The Voluntary and Community Sector and Localised Health Commissioning
What are the issues and how can we start to address them?

This paper is being drafted following a series of meetings of voluntary and community sector infrastructure organisations with NHS England. With the move towards more localised commissioning in health, some voluntary and community organisations (VCOs) have been reporting difficulties in linking new commissioners, in order to get the issues of their beneficiaries addressed. This can be because:

- the needs of communities 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
- VCO services are not funded (and it's a difficult funding environment)

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.

More widely, 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,
- user-led organisations can facilitate conversations between service users and commissioners and establish peer-led activities[1]
- support for people to understand and use personal budgets

However, there has so far been little policy discussion about how best to remove barriers and design the partnerships, incentives, contracts and other mechanisms that would enable VCS organisations to make these contributions.

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[1] e.g. Peer Support North East, in Gateshead, aims to quality-check providers and deliver peer support in a one-stop shop

The Commissioning Assembly, however, 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. We need to work together across the system to help create bridges between the VCS and the commissioning system, locally and in particular across larger geographic areas.

Aim of this work - to explore, develop and share learning around resources, levers, incentives, wider guidance and contracting models that will help VCOs work with commissioners to improve health outcomes for the communities they serve.

Support to address the issues- The Health and Social Care Voluntary Sector Strategic Partnership, and VCS Infrastructure Bodies, would like to work with the Commissioning Assembly to address these issues- to help commissioners work better with the voluntary sector (and the people they work with)- to evidence needs and assets in their area and to co-produce plans and commissioning intentions with the VCS- with a view of reducing health inequalities and improving outcomes for people.

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	Issue	Danger	Example	Possible levers/remedies
1	VCOs with a large geographic footprint are not being commissioned in some places because CCG capacity to engage with them is low; and/or relationships were lost during the structural reforms	Patchy service across England and/or services that some areas value needing to close as become unsustainable	Bobath Centre - a London based national service for children with cerebral palsy	Discussion between Commissioning Assembly +voluntary sector (Health and Care Strategic Partnership+infrastructure bodies) to identify solutions NHS England's developing Who's Who guide to specialist commissioning and Regional Voices Who's Who in Health and Care in the Regions
2	VCOs with a large geographic footprint are **not able to engage with 211 CCGs**, 151 health and wellbeing boards, and input into all JSNAs- to help shape commissioning.	Loss of expert input to JSNA and commissioning cycle	Equalities organisations such as Women's Health Equality Consortium and Organisations advocating for particular groups' needs such as RNIB, Epilepsy, Sense).	Discussion between Commissioning Assembly +voluntary sector (Health and Care Strategic Partnership+ infrastructure bodies) to identify solutions
3	Need for clarity about where commissioning responsibilities lie- between area teams and CCGs	Frustrated staff! Human rights	MNDA where confusion in the system/lack of	NHS England, Commissioning Assembly

		implications Variability in quality of service received	responsibility means people are relying on the VCS when it should be a statutory provision. Health and justice services and for violence against women and girl services, where funding responsibility falls between CCGs, local authorities and Police and Crime Commissioners.	and voluntary sector discussions (Health and Care Strategic Partnership+infrastructure bodies) to identify solutions Survey to find where issues lie??
4	VCOs (large and small, though particularly small) are **disadvantaged by a commissioning process driven by competitive tendering**. Needs more scope for co-design and for **proportionate funding mechanisms**. Concentrating on commissioning a "service" also means that there's a loss of more flexible funding- organisations are struggling to cover core costs and other services that make their offer more "holistic".	A **loss of choice** for service users- particularly **for harder to reach groups** who rely more on VCS organisations More time spent on tendering, less on delivering and developing services	• Local Mind organisations • Local race equality organisations working to promote health in specific communities	Simon Stevens agreed to explore a more a more **proportionate contract** for smaller scale work with the Health and Care Voluntary Sector Strategic Partners NHS E (PPV team) and Regional Voices have drafted a publication about status of **grants** in new system- to be published soon. Includes legal standing.
5	Locally based 'larger' voluntary sector service providers, might be being commissioned **should have creative conversations with commissioners about the future direction of services**.	Wasted opportunity to be creative about service design	Hospices/learning disability service providers	Discussion between Commissioning Assembly +voluntary sector (Health and Care Strategic

	Commissioning currently equals contracting rather than a sharing of a quality improvement conversation. Providers are given too little autonomy/flexibility/incentive to personalise services			Partnership) to identify solutions
6	Medium sized VCOs working over larger geographic areas that have a potential service offering for smaller numbers of people locally and have **limited capacity to make relationships with multiple commissioners**	Patchy service and/or services that some areas value needing to close as become unsustainable- reduces choice		Events like RAISE's Who's Who in the South East could help link commissioners and VCOs across a bigger area, perhaps thematically
7	**Small, local VCOs may struggle to engage with new commissioning system**-recovering from change in relationships, lack of clarity whether funding should be public health or CCG, capacity to demonstrate evidence, shrinking local budgets.	Risk of loss of local services/organisations which have evolved over the years to meet local need- and associated expertise and networks[2]		Discussion between Commissioning Assembly +voluntary sector (Health and Care Strategic Partnership+ infrastructure bodies) to identify solutions
8	Organisations that are providing a service that is part of recognised local provision, but are not in fact 'commissioned' to do this – it is **treated as 'free'** by	Financial stress on VCOs Loss of	• MND communication aids • IAPT/rape crisis[3]	Discussion between Commissioning Assembly +voluntary sector (Health

[2] Link to Comparing apples with oranges? How to make better use of evidence from the voluntary and community sector to improve health outcomes and supporting case studies

[3] IAPT refer women to rape crisis services as they can't treat them, but that referral is not monitored and they are not always funded to deliver support – they cannot receive IAPT funding.

