our changing population. Indeed, some groups and communities have fallen behind.

Improving health and wellbeing outcomes cannot be achieved through more efficiency in services alone. It requires both the services, and the systems within which they sit, to be able to collaborate with people, families and communities. It needs to draw on and share the full range of resources at our disposal – social action and community resources as well as money – and combine these resources to much greater effect. And it requires a focus on the outcomes that matter to people. To reach and engage communities the statutory sector needs to collaborate effectively with people, community groups, charities and social enterprises.

VCSE organisations have long made – and demonstrated – the case for a more effective health and social care system that is focused on personalisation, prevention, and a holistic approach to the wellbeing and resilience of people and communities.

We help to improve health outcomes and tackle health inequalities not only by delivering services, but also by shaping their design and advocating for, representing, and amplifying the voices of service users, patients, and carers. Our perspectives often differ from those of traditional and standardised clinical approaches to health because we are rooted in communities and expert at working with people with multiple and complex needs. Frequently those needs are for early intervention or action to address the wider social determinants of health and wellbeing. But neither clinical approaches nor community-based interventions can solve the UK's health inequalities alone. It is only through partnership, we can – and must – do much more.

Government policy acknowledges the vital role of the VCSE sector and its contribution to health and wellbeing goals, for example the Care Act; the Social Value Act; NHS England's *Five Year Forward View*; and Public Health England's "*From evidence into action: opportunities to protect and improve the nation's health*". These all share a desire to move toward a system with greater emphasis on personalisation, prevention, wellbeing, community resilience, and a holistic approach to engaging with people and communities – characteristics of much of the VCSE sector's work.

This report summarises the initial findings of our review and has been developed in co-production with the statutory and voluntary sectors[1]. We were tasked with the challenge of exploring how the sector could:

- maximise and demonstrate its impact;
- build sustainability and capacity;
- promote equality and address health inequalities

[1] A full list of the Advisory Group members can be found in annex eight

From January to March 2015 we have engaged with around 4,500 people and organisations, and heard how the statutory and VCSE sectors could better work together.

We have heard

We heard much affirmation for the continued role of the statutory sector as a funder of VCSE organisations. But, we also heard the case for a much deeper collaboration, one in which risks, rewards, and resources are shared in pursuit of co-designed goals.

It is often suggested that the VCSE sector should become more like the statutory or private sectors. But we have heard that in this 'professionalisation' of the sector – building its capacity to respond effectively to statutory sector opportunities and to demonstrate it achieves outcomes defined by that sector – we would lose as much as we would gain.

These are challenging times and the VCSE sector must accept step up to this and address variations in its quality and effectiveness. But the sector's response to these challenges should not be to become identical to other sectors, it must be to establish and demonstrate its unique contribution.

We have heard that current approaches to partnering with, funding, and commissioning the VCSE sector are not creating an environment in which better health and wellbeing outcomes are likely to be achieved at either a national or local level. Although our role is now embraced in policy, it is not consistently supported in practice.

It appears that parts of the sector, such as smaller organisations, and those with an infrastructure or equalities function are particularly challenged by current approaches, and have experienced a disproportionate loss of funding.

There is a feeling that at times commissioners do not recognise the multiple outcomes and wider value that VCSE organisations deliver, so that the playing field is not always level when it comes to defining, demonstrating and rewarding impact.

We have heard about the sector being destabilised by short term funding and moves from grants to contracts, and about commissioners favouring scale and size, even when that comes at the expense of quality and better long-term value or reinforces service silos. All of this limits the potential of the VCSE sector, which in turn limits improvements in health and wellbeing outcomes across the country.

Every local system leader recognises that the wider resources and assets brought through the VCSE sector are of significant value, and yet the sector does not receive the support it needs to thrive. Too often we have heard that statutory bodies hope to have it both ways: wanting more and more from community groups for less and less whilst continuing to treat their work as an 'add on' which can be repeatedly resourced with short term funding. This has to change.

Our vision

There is another way; through greater flexibility, looking to where organisations are effectively funded, and working collaboratively, the statutory and VCSE sectors have an opportunity to maximise the benefits they bring to communities across the UK.

So, while continued statutory funding for the VCSE sector is vital, we recognise that improving health and wellbeing outcomes is not going to be achieved by more effective funding alone. Rather, we are arguing for a system which has co-design and collaboration as its core values: a system which looks for and values all of the resources available to it, not just money and the staff, kit, and buildings it can buy, but also community resources, social action, peer leadership, and volunteering. There are already examples of where this has worked to great effect and there is plenty more to learn about how to take this forward.

In this report we set out some options for changing the landscape through:

- co-commissioning,
- co-designing and measuring outcomes,
- rebalancing the mix of grant and contract funding and,
- re-focusing the central grants programme

We want to caveat our initial findings with an honest acknowledgement of the limited time we have had for this first phase. Where we go beyond reflecting back what we've heard, we want to stress that we are identifying options and the issues about which we need a deeper conversation with the sector: we are not presenting the settled view of our very diverse sector. That will be the job of the next phase of this work.

If you are interested in following the progress of the review, please continue to check our website over coming weeks: http://vcsereview.org.uk/ This is just the start of a conversation that we intend to continue after the general election in May.

Alex Fox, Chair of the review
CEO Shared Lives Plus

Introduction

Why review?

1. The Voluntary Community and Social Enterprise (VCSE) sector is crucial to sustainable delivery of health and wellbeing outcomes. The sector has significant expertise that is invaluable in helping to achieve improvements across the health, social care and public health system. Policy makers and practitioners agree that we need models of working which are more collaborative and enabling, helping people to live well and avoid, delay, or reduce crises. The VCSE sector leads the way in developing collaborative and enabling models of care, support, and inclusion. It is the natural home of community building. The statutory system can become better at collaborating with people, families, and communities through stronger partnership working with community groups and the charities and social enterprises into which many of those groups develop.

2. The Department of Health (DH), Public Health England (PHE), and NHS England (NHSE) wish to build on the strong partnership that already exists with the sector and together work to deliver the visions set out in the Care Act; NHS England's *Five Year Forward View*; and Public Health England's "*From evidence into action: opportunities to protect and improve the nation's health*"; all of which recognise that VCSE organisations are fundamental to their successful delivery.

3. However, as resources continue to be scarce across the health and care system, collaboration and partnership between statutory services and the VCSE sector is becoming ever more critical.

4. The VCSE sector is diverse and includes organisations with very different sizes, roles, and structures. These organisations make contributions in different ways, from the tiny community group which helps a seldom-heard community to influence local plans, to the national charity which delivers vital services to thousands of people. They also face different challenges, both in terms of the amount of investment which is available and in variable practice in partnership working, investment and funding.

5. There are different ways in which the health and care system invests in the sector: through central grant funding held by DH on behalf of itself, NHSE and PHE to support and build capacity across the VCSE sector; through a wider range of investments across system partners; and through significant local investment across the whole health and care system to support local provision across communities.

6. The review was initially established to consider whether changes are required to the central grant funding to support:

    i. the demonstrable contribution of the VCSE sector to achieving health and wellbeing goals;
    ii. the capacity and sustainability of the sector;
    iii. the independence, inclusivity and diversity of the sector, including its ability to promote equality, address health inequalities, and provide an effective voice for the most disadvantaged in society

7. The review also felt it important to consider central funding in the context of broader national and local funding and partnership arrangements, and the implications of these for further action.

What has happened so far?

8. The review is being co-produced through an advisory group of system partners (DH, NHS England, and PHE) and voluntary sector representatives working together in an open process and with wider public engagement.

9. So far, the group has split the work into three work streams, each with a VCSE and system partner lead:

   i. **Maximise** and **demonstrate the contribution** of the VCSE sector to achieving health and wellbeing in the UK, based on a shared understanding of the range of ways in which different kinds of organisations can have **impact**.
   Co-led by Sian Lockwood (Community Catalysts), Sarah Mitchell (Local Government Association) and NHS England

   ii. Build the **sustainability** of the VCSE sector and its on-going **capacity** to deliver health and wellbeing, working effectively alongside other partners.
   Co-led by Simon Blake (Brook / Compact Voice), Mark Winter (ACEVO) and the Department of Health

   iii. Ensure that the VCSE sector is able to **promote equality and address health inequalities**, helping a wide range of people and communities including those often excluded to have a voice in healthcare and social care planning and commissioning.
   Co-led by Jabeer Butt (Race Equality Foundation), Bev Taylor (Regional Voices) and Public Health England

10. For each work stream, some key issues have been identified and used to begin engagement with the sector. VCSE partners have convened eight workshops through their contacts and have engaged through social media. The engagement at this pre-election phase has necessarily been brief. However, it is the beginning of the journey, and this report presents the interim emerging findings and suggestions at this stage. Subject to the views of the new government, the advisory group will continue the engagement post-election. In the meantime, any views on this document can be submitted via the website: http://vcsereview.org.uk/

The VCSE sector

11. VCSE organisations include small local community and voluntary groups, registered charities both large and small, foundations, trusts, and the growing number of social enterprises and co-operatives. These are often also referred to as third-sector organisations or civil society organisations.

12. The sector is diverse in size, scope, staffing, and funding. It provides a broad range of services to many different client groups. However, VCSE sector organisations share common characteristics in the social, environmental, or cultural objectives they pursue, their independence from government, and the reinvestment of surpluses for those objectives.

13. VCSE organisations play critical and integral roles in health and social care including as: providers of services; advocates; and representing the voice of service users, patients, and carers.

What we have heard

14. A summary of the common themes in written submissions we have received so far are in annex three. The remainder of the report tries to bring together what we have heard through all our engagement so far, on the offer the sector can make, the challenges, the potential, and suggestions for the future.

Health and Social Care System

15. There are key challenges facing the health and social care system. Pressure from reduced funding and a much slower growth in health funding in the coming years has led to speculation that we could be facing a possible deficit of £30bn in the NHS and £4.3bn in social care by the end of the decade. At the same time we need to meet the needs of a growing and ageing population and to improve the quality of health and wellbeing outcomes. Continuing to support the system in the same way we always have will not address these challenges. Creative and innovative solutions need to be found.

16. The traditional role of the health and care system is to 'fix problems', in this context value could be measured in terms of the cost and effectiveness of staff, kit and drugs. However, in a system focused on enabling people, including those with long term conditions, to live well for longer, value cannot be found solely in the reduction of unit price. Instead value becomes the effectiveness of interventions in unlocking and supporting the capabilities of people, their families, and communities. This is the kind of value which the VCSE sector is already adding[2], but where only a fraction of its potential is being realised.

New kinds of value

17. The sectors models of working ensure that they do not just deliver on the narrow goals of a particular project or programme. Through their personalised approach, many VCSE organisations already demonstrate and deliver the holistic and integrated interventions which the statutory sector can struggle to deliver. They also:

    i. Add wider social, economic and environmental value
    ii. Generate innovation and creativity

[2] See Annex four: Distinctive VCSE Health and Social Care Offer

iii. Offer insights that can be used to improve services over time
iv. Catalyse and manage volunteering and social action in health and social care

> *Around 27% of regular formal volunteers are engaged in helping health, disability, and social welfare organisations ... There are an estimated 3 million volunteers in health and social care, and 5 million unpaid carers* [3]

18. Alongside value in delivery[4] the VCSE sector also enables statutory agencies to co-design services and systems with their communities. This often involves helping people challenge services which are misaligned. As areas become better at collaboration and co-design, the practice of sharing responsibility, risk and resources may become easier, but this challenging role is essential in order to continually improve our health and care system. The sector also supports commissioners to effectively meet their legal duty to involve patients and the public.

> *"Acting as a critical friend to statutory bodies is one of the key roles of the community and voluntary sector. Public services will be more responsive to the needs of people if charities amplify their voices and are actively involved in scrutiny."* [5]

Equality and health inequalities

19. Health and care inequalities persist and discrimination on the grounds of age, disability, ethnicity, gender and sexuality continues to lead to poorer outcomes for people. One of the biggest challenges for our health and care system, particularly as it aspires to become more personalised, is to provide care and support to people with complex needs and those from minority or excluded groups.

> *Evidence shows that LGB&T people are disproportionately affected by a range of health inequalities, including: poor mental health and higher risk of self-harm and suicide; increased prevalence of STIs including HIV; increased use of alcohol, drugs, and tobacco and higher likelihood of dependency; increased social isolation and vulnerability in old age; and poor access to services.*[6]

20. Large providers can deliver volume-based services but do not always have the relationships needed to promote equality and tackle localised health inequalities.

21. Many VCSE organisations have their roots in small geographic areas, have grown out of unmet need, or tackle discrimination faced by people with protected characteristics. Promoting equality and addressing health inequalities can often best be supported by VCSE organisations, born out of, based, and with existing relationships in excluded and minority groups.

[3] NCVO & Compact Voice (2015) Health VCSE Review: background paper
[4] The VCSE sector does not only provide additional or new forms of value – in some cases they are the leading market provider: as is the case in specialist palliative care.
[5] Children England and TUC (July 2014) Declaration of interdependence
[6] National LGBT Partnership (2015) Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations

Studies on social enterprises reported a key outcome was the reduction in the public stigmatisation of marginalised groups, e.g. people living on the street, those with mental health problems or ex-offenders. It was found that social enterprises provide a window of opportunity for mutual understanding and interaction with the community…..and play a critical role ….demonstrating that members of such groups can be capable, productive workers and members of society.[7]

Prevention and resilience

22. For many years there has been an aspiration to create a more preventative health and care system which intervenes earlier. However, there is a feeling that conventional systems have struggled to conceptualise, deliver, or commission services for prevention. Some VCSE organisations have developed a deeper understanding of prevention based not on the perspective of services and reducing demands upon them, but upon building the resilience of individuals, families, and communities.

23. The VCSE sector has not yet developed a consistently clear and demonstrable model of prevention. But there are three aspects of prevention the sector is well placed to deliver, where they are rooted in communities, trusted to play to their strengths, and challenged to demonstrate outcomes (rather than outputs or processes). VCSE organisations:

    i. Often have a good understanding of the broader factors that affect demand on health and care services. A full picture of a community's needs and capabilities is an essential but rarely achieved foundation for an effective strategy for avoiding, reducing, or delaying the appearance of support needs.
    ii. Can identify those at risk whilst maintaining an enabling (rather than risk-averse) approach that avoids funnelling people who are developing support needs into acute services. This makes the VCSE sector ideally placed to deliver on what is often classed as secondary prevention.
    iii. Can tackle the wider determinants of health, from the provision of housing to the promotion of healthy behaviours and truly demonstrate 'integration' in its wider sense. But it will only be able to reach its full potential in this area where there is true collaboration between partner agencies.

Frequently seen as completely separate, transport is in fact critical for access to health and care services for those who cannot drive or do not have access to a car. How health and care services will be accessed needs to be part of the discussion about service planning right from the outset. This relates to a further question about the boundary between 'health' and 'non-health' activities, given the evidence on the impact of wider determinants of health such as education, employment and housing and the roles of public, private, and VCSE organisations in each of these areas.[8]

Community-based collaborative care

24. It is not enough to move our current services into 'community settings'; indeed, this may increase unit costs without necessarily resulting in people living well. Community is not a place, but a set of relationships and VCSE organisations are often born out of people's

[7] Roy, M et al (2014) The potential of social enterprise to enhance health and well-being: a model and systematic review, Social Science and Medicine, 123 pg182-193
[8] VCS Engage (2015) Norfolk, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations

connections to each other: the mission of many VCSE organisations began as a conversation within a community.

25. VCSE organisations that are rooted in their community have networks of relationships and understand the needs and capabilities of the community they serve. Where there is the support, resources, partnerships, and freedom to deliver interventions which enable people to build and maintain their connections to others, there is much evidence that those people are likely to make less use of hospitals and acute services.

> *Age UK's Newquay Pathfinder project helps older people with multiple long term conditions remain independent and stay out of hospital. Volunteers listen to the older person's needs and desires so that, together, they can work to achieve their goals in a shared care plan which suits their life and will help them maintain their health and wellbeing. The pilot project has led to a 25% reduction in emergency hospital admissions. By focusing on the needs of the individual, the quality of life, confidence, and wellbeing of those people taking part have also improved significantly.*[9]

> *Turning Point is a social enterprise offering over 250 specialist and integrated services across England and Wales, focusing on substance misuse, learning disability, mental health and employment. It has delivered its Connected Care model of community-led commissioning across 14 areas in England. This model enables communities to be involved in the design and delivery of services and has resulted in services that are more effective. The model has also delivered significant net benefit to the public purse; a cost benefit analysis of one area found that with every £1 invested a return of £4.44 was achieved. When the benefits of improving quality of life are included, a return of £14.07 was gained for every £1 invested.*[10]

Personalised and co-designed approaches

26. VCSE organisations are often better at looking at the strengths and gifts of people (and whole families and communities), rather than focusing on only a medical need or on a snapshot of the person's life at the point of medical or crisis intervention. They are therefore often more able to support them to achieve holistic goals for a good life. As health is not separate from other social outcomes, taking this person-centred approach can often help to secure better whole-person outcomes for people that also include better health outcomes. Some VCSE organisations, particularly user-led organisations, have a person-centred and co-designed approach embedded throughout their work, building wellbeing through the way they try to achieve their goals as well as through achieving the goals themselves.

> *It is being increasingly recognised that voluntary and community sector (VCS) inputs will form a significant part of future care provision, for example through social prescribing, community development approaches to health, the 'more than medicine' elements of the House of Care, and support for people to understand and use personal budgets. User-led organisations (ULOs) can facilitate relationships between people with support needs and providers or commissioners. ULOs can also help*

[9] Age UK (2015) "People, Place, Purpose" quoted in NCVO & Compact Voice, Health VCSE Review: background paper

[10] http://www.turning-point.co.uk/about-us/who-we-are.aspx quoted in NCVO & Compact Voice, Health VCSE Review: background paper

establish peer-led activities (in the place of services if this strengthens independent living more effectively).[11]

[11] Regional Voices & National Voices (2015) The Voluntary and Community Sector and Localised Health Commissioning, What are the issues and how can we start to address them?

Current challenges

27. We heard many examples of the VCSE sector achieving the kinds of value outlined above. However, many organisations that participated in our engagement exercises described a sense of crisis, particularly in some of the areas of work which are most pertinent to achieving a sustainable and inclusive health and care system. Participants were clear that the challenges they face are not only due to reductions in the amount of resources in the system, but are more to do with the approach taken to managing limited resources. They were equally clear that there are solutions to the issues facing them and we have set out some suggestions for these and examples of them already happening, later in the report.

28. There was a strong sense that the challenges set out below must be addressed in order to ensure a viable VCSE sector is maintained in order to realise its huge potential to help build a sustainable health and care system.

Reduced funding and system reconfiguration

29. Increasing budget pressures and rising demand are hitting both the statutory and the VCSE sectors. Health and care commissioners are not always incentivised to see financial resources as just a part of the wider resources of their communities; so in many areas they have reduced funding for the sector's work with communities first, in an attempt to protect budgets for what they regard as their 'core business'. As one commissioner put it:

> *"We want to invest in the voluntary sector but the cuts are serious now and we've got to deliver our statutory work first."*

30. The challenges facing VCSE organisations due to the reduction in funding and system changes include:

    i. Loss of advocacy work
    ii. Reduced funding for equalities organisations
    iii. Loss of infrastructure organisations
    iv. A lack of core funding
    v. A culture of enforced volunteering
    vi. Small national organisations struggling to be heard by the large number of commissioners

31. Where VCSE work continues to be funded, it is often on a reduced unit cost basis, and with lower expectations and shorter term goals. VCSE organisations have told us about an atmosphere of diminishing trust which constrains them from exercising their discretion to use skills which their statutory partners lack, or approaches they do not understand. We have heard that work such as advocacy, empowerment, support to navigate the system, engagement in commissioning and community building have all been less likely to receive continued funding than crisis and short-term support. At a time when constructive challenge to the status quo is vital, some organisations report self-censoring out of fear that by helping people to speak out, they may threaten future funding[12].
32. We heard that the numbers of organisations focusing on progressing equality and addressing health inequalities is decreasing and there is evidence that some

[12] NCVO & Compact Voice (2015) *Health VCSE Review: NCVO & Compact Voice Background Paper*

organisations have had to use their reserves to continue to operate[13]. There is evidence to show that geographically, places where inequalities are highest, resources are even more pressured. It can be argued therefore that those who are hardest to reach, whether that is because their 'cause' is not seen as a priority by commissioners or the public, or because their needs are not understood, face even greater financial pressure and therefore have a greater need for support.

33. In addition, income of infrastructure bodies fell from £538m in 2009/10 to £475m in 2011/12[14]. Some commissioners may believe that this is better than cutting front-line delivery, but in reality it leads to a lack of vital support to smaller and start-up VCSE organisations to:

    i. Navigate the rapidly-changing health and care system
    ii. Identify and apply for funding
    iii. As a route into essential networks.

34. This also removes an important channel through which statutory bodies can reach the small, local organisations that can help deliver their preferred approach to health and social care.

35. A particular challenge now exists for the smallest community enterprises that are often prevented from accessing the support offered by VCSE infrastructure because they do not fit the criteria set by funders.

36. We have also heard from organisations that there has been a decrease in core-funding to the VCSE sector which has affected their stability.

37. To ensure continuity of support where there are reduced budgets staff have had to work unpaid hours, take pay cuts and double-up jobs, this has been described to us as a culture of "enforced volunteering" and was not seen as sustainable.

> *It may be semantics, but it has been argued that the use of the term 'voluntary sector' is unhelpful, suggesting as it does that the sector consists primarily of volunteers. In fact, as anyone working with or in it will quickly realise, the charity sector relies on large numbers of highly qualified and deeply committed staff.*[15]

38. The new health and care system has also created some specific challenges for small VCSE organisations that work nationally. For example, we heard from small organisations, working with a national constituency of people who have a rare disease that are struggling to find the capacity to gain traction and awareness among the large number of CCGs and so see the numbers of referrals to their services drop significantly. This risks reducing patient choice.

Short funding cycles

39. We have seen an increase in the use of short-term, unstable funding and of this being seen as inevitable for certain kinds of activity and organisation – rather than the result of national and local policy choices. For instance, through necessity, large building projects

[13] See Annex two: Continuity and change in dealing with equality and health inequalities.
[14] NCVO (2014) Civil Society Almanac
[15] VCS Engage (2015) Norfolk, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations

have sometimes been funded on a multi-decade basis (e.g. PFI projects to refurbish or replace hospitals). In contrast, it is rare for investment in communities to follow the same long-term view.

40. One example of where this has been done is Leeds' 10+ year investment in its user-led Neighbourhood Networks and a number of linked VCSE organisations.

41. Short funding cycles inevitably lead to a lack of stability in the sector; unlike commercial organisations, VCSE's often run with little reserves. Organisations are unable to make long term plans and the people they are supporting cannot be sure if the services they rely on will continue, exacerbating a drain in crisis services resources. As a parent remarked at an engagement event:

> *"My daughter's statutory service was becoming little more than 'warehousing' so I wanted to spend our Personal Health Budget on a local charity, but moving her services to this sector always feels risky and it is about 'how sustainable is the organisation' that we want to use."*

42. Some grant programmes also specifically fund innovation; assuming that if a project is then successful the VCSE organisation will be able to become sustainable through commissioning. However, the short-term nature of this funding (even funding that is three years) can make it difficult to fully evidence impact and develop the necessary relationships subsequently to seek a contract, because longer-term evidence is often needed.

43. We have heard from some VCSE organisations that this instability has led to greater staff turnover meaning that skills and experience are lost, which in turn further reduces the impact of the sector and its value for money.

> *VCSE organisations have responsibilities just like any other employer, and although contracts may ultimately – often at very late notice – be renewed or rolled over from one year to the next, the continued uncertainty impacts on the retention of experienced qualified staff. Existing hand to mouth, as many VCSE organisations do, does not favour effective business planning.*[16]

Defining and demonstrating impact

44. While they may have a great understanding of the benefits of their services, stemming from their close proximity to the people and communities they work with, VCSE organisations can sometimes struggle to demonstrate the impact of their work[17]. There are several reasons why the sector can find it difficult to show robust evidence and so make a compelling case for their work:
    i. Impact measurement, research, and investment in outcome measuring tools follow the money, creating a virtuous circle of increased investment, research, and evidence for mainstream, medical, and short-term interventions. But, in turn this creates a vicious circle for much VCSE work, particularly where it relies heavily upon

[16] VCS Engage (2015) Norfolk, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations
[17] This is explored in Annex five: Measurement Gaps

community resources and social action, and therefore has little prospect of becoming an area of high financial activity.

ii. Often VCSE organisations do not have a strong culture of collecting data and using outcome measuring approaches. Most of the sector appears willing to address this but is unsure of how to do so or how to resource such work.

iii. Some organisations have reported a lack of clarity over which impact measurement tools they should use and are seen as credible

iv. Where the VCSE sector does produce evidence of outcomes, this does not necessarily lead to investment. One mental health charity CEO told us that commissioners would continue to invest in mainstream mental health services with little evidence of strong outcomes, whilst using lack of evidence as a reason not to invest in alternatives and called for "the evidence playing field to be levelled":

> *"When it comes to evidence generation, we're ignored if we do and damned if we don't."*

v. There is a feeling that the statutory sector, at times, guards its ownership of the definition of 'impact', resisting co-designing ideas of what constitutes health and wellbeing with communities and the VCSE organisations closest to them.

vi. Evidence gaps around needs analysis, data sharing and finding the data to measure against outcomes frameworks[18].

45. While there are some helpful evaluation tools out there, we heard from organisations that it is a particular struggle to demonstrate the impact of work which aims to amplify the voice of communities in service or policy design and work which is preventative, cross-cutting, or long-term. Many VCSE organisations also struggle to collect or access the data they need.

46. More work is also needed to educate commissioners in the value of narrative and qualitative evidence that the VCSE sector is already well placed to provide. This should not be seen as a VCSE sector need, but as a need for the whole system if it is to achieve measureable improvements in wellbeing and resilience, in place of the current focus on outputs and activity.

> *"The review paper notes that not all VSCE organisations are able to demonstrate their impact clearly. This clearly demonstrates the importance of capacity building across the sector to improve skills in this area, but also shows the importance of commissioners and funders valuing different types of evidence (e.g. case studies as well as quantitative data)."*[19]

Local commissioning processes

Big is seen as better and safer

47. We have heard that commissioners often seem more focused on reducing the unit costs of procuring current services, than innovating or creating better outcomes. This can lead to a focus on economies of scale.[20] Commissioners often invest in large-scale provision in a drive to reduce transaction costs through fewer, larger contracts, particularly where

[18] See Annex five: Measurement Gaps
[19] National LGBT Partnership (2015) Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations
[20] NCVO & Compact Voice (2015) *Health VCSE Review: NCVO & Compact Voice Background Paper* page 10

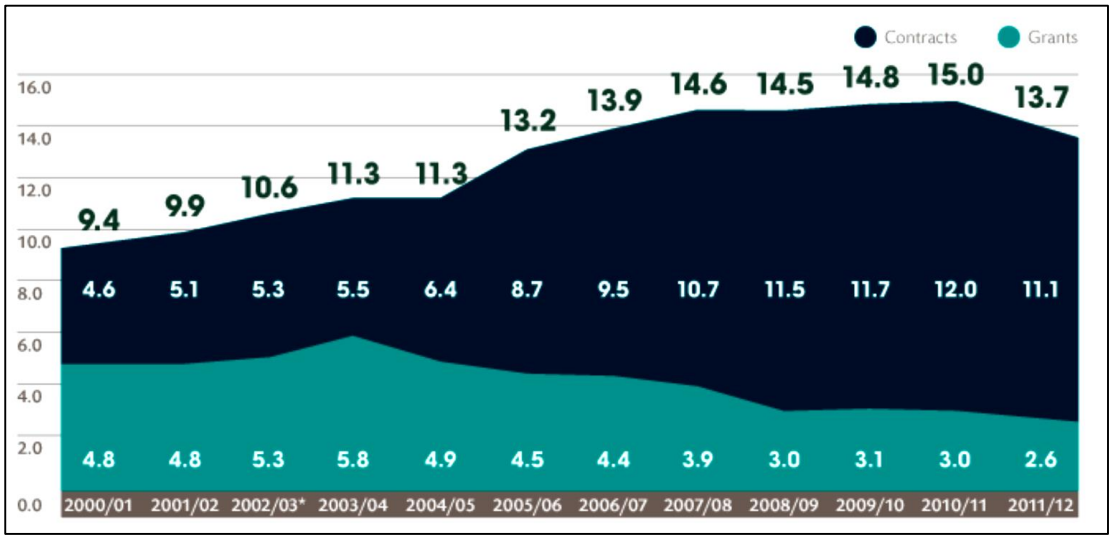
the commissioning team is itself facing resource pressures. This may have reduced costs in some areas but has also had unintended consequences:

i. Smaller VCSE organisations are placed at a disadvantage, particularly niche and equalities organisations, or those working with specific groups.
ii. The drive towards scale combined with a tendency to commission for activity and outputs (rather than impact), pulls against moves towards personalised care and community-building approaches.
iii. In some instances, commissioners have simply outsourced their contracting costs through contracting with large providers who sub-contract to smaller organisations. The total contracting costs of the whole system grows in this model, with little evidence that the combined commissioning activity becomes more clearly focused on the right outcomes. Arrangements of this kind can shift power further away from communities.
iv. Exclusive reliance on large contracts can reduce provider diversity (contrary to the new Care Act duties) and even create local monopolies, limiting the impact of personal care budget and Personal Health Budget reforms.

Grants / contract balance

48. The balance between grants and contracts has moved from 50:50 in 2000 to 20:80 in 2010.

Voluntary sector grant and contract income from government, 2001/01 – 2011/12 [21]
(£ billions, 2011/2012 prices)



49. This change in balance is affecting different types of organisations and kinds of work in different ways:

i. We have heard that a move to contracts and tendering is proving problematic for many smaller VCSE organisations: several said that they are poorly equipped to engage effectively and compete with large providers in tender processes.

[21] NCVO & Compact Voice (2015) *Health VCSE Review: NCVO & Compact Voice Background Paper*

The think tank, New Philanthropy Capital show that the private sector far outcompetes the VCSE for new CCG contracts, even for community care, where the VCSE sector has a much stronger track record of community engagement[22].

ii. Tendering processes can be inappropriate for investing in innovation (where activities and targets need to be built and revised collaboratively) and in work intended to have holistic and preventative impacts.

iii. We have heard that the complexity of procurement processes often do not feel like they reflect the amount being applied for.

"When I'm applying for £500 it's like I'm applying for £500 million."

iv. Payment by Results (PBR) can lead to cash flow risks being unequally shared by commissioner and provider. This can put smaller organisations (particularly those with less cash reserves) off applying and does not take count of innovation.

Emerging evidence indicates that the mixed funding approach of the Department for Work and Pensions (DWP) Work Choice contracts is proving more effective than other PBR initiatives for both users and providers. The programme pays providers 70% of their monthly contract price in arrears to ensure suppliers maintain a minimum number of people on the programme at any one time, and to provide a degree of certainty in meeting fixed costs. The remaining 30% is paid when performance targets are met. NCVO recently published a report which found that the needs of people with complex or multiple needs is better met by a co-designed, locally-led service delivery approach based on smaller contracts and flexible payment models of this kind.[23]

v. The NHS standard contract has been raised as a particular barrier for many organisations, it includes requirements that many smaller organisations cannot meet and can be inappropriate for the service being commissioned.

vi. We have heard that some tenders exclude some sector organisations from applying as they include requirements that small VCSE organisations cannot possibly meet.

50. Efforts to support the sector have tended to be based on the assumption that VCSE organisations should be supported to compete for large contracts (or subcontracts of large contracts) issued through formal Invitation to Tender (ITT) processes. Whilst this may be appropriate for large VCSE organisations that wish to compete for high-value contracts, the feeling among the sector is that there is little evidence contract culture is capable of driving resources towards community building work, prevention, or other areas of VCSE specialism.

Intelligent commissioning would be conducted by appropriately skilled people with relevant sector expertise and through effective partnership with practitioners, children, and families in the design and delivery of the services. It should utilise a full range of tools, of which procurement may be one element.[24]

51. We are at the early stage of exploring the opportunities offered by new sources of social investment, such as, social Impact Bonds which can be used to transfer the risk from the

[22] David Bull, Farooq Sabri (24th February 2015) Analysis of CCG Contracts Data, BMJ Handout, data from April 2013 – August 2014
[23] NCVO (July 2014) *Stepping Stones*
[24] Children England and TUC (July 2014) Declaration of interdependence

provider to a third party investor. There are already several health programmes in existence or being designed that are testing the model as a way of getting the benefits of PBR without placing high risks on VCSE organisations.

The potential of the VCSE sector

52. If VCSE organisations are systematically engaged as an equal partner at every stage of designing, delivering, and improving services, over time we have heard this could[25]:

New kinds of value

53. The VCSE sector, along with NHS and Local Government partners, already catalyses the contribution of more than three million volunteers in health and care, and 12.7million people who volunteer once a month in all sectors. The sector, working in genuine partnership with NHS and LA partners, is the only credible route to a significant and sustainable increase in social action, through volunteering, approaches which mix paid and unpaid work, peer led initiatives, user-owned and led services, and user-led commissioning. The sector can also catalyse the contribution of local resources, buildings, land, and money from philanthropy. A period of austerity, when financial resources are reducing, is the right time to build a new model of value, but this will only happen if the statutory and VCSE sectors find a workable approach to pool and share responsibility for all of their combined resources: money, social action, community resources, knowledge, and power.

Equality and health inequalities

54. More effective partnership working with VCSE organisations would enable statutory agencies to promote equality and address health inequality, to reach sections of the population that it is currently failing to through conventional service provision, including people with multiple or complex needs and communities which are currently considered 'hard to reach'. Effective VCSE organisations not only reach those groups, but can also provide channels through which volunteers and employees from those groups can bring their skills and expertise into the system.

Prevention and resilience

55. Whilst many current 'prevention' initiatives start from the perspective of services, a co-produced health system will have a much stronger focus on building personal, family and community resilience, to delay, reduce, or avoid the need for more formal kinds of support. As one health leader put it:

> *"The NHS will get prevention when it gets the voluntary sector, and vice versa".*

Personalisation and co-production

56. VCSE organisations working in equal partnerships with statutory bodies can overcome barriers based on institutional and departmental budget and service silos, through their focus on working co-productively with people, families, and communities to identify needs, strengths, and capabilities and develop holistic solutions that meet those needs. Participants at one engagement event talked about a constant battle between their desire to stay true to a mission created by their community and the need to chase contracts. While others described being able to design funding around a shared

[25] Also see annex five: Measurement Gaps

understanding of local people, which meant they were then challenged to deliver impacts that felt personalised to the people they worked with.

Emerging themes

New mix of funding at local level

57. We suggest research into a new funding mix at local level; our conversations so far suggest any new mix should include the following:

Grant funding

58. There should be an increased role for multi-year grant funding at a local level and for small organisations with a national reach, for example those dealing with rare medical conditions and diseases. There should be no opaque or 'cosy' grant funding arrangements which are not linked to impact. Instead we suggest exploring how to bring together the principles of the Social Value Act with recent learning from grant making organisations with a view to introducing 'Social Value Grants' as a legitimate and desirable aspect of any local investment strategy. This would support VCSE organisations to provide better, more sustainable health and care support to their local communities, promote equality and address health inequalities, and develop long-term health and wellbeing goals.

There is a different way

Trusts and foundations[26] that currently provide over £2bn per year in funding largely to small local charities many of which work in health and social care and/or address the wider determinants of health, have expressed their concern about the shift from grants to contracts. Their view is that 'current commissioning is not suited to small and local organisations'. As a consequence of this many small and local organisations are facing decreased funding at a time of rising demand. This group of trusts and foundations have made the following arguments to the review in favour of increased use of grant funding:

- *Provision of person centred holistic approaches*
- *Local solutions to local problems*
- *Enabling greater customer focus and direct user engagement*
- *Encouraging collaboration between organisation which need to work together rather than compete*

They recognise grants are not right for all service provision but believe that they are particularly well suited to addressing the complex needs faced by many high needs – and high demand / cost – service users.

