Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector

Final report produced in partnership by representatives of the VCSE sector and the Department of Health, NHS England, and Public Health England.

May 2016

Introduction

In November 2014, the Department of Health, Public Health England, and NHS England initiated a review of the role of the VCSE sector in improving health, wellbeing and care outcomes. The purpose of the review was to:

- Describe the role of the VCSE sector in contributing to improving health, well-being and care outcomes
- Identify and describe challenges and opportunities to realising the potential of the sector to contribute to these outcomes
- Consult on options for policy and practice changes to address challenges and maximise opportunities, then develop final recommendations

It had two elements:

- A review of wider funding and partnerships between health and care agencies and the VCSE sector across England which would focus on three areas: defining, achieving, and demonstrating impact; building capacity and staying sustainable; promoting equality and addressing health inequalities
- A review of their Voluntary Sector Investment Programme: The Strategic Partnership Programme; The Innovation, Excellence and Strategic Development Fund; The Health and Social Care Volunteering Fund

The review was produced in partnership through an advisory group of system partners (Department of Health, NHS England, and Public Health England) and voluntary sector representatives working together in an open process (see Annex B for a full list).

Following an initial consultation in early 2015, the advisory group published an interim report in March 2015[i]. The findings of this report informed a more comprehensive consultation process which ran from August to November 2015 (see Annex A for details of consultation). This report is the result of that engagement process.

Vision

Alex Fox, Chief Executive of Shared Lives Plus and Chair of the VCSE Review

The goal shared by everyone who delivers and organises health and care services is wellbeing: its creation and its resilience. Whilst we do not want to spend increasing proportions of our lives in medical nor social care, we will all draw upon primary, acute or specialist services at various points in our lives and we want to find them available, caring and well run when we do. However, whether for people with lifelong disabilities, the ever growing older population or those with long term health conditions and support needs, our dreams remain rooted in living well at home as part of welcoming, inclusive communities. To achieve that goal, we need health and care systems which are organised around and support our lives: which can reach us in our homes, support our families to care, and release the full potential of communities.

The VCSE sector has a consistent track record of working in that way: holistic, long term, relational and locally-rooted. With over 35,000 charities working in the health and social care sectors[ii], plus at least 10,000 more social enterprises[iii], and tens of thousands more unregistered community groups operating below the radar[iv], the VCSE sector can reach the whole community, think whole person and act whole lifetime.

At its best, the VCSE sector does not just deliver to individuals, it draws upon whole communities: for volunteering and social action which addresses service-resistant problems like loneliness and stigma, and for the expertise of lived experience in designing more effective, sustainable services and systems. This is the way to address the social determinants of health, build resilience and promote self-care and independence, all of which should be clear in both our public services' visions and in their allocation of resources.

We did not find the VCSE sector consistently at its best. We found many organisations lacking confidence, some lacking hope and most torn between following missions which were born from their communities and meeting the demands of contracts and grants which were defined elsewhere and which in many cases are becoming shorter term, more narrowly focused and more medicalised.

Partly this was the impact of austerity. There is significant and often invisible churn in the sector. In many places the sector is shrinking. But we heard that these impacts are unevenly distributed, with some kinds of VCSE organisation, including equalities and local infrastructure groups, facing an imminent crisis in many areas. Local systems need these kinds of organisations to reach individuals and groups living in potentially vulnerable or marginalised circumstances, support the innovation of new social enterprises, and benefit from the smallest community groups which are the glue keeping our communities together.

Conversely, some local systems have recognised that their VCSE resources are now more important than ever and are embedding the sector into their planning