	local partners	willingness/ability to help	• Small patient groups providing peer support (e.g. for mental health/ diabetes/MS) but not recompensed for contribution to both health outcomes and freed up GP time.	and Care Strategic Partnership+ infrastructure bodies) to identify solutions
9	Demand management and **market position strategies** are not taking into account **VCS provision** and how many VCS organisations are struggling to meet the demands left by a reduction in statutory services. With move towards community based social models of provision, more work needs to be done to understand the volume and coverage of such provision and to consider the sustainability and funding of it (outside of contracted services).	If market position strategies do not involve wider VCS provision, a true picture cannot be formed. .		Support to help sourcing of services come out of silos. Discussion between Commissioning Assembly, ADASS +voluntary sector (Health and Care Strategic Partnership+ infrastructure bodies) to identify solutions
10	The sourcing of services tends to be carried out in silos- linkages are made to source services that meet the same outcomes through different funding mechanisms (e.g. procurement of contracts, grant funding, community development funding all seem to happen to different time-scales and different departments - even where these services are seeking to meet the same broad outcomes – needs to be more focus on the outcome not the funding	Duplication of commissioning work		Discussion between Commissioning Assembly, LGA +voluntary sector (Health and Care Strategic Partnership+ infrastructure bodies) to identify solutions

	mechanism)			
10	VCOs which provide "**ancillary services**" locally– to which people may be referred, but which are not explicitly commissioned, and therefore there is **no cost recovery**	Financial strain on VCO services- may not be able to meet need- especially small scale/low cost services	Mental health recovery support, advocacy, rehabilitation activities, befriending, social prescribing[4]	Support for commissioners (CCG, AT+PH) to build up the engagement of the local VCS to provide a menu of services/activities that support health and wellbeing
11	**Barriers to VCOs being equals in integrated care programmes** and service/pathway redesign	VCS experience and skills not integrated- support lost	Integrated Pioneer experience- VCS involved, but can't have information in a timely way, due to data sharing issues	Data sharing issues may start to be addressed in Data Sharing White Paper due soon
12	VCOs providing a service that is low capital value and geographically spread – where the **demands of servicing several CCGs via multiple contracts far outweigh the value of the income.**	Strain on services	•	Discussion between Commissioning Assembly +voluntary sector (Health and Care Strategic Partnership+ infrastructure bodies) to identify solutions Proportionate contracting requirements
13	There is often an expectation that **VCS local infrastructure organisations** (LIOs) will strategically engage with health and involve the VCS	Expertise from non-commissioned organisations (the	•	Discussion between Commissioning Assembly +voluntary sector (Health

[4] Social prescribing (More than Medicine) work may help with this (see Building Health Partnerships and NESTA- Regional Voices aim to do something on this later in the year)

	for free. This is increasingly difficult as core funding is reduced. LIOs traditionally have a role in supporting VCS engagement in health, wellbeing and care (particularly non-commissioned smaller organisations)- including around the wider determinants of health[5]. There is a particular issue in how to engage VCS groups which do not receive statutory funding and make up the majority of VCS. Recent research has revealed a widely variable level of engagement and funding from CCGs to LIOs. A small minority of CCGs have made significant investment in VCS engagement and voice work, but many areas report no funding from CCGs. In some areas funding that was received from PCTs has gone under the new structure, with talk of organisational memory and understanding of the VCS's role in health being lost.	wider VCS) often working around the social determinants of health, is being lost to the system- to JSNA and commissioning discussions. Easier for commissioners to engage with one network than a multitude of organisations!		and Care Strategic Partnership+ infrastructure bodies) to identify solutions
14	JSNAs don't always capitalise on assets already in existence- such as the voices of 3 million volunteers in health and social care	Commissioning decisions remain based on deficit model, with financial and efficacy implications	Interesting examples Bucks County Council and Helen Sanderson's community mapping work	Discussion between Commissioning Assembly +voluntary sector (Health and Care Strategic Partnership+ infrastructure bodies) to identify solutions
15	"Best value" commissioning can be seen to be	Preventative services		Inspired leadership e.g.

[5] NAVCA Health Research Briefing, Local Need and the JSNA

	cheap services that demonstrably "meet needs." Received wisdom says that the way to get this is block contracts/institutional care arrangements/high volume, low unit cost arrangements - often with big providers.	lost- which would work out as better value		West Sussex, under John Dixon's leadership, prioritized building community capacity and inclusion

Some key questions

1. What are commissioners' experiences of trying to involve VCOs as partners?[6]
2. What are commissioners' experiences of trying to use VCOs as providers, particularly for smaller inputs?
3. What has been learned about barriers/solutions by those CCGs that have established social prescribing?
4. Do current contracting rules and specifications act as a barrier to VCS provision?
5. Is the current grants regime sufficient to enable partnerships between health commissioners and the VCS? Are commissioners sufficiently aware of it?
6. Where are the models for good practice in involving the local VCS collectively to influence commissioning intentions and co-design services?
7. What are the likely pros and cons for the VCS of contracting models such as alliance contracting; accountable lead provider; commissioning for outcomes; integrating (paid) peer support in the support offer? Who is investigating these and sharing the learning with the VCS?
8. What help could the Social Value Act 2012 provide? Are commissioners aware of it and applying it?[7]

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[6] See also Comparing Apples with Oranges? How to make better use of evidence from the voluntary and community sector to improve health outcomes

[7] NAVCA are finding limited focus on the SVA from CCGs, but also NHS and Public Health England. System Partners need to better promote the Social Value Act and its a role as a tool to reduce health inequalities work.

9. How could the involvement of the VCS in JSNAs be systematically addressed? And promote an assets based/empowering approach to JSNAs.