They also recognise the commissioning challenge of needing to work with a larger number of smaller, often local organisations, but see this arising from the misapplication of a contractual model (best suited for larger standardised provision) to holistic person centred services. Based on their experience of funding, they argue that a grant making approach taken by commissioning could:

- *Deliver lower transaction costs for both funder and funded organisation*
- *Enable a discerning approach with selection of the best and proper assurance and monitoring*
- *Lead to greater learning*
- *Have a higher impact, with outcomes co-designed by funder and recipient Be more easily tied to outcomes, particularly longer term, person centred and holistic outcomes*
- Be more flexible, particularly in enabling innovation[27]

59. The review group believe there is a role for grants at the local level that:

i. Are co-designed with people and communities as well as the VCSE sector
ii. Are open and challengeable including by people using the health and care system
iii. Have clearly defined outcomes, with the tools identified to measure them
iv. Adopt risk-sharing approaches and flexibility, encouraging innovation and pragmatism
v. Build the production of learning and resources into expected outputs
vi. Include appropriate and proportionate monitoring and generate open data, potentially including a requirement for shared learning and collaboration that would help shift towards a collaborative culture.

[26] Lloyds Bank Foundation in collaboration with Calouste Gulbenkian Foundation, City Bridge Trust, Comic Relief, Esmée Fairbairn Foundation, Lankelly Chase Foundation, The Association of Charitable Foundations, The Henry Smith Charity and The Tudor Trust.
[27] See annex six: An Independent Funders Perspective

60. The sector partners need to establish stronger strategic relationships with grant-giving trusts, philanthropists and hospital charities to maximise cross-sector impact and minimise duplication and gaps.

Contracts and tendering

61. Our conversations so far suggest that contracts and tendering are an essential part of any new funding mix. But how and when they are used needs to be carefully examined, rather than, as at present, using them as a default. Commissioners need more support to weigh up the savings gained through the economies of scale achieved by larger contracts, against risks to achieving outcomes, loss of provider diversity and other potential costs generated by exclusive reliance on large scale commissioning.

62. Contracts can be particularly useful in funding work which is large scale, for single-issue interventions, where desired outcomes are short term and have a well-established evidence base. Approaches such as Framework Agreements and Alliance Contracting should be further explored and evaluated for larger public service delivery contracts. Research is needed into the total transaction costs of differing approaches to contracting and ways of reducing the overall burden.

63. Changes are needed to commissioning culture so that small organisations are not placed at a disadvantage when bidding for contracts and seeking to shape and monitor those services in ways that benefit communities. For example:

    i. Pre-procurement timetables need to be sufficient to co-design goals
    ii. Paperwork needs to be proportionate to contract size
    iii. Opportunities need to be found to engage VCSE organisations in mapping communities' needs and assets
    iv. Approaches need to be built on a comprehensive understanding of all sections of the community and in particular groups which are often overlooked or which experience health and wellbeing inequalities.

64. Our conversations to date have also identified that the NHS standard contract is inappropriate for many VCSE organisations and there are calls for a standard "contract light" to be considered.

Social Investment

65. There could be a greater role for social investment in the sector and more research is needed into its potential to fund innovation and to bridge double-funding periods when emerging systems require resourcing alongside the continuation of existing systems.

66. Some social investors have demonstrated that they can be 'patient investors', understanding that radical work takes time to grow and deliver results. Lessons for commissioners from best practice include:

    i. Identifying models which can deliver savings
    ii. Understanding how to assess and value a team's passion, competence and experience
    iii. Sharing risks and being prepared to work in collaboration with providers

67. There are a number of ways in which social investment could support VCSE organisations working in health and care:

i. Catalysing a shift from acute spending to prevention, and enabling charities and social enterprises to deliver outcome based contracts (e.g. Social Impact Bonds)
ii. Providing finance to develop new interventions or scale existing interventions without a reliance on “stop-start” funding
iii. Enabling investment in infrastructure

68. However, the potential of social investment to address the financial challenges faced by small organisations remains largely unproven, and more effort is needed to understand and address the barriers to organisations becoming investment-ready.

Personal care and health budgets

69. Integrated personal health and care budgets have an important role to play in driving resources towards holistic, locally-rooted and personalised approaches, providing they allow real choice, are introduced alongside a provider market development programme and comprehensive information system and as part of the wider culture shift towards collaborative care. They also therefore have the potential to be an important driver for resources towards the VCSE sector, where VCSE organisations are genuinely co-produced, have strong community relationships and have access to local marketplaces.

70. It is not always necessary to expand individual organisations in order to achieve scale: personal budgets have demonstrated it is possible to create systems which enable personalised and small-scale approaches to become widespread rather than needing necessarily to grow individually. Local Compacts and partnerships managed by local infrastructure bodies both help in achieving this approach, but more work is needed to establish and evaluate what works in creating diverse local provider marketplaces and reducing unmet choices.

Design principles for local health and wellbeing system:

71. The concept of added value and social value as fundamental to all contracts and grants needs to be established, mandating much better use of the Social Value Act (SVA), which could include:

i. Auditing contracting compliance with SVA
ii. More vocal national leadership and greater role-modelling of use of SVA by central government and its partners
iii. Guidance on read-across from SVA to the health inequalities duties in HSCA and the wellbeing principle in the Care Act
iv. More consistent, proportionate principles, approaches and standards in regard to social value.

Possible solutions to wider national challenges

72. We have heard a number of suggestions around the wider funding context. There are by their very nature more complex and generally outside of the ‘gift’ of any single organisation, but at this stage they do warrant further consideration.

Dedicated support for infrastructure

73. Infrastructure organisations could be a key partner in the health and care economy if effectively supported and their operating principles co-designed with the wider sector.

74. VCSE infrastructure organisations play a vital but often hidden role in our country's civic life by connecting VCSE organisations, strengthening their capability and capacity, and ensuring effective two-way communication between the statutory and the VCSE sectors. They also have a role in supporting the development of new VCSE organisations in response to local unmet need. The complexity and number of local statutory bodies in health created by recent reforms has led many local infrastructure organisations to step up their role in co-ordinating strategic engagement between government bodies and local VCSE organisations. Ensuring the sector is involved in shaping and delivering local services, and that small organisations do not waste resources on managing multiple relationships. Some have helped VCSE organisations develop formal partnerships and consortia. A few are experimenting with ways to draw on the capacity of local people and VCSE organisations themselves, to provide more effective support to members and extend their reach into local communities, by for example using time-banking approaches. Infrastructure organisations typically enable others to deliver frontline services rather than doing so themselves, which means they often lose out on funding that requires the demonstration of how their work impacts directly on outcomes.

A social value approach to commissioning

75. A shift in thinking is needed to move commissioning from an understanding of value based on lowest cost, to one centred around quality and social value (as set out in the Social Value Act) and its relationship to health and wellbeing. This could involve training all levels of commissioning and procurement staff to understand the value of VCSE organisations and how to engage with them effectively, whether through the Commissioning Academy or other means. It could also involve helping procurement staff to identify and change systems and process which exclude smaller VCSE organisations. This will depend on improved approaches to measuring and capturing social value that are compatible with locally-specific approaches to services.

A more strategic approach to co-ordinating partnerships

76. To address confusion about changes to the commissioning landscape, and capacity constraints in VCSE organisations around engaging with such a wide range of bodies, more effort is needed to support strategic partnerships using local Compacts and other partnership arrangements.

Addressing evidence gaps

77. There are several evidence gaps affecting the VCSE sector that need addressing:

i. Official statistics on the voluntary sector are insufficiently detailed and do not provide a suitably nuanced evidence base for decisions about how government can best engage health and care organisations, particularly those with an equalities focus.
ii. There is a need for improved approaches to measuring the social value and health, wellbeing, and community capacity impacts of VCSE organisations, that are nuanced enough to take account of different types of VCSE provider.
iii. There is also a need for much more supply-side data from government on its own contract funding to the sector at both prime and sub-contractor level.
iv. Although there is a perception in the sector that the number of VCSE organisations overall is decreasing, there is a lack of data evidencing whether this perceived trend is accurate, whether it is greater amongst equality groups or in different geographical areas, or the impact of this trend on the outcomes experience by the public. A

dedicated survey which addresses this and can be replicated on a regular basis would therefore be beneficial.

More support for the sector to demonstrate impact effectively

78. VCSE organisations often struggle to demonstrate impact in ways that are understood by commissioners. There are many outcomes tools available, but none have strong enough currency with the sector and commissioners and many are inappropriate to smaller VCSE organisations. A programme of work to support VCSE organisations to use and, where necessary, develop effective monitoring tools could help support the sector.

    i. The Health and Social Care Information Centre are currently exploring the feasibility of an analytical service which utilises existing data sets to provide a cheap and robust way for providers to demonstrate their impact. We recommend that system partners engage with the prototyping of this service.
    ii. There is a growing library of measurement tools available through the Inspiring Impact Hub – a sector collaboration of umbrella organisations and measurement specialists which is being managed by New Philanthropy Capital. We suggest the VCSE sector and systems partners work together to link up to this and ensure that this reflects the needs of VCSE organisations working in health and care.

Central grant programme

79. Although it represents a relatively small proportion of the grant funding to the VCSE's working in health and care, the sector feels that the current central grant programme run by the system partners plays a crucial role. It has funded important and impactful work and is a tangible way that the system partners demonstrate they value the sector. It could be a way to role model best practice in investment and partnership building. Currently the programme supports three streams: The Health and Social Care Volunteering Fund; the Strategic Partner Programme (SPP); and the Innovation, Excellence and Strategic Development (IESD) grant fund.

80. Our discussions have identified several areas for potential improvement in the programme:

    i. The Volunteering Fund could benefit from greater clarity on the rationale for what is being funded at national level as distinct from volunteering funded by local bodies (reduced as it is by cuts in funding for volunteer centres). There could be stronger links to policy development around volunteering across government, including the Cabinet Office's Centre for Social Action.
    ii. The SPP is at risk of losing its strategic focus. In 2008, 12 organisations or consortia were funded whereas now 22 consortia containing more than 70 organisations are receiving funding, working not just with the system partners but also arms-length bodies such as the CQC. There is a tension between focus and the laudable desire to be inclusive.
    iii. The sector considers it vital that government and its partners have a forum in which to co-produce policy with the VCSE sector and that this is centrally funded. However, VCSE organisations report that too often co-production of policy remains an aspiration rather than an imperative, especially when disruptive innovation is proposed.

iv. There are challenges around insider advantage in competing for other government funding arising from being a strategic partner. There is also funding uncertainty within the SPP – it is an annual programme so partners do not know the budget they will be allocated each year, which encourages short- termism.
v. IESD grants appear to be increasingly favouring large over small organisations. The number of projects funded has declined to only 30 in the latest round and it is felt that the application process favours organisations with professional bid writing teams and existing contacts with system partners. There is a view expressed that its impact has also been constrained by variable links to policy development within system partner organisations.

81. We need the central grant programme to meet the challenges that are currently facing the VCSE sector's ability to deliver health and care goals, as presented earlier in this report:

i. Reduced funding and system reconfiguration
ii. Short-term funding
iii. Defining and demonstrating impact

82. We suggest that the central grant programme is reviewed, one approach to this could be to simplify it into two distinct programmes: a refocused Strategic Partner Programme and a single new Grants Programme. Both should be more clearly co-designed with the VCSE sector and focused upon a smaller, clearer set of outcomes. The Strategic Partner Programme is the way in which central government and its partner's resource on-going liaison and partnership working with the VCSE sector and therefore some of the work is necessarily reactive to changing government policy priorities. The grants programme, however, should be more strategic, with clearer outcomes identifiable in advance.

Strategic Partner Programme (SPP)

83. The refocused SPP should build upon its mission to enable VCSE organisations to work "in equal partnership" with the three system partners to develop and implement better policy. The partnership's success revolves around its effectiveness as a two-way channel of communication.

84. We suggest exploring the following criteria and processes, which build upon the existing ethos:

i. Applicants should be required to demonstrate a mandate from people including those using services and their carers. Collectively, they should represent a broad section of groups and communities, with particular attention paid to equality and health inequalities;
ii. Partners should be able to demonstrate reach and impact into the wider VCSE sector, through membership, partnerships, or other tangible forms of engagement;
iii. People who use the health and care system, and carers should be involved in the application and decision-making process;
iv. Assessment of partners' performance should include an element of peer review from the sector and the people they serve;
v. Partners could play a role in defining grant programme priorities, providing they were themselves excluded from applying for funding from the grant programmes.

85. In order to consider options for developing this programme we recommend looking further into evidence from comparable models including Think Local, Act Personal and other grant schemes to see what works well.

Grant Programme

86. A single grants programme with a smaller set of policy priorities could be co-designed with the VCSE sector and jointly reviewed on a regular basis. This may not be straight-forward; it will need to bring together system partners' priorities with sector needs, to achieve the most impact with the funding available.

87. One result of narrowing the focus would be to reduce the over-subscription which represents a significant of waste of VCSE resources.

88. We feel that this programme, like the SPP, should promote equality and address health inequalities and seek to have lasting change or impact beyond the funded period of work, possibly through funding work which creates tools, learning, or resources the wider sector.

89. There are a number of possible ways to do this and we recommend working with the sector to identify the most effective:

    i. Continuing to fund innovation, including, work which attempts to start or drive culture changes. Such as, personalisation, collaborative care, or user-leadership
    ii. Promotes equality and reduces health inequalities including potentially a weighting towards relevant projects
    iii. Develops social action and volunteering
    iv. Attempts to bring well-evidenced work to scale.
    v. Positively disrupts provider marketplaces
    vi. Increases the capability of the sector to demonstrate impact and supports effective sharing of good practice

90. This new grants programme could also consider:

    vii. New and creative ways of applying (rather than just a written application system) e.g. video-based applications
    viii. Building evidence libraries through greater efforts to measure and capture data and more focused evaluation
    ix. Building partnerships with other funding bodies and/or academia

Next steps

91. From January to March 2015 we have been engaging with key members of the VCSE sector – from small to large, local to national – we have found a great appetite among the sector to have this conversation, and to those who have taken part so far we would like to extend our thanks.

92. Following the election, and with the support of the next government, we would like to continue to work in co-production between the systems partners and the VCSE sector to test and challenge our recommendations and produce a plan for implementation.

Annex one. The contribution to and impact of micro, small and medium sized VCSE organisations on national health and well-being; early Findings

Paul Streets, Chief Executive Lloyds Banking Foundation
Sian Lockwood OBE, Chief Executive, Community Catalysts CIC
25th February 2015

The VCSE sector and health and well-being

According to the NCVO Civil Society Almanac 2014, more than 36,000 charities work in the health and social care sectors. The numbers of VCSE organisations that are not charities working in the field (social and community enterprise) is likely to be even higher. [28]

The largest national VCSE organisations have long played a role in large scale whole population interventions at national level, for example in population based information delivery, as one component of primary prevention, and in targeted interventions focused on groups and issues where there is a pre-existing health or social care diagnosis whether this is condition or demographic specific: in health **terms secondary prevention** like Diabetes, COPD, MS, Sexual Health/HIV, Cancer. Many are funded from voluntary income completely or largely independent of the state.

This cohort are distinct from large national and regional VCSE providers involved in the direct delivery of care (including health care) under contract from local authorities or CCGs. These providers can have significant funding from voluntary income but are increasingly reliant on contracts for funding to deliver their services. Adding to this group are the new social enterprises established to take on the delivery work of public bodies. They vary significantly in size, from those established to take on all health delivery apart from acute care (for example Care Plus Group http://www.careplusgroup.org/pages/about-us) to the spin-out of one specialist social work team, with just a handful of staff. These new entries into the VCSE sector are entirely dependent on contracts.

The bulk of the VCSE sector is however small or medium sized and local – 97% of charities in the UK have an annual income of less than £1m[29]. They are often set up in response to a local need and provide services tailored to meet that need, with the person using their service being part of the solution. Their services are usually highly personalised. Their funding used to come principally from grants but this is changing in many areas, with the ending of local authority grant-funding. Small and medium VCSE providers in areas which have stopped their grants programmes are now reliant on funding from contracts with local authorities and CCGs, but in many cases these contracts are out of their reach.

[28] Newly established community enterprises rarely take charitable form. They often start as single-person or small-group initiatives and only become constituted as they become established and begin to grow. The most common legal form for the more established enterprises is now a Community Interest Company. We estimate that there are about 10,000 community enterprises operating in England, most unknown to the local authority and purchased by people from their own money or personal budgets,
[29] Civil Society Almanac (NCVO, 2014)

Large VCSE organisations experience a range of barriers to contribution, but these are different to those experienced by micro, small and medium organisations. We are keen in this review to make sure that the voice of the bulk of the VCSE sector, micro, small and medium organisations are heard. This group is particularly pertinent to the review because of the increasing pressures they face set against their value to the health and wellbeing of their local communities. This paper therefore focuses on the contribution and impact of this part of the sector and the barriers they face.

1. The importance of VCSEs to the health and well-being of local communities

Health and social care needs in England cannot be met without the work of VCSEs. Small and local organisations are central to the health and well-being of their local communities

10 reasons why micro, small and medium sized VCSE organisations are important

1. Their local roots means that they can identify and understand the needs of local people and their community
2. Their size allows them to shape their services around the person, providing a joined-up response, linking services such as social care, housing, and specialist health.
3. These holistic, personalised services work well for people with more complex needs, delivering excellent outcomes and helping to save money by providing an alternative to more expensive residential care services and reducing repeat demand for costly health and care interventions.
4. They work co-productively with people, supporting them to be part of the solution, which leads to better long-term health outcomes
5. They are trusted by communities so can provide a voice for the voiceless and link with the traditionally 'hard to reach' communities, helping people to find solutions which work for them and supports their health and wellbeing.
6. Many provide highly effective early intervention and prevention – their effectiveness is enhanced because they are trusted, local, rooted and independent. Effective preventative services reduce the demand for high cost services.
7. They help build social capital, which is important to people's well-being
8. They create local jobs and volunteering opportunities; provide a route to qualifications; and help local money stay local. They therefore contribute significantly to their local economy and the broader well-being of their community.
9. The number and spread of small local VCSE organisations combines for national impact. Scaling out has as much if not more impact than scaling up,
10. Their local roots allow them to draw on community resources (buildings; people; access to jobs) as well as sources of funding inaccessible to public bodies. This helps to deliver value for money.

Very small community enterprises and VCSE organisations often work across a number of sectors as they focus on meeting the needs of the people they support

Your Choice Leigh

Your Choice was inspired by the experience of Colin Welsh, whose life changed when he developed mental health problems which resulted in hospitalisation. Colin was determined never to return to hospital and on discharge joined a community based support service, which he found invaluable. When the service had to close because of lack of funding, Colin started his own peer support group, Your Choice Leigh. He found a room to rent and set about creating a homely friendly space for people to meet up.

Your Choice opens every weekday from 10am until 3.30pm and has gone from strength to strength. It supports up to 20 people every day and charges just £1 for unlimited cups of tea. In addition to providing a safe friendly place, Your Choice also offers arts and craft sessions; access to a local allotment, a reading group in the local library and organises trips for all who attend. The group recently had a 3 day trip to a retreat in Conway.

After years of struggling with his mental health, isolation and loneliness one member of the group explained how the support he has received from Your Choice has enabled him to turn his life around. In the past he was regularly arrested due to alcohol related anti-social behaviour and he was admitted into hospital on numerous occasions due to suicide attempts. His family lived in constant fear for his wellbeing. Through the support of the group he is no longer using alcohol; he has formed meaningful friendships, loves arts and crafts and has been on several trips away.

Your Choice provides a place where people struggling with mental health problems and addiction issues can find friendship and support. It helps to reduce isolation and hospitalisation and the benefits to health and social care are clear. But benefits accrue across a range of other government and public sector demarcations – Ministry of Justice (reducing criminality and anti-social behaviour), Communities and Local Government (reducing anti-social behaviour, helping people maintain tenancies) and even DWP (confidence-building is helping some people into volunteering and then work).

Essentially, small and local VCSEs achieve things that large scale, single issue providers cannot. This is particularly true when working with individuals with multiple needs who drive the highest public costs across a wide range of services.

Ensuring VCSEs have the resources to address these multiple issues can lower demand for services, improving health and care outcomes as well as reducing costs of health and care services going forward. For example, HALE in Bradford runs a range of services which include work to improve blood pressure, tackle obesity and reduce alcohol consumption. Following engagement with the charity, many participants report less need to visit their GP.[30] Similarly, Age UK's Newquay Pathfinder project led to significant reductions in demand for health services following engagement with their service. The project provides wrap-around, targeted support to 'at risk' older people, coordinating services that can support them. It also uses volunteers to build individuals' social networks, connecting them to the community and making them more resilient. A project evaluation indicated:

- 23% improvement in people's self-reported well-being
- 30% reduction in non-elective hospital admission costs
- 40% drop in acute hospital admissions for long term conditions

[30] Do Local Voluntary Organisations Hold the Key to Improving Health Outcomes? (Kinds Fund, 2012)

- 5% cost reduction and reduction in demand for adult social care.[31]

2. Barriers to VCSE providers bettering health outcomes

Many small and medium sized VCSE organisations, because of their person-centred approach, deliver services that do not fit into government or public sector demarcations which are focused on single-issue service delivery that often fail to reach those with the greatest health needs. Excluding small and local VCSEs from the commissioning process limits the potential of VCSEs to meet demand and ultimately, limits government's ability to meet health and social care needs.

The fiscal environment within which local government is working is inevitably driving a focus on cost-cutting. This has led to a focus on unit cost rather value, evident through:

- large scale contracts;
- standardisation and specification of uniform outcomes;
- short term contracts with a reduction in financial security;
- payment by results, which risks focus on those with the lowest cost of delivery, rather than greatest benefit

The engagement exercise that accompanies this review has provided many examples of contracting and procurement practices which put the small and local VCSEs that offer so much in terms of health and care benefits at a disadvantage. It is for example impossible for small organisations with little working capital and few assets to compete for larger contracts because:

- they work on a small scale and simply cannot deliver the large-scale outputs required
- the tender process is complex and costly to complete
- tender requirements may be unattainable for very small organisations (e.g. with a requirement for a NEBOSH-qualified health and safety employee)
- contracts have tightly-defined and rigid outcomes which do not allow for individualisation, which is the essence of small and local VCSEs' success
- short-term contracts make it difficult for small and local VCSEs to plan and innovate. The need to constantly seek funding distracts the organisation from its purpose.
- small and local VCSEs do not have the resources to take on the financial risk of payment by results contracts.

Even where VCSEs are able to compete for contracts, the nature of the secretive, competitive process can stifle innovation and collaboration which are central to improving learning and ultimately, improving health and social care outcomes. Similarly, focusing on tightly defined outcomes in contracts makes providers accountable to the commissioner as opposed to the service user.

The focus on immediate cost-cutting rather than prevention, and on bulk rather than specialised services is leading to an unsustainable situation in which there are fewer valuable and experienced VCSE providers delivering personalised support that helps people stay rooted in and supported by their local community. This is accompanied by growing

[31] People, Place, Purpose: Shaping services around people and communities through the Newquay Pathfinder (Age UK Cornwall & Isles of Scilly)

demand for support for people whose needs have become critical, who have limited access to community support and need expensive state-provided solutions.

Personal budgets are also excluding small and local VCSEs from health and social care provision. While they have always been an important tool in delivering personalisation, their concept – giving people up-front information about the money available to spend on their service and then control over how that money is spent – seems to have been corrupted in many areas. Local authorities are setting rules about how the money can be spent – e.g. only on services delivered by providers on an 'approved list' – and also limiting information about the services that are available. It is often impossible for small VCSEs to get onto approved lists or to tell people with personal budgets about their services.

The regulatory and legislative environment in health and social care also creates complex barriers that deter many people thinking of setting up a VCSE organisation in response to local need and force good providers, delivering a valued service, to close down. Providers need dedicated help to negotiate or (in some cases) to challenge these barriers.

These barriers should raise considerable concern for government: the exclusion of small VCSEs from commissioning limits their ability to improve health and care outcomes. The risk is most acute in those areas where needs are highest and third-sector infrastructure is weaker. It is in these areas that government support for VCSEs is particularly important.

Some barriers to VCSEs contributions to bettering health and social care outcomes come from within the sector itself.

Challenges for the VCSE sector

The sector needs to:

- Become better at forward planning - thinking beyond the next year
- Provide evidence of value and impact which changes the conversation with commissioners away from the focus on cost
- Share learning and collaborate rather than merging unless that makes sense.
- Plan for income diversification.
- Stick to mission - not simply go where the funding flows.
- Support key leadership and organisational development.

Overcoming the barriers:

To overcome the barriers limiting the benefits that VCSEs can bring to health and social care in England, it is important to take on board learning from those already supporting these VCSEs.

A Different Approach – learning from foundation and trusts

Foundations give £2bn a year in grants, much of that to small VCSE organisations. They can demonstrate that many barriers could be overcome through adopting a more flexible funding mix that could allow VCSEs to thrive. A more flexible funding approach means supporting different services, in different ways according to need. It allows for contracts where single-issue, standardised interventions can work but also for grants that enable smaller, local organisations to receive funding. Adopting a more flexible approach that includes a greater focus on grants could overcome many barriers whilst also retaining safeguards included in contracts:

- It is possible to discriminate and fund the best applicants delivering the best outcomes, without needing a contract.
- Co-designing outcomes with the funded organisations is much more effective than imposing outcomes
- A focus on benefit and value as defined by the beneficiary helps discriminate between applications
- The grant funding process has a lower transaction cost for the funder *and* the funded, than contract funding
- Funding for the long term supports sector stability and provides freedom to innovate

A Different Approach – learning from social investors

Social investors are comparatively new players but becoming increasingly important to the funding of the VCSE sector. As with the much more established charitable trusts they are developing learning about what works in funding VCSE providers which will be of value to central and local government. Social investment should be part of the funding mix available to the VCSE sector and could help overcome current barriers.

- Working collaboratively with organisations to identify definitions and measures of social impact allows proportionality and is effective ,
- Patient investment understands that radical work takes time to grow and deliver results.
- Identifying and investing in models of care and health which produce good outcomes can deliver savings is effective in driving choice for people
- A focus on identifying people that have the passion, competence and grit to do a good job helps to ensure investment is used well and organisations deliver their potential.

A Different Approach – learning from community micro-enterprise support

Some local authorities have invested in local support for people running or wanting to set up a community micro-enterprise. The supporter:

- Finds out what people who use support services want and connects them with local people wanting to help
- Signposts to local agencies and sources of specialist help and advice
- Helps people negotiate complex regulatory and legislative rules
- Helps people come together to support each other
- Engages with policy and decision makers and challenges systems that don't work

In Nottinghamshire over a four year period of support, 68 community enterprises were helped to be successful with only 3 failures over that time. 900 older or disabled people used their services. 130 jobs and over 80 volunteering opportunities were created.

3. Some design principles for a new approach to the VCSE sector

Taking this learning on board allows us to develop some design principles that could ensure the VCSE sector thrives in delivering better health outcomes. Central to these principles is the belief that communities need a plurality of providers, providing a wide range of different services shaped to the needs of local people -matching the plurality of funders (people with personal budgets, local authorities and CCGs).

- Commission services on purpose not outcomes, allowing those who understand needs best to design and deliver the solutions,
- Focus on person-centred, holistic support to deliver better outcomes at a lower long-term cost– especially where the person has complex needs. .
- Commission services from a range of organisations but with a bias to the locally-rooted who are likely to achieve a bigger cross-sector impact with the same money
- Help people who need care to be part of the solution, enabling them to help themselves
- Focus on value, not unit cost. Economies of scale do not always mean better value and standardised interventions do not always meet individuals' needs[32]
- Facilitate an effective funding mix so that different types of funding can be applied to different types of intervention and organisation. Funding is best delivered through a mix of grants, contracts and investment
- Design processes to promote diversity of provision, with a conscious focus on accessibility for smaller organisations and those from more marginalised community groups
- Ensure accountability is to the person using the service, as opposed to the commissioner
- Introduce longer-term funding to help organisations to plan and innovate, and stay sustainable.
- Provide small VCSE providers with specialised and dedicated help to understand and negotiate regulatory and legislative barriers, demonstrate impact and have different types of conversation with funders.

[32] Locality Saving Money by doing the right thing March 2014

Annex two: Continuity and change in VCSE dealing with equality and health inequalities

Jabeer Butt, Megan Wong and Saliha Majeed
Race Equality Foundation
6 March 2015

There are challenges in disaggregating experiences of VCSE organisations specifically working on equality as opposed to 'mainstream' organisations that also address equality. For example, Black Health Initiative work to end discrimination and disadvantage experienced by black and minority ethnic people with cancer, whilst MacMillan Cancer Support, a mainstream cancer charity, also work to improve support for black and minority ethnic communities. Despite these similarities, MacMillan has seen significant income growth over the past five years, whilst BHI's has been more chequered.

The conclusion to be drawn from the engagement events and a number of specific or local reviews on the experiences of charities specifically focusing on progressing equality in health and social care is that the past five years has seen a dramatic decline in numbers of organisations, as well as the resources available to them. For example, women's organisations, specifically those led by black and minority ethnic communities, LGBT or women with disabilities, have experienced a significant level of funding cuts and have had to resort to their reserves to continue delivering services[33]. However, others may have also been impacted, such as faith-based organisations as well as those working with children and young people.

Importantly, whilst there is some quantitative evidence of the differential impact on smaller organisations as opposed to larger organisations, it is not presently possible to disaggregate the data to understand other aspects of the equality agenda. There is limited statistical evidence available to understand the overall impact on organisations specifically focussing on equality, or for organisations whose main beneficiaries are people who have one or more of the nine protected characteristics. Some of the national surveys that could have allowed for this type of enquiry no longer run, for example the National Survey of Charities and Social Enterprises was discontinued in 2012. However, discussions as part of the VCSE review have highlighted that the data used to compile the Civil Society Almanac could be disaggregated to produce a picture better informed by numbers.

Differential impact of austerity has been a consistent theme in many of the discussions, in addition to the negative consequences it will have on the progress on equality and health inequalities. However, without statistical evidence, it is impossible to measure impact across the country and amongst organisations. The engagement events suggested that differential impact had a geographical dimension too. For example, some organisations argued that impact of austerity in the North or in Northern cities had been more significant. Some work has argued that the government's settlement does not acknowledge both the regional

[33] Women's Resource Centre, 2013, *The Impact of Public Spending Cuts on women's voluntary and community organisation in London.* [Online] Available at http://thewomensresourcecentre.org.uk/wp-content/uploads/London-report-FINAL-for-website.pdf.

variations between the North and South of Great Britain, but also between different "communities of geographies and interest"[34]. Also highlighted was the consequences of uneven economic recovery across the country, with the suggestion that the process of recovery would be slower in the North. These points were made in the context of evidence that the VCSE infrastructure is smaller and more limited in areas with greater social and economic deprivation.

It was also suggested that the experience of minorities within minorities may be poorer: for example VCSE working to support Gypsies and Travellers. This echoed other work. In a report published by the National Council for Voluntary Youth Services (NCVYS) it was identified that "organisations providing mental health and advice services for young people are struggling to cope with multiple cuts"[35].

There appears to be significant change in the availability of grants for local delivery. Local authorities appear to be cutting back at the same time as the demise of Primary Care Trusts (PCT), with some suggesting that obtaining Big Lottery money had become more difficult. From the engagement events, few could identify whether 'public health' money was being used to address equality or health inequalities. Potentially also worrying was that there appeared to be little or no experience of the use of social investment to progress equality and address health inequalities.

From the engagement events, while the success of foodbanks was highlighted, it was difficult to identify any change in public sentiment that had led to those specifically working on equality or communities with one or more protected characteristics securing more or new money from direct appeals to the public. It has been suggested that public sentiment may be impacted by government or media policies and views.

In this context, a fundamental problem for the VCSE dealing with equality and health inequalities, is that the present health and care system (JSNA's Health and Wellbeing boards, etc.) does not appear to be good at identifying the needs of a range of groups and even less able to do this for minorities within minorities (Gypsies and Travellers, older LGBT, amongst others). This is accompanied by a model of securing support that prioritises tendering and contracts, and rarely sees grant funding as a viable or valuable option.

As noted already there have been VCSE who have continued to thrive. This appears to be mostly larger charities with the infrastructure to compete for contracts that have been tendered and those who are able to appeal to the public for funds. Smaller charities stated that there was unequal access in competition to win contracts which delivered public services and, in turn they were unclear as to whether reductions in local authority funding had been fairly prioritised[36]. This led some to argue that funding appears to be more directed at larger, more prominent organisations, whilst small charities are often asked to engage on key pieces of work with little or no resources. But it may also be the case that

[34] Lachman, R., Malik, F., 2012. *West Yorkshire Public Sector Cuts: The Impact of the BME Voluntary and Community Sector.* [Online] Available at: http://www.justwestyorkshire.info/wp-content/uploads/2011/10/West-Yorkshire-Public-Sector-Cuts-The-Impact-on-the-BME-VCS.pdf.

[35]National Council for Voluntary Youth Services, 2011, *Where are we now for young people and the voluntary and community youth sector?* [Online] Available at: http://www.gup.org.uk/sites/www.gup.org.uk/files/11_ncvys_comprehensive_cuts_3.pdf, p.4.

[36] The Foundation for Social Improvement, 2014, *The Relationship between Small Charities and Public Sector Involvement: the Missing Pieces,* [Online] Available at: http://www.thefsi.org/wp-content/uploads/2014/06/2014-Research-the-Missing-Pieces.pdf.

charities, as a whole, have struggled to secure contracts in the new health and care market. A recent report published by New Philanthropy Capital (2015) highlights the uneven distribution of CCG contracts to NHS providers, private companies, charities and social enterprises during the period April 2013 to August 2014. Charities and social enterprises are currently under-represented in securing contracts, particularly in the provision of community-based services where they are expected to thrive. Compared to NHS providers, local authorities and universities who received 43% of contracts, charities and social enterprises were only awarded 11% of contracts. Private providers secured almost three times more community-based service CCG contracts than charities and social enterprises[37].

Participants at the engagement suggested that what appeared to accompany contracts was for smaller amounts of local delivery, and for shorter time periods. This posed a range of challenges for organisations, including cash flow, additional transaction costs, difficulties in retaining staff, and difficulties in managing events such as sick leave when everyone is on limited contracts. This inevitably poses a challenge for sustainability too. At the same time it appeared to be becoming more difficult to secure money for advocating for equality. This appeared to be consistent across groups with protected characteristics, whether it was to do with disability, gender, race, age or sexuality. While Table 1 is essentially descriptive, it does show cuts across a range of protected and vulnerable groups.

Table 1: Cuts in the London Boroughs Grants Scheme in 2011-12 broken down by the communities for which service were provided[38]

Specialist Services provided for:	% of Organisations Cut by Number	% of London Councils Fund Cut
Children and young people	36	37
BAME	16	15
Women	5	4
Disabled people	5	4
People of a particular religion or belief	4	3
Older people	2	3
LGBT	2	1
Carers	2	1

At the engagement events, some organisations said that contracts often dictated by how services should be delivered, and therefore did not focus on VCSE expertise. Many have felt they are at a disadvantage because of their size, suggesting that the commissioning process is more arduous for smaller organisations[39]. Some have suggested that a lack of statutory sector engagement with the community, along with a mixed level of understanding between the two sectors, has led to the development of contract bids that do not necessarily outline the outcomes required to address the specific needs of community groups. Furthermore, whilst many welcomed the development of a 'short' version of the NHS

[37] New Philanthropy Capital, 2015, *Analysis of CCG Contracts Data*, February 2015 [Online] Available at: http://www.thinknpc.org/publications/analysis-of-ccg-contracts-data/

[38] London Voluntary Service Council, 2012, 'The economic climate, Londoners and the voluntary and community groups that serve them' in *The Big Squeeze 2012: surviving not thriving*, [Online] Available at: http://www.lvsc.org.uk/media/117415/big-squeeze-2012-final%5b1%5d.pdf, p.24.

[39] The Foundation for Social Improvement, 2014, *The Relationship between Small Charities and Public Sector Involvement: the Missing Pieces,* [Online] Available at: http://www.thefsi.org/wp-content/uploads/2014/06/2014-Research-the-Missing-Pieces.pdf.

standard contract to alleviate the burden of VCSE, few had heard about this change. Many wondered what difference it would make as it was the difficulties in securing contracts that was the challenge.

In addition, some argued, that the possible demise of this sector would mean that some of the health and care structures that saw engagement of voluntary and community organisations as part of the process of transformation would, over time, find it more difficult to engage with perhaps the most excluded groups or communities.

Possible ways forward were suggested: a co-production model used by Lankelly-Chase to award a grant was highlighted as particularly valuable. Leeds Gate submitted an 'expression of interest' through a video based on their service users. The Lankelly-Chase grants officer then worked with the organisation to develop the actual grant bid. There appeared to be benefits to both sides, with Leeds Gate concluding that they were able to develop a stronger proposal and Lankelly-Chase being clearer about what the grant would achieve.

National evidence has suggested that the VCSE workforce has shrunk and the engagement events appeared to have confirmed this, with the additional suggestion that it is perhaps the small to medium organisations that have seen the greatest decline. It was not clear what, if any, impact these changes had on the skills base, except that some noted that with a smaller staff group and limited resources investing in staff development was proving to be more of a challenge in addition to the loss of skilled and experienced staff.

Whilst there is limited data available relating to the impact of funding cuts and austerity on wages and working hours, recent studies have shown there has been a steady increase in wages amongst the voluntary sector, despite still being relatively lower than the public and private sectors[40]). Employees on part-time contracts work slightly longer hours in the voluntary sector than those in the private sector, despite earning a weekly average of £83.87 less. Full time workers work similar hours across the sectors[41]. Other small scale studies have noted a negative impact on employment, including "…job insecurity, salary reduction, casualization, work intensification and a fragmentation of pay and conditions.[42]

Volunteering in some areas appears to have allowed VCSE to continue to provide support, in particular for those groups who had a history of hiring volunteers to provide support. However, it has also led to, for want of a better phrase, "enforced volunteering" where paid staff and managers have taken pay cuts, but are now also 'working' extra unpaid hours to ensure continuity of support. One chief executive said that a commissioner often said that we needed 'to get more for less', but she now feels you will get less for less.

Many recognised that a key strength of their organisations was their staff. However, with the combination of pay cuts, the need to work across 'contracts' and grants and the short-term nature of much funding had led to significant instability in the minds of the workforce. Some suggested that this was already leading to greater staff turnover, only likely to get worse.

[40] Taylor, R., Kamerade, D. and Mckay, S., 2014, *Reviewing the Literature on Pay and Non-Standard Employment Taking a Cross Sector Perspective.* Third Sector Research Centre. Working Paper 120, April 2015.
[41] Skills-Third Sector, NCVO and Third Sector Research Centre, 2013, *UK Voluntary Sector Workforce Almanac* [Online] Available at: http://www.3rdsectorworkforce.org.uk/
[42] Taylor, R., Kamerade, D. and Mckay, S., 2014, *Reviewing the Literature on Pay and Non-Standard Employment Taking a Cross Sector Perspective.* Third Sector Research Centre. Working Paper 120, April 2015.

The combination of these developments has led a number of participants to conclude that those communities and individuals served by VCSE focusing on equality and health inequalities were now at crisis point. A key challenge posed to those carrying out the review was not only whether Department of Health, NHS England and Public Health England would listen and act on the recommendations of the review, but whether the review would present the scale of the problems faced by the VCSE sector and in particular those specifically progressing equality and addressing health inequalities.

What should be done?

Specific action and mainstream change:

There needs to be recognition that equality is to be progressed and health inequalities are to be addressed through specific action as well as mainstream change. National and local funding should prioritise progressing equality and addressing health inequalities and then demonstrate how this has been translated into actual support. It should eventually report on what impact it has had overall.

Improved practice in identifying needs and agreeing local practice:

There was recognition that some of the existing processes could be developed to help organise local support and allocation of funds could be useful, but engaging with equality and health inequalities needs to progress further. This should include greater (and compensated) involvement of the VCSE in bidding processes.

Better commissioning practice is needed:

In particular, there should be an acknowledgement that grants and grant making processes can be used, but also a recognition that the process chosen for securing best value has to be proportionate and informed by the 'local market', with proper recognition of social value. An element of this should be using co-production models though out the process, including the application phase.

Greater support required for VCSE infrastructure:

Specific support is required for the VCSE infrastructure the expectation that VCSE could bid for contracts including coming together to make partnership/consortium bids is dependent on a local infrastructure that can facilitate this.

Annex three. Summary of common themes in written submissions to VCSE Health Review

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March 2015

This summary draws upon submissions from fifteen separate papers. Some were submitted jointly by alliances, others by frontline charities or infrastructure organisations. Relevant extracts from papers are quoted in the text boxes. This document is an early distillation of emerging themes. It is anticipated that a call for evidence post-election would provide a more systematic overview of themes and examples.

Review theme 1: The impact and potential of the VCSE sector

Reach and diversity of VCSEs - At this initial phase, the evidence indicates how the sector reaches and engages people (e.g. at a local level, through shared experience, within overlooked groups and with specific health conditions). Further evidence is required to fully map the reach of the sector in health and care across England.

> "36,337 VCS organisations work directly in social services and health. Many more work in areas linked to the wider determinants of health, including education, employment and housing."[43]
>
> "VCSE organisations participating in programmes financed by the Social Investment Business 'work primarily in physical, mental health and healthy living (28%) followed by education and learning skills (23%) and employment and training (14%). The main beneficiary groups are children, young people and families (23%) followed by the general public and community (23%) and people with disabilities (15%). VCSEs tend to work in the most socially deprived areas. "[44]
>
> "Social enterprises are very heavily concentrated in the UK's most deprived communities. 38% of all social enterprises work in the most deprived 20% of communities in the UK, compared with 12% of traditional SMEs."[45]
>
> "There are 240 organisations providing hospice care in the UK, the majority of which are local charities. Charitable hospices provide 2,570 specialist palliative care beds, representing 80% of the beds within our healthcare system. In contrast, there are just 630 specialist palliative care beds available in the NHS."[46]

Impact of the sector –The sector makes a major contribution to the improvement of health outcomes. However, it is constrained in demonstrating its impact by a number of factors.

> **Impact:**
> "Case study: Age UK's Newquay Pathfinder Project - Age UK's Newquay Pathfinder project helps older people with multiple long term conditions remain independent and stay out of hospital. Volunteers listen to the older person's needs and desires so that,

[43] NCVO & Compact Voice, Health VCSE Review: background paper, 2015
[44] Social Investment Business response to the Health VCSE Review, February 2015
[45] Social enterprise UK, The people's business – state of the social enterprise survey 2013
[46] Hospice UK, Joint review of health and care sector investment in VCSE organisations – Response, March 2015

together, they can work to achieve their goals in a shared care plan which suits their life and will help them maintain their health and wellbeing. The pilot project has led to a 25%

reduction in emergency hospital admissions. By focusing on the needs of the individual, the quality of life, confidence and wellbeing of those people taking part have also improved significantly."[47]

"Case study: Early Presentation of Cancer Symptoms - North East Lincolnshire Care Trust Plus. The Early Presentation of Cancer Symptoms is a community led programme run by four teams of volunteers who work across deprived communities in North East Lincolnshire to gather an understanding of local community needs. This knowledge is used to develop social marketing tools that raise awareness of the signs and symptoms of cancer and encourage earlier presentation. Key achievements include a 25%, 50% and 67% increase in gynaecological, bowel and prostate cancer two week referrals respectively."[48]

"Case Study: Turning Point- Turning Point is a social enterprise offering over 250 specialist and integrated services across England and Wales, focusing on substance misuse, learning disability, mental health and employment. It has delivered its Connected Care model of community-led commissioning across 14 areas in England. This model enables communities to be involved in the design and delivery of services and has resulted in services that are more effective. The model has also delivered significant net benefit to the public purse; a cost benefit analysis of one area found that with every £1 invested a return of £4.44 was achieved. When the benefits of improving quality of life are included, a return of £14.07 was gained for every £1 invested."[49]

"Hospices pioneer innovative approaches to improve people's experiences of care. Hospice-led initiatives are helping to:

Reduce unnecessary admissions to hospital; facilitate rapid discharge from hospital for people who no longer need to be there; provide alternative inpatient care for people who are unsuitable for home care; help provide home based care for people who wish to die at home; and deploy telemedicine to support people at home."[50]

Challenges:

"The review paper notes that not all VSCE organisations are able to demonstrate their impact clearly. This clearly demonstrates the importance of capacity building across the sector to improve skills in this area, but also shows the importance of commissioners and funders valuing different types of evidence (e.g. case studies as well as quantitative data)."[51]

"In terms of monitoring their work (children and young people's voluntary sector) and demonstrating their wider impact, a number of challenges were reported, including:

- Inconsistent monitoring processes both within and between funding streams
- Monitoring information requirements being disproportionate to the size of the contract awarded

[47] Age UK, "People, Place, Purpose" quoted in NCVO & Compact Voice, Health VCSE Review: background paper, 2015
[48] IVR, "Volunteering and health: good practice case studies (July 2012) quoted in NCVO & Compact Voice, Health VCSE Review: background paper, 2015
[49] http://www.turning-point.co.uk/about-us/who-we-are.aspx quoted in NCVO & Compact Voice, Health VCSE Review: background paper, 2015
[50] Hospice UK, Joint review of health and care sector investment in VCSE organisations – Response, March 2015
[51] National LGBT Partnership, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015

- The difficulty in measuring longer term outcomes – which is key to the children and young people's voluntary sector
- Distinguishing the impact of the voluntary sector programme from the wide range of other services children and young people access – and demonstrating how the former supports the latter to be more effective
- Wider positive knock-on impacts on families and peers of children not being reflected in evaluation and monitoring."[52]

Solutions:

"Measurement of social value is not yet fully developed. It is proposed to ask Inspiring Impact, a ten year programme led by the voluntary sector to develop impact measurement including a methodology for commissioners to assess additional value provided by social value, set standards for measurement for different types of procurement and promote good measurement principles across sectors, paying particular regard to the need to avoid any potential burdens on the VCSE and SME sectors."[53]

User voice and citizen participation – The sector has a strong track record of empowering people to express their views and take an active part in decision-making and positive change, for example through volunteering and participation in co-production of services.

"Acting as a critical friend to statutory bodies is one of the key roles of the community and voluntary sector. Public services will be more responsive to the needs of people if charities amplify their voices and are actively involved in scrutiny."[54]

"VCS organisations also catalyse the wider contribution of volunteers. Around 27% of regular formal volunteers are engaged in helping health, disability and social welfare organisations with 16% engaged in supporting older people. There are an estimated 3 million volunteers in health and social care, and 5 million unpaid carers."[55]

"There are at least 125,000 volunteers contributing to the delivery of hospice care in the UK. The equivalent financial value of their contribution is estimated to be £209 million each year. Volunteers are vital to the high quality experience of those who receive hospice care. They will play an important role in ensuring the success of hospice care in the future."[56]

"Many VCSE organisations we have spoken to are concerned by the apparent perception among the public sector, at both the national and local level, that volunteers are an additional resource that comes completely free. They point out that there are costs attached – of recruitment, training, management and expenses, all of which are important to a positive volunteer experience, and therefore to volunteer retention."[57]

[52] NCB, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015
[53] Cabinet Office, Social Value Act review, February 2015
[54] Children England and TUC, Declaration of interdependence, July 2014
[55] NCVO & Compact Voice, Health VCSE Review: background paper, 2015
[56] Hospice UK, Joint review of health and care sector investment in VCSE organisations – Response, March 2015
[57] VCS Engage, Norfolk, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015

Addressing the wider determinants of health – Whilst some charities, social enterprises and community groups have a direct health focus, others improve health outcomes by addressing wider determinants. These include: socioeconomic status, education (opportunities and attainment), teenage pregnancy, alcohol and drug misuse, the physical environment (living and working conditions) and the social environment (support networks and social interaction).

> "Frequently seen as a completely separate service, transport is in fact critical for access to health and care services for those who cannot drive or do not have access to a car. How health and care services will be
>
> accessed needs to be part of the discussion about service planning right from the outset. This relates to a further question about the boundary between 'health' and 'non-health' activities, given the evidence on the impact of wider determinants of health such as education, employment and housing and the roles of public, private and VCSE organisations in each of these areas."[58]

Personalised and holistic support – VCSE organisations typically provide services holistically, working with individuals to shape and personalise the support that they receive.

> "It is being increasingly recognised that voluntary and community sector (VCS) inputs will form a significant part of future care provision, for example through social prescribing, community development approaches to health, the 'more than medicine' elements of the House of Care, and support for people to understand and use personal budgets. User-led organisations (ULOs) can facilitate relationships between people with support needs and providers or commissioners. ULOs can also help establish peer-led activities (in the place of services if this strengthens independent living more effectively)."[59]
>
> "Hospice care began as a community response to the basic human need for dignity and compassion at the end of life. It takes a holistic approach to meeting people's physical, social, psychological and spiritual needs, and provides support to families and carers before and after bereavement."[60]

Value for money - VCSEs help commissioners achieve value for money by cutting the cost of delivery (involving volunteers and mobilising communities to make changes for themselves) and making savings to other public services (reducing A&E visits and hospital stays).

> "SIB has also delivered some funds as part of the Cabinet Office's Centre for Social Action, which has provided grants to VCSEs that can demonstrate volunteer led approaches to mobilise or scale up initiatives around:
>
> - Reducing pressure in Hospitals – this £1.4m fund has supported 7 groups to run projects that help older people stay healthy and recover quicker from illnesses.
> - Carers' social action support fund - this £1m fund has supported 7 organisations with a social mission who provided public services that were looking to build on, or adapt, inspiring social action projects for carers to apply for funding.

[58] VCS Engage, Norfolk, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015
[59] Regional Voices & National Voices, The Voluntary and Community Sector and Localised Health Commissioning, What are the issues and how can we start to address them? 2015
[60] Hospice UK, Joint review of health and care sector investment in VCSE organisations – Response, March 2015

With both funds, a small amount of targeted grant money can be shown to produce strong impact for frontline organisations involving volunteers in the community:

- Providing training and work experience opportunities.
- Enabling volunteers to contribute towards improving carer experience in their communities.
- Providing a network of volunteers that health service professionals can refer to for support.
- Supporting over 1,500 carers that are socially isolated or at risk of isolation to achieve better levels of health and wellbeing.
- Recruiting over 600 volunteers to support over 5,500 older people, reducing hospital readmissions."[61]

Useful tools

Think Local Act Personal's Map of Quality Initiatives. This online "map" helps providers of adult social care navigate the complex quality system. It identifies the organisations responsible for policy, setting quality standards and guidance, along with key frameworks and initiatives that providers need to know about. The map will evolve over time as new organisations or initiatives are added when appropriate. This work follows on earlier work by the National Market Development Forum on the Driving Up Quality briefings.[62]

Gaps in research

Further evidence is needed regarding the reach and impact of the VCSE sector.

"The disjuncture between central Government policy and variation in local delivery needs to be understood, assessed and addressed."[63]

"Clear need for research to better understand and evidence causal mechanisms to show how social enterprise enhances health and well-being, and to explore the impact of social enterprise activity and wider civil society actors, upon a range of intermediate and long-term public health outcomes."[64]

Review theme 2: Sustainability and capacity of the VCSE sector

To understand how sustainability and capacity play out across the sector, it is essential to differentiate between the different types of organisations. The sector includes frontline and infrastructure organisations, large national and international charities, local charities and community groups, social enterprises with community roots and spin-outs from the NHS and social care.

"We have had some interesting discussions about language in the course of this work. It may be semantics, but it has been argued that the use of the term 'voluntary sector' is unhelpful, suggesting as it does that the sector consists primarily of volunteers. In fact, as anyone working with or in it will quickly realise, the charity sector relies on large numbers of highly qualified and deeply committed staff. What voluntary, community and social enterprise organisations have in common is their motivation and commitment to a mission,

[61] Social Investment Business response to the Health VCSE Review, February 2015
[62] Think Local Act Personal, Map of Quality Initiatives
[63] Social Investment Business response to the Health VCSE Review, February 2015
[64] Roy, M et al, The potential of social enterprise to enhance health and well-being: a model and systematic review, Social Science and Medicine, 123 (2014) 182-193

and we are therefore inclined to prefer the term 'not for profit' when talking about the sector in future."[65]

Rising demand – The VCSE has experienced an increase in demand for its services due to changes and cuts in statutory provision as well as the demographic challenge of an ageing population.

"With an ageing population, increasing pressures on resources and a greater focus on personalisation, small charities and voluntary organisations are well positioned to support the health and social care sector to deliver essential services."[66]

"The increase in the number of older people means that by mid-2037 one in 12 of the population is projected to be aged 80 or over….A growing number of older people means an increased demand for care to help with multiple illnesses and chronic conditions common in old age.

The number of young adults living with life-limiting conditions is also on the increase and there is evidence of growing numbers of young people with highly complex needs moving from children's services into adult care."[67]

Forms of funding – There has been a change in how government funds the VCSE sector with grants being replaced by contracts. We have also seen the rise of alternative forms of finance. Both these trends represent a challenge for VCSEs.

"VCSEs are seeking to meet rising demand for their services with reduced government funding. The shift from grants to large contracts and payment by results presents particular challenges for VCSEs."[68]

"The median amount of finance sought by social enterprises was £58,000 – below the minimum thresholds of many specialist social investment vehicles."[69]

"There may be opportunities for larger spin-outs to lend to smaller social enterprises using a peer-to-peer model. Resources could also be pooled through a special purpose vehicle (an Industrial and Provident Society or Limited Liability Partnership)."[70]

"Issues that investees encounter include:

1. Organisational lack of commercial skills.
2. Failure of Board to challenge the Management Team.
3. No independent Board.
4. Lack of (financial and commercial) skills in the Management Team.
5. Financial governance.
6. Financial planning and control.

[65] VCS Engage, Norfolk, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015
[66] Kent County Council and Kent Clinical Commissioning Groups, 2014-15, STAMP Programme Overview
[67] Hospice UK, Joint review of health and care sector investment in VCSE organisations – Response, March 2015
[68] NCVO & Compact Voice, Health VCSE Review: background paper, 2015
[69] Social enterprise UK, The people's business – state of the social enterprise survey 2013
[70] Social enterprise UK, Spin out, step up, June 2013

7. (Over optimistic) forecasting of revenue generation.

8. Establishing viability of debt servicing.

9. Reliance on a single unsuccessful product or service.

10. Not understanding / responding to changes in the commissioning environment.

11. Not being able to develop new income generation.

12. Not being able to conduct appropriate remedial actions to ensure survival and recovery during periods of difficulty. ”[71] “

There are now new investment readiness funds for the sector (such as £10m Big Potential Breakthrough and £10m Big Potential Advanced), a range of specialist support providers building a track record and evidence base around the organisational development needs of the sector, and a growing number of new investment

deals being made and contracts being delivered for social impact…Time, resource and space needs to be provided to develop approaches such as payment by results vehicles, alliance contracting, etc.”[72]

Access to finance – Limited access to finance is a significant barrier to VCSEs taking on public service contracts as prime providers. Despite more certain income streams, public sector spin-outs also face challenges when seeking investment.

“VCSE organisations typically lack access to the financial capital required to become a prime provider and as members of supply chains can be ill-equipped to negotiate a fair share of the contract value from a large private sector provider. This has implications for the diversity of future public services markets when it results in VCSE organisations withdrawing from providing the service or going under, as has happened to some organisations under the Work Programme.”[73]

“Public service ‘spin-outs’ are fortunate to have a relative degree of certainty to income streams compared to the wider SE sector. However, they do face challenges in building up balance sheets and asset base from a standing start. However, as the City of London describe “Public sector spin-out investment opportunities are of interest but are viewed as risky…clarity over contracting arrangements for spin-outs…is vital to reassure investors in the business proposition.””[74]

Commissioning and procurement practice – VCSEs can be prevented from participating in public service markets by the multiplicity of commissioning authorities and the resulting variability in practice and quality that entails. Commissioning and procurement can be particularly poor for cross-cutting issues and groups.

“Commissioning practices are often characterised by a focus on cost and price instead of quality and added social value, short timeframes, limited opportunities for dialogue, and disproportionate paperwork.”[75]

“Intelligent commissioning would be conducted by appropriately skilled people with relevant sector expertise and through effective partnership with practitioners, children and

[71] Social Investment Business response to the Health VCSE Review, February 2015
[72] Social Investment Business response to the Health VCSE Review, February 2015
[73] NCVO & Compact Voice, Health VCSE Review: background paper, 2015
[74] Social enterprise UK, Spin out, step up, June 2013
[75] NCVO & Compact Voice, Health VCSE Review: background paper, 2015

families in the design and delivery of the services. It should utilise a full range of tools, of which procurement may be one element. Recognition of the value of discretionary public sector grants as low-bureaucracy creative investment tools that nurture non-statutory community activities and promising local social entrepreneurship. The acknowledgement and sharing of risks between commissioning authorities and providers that does not prevent local community and voluntary groups from being able to participate."[76]

"A lack of consistency of approach between CCGs, with different processes, requirements and objectives. This is a particular concern where hospices work with a number of commissioning bodies: providing different data,

responding to different objectives and requirements adds to the burden for organisations that are, in a vast majority of instances, not receiving anywhere approaching full funding."[77]

"There is an acknowledgement that the (social enterprise) sector can compete on delivery but not on bidding. The sector is also disadvantaged when commissioners require a guarantee against the failure of a provider to deliver a service."[78]

"Need for clarity about where commissioning responsibilities lie for cross-cutting issues such as violence against women and girl services, where funding responsibility falls between CCGs, local authorities and Police and Crime Commissioners."[79]

Staffing capacity – Short term contracts, which do not cover core costs and require regular retendering, place significant pressures on VCSEs and their staff.

"One social enterprise spin-out reports that "Where you have to deliver on contract numbers, it's very difficult to free existing people for new roles."[80]

"More than half of hospices (53%) surveyed reported an increase in staff time taken up or additional costs incurred in responding to commissioning or contracting requirements. An increase in costs and the uncertainty of funding is impacting on services to patients, with some hospices reporting reductions in some services, keeping staff vacancies open longer to make savings or halting service expansions and innovations."[81]

"VCSE organisations have responsibilities just like any other employer, and although contracts may ultimately – often at very late notice – be renewed or rolled over from one year to the next, the continued uncertainty impacts on the retention of experienced qualified staff. Existing hand to mouth, as many VCSE organisations do, does not favour effective business planning."[82]

"Low wage employment in any sector is a 'false economy' that keeps welfare bills high and embeds unsustainable business models into our economy, reliant on 'invisible' state subsidy. Such forms of employment include zero-hours contracts, agency and casual work."[83]

[76] Children England and TUC, Declaration of interdependence, July 2014
[77] Hospice UK, Joint review of health and care sector investment in VCSE organisations – Response, March 2015
[78] Social enterprise UK, Spin out, step up, June 2013
[79] Regional Voices & National Voices, The Voluntary and Community Sector and Localised Health Commissioning, What are the issues and how can we start to address them? 2015
[80] Social enterprise UK, Spin out, step up, June 2013
[81] Hospice UK, Joint review of health and care sector investment in VCSE organisations – Response, March 2015
[82] VCS Engage, Norfolk, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015
[83] Children England and TUC, Declaration of interdependence, July 2014

Collaboration and consortia – There is consensus about the importance of working collaboratively and a range of effective partnership approaches are being used. The interest in forming consortia is gaining momentum but there are challenges.

> "There does need to be a space for strategic conversations to take place between providers and commissioners, although there is no single answer as to the best way to do this. There need to be honest conversations about the benefits for both sides, as well as the cost of supporting that engagement."[84]
>
> "The Commissioning Assembly could be a useful forum to engage in a collective conversation with VCS infrastructure/ umbrella bodies, as it brings together leaders from CCGs, Area Teams and NHS England. Its purpose is to build collective leadership, co-produce national strategy, think about future direction and influence as a collective system. There are 15 working groups within the Commissioning Assembly and further rapid reference groups which test new and emerging ideas."[85]
>
> "Consortia are often suggested as a means by which smaller-scale providers can access contracts. However, they carry their own challenges. For example, it is still necessary to find a prime willing and able to carry the associated risk, which may not always be possible. Furthermore, due diligence may require the prime, often a much larger organisation, to gather commercially sensitive information from subcontractors which can deter those organisations from participating."[86]
>
> "SEUK, among others has suggested that joint ventures and other partnerships may be vehicles for enabling expansion."[87]

Gaps in Research – More information is needed on the funding of health and social care VCSEs.

> "The development of data sets to provide a fuller more accurate picture of financing needs of health and care spin-outs, particularly around profitability where there is currently little or no data."[88]
>
> "The sector should take ownership of its own data collection, seeking support from the Mutuals' support programme."[89]

Review theme 3: Equality and health inequalities

The written submissions contained limited evidence on this theme. There will be a need for a concerted call for evidence in this area in the next phase of the review.

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[84] VCS Engage, Norfolk, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015
[85] Regional Voices & National Voices, The Voluntary and Community Sector and Localised Health Commissioning, What are the issues and how can we start to address them? 2015
[86] VCS Engage, Norfolk, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015
[87] Social enterprise UK, Spin out, step up, June 2013
[88] Social enterprise UK, Spin out, step up, June 2013
[89] Social enterprise UK, Spin out, step up, June 2013

Supporting marginalised groups – Many VCSE organisations have their roots in small geographic areas, have grown out of a specific unmet need or tackle discrimination faced by people based on their protected characteristics.

"The needs of some communities are not being fully understood (e.g. each JSNA does not pick up the needs of each community). The groups that are affected by the issue are not involved in commissioning decisions locally (e.g. shaping pathways) - so little co-design to impact on issues. These difficulties can be more pronounced for organisations with a larger geographic footprint, which need to deal with more than one set of commissioners. Often these are condition specific organisations- but also equalities groups, and have in common that:

- nationally they work with a significant community
- small numbers of people locally
- they do not all fall under the remit of NHS E's "specialised commissioning" or commissioning of a pathway is split between specialised commissioning and local commissioning."[90]

"A strong evidence base shows that LGB&T people are disproportionately affected by a range of health inequalities, including poor mental health and higher risk of self-harm and suicide; increased prevalence of STIs including HIV; increased use of alcohol, drugs and tobacco and higher likelihood of dependency; increased

social isolation and vulnerability in old age; and poor access to services, including severe delays in access to specialised gender identity services for trans people."[91]

"Recent research has found that the LGBT VCSE has been particularly hit by the impact of austerity (TUC and London Metropolitan University, 2014)."[92]

"Duties under the Equalities Act and new equalities and patient and public involvement duties introduced by the Health and Social Care Act 2012 could form the basis of a focus for national work such as the strategic partnership. This might include longer term awareness raising and capacity building work with local health agencies and charities as well as reactive work to help ensure ministerial priorities and new policies take into account the needs of the diverse groups the sector represents. Building the programme around these more tangible concepts may also support longer term contracts and support well planned and evaluated work addressing some of the issues highlighted in the sections below on sustainability and capacity and inclusion and equality."[93]

"Studies on social enterprises reported a key outcome was the reduction in the public stigmatisation of marginalised groups, eg. People living on the street, those with mental health problems or ex-offenders. It was found that social enterprises provide a window of opportunity for mutual understanding and interaction with the community…..and play a critical role ….demonstrating that members of such groups can be capable, productive workers and members of society."[94]

"(Social enterprises) are far more likely to be led by women; 38% have a female leader compared with 3% of FTSE 100 companies, 91% of social enterprises have at least one woman on their leadership team. 15% of social enterprise leaders are from Black, Asian

[90] Regional Voices & National Voices, The Voluntary and Community Sector and Localised Health Commissioning, What are the issues and how can we start to address them? 2015
[91] National LGBT Partnership, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015
[92] National LGBT Partnership, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015
[93] NCB, Submission to the Joint review of health and care sector investment in Voluntary Community and Social Enterprise organisations, 2015
[94] Roy, M et al, The potential of social enterprise to enhance health and well-being: a model and systematic review, Social Science and Medicine, 123(2014)182-193

and Minority Ethnic (BAME) communities; 28% have leadership teams with BAME directors."[95]

Geographical distribution of VCSEs – There is difference between urban and rural areas. In some regions the size of organisations tends to be smaller with few national charities located there.

"Across the country, local authorities have responded to reduced funding levels in different ways, meaning that there is regional variation in terms of funding and support for LGB&T VCSE organisations. This has an impact on the capacity of the LGB&T sector in different parts of the country and raises the serious challenge of sustainability in areas where funding is significantly reduced.

The limitations of the localism agenda for communities of identity, particularly those who are non-geographically specific, means that the standard model of service provision is not working for many LGB&T people. A new way of working across geographical boundaries, with genuine collaboration between sectors, is needed to fully integrate and tailor services to meet the specific needs of LGB&T people. Not all organisations are locality-based, with many specialist organisations working across non-geographic communities (e.g. sexual orientation and/or gender identity work), and even delivering much of their work virtually, online or via nationally available helplines."[96]

Gaps in research - More information is needed on the funding environment for VCSEs focussed on equality and health inequalities.

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Annex four. Distinctive VCSE Health and Social Care Offer

Cabinet Office, New Philanthropy Capital and NCVO
March 2015

Introduction

The recently published Five Year Forward View sets out a number of key challenges currently faced by the health and social care system, and outlines some important priorities to tackle these over the next five years. As the Forward View itself recognises, the voluntary, community and social enterprise (VCSE) sector has an important role to play in meeting some of these challenges.

Working closely with beneficiaries (including those with multiple and complex needs), being rooted within communities, and sitting outside the clinical health system means that VCSEs are often uniquely well placed to deliver better health and social care outcomes. The following paper sets out four key challenges, discussed in the Forward View, that the VCSE sector is well placed to tackle:

1. Increasing the efficiency of the NHS
2. Tackling demand
3. Maximising the potential of patients and communities
4. Developing new models of care that are fit for the future

Increasing the efficiency of the NHS

The Forward View warns that the NHS is facing a possible deficit of £30bn by 2020. Delivering better value for money is therefore essential - both within the NHS and within social care which also faces severe local authority cost saving pressures.

VCSEs can often deliver better value for money, in a number of ways:

- Delivering wider social, economic and environmental benefits which in turn support better health outcomes, ultimately leading to cost savings for the commissioner;
- Taking a person-centred approach which can take better account of 'whole person' or lifecycle costs, enabling services to be more holistically and accurately costed;
- Using their unique proximity to and understanding of certain patient groups, and their understanding of the 'whole person', to help commissioners design more fit-for-purpose services that waste less money;
- Delivering services with a focus on prevention that reduce pressure on the more expensive parts of the system, for example acute healthcare services, and also prevent further expenditure on remedial services at a later date;
- Mobilising volunteers, which can often result in significant cost savings

Delivering wider social value - Start in Salford:

- Start in Salford is contracted by Salford CCG.
- Its Inspiring Minds programme supports vulnerable people to build confidence and self-esteem through participation in creative activities delivered by professional artists,

including for example visual arts, photography, gardening, or woodwork. The project helps people to move into pathways including employment, volunteering, leisure activities, or education.
- It also offers a weekend project supporting disabled children and their siblings.
- Start has conducted an SROI report, which has estimated Social Return on Investment of between £6 and £10 for every £1 invested.

Designing fit-for-purpose services - the Royal National Institute for the Blind (RNIB):

- In Bristol, the RNIB, working with commissioners, provided evidence on the prevalence of sight loss and the most cost-effective interventions for reducing blindness, which was used to support the case for the new patient support service in Bristol Eye Hospital and to defend cuts to the rehabilitation service.
- The RNIB has also developed the Sight Loss Data Tool to help health and wellbeing boards map the local needs of blind and partially sighted people and those at risk of sight loss.

Tackling demand

The pressure on acute health services has been well documented. The Forward View makes a call for a greater focus on prevention. It also discusses several acute 'pulls' on demand, including an ageing population, an increase in long term conditions, a challenging public health context, and areas such as mental health where provision is not currently sufficient.

VCSEs are often rooted in communities and have a good understanding of the wider factors that might affect demand on health services - the social and economic determinants of demand. This provides VCSEs with greater scope to reduce demand for health services by shaping and delivering services that tackle some of the wider factors that cause this demand.

This understanding of demand, and sitting outside of a clinical setting, also provides VCSEs with greater scope to focus on prevention – both in terms of their own services but also in terms of their role in helping commissioners to design services.

Through the Cabinet Office and NHS Tripartite funded Reducing Winter Pressures Fund, seven VCSE organisations are being funded to scale up and robustly evaluate social action programmes aimed at reducing avoidable hospital admissions, readmissions, length of stay, and use of A&E. Westbank Community Care, based in Exeter, is mobilising volunteers through its Neighbourhood Friends scheme which enables socially isolated people aged 75 and over to live as part of the community and stay connected to those around them, reducing their reliance on medical and social care interventions. Volunteers provide practical support, transport, assisted shopping, and befriending in individual's homes. In addition, they refer and support people to access the range of other VCSE support available in Exeter, including benefits advice and lunch clubs. Full evaluation of these projects will be completed in July

2015 but early indications are promising in terms of the impact the programmes are having on use of services.

Emmaus is a federation of social enterprises that offers homeless people a home for as long as they need it, as well as meaningful work in a social enterprise. They say that doing this helps to restore self-esteem that is often lost when someone is homeless and provides stability that makes it more likely an individual can overcome homelessness long term.

Emmaus seeks to secure a range of better outcomes, including fewer rough sleepers, reduced pressure on statutory services from homelessness, fewer people on housing lists, fewer people claiming benefits, reduced substance misuse, reduced crime, and fewer health problems.

Clearly, a number of these outcomes will also impact on health, and Emmaus has recently calculated savings of £1,478,506 to the Department of Health in reduced NHS and emergency costs.

The Food Loop is a project in the Maiden Lane estate in Camden. It uses volunteers to collect the food waste, composts it on site, and uses it as fertiliser to grow flowers, fruit and vegetables on the estate. This is an innovative, community based approach to reducing food waste whilst at the same time improving difficult to tackle health behaviours such as healthy eating and exercise, and reducing loneliness and isolation by bringing together residents to volunteer.

Maximising the potential of patients and communities

The Forward View talks about the need to fully harness the "renewable energy" of patients and communities, given the pressure on services and spending. It also observes that the line between patient and clinician is changing, with the potential for more informed and better engaged patients who will have even greater potential to improve health outcomes.

Maximising the contribution of service users

Patients are underutilised as a resource to improve health outcomes. VCSEs have an important role to play in maximising this potential contribution from service users, in two main ways:

a) Facilitating user voice in commissioning decisions and in monitoring and evaluation to ensure services are fit-for-purpose and effective;
b) Delivering services that promote self-care and peer support.

Diabetes UK has formed a partnership with Cambridge University Hospitals to scale up a peer support programme aimed at managing diabetes and associated conditions such as heart attack and stroke.

The peer support programme engages people who have recently been diagnosed with diabetes with Peer Support Facilitators – volunteers from the local community who have longer experience of living with diabetes and have good control of their condition. Peer Support Facilitators are given training to facilitate peer support groups and provide encouragement for those recently diagnosed to adapt their lifestyle, diet, and exercise regime to manage their diabetes well.

Each group is linked with a Diabetes Specialist Nurse who provides clinical support to the group and also gets involved in recruiting and training the Peer Support Facilitators. Alongside GPs, the Diabetes Specialist Nurse plays a crucial role in promoting the programme and encouraging people living with diabetes to take part.

Diabetes UK aims to recruit 284 Peer Support Facilitators, reaching 5,000 to 7,000 people living with diabetes in eight CCG areas by the end of 2015.

While findings are awaiting peer review, a Cambridge University Hospitals RCT has shown that the peer support facilitation model can lead to a 2-4% reduction in diabetes–related deaths and a 4-6% in reduction in incidence of stroke.

Leicestershire Community Projects Trust is a project based in GP surgery waiting rooms which assists mentally ill substance users to tackle their addictions and access appropriate care for their mental illness. The Office for Civil Society Rehabilitation Social Action Fund has funded a peer mentor project. The interim evaluation is positive and suggests that the peer mentors also benefit from improved mental health as a result of participation in the project.

Maximising the contribution of communities

It is well documented that most patients - even those with long term conditions - will spend the vast majority of their time outside of formal clinical settings. Tapping into the informal support networks that exist within communities therefore has great potential to improve outcomes for patients.

Mobilising citizens alongside and in health and care services is not a new phenomenon. There is a long history in the UK of people helping people alongside public services, from the faith–based volunteering organisations of the 19th century, such as the St John Ambulance Association, to the Voluntary Aid Detachment nurses formed in the years prior to the First World War, to the hospice movement. Social action or volunteering can include, for example,

small acts of kindness and neighbourliness, one–off volunteering in a time of crisis or in response to a specific request, through to regular, formal volunteering.

Volunteering also often has positive impacts on the volunteers' own health and wellbeing.

About 670,000 people in England are living with dementia and this number is expected to double over the next 30 years. The financial and social impact is significant – it costs the NHS £1.3 billion each year and two–thirds of people living with dementia do not feel part of their community.

Launched in February 2013 by the Alzheimer's Society, Dementia Friends aimed to create one million Dementia Friends by March 2015. People can become a Dementia Friend by attending a 45 minute face–to–face session, or by completing a ten minute online session – both of which are free. At the end of the information sessions, new Friends are encouraged to consider a number of ways they could lend their support through social action, from making efforts to visit a friend or relative living with dementia to making a commitment to volunteering.

The target of a million was reached in February 2015.

Reach to underserved and specialist groups

Part of the reason that VCSEs are ideally placed to mobilise service users and the wider community is that they often work directly with underserved and specialised groups, often providing services to communities which may be harder to access via mainstream clinical routes.

The Hayaan Project was launched in October 2010 by mental health charity Mind. It was developed from the Somali Mental Health Advocacy Project, which was a research based project funded by the Kings Fund for three years.

The term 'Hayaan' in Somali is a nomadic term to mean 'moving on to a better place'. The project offers an innovative approach, recruiting and training a team of 'peer educators' from the local Somali communities to help increase awareness of and access to mental health support to the wider Somali community living in Harrow.

The Hayaan Project aims to help reduce the sense of isolation experienced by Somalis with mental health difficulties, help increase wellbeing and self-confidence of Somali mental health service users, and provide advocacy and interpreting support to Somali mental health service users to help them understand and access mental health and other social welfare services.

A social impact report is available for the project and reports a number of positive outcomes, including better than expected results for volunteer rates and self-reported reduction in isolation / increase in mental wellbeing.

Developing new models of care

The Forward View places an important emphasis on developing new models of care that are fit for the future. Key areas of focus include:

- Removing arbitrary or historical barriers between different parts of the health and care system;
- More community or out-of-hospital care;
- Greater emphasis on services co-ordinated around the whole person; and
- Looking at new or innovative models.

Integration of different parts of the system

Occupying a unique position between the system and beneficiaries, VCSEs can play a useful role in joining up different parts of the system and breaking down some of the barriers described in the Forward View. For example, a VCSE might provide a useful link in the transition between a patient's immediate acute care and longer-term community based care.

A consortium of Devon based statutory and VCSE partners have recently been awarded Transformation Challenge funding from the Department for Communities and Local Government to generate a cross organisational workforce moving key frontline posts to single, common roles across agencies.

New voluntary sector roles will be developed to facilitate a more integrated response in our high-risk categories. Patients identified at moderate risk will benefit from support through community based wellbeing networks to deliver alternative and early intervention services.

A number of entrepreneurs from within the VCSE sector are creating innovative 'start-ups' in response to gaps they recognise in healthcare provision. Many of these start-ups are being accelerated by social incubators, such as Bethnal Green Ventures, Wayra UnLtd, and Health Social Innovators' Fund.

Health Social Innovators', a collaboration between Healthbox, Numbers for Good and UCLB, recently completed its first programme. Among the start-ups supported by Health Social Innovators is Sensewheel, which has created a lightweight wheel for wheelchair users with embedded technology to measure how the wheelchair is being utilised.

More community or out-of-hospital care

VCSEs usually work in a non-clinical setting, are rooted within their communities, and support beneficiaries with a wide range of issues that may impact (and be impacted by) health. This often enables VCSEs to design and deliver community based care.

First Step Trust is a charity which runs a number of social enterprises employing people with mental health problems and other disadvantages. First Step Trust operates a number of garages, as well as cafes and caterers in London and Sheffield, a design and print company in Manchester, and grounds maintenance, gardening and decorating businesses in London and on Merseyside. Providing work which comes with responsibility and opportunities for development is a non-clinical approach to helping people with mental health difficulties stay well. The approach has seen a number of successes: in 2013-14 it helped to move 30

trainees into further full time jobs and 12 into part time jobs with continuing support, and enabled 94 trainees to gain a total 142 qualifications.

Salford Social adVentures is a social enterprise. It is contracted by Salford City Council to deliver their mental health and horticulture recovery programme. Social adVentures employs mental health service users in their garden centre. Service users are able to work in a revenue-earning enterprise which is strongly rooted in the local community - for example, the garden centre hosts a number of community events and runs a community magazine.

Co-ordinating services around the whole person

VCSEs are often adept at taking a person-centred approach. Their work tends to focus on an understanding of the whole person, and a person's full lifecycle, rather than focusing just on a medical need or on the point at which there is a state or clinical intervention (which might see the person in relation to a specific part of the system).

As health has such an influential relationship with other social outcomes, taking this person-centred approach can often help to secure better health outcomes. This will often have a direct impact on the wellbeing of the service user and the cost of providing support, particularly for the service users with the most multiple and complex needs who might touch several parts of the system at once.

The Big Lottery Fund *Fulfilling Lives: Supporting people with multiple needs* programme funds 12 projects around England which bring together different organisations and services to offer individuals with multiple or complex needs one co-ordinated support service that meets all their needs. The programme aims to build evidence about how services can better support individuals with a combination of homelessness, reoffending, problematic substance misuse and mental ill health, to prevent the problem of these individuals rotating through various welfare and justice systems which can often deepen the problems in their lives at a cost to both the individual and wider society.

Annex five. Measurement Gaps

Cabinet Office, New Philanthropy Capital and NCVO
March 2015

Introduction

Measurement has a number of important functions for VCSEs and funders/commissioners working in health and social care, including:

- Supporting the development of an intervention, for example understanding what works for whom;
- Building an evidence base for effective interventions (if evaluations are shared);
- Supporting the growth of innovative models and testing whether they work;
- Ensuring that resources are spent in the most effective way.

The following paper outlines the key challenges experienced by voluntary, community, and social enterprise (VCSE) organisations seeking to measure and demonstrate their impact specifically in a health setting.

Needs analysis

Being able to map health needs is important for VCSEs, as it can allow them to focus their work where it is needed most, tailor their interventions effectively, and make a case to commissioners. VCSEs will often have a good level of understanding around need stemming from their close proximity to and direct work with beneficiaries. However, VCSEs will often struggle to back this up with robust evidence and make a compelling case to commissioners.

This is because VCSEs often struggle to access and use the data they need. Many VCSEs are not aware of the Health and Social Care Information Centre (HSCIC), which is the national provider of data for health and social care. If VCSEs are aware of the HSCIC, they often find it difficult to navigate and make use of the data sets available within it.

Further work by sector infrastructure bodies might look at both promoting the HSCIC as a data source and also supporting VCSEs to make use of this resource, for example by producing a short VCSE focused guide to the HSCIC.

Data sharing

Some VCSEs have reported difficulty in accessing the patient data they need to ensure they are providing the most appropriate support for the patients they see. This often stems from a difficulty in sharing patient data between CCGs and VCSEs, and results in risks - for example from patients not being seen by an appropriately trained member of staff at the VCSE.

To tackle this, further investigation is needed into what would better facilitate data sharing - for example, into the required levels of consent that would allow this to happen.

Analytical capability

Being able to evidence the effectiveness of their work is another challenge for VCSEs working in health. It can be difficult for a VCSE to access the data and have the analytical

capability to make a robust case that a specific intervention led to a quantifiable outcome (such as reducing hospital admissions).

To tackle this problem, New Philanthropy Capital has been funded by the Cabinet Office to investigate with the HSCIC the business case for developing a health analytical service. The service would allow VCSEs or other providers to send in information about a cohort of beneficiaries they have supported, and compare outcomes for these beneficiaries against outcomes for a control group who have not been through that specific intervention. It therefore provides a means to understand and demonstrate the effectiveness of specific interventions on secondary care.

Outcomes frameworks

Many VCSEs use the NHS, public health, and adult social care outcomes frameworks as a basis for measuring their impact, because they understand that these frameworks are also used by health commissioners. However, many VCSEs find it difficult to access the data relating to these outcomes.

There is a growing library of measurement tools available to help organisations in measuring their impact. Links to many of these measurement tools can be found on the Inspiring Impact Hub (http://inspiringimpact.org/listings/). This is a sector collaboration of umbrella organisations such as NCVO and ACEVO and measurement specialists, which is managed by NPC and was funded in its first two years by Cabinet Office.

There is also a growing library of unit costs and financial proxies that VCSEs can use to measure their impact against specified outcomes, including:

- New Economy unit cost database: http://neweconomymanchester.com/stories/832-unit_cost_database
- Personal Social Services Research Unit unit cost database: http://www.pssru.ac.uk/
- The Housing Associations' Charitable Trust (HACT) list of financial proxies: http://www.hact.org.uk/social-value-bank

Further work by sector infrastructure bodies may be required to increase awareness of these resource amongst VCSEs.

Investment in leadership and skills

Impact measurement is a growing field, with increasing instances of good practice within the sector. However, it is important for the sector to invest in further building capacity in this area, and for sector leaders to take a role in leading a shift in culture towards providing robust evidence of impact.

Behaviour and expectations from funders

There is currently a degree of variation in what evaluation is expected from VCSEs by funders, including commissioners (for example CCGs and local authorities) and philanthropic foundations.

As well as helping funders and VCSEs to really understand the impact of their work, evaluation requested by funders is also a helpful way to build capacity in this area within the sector, and to promote a culture shift whereby robust evaluation is seen as central to VCSEs' work, rather than as an 'add on'.

It is important for commissioners to make proportionate demands for evidence that are supported by the development of standardised clear metrics that all VCSEs can use. Considering social value can also help commissioners understand the wider value that VCSEs are often well placed to provide.

Annex six. VCSE Health review: An Independent Funder Perspective

The Lloyds Bank Foundation in collaboration with Calouste Gulbenkian Foundation, City Bridge Trust, Comic Relief, Esmée Fairbairn Foundation, Lankelly Chase Foundation, The Association of Charitable Foundations, The Henry Smith Charity and The Tudor Trust. February 2015

The Department of Health, NHS England and Public Health England are conducting a review into how they work with the VCSE (voluntary, community and social enterprise) sector. They want to understand how statutory funding and commissioning affects the sector and ultimately, health and social care services in England. As part of this review, eight foundations and the Association of Charitable Foundations have come together to offer a foundation perspective. Using their knowledge and experience of working with thousands of charities delivering different services across the country, foundations are well placed to see how charities, services and commissioners are impacted by statutory funding frameworks. In this paper they offer advice to commissioners about how identified problems may be overcome, namely through a more flexible funding mix that allows the right funding to be provided in the right way to the right service to meet the right needs.

- VCSEs are essential to the delivery of better health and social care outcomes.
- Small and local VCSEs provide person-centred care that can be central to effectively meeting health and social care needs, especially for the most vulnerable.
- Current commissioning is not suited to small and local organisations so they are facing decreased funding at a time of increased demand for their services.
- This risks excluding those with complex needs from receiving effective care.
- A more flexible funding mix is needed to allow different funding approaches to fund different types of projects to meet different health and social care needs.
- This more flexible funding approach would ensure small and local organisations survive and thrive so they can deliver essential health and social care services that meet the demands of those who need them most and reduce health and personal costs.
- Grants offer a more flexible funding approach that could be used more widely in a more diverse funding mix to bring better health and social care outcomes by ensuring the sustainability of small and local organisations.

The top 300 foundations[97] account for 90% of all UK foundation giving and provided £2.4billion of funding to the VCSE sector in 2012/13. Almost 40% of Association of Charitable Foundation members reported funding in health and/or social care with a significant proportion funding in both[98]. Figures from the NCVO Civil Society Almanac also show that over £800m was given by the voluntary sector to health and social care charities in 2011/12, much of this through foundations[99]. Through providing this support foundations have valuable insights into what works in supporting health and social care needs. They also share the government's wish to see a thriving and effective VCSE sector and are keen to

[97] Foundations is used to refer to all Independent Funders as defined by the Association of Charitable Foundations

[98] Giving Trends: Top 300 foundations 2014 report (Association of Charitable Trusts, 2014)

[99] The UK Civil Society Almanac (NCVO, 2014)

offer their experience of funding that could result in better health outcomes in fiscally constrained times, and welcome the opportunity to contribute to this review.

The VCSE sector forms an essential part of health and social care. The majority of these organisations are small and local[100], who in themselves carry out vital services especially in terms of reaching the most vulnerable; without these small organisations' expertise and reach, many health care interventions would fail those who need it most. While these small charities often receive a proportion of their funding from foundations, many also rely on statutory funding[101] in order to survive. These organisations are losing out as statutory funders (including central government, local government, CCGs and local commissioners) increasingly use contracts to fund health and social care services.

In 2011/12, more than 80% of statutory funding in the VCSE sector was in the form of contracts for delivering services, rather than grants to support organisations' work. This represents a significant rise since 2000/01 when 49% of statutory funding was through contracts[1]. For many charities, this has led to a decrease in available funding set against a period of increasing demand for their services. Many in the sector believe the emphasis on large scale contracts is detrimental to the funding mix and the sustainability of both VCSEs and the delivery of health services that foundations support because small and local charities have been unable to compete - this presents a considerable risk to delivering better health outcomes as the services they deliver are so important.

Government needs to find a way to ensure effective small and local charities can not only survive but thrive if health and social care issues are to be tackled effectively: Government cannot reach everyone without them. Foundations believe a more flexible approach to statutory funding offers a solution and this more flexible approach could be delivered by increasing the role of grants within an effective funding mix. It is this flexibility that would allow government to ensure the right funding approach is used to support the right projects which address the right needs.

This discussion paper sets out how a more flexible public funding approach could lead to better health and social care interventions. It focuses on how grants can provide the flexibility needed and can be used to overcome some of the problems stemming from the drive for contracts and scale[102] in order to achieve better health outcomes.

Achieving better health outcomes: the importance of small and local

Local, small scale and person-centred for better outcomes

There is increasing recognition of the value of holistic services in addressing health and social care issues.[103] Small and local[104] organisations often reach individuals in a flexible way, ensuring they receive more holistic support by considering all the inter-connected issues an individual is facing and supporting them all rather than delivering single issue health outcomes. These organisations represent a significant number of VCSEs. Over 97% (156,463 voluntary organisations in the UK) have an income of less than £1m. These organisations are often best placed to provide the person-centred support which is central to

[100] Organisations with less than £1m income; The UK Civil Society Almanac (NCVO, 2014)
[101] Statutory funding includes central government, local authorities CCGs and other local commissioners
[102] Health VCSE Review: NCVO & Compact Voice Background Paper (2015)
[103] Integrated Care and Support Pioneer Programme: Annual report 2014 (NHS England, 2014)
[104] Throughout this paper 'local' refers to small, local charities and federated charities that are locally embedded.

the government's *Think Local/Act Personal* policy yet they are rarely included in the commissioning process.

Inherent within this person-centred approach is the recognition that better health outcomes are often a result of wider interventions that combine both health and social care. These are often dependent on whole-person interventions that involve wider social problems such as substance misuse, social isolation in older people, domestic violence and homelessness. Addressing these issues together can reduce demands on health services overall as interventions are more successful.[4] The Pathway project at University College Hospital, which was set up with funding from University College London Hospitals Charity, is an excellent example of this.

> *Case study: Pathway*
> Pathway is a charity which works with single homeless people in hospitals to provide joined-up care and reduce re-admittance to hospital for the 70% of homeless people who are discharged from hospital and end up back on the streets, who then face further damage of their health and further costs for the NHS[105]. Originating in University College Hospital in London, the approach led to a decrease in the number of bed days for homeless people from 2008-11. This was attributed to improved case coordination and discharge planning through multi-agency working and was estimated to save £100,000 per year[106]. The model has since been replicated in other hospitals and is currently being piloted with JustLife, a medium sized charity based in Brighton and Manchester, to reduce demand on ambulance services and A&E. The early results are encouraging.

Social value

Pathway demonstrates the benefits of a person-centred approach, both financially and for individuals. By tackling all the issues a person faces, considerable health, social and financial saving can accrue. This chimes with the essence of the Social Value Act which allows funders to assess programmes on their total value rather than their cost of delivering single outcomes. But as funders, many of us are concerned that the wider benefits which the Social Value Act aims to address are being overlooked by a narrower focus on short term commissioner-specific costs and benefits.

> *Case study: Rotherham Social Prescribing Service*
> Run by Voluntary Action Rotherham on behalf of NHS Rotherham CCG, the programme is part of a wider Integrated Case Management Programme in primary care. It works with mainly older people who have long term conditions. They offer a range of non-clinical support through partner charities to improve health including through providing advice and information, dementia services, befriending and community engagement groups. Evaluation of the pilot phase indicated c20% reductions in inpatient admissions, A&E admissions and reduced outpatient appointments[107].

[105] Improving Hospital Admission and Discharge for People who are Homeless (Homeless Link and St Mungo, 2012)
[106] A General Practioner and Nurse Led Approach to Improving Hospital Care for Homeless People (British Medical Journal 2012)
[107] Promising Approaches to Reducing Loneliness and Isolation in Later Life (Age UK & The Campaign to End Loneliness, 2015)

The Rotherham Social Prescribing Scheme is another example of the wider health benefits of more social-care focused services. It demonstrates how charities are able to deliver real health outcomes and how commissioners are able to achieve better results both socially and financially, where a more local, integrated approach is taken.

Barriers to better health outcomes: problems facing commissioners

Commissioners are increasingly limited in their ability to fund the small, local charities that have been shown to be an essential component of successful health care services.

Problems with contracting

One size fits all top-down prescribed approaches from government have often failed [108] as they have squeezed the knowledge, experience and services delivered by small and local organisations from health and social care. The government has acknowledged that a new, more holistic approach is required to address health needs, particularly for those with complex needs where public costs are particularly high.[109] Under current systems, commissioners are restricted and often unable to fund projects that best meet the needs of the most vulnerable because their processes are often focused on large scale, single issue interventions.

Need for value

In fiscally austere times, the drive for central and local government to cut its direct costs has resulted in fewer small and local charities receiving public funding to carry out these effective, person-centred interventions whilst at the same time experiencing an increase in demand for their services. The move towards contracts and scale under the assumption of 'better value' has been significant yet value for money doesn't always mean economies of scale and competition and lowest cost does not always mean best value overall. Where large scale contracts fail, overall costs can be higher as people re-enter the health and social care system. Commissioners need more flexibility in how they achieve value, so that large contracts can be used where economies of scale and standardisation are effective at tackling single health issues and other approaches, such as grants can be adopted where issues are more complex.

Grants as a means of overcoming barriers to better health and social care

Grants have been used by foundations, and historically by many local authorities, to successfully support the small and local organisations that are so important in the health and social care sector. Their flexibility can help commissioners to overcome some of the existing barriers to better health outcomes.

Local solutions to local problems

Localised, programme-based funding makes it possible to support small and local charities and meet different needs in different areas. Grant funding would enable commissioners to work with small and local organisations more easily, as well as those working with the most disadvantaged, high cost service users. Grants can operate at different scales, suited to the demands of the organisation they support - foundations in England support organisations of many different sizes, from the micro sized through to the major national charities.

[108] Rob Wilson speech, Centre for Social Justice (January 2015)
[109] Public Health System Group Stakeholder Forum (January 2015)

Enable greater customer focus

Research by the Centre for Social Justice highlighted that 67% of charities were not consulted on the design of services by commissioners[110], despite their inherent understanding of need and what works in their area. By focusing on the purpose of the organisation's work, as grant funding does rather than the prescribed terms of contracts, organisations themselves can establish how to meet needs, drawing from their in-depth understanding of need in their area and how it is best tackled. Grants can also enable greater user engagement in service design whereas contracts typically require commissioners to determine how projects should be run.

Encouraging innovation

Grants often allow creativity to tackle national issues at a local level and accept the risk inherent in focusing on work where the 'answers' are not straightforward. This facilitates a continuous search for better interventions as a means of future-proofing interventions.

Enabling collaboration

While the focus of small programmes is inherently local, they can tackle multiple issues on a national level through collaboration. Collaboration is not encouraged in a competition based environment dominated by the process of competitive tendering and secrecy of contract clauses but can be through grants. The *Making Every Adult Matter* Coalition is a leading example of how effective such collaboration can be, financially and socially, particularly when working with people with multiple needs. It also shows how scale can be achieved through multi-sector coalitions and demonstrates the benefits that can be found when both different providers and different funders work together. Partnership working in this way allows both funders and the funded to rally around a common purpose, rather than forming relationships dominated by the auditing and compliance of commercial contracts.

Case study: Making Every Adult Matter (MEAM)

MEAM is a coalition of four national charities: Clinks, DrugScope, Homeless Link and Mind. It represents 1,600 frontline organisations working in the criminal justice, drug and drug treatment, homelessness and mental health sectors. Through their collaboration, person-centred, holistic services are provided that can result in better outcomes both socially and financially.

Evaluation of its pilot project showed impressive results even after just one year including: up to 26% reduction in service use costs over two years; significant reductions in costs associated with crime; 86% housing situation improvements; 71% consuming less drugs/alcohol; 79% less involved in crime; 57% better mental health. ***111***

The coalition is funded by the Calouste Gulbenkian Foundation, Garfield Weston Foundation and Lankelly Chase Foundation.

The Making Every Adult Matter case study highlights the value of integrated services in delivering person-centred services that tackle health and social issues holistically. This is supported by research into the profile of people facing severe and multiple disadvantage[112]. This partnership approach between funder and funded, facilitated through grants rather than

[110] Social Solutions: Enabling grassroots charities to tackle poverty (The Centre for Social Justice, 2014)
[111] Implementing the MEAN Approach Locally: One year on (Making Every Adult Matter, 2013)
[112] Hard Edges: Mapping Severe and Multiple Disadvantage (Lankelly Chase, 2015)

contracts, focused on shared problems allows flexibility through learning as the work progresses, rather than the strictures of the contract.

Selection and assurance

One of the key arguments supporting the move towards commissioning contracts has been that the process of competition allows commissioners to be discerning and to raise the quality bar amongst those competing for services. Allocating grant funding in itself can also however be discerning, as demonstrated by foundations – only a small proportion of charities succeed in obtaining grants as the process is selective, supporting only the most effective projects. A key difference between this process and that for contracts however is that the decision-making is based on purpose and quality rather than the delivering of specific services prescribed in contracts. The quality of the service funded can also be measured by empowering service users and foundations are increasingly asking for evidence of how the organisations they fund genuinely involve and empower those who they are working with. Allowing service users to rate and stop using services where they don't meet their needs can ensure charities are accountable to those that they serve, rather than being accountable to commissioners per se. This provides assurance that services are meeting needs effectively, as opposed to meeting pre-defined contract terms, and subsequently that commissioners are achieving real value for money.

Through established processes, foundations carry out due diligence checks to manage risk and ensure funds are distributed fairly and effectively. Similarly, despite allowing organisations to establish how projects are run, funders align who they fund with their own strategic priorities. Clear grant terms and conditions provide assurance and direction on how funds are used by grantees and often preclude further applications if these are not met. All of this is done with limited resources by avoiding the excessive bureaucracy that has become inherent in many commissioning processes. For smaller scale projects, trust and a focus on good relationships is central to this. Yet even for Big Lottery Fund, the biggest grant giver in the UK where more stringent processes are required, a strong focus on efficiency means that costs remain modest.[113] Similar checks and balances could be adopted by commissioners as an alternative to contract clauses, where appropriate.

Transaction costs

Making more use of grants does not have to be achieved at the expense of the public purse. Grant making can be less onerous and better value for commissioners. It can allow commissioners to balance appropriate checks and balances with the flexibility needed to tackle complex health issues. As a system, grant funding is less expensive to operate, both for funders and applicants. This means more money can be directed to services. For example, monitoring grants comes at a lower cost than monitoring contracts – when organisations are funded based on their expertise and purpose, fewer resources are required than in policing the strict terms of a contract. Savings can also be attributed to fewer restrictions – grant funding, while allowed under the Health and Social Care Act, is not subject to strict EU procurement rules.

Learning

Foundations use monitoring and evaluation of grant-supported projects to help build the evidence base of what works in delivering health and social care. Through a growing number

[113] Statement about Big Lottery Fund Operating Costs (Big Lottery Fund, 2011)

of funder-plus models, foundations are further supporting charities to build capabilities in this area too and share learning more widely. The monitoring and evaluation of grants can support those organisations delivering the services in question but it also offers wider benefits to the sector. Due to the openness and flexibility offered by grant making, charities are able to learn from each other's experiences, contributing to a stronger and more effective health and social care sector. This is in contrast to contracts, where tight competition discourages collaboration. By enabling charities to establish how best to meet health and social care needs, they are better able to share learning about what works, where and why. This flexibility facilitates more collaboration because they are not competing against others for the opportunity to deliver exactly the same service that has been prescribed in a contract.

Inevitably more work is needed in this area as debates around what constitutes good evidence rumble on but central to this has to be an understanding that monitoring and evaluation must be proportionate to the services delivered. A number of helpful initiatives are already established such as Inspiring Impact and the ESRC's What Works Centres but this work must be progressed further. Through their resources and networks, foundations could be well placed to work with commissioners and other stakeholders in this area to further advance thinking.

Why this matters to Foundations

The charities foundations support need a healthy funding ecology in order to improve outcomes for their beneficiaries - many of these charities also receive some statutory funding. Foundations provide the means for activities which go beyond statutory needs. Both the core statutory services and the additional services supported by foundations are critical to successful health and social care outcomes. Foundations are not in a position to replace statutory funding but do depend on an effective use of statutory resources in order for the charities they support to survive and vice versa. Indeed, statutory and voluntary funding for health and social care are symbiotic: without one, the other will not thrive. As such, foundations have been concerned with the move towards a dominance of large scale contracts in statutory health and social care funding and the problems it is leading to.

Some Conclusions

While foundations have adopted grant making as their primary means of distributing money they recognise grants are not a single solution to addressing health and social care issues in England. They can demonstrate to commissioners, however, that grants are an essential part of a healthy funding mix. Offering a range of funding options at different scales enables the right funding to be sought for the right services at the right scale. The table below highlights the key features of contracts and grants and where they might be most appropriate for different audiences. It does not explore other funding models which also a have a role to play in an effective funding mix but highlights those areas for which foundations have most experience. It recognises that different approaches are needed that align with the needs of the beneficiary group and project.

Table showing the key features of contracts and grants for different audiences

	Contracts – large scale, single issue, lower individual cost	**Grants** – localised, personalised holistic support
For beneficiaries	- Single issue services – may not address all needs if multiple needs are presented - Providers may not deliver personalised care (as focus is usually on lowest cost)	- Integrated, holistic support focused on person – combining health and social care - May be less likely to have to re-enter the system
For VCSEs	- Difficult for smaller organisations to compete; encourages competition, not collaboration - Dictates how services are delivered – doesn't use their expertise - Administrative burden; complicated; costly - Tight timescales	- Can enable local solutions to local problems (smaller scale) - Administratively less demanding - Costs switch to partnership with larger number of funding relationships
For Funders (grant giver/ contractor)	- Outcomes set by commissioners – more control/assurance - Strict EU procurement rules - Costly process for government	- Flexibility in what is funded - Solutions driven by those that understand issues best

There is still more to do to ensure the best health and social care outcomes, including improving collaborative working and agreeing standards of evidence but flexibility in funding is a good start if better health outcomes are to be achieved**.** It is only through a plurality of funding opportunities that a plurality of services can be delivered by a plurality of providers to meet the plurality of need. [114]

[114] Stepping Stones (NCVO July 2014)

Annex seven. Role of Social Investment in sustainability of VCSEs in Health and Social Care

Big Society Capital

Introduction to Social Investment

Over the last 20 years, VCSE organisations have increasingly moved to develop diverse business models and away from full reliance on grant and donation. They are developing revenue streams – via consumer markets, business-to-business sales or public sector contracts –that offer a more sustainable long term model and in turn greater impact. Access to investment capital can help VCSEs develop and scale these models, and the establishment of initiatives, such as Big Society Capital, has taken place in response to those needs.

The UK is at the forefront of innovation in social investment which is helping connect VCSE organisations in need of capital with socially motivated investors. A range of social providers of finance are emerging across the country and helping to support VCSEs. Although grant funding will continue to play a role for the sector, social investment will be an important source of capital funding, particularly where other sources of capital might not be available due to the perceived risk of organisations. Additionally, the alignment of investor and investee motivations, as well as the rigour associated with taking on investment, is often crucial to the success of the organisations taking on capital.

Use of Social Investment by VCSE organisations in health and social care

There are a number of ways in which social investment can support the sustainability of the sector including:

1. **Investment to provide upfront working capital for delivering outcome based contracts or taking part in Social Impact Bond (SIBs).** SIBs are a form of investment that makes it easier for charities and social enterprises to deliver Payment by Results (PbR) contracts. SIBs have been used to enable upfront investment in preventative action and improve outcomes of publically funded services by making funding conditional on results. In a SIB, the social investor provides upfront capital at risk for the delivery of an intervention by a social enterprise or charity. If the interventions are effective at producing the desired outcome (e.g. reduction in care home placements or A&E admissions), the social investor is paid back by the commissioner. An example of a SIB being developed to improve health outcomes is the Ways to Wellness SIB

Ways to Wellness Social Impact Bond

This Social Impact Bond aims to improve the quality of life of people with long term conditions (LTCs) by giving them access to social prescribing. The Social Impact Bond is commissioned by Newcastle West CCG. Bridges Ventures, a social investor, will provide upfront funding for local VCSEs to deliver social prescribing in GP practices to people with LTCs. The programme is aimed at c.1800 patients per year, aged 40 - 75 living in the area, who have one or more specified LTCs who have expressed willingness/ability to change. The Newcastle West CCG will make payments to investors subject to three outcomes being achieved: more cost effective patient use of prescription drugs, reduced hospital bed days, and increased patient self-reported wellbeing.

2. **Developing new and scaling existing services.** Start up VCSEs or established VCSEs looking to develop new models of care and new products can use social investment to hire additional staff for service delivery or invest in business development to sell those services into new markets. An example of an organisation taking on investment to scale their services and in turn deliver greater impact for people with mental health issues is Big White Wall

Case study Big White Wall
Big White Wall is an anonymous digital mental health and wellbeing service where people who are experiencing mild to moderate mental health issues can talk freely about their problems and self-manage their own mental health. Big White Wall members get instant access to 24/7 support, are supported to self-manage their mental health without recourse to further help, with 95% of users reporting improvements in their wellbeing. Big White Wall received an investment of £2m from LGT Ventures to expand their services into new geographies and secure contracts with new commissioners. The investment is repaid through subscribing organisations, including NHS providers, government departments, the armed forces and universities, as well as individuals

3. **Purchasing fixed assets (e.g. to develop new care facilities for services users or to invest in ICT to support business development).** Buying an asset is one of the most common uses of social and mainstream investment whether it is support the VCSE itself or to enable service delivery.

   The ageing population and the rise in learning disabilities will be accompanied by an increasing need for accommodation for those vulnerable groups. Social investment can enable VCSEs to purchase assets directly or to lease assets for service delivery in order to provide a combination of community based and residential care models. There are a number of funds that provide investment to purchase assets including Big Issue Invest. An example of one of their investments is outlined below.

Case study Sandwell Community Caring Trust
Sandwell CCT provides high quality, personal residential care for older people with dementia and supported living for people with physical and learning disabilities. Social investment was used alongside a loan from Unity Trust to help it acquire a 62-bed residential care home for £4.25 million to expand its operations. More than 700 vulnerable people from in and around the Black Country are looked after by Sandwell CCT.

Role for System partners

Although the development of social investment will support VCSEs in accessing the capital they need to deliver impact, there remain a key role for Department of Health, NHS England and PHE in:

1. Unlocking acute spending and shifting to models of outcome based commissioning. This could be done through a central government outcomes fund targeting complex and expensive social issues such as dementia, obesity or other long term conditions. Such a fund would mimic other models in building preventative markets e.g. the

DWP's Innovation Fund for NEETs and the more recent Fair Chances Fund for youth homelessness commissioned by DCLG and CO. Below is an example of how a Dementia Outcomes Fund might work

Possible example: Dementia Outcomes Fund

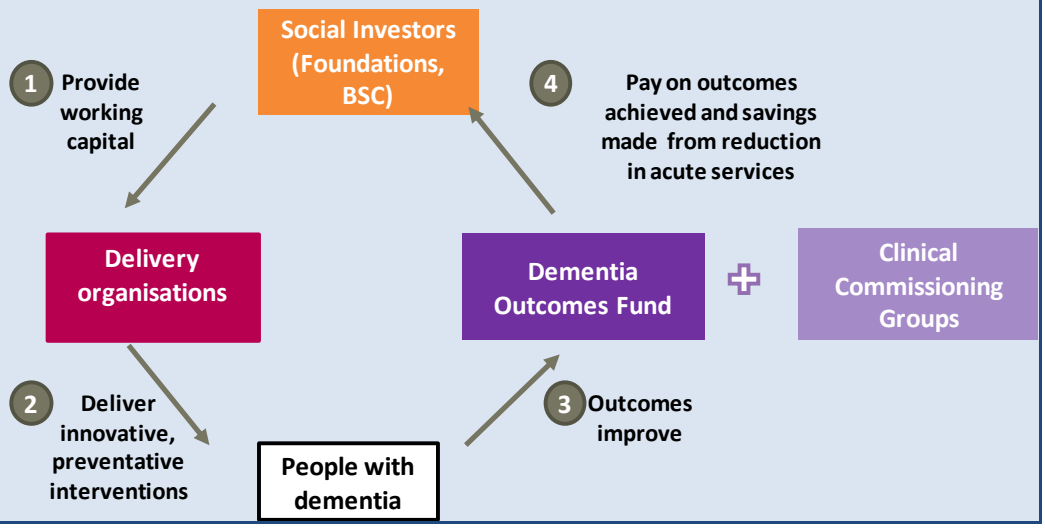
Early–stage interventions for people with dementia are emerging, as are social sector providers to deliver them. However social organisations cannot easily scale early stage interventions, as there is no clear market to pay for them given the problem of "double running" services local health commissioners (e.g. CCGs) face.

To pump prime a market for early stage organisations, System Partners could put together an Outcomes Fund for dementia. This would involve:

- 4-5 outcome based contracts targeting outcomes such as hospital admissions avoided, length of stay, maintained independence, deferring care home admissions and others.
- Requirement for CCGs to provide portion of funding
- Contract sizes large enough to build on a business case for CCGs later on

Such an Outcomes Fund would enable

- VCSEs to build up an evidence base of what works
- Clinical Commissioning Groups to shift spend from acute services to prevention
- Cost savings to government



2. Educating commissioners about procurement and contracting practices that prevent VCSEs from competing in public sector markets and creating greater impact. These include
    a. Proportionate financing requirements, including parent company guarantee requirements
    b. Transparency over values and volumes at subcontracting levels
    c. Retention of focus on social outcomes and appropriate payment for outcomes

Social Investment and a changed approach to commissioning can work in sync to deliver better outcomes, increased sustainability and more efficient use of public funds.

3. Supporting capacity building for the sector with programmes parallel to Cabinet Office Investment and Contract Readiness Fund or DfE's Childcare Readiness fund.

4. Raising awareness of investment availability across the sector.

Annex eight. List of Advisory Group members

Name	Organisation
Mark Winter (Co-lead: sustainability and capacity theme)	ACEVO
Matt Smith	Big Lottery Fund
Daria Kuznetsova	Big Society Capital
Simon Blake (Co-lead: sustainability and capacity theme)	Brook / Compact Voice
Aigneis Cheevers	Cabinet Office
Louise Beatty	Cabinet Office
Sarah Hurcombe	Cabinet Office
Sian Lockwood (Co-lead: contribution and impact theme)	Community Catalyst
Andie Michael	Department of Health
Flora Goldhill	Department of Health
Helen Walker	Department of Health
Howard Chapman	Department of Health
Lorna Demming	Department of Health
Marcia Johnson	Department of Health
Vanda Gohil	Health Watch Leicester
John Taylor	Legacy Trust UK
Sarah Mitchell (Co-lead: contribution and impact theme)	LGA
Caroline Howe	Lloyds Bank Foundation
Duncan Shrubsole	Lloyds Bank Foundation
Paul Streets	Lloyds Bank Foundation
Jeremy Taylor	National Voices
Angie McKnight	NCVO
Ruth Driscoll	NCVO
Emma Easton	NHS England
Giles Wilmore	NHS England
Olivia Butterworth	NHS England
Catherine Davies	PHE
Tricia Rich	PHE
Usama Edoo	PHE
Jabeer Butt (Co-lead: equality and health inequalities theme)	Race Equality Foundation
Bev Taylor (Co-lead: equality and health inequalities theme)	Regional Voices
Alex Fox (Chair)	Shared Lives
Dan Gregory	Social Enterprise UK

James Butler	Social Enterprise UK
Nick Temple	Social Enterprise UK
Kevin Halden	Towards Excellence in Adult Social Care
Richard Paynter	Vinspired
Patrick Reyburn	Voice Ability
Ben Smith	Voice4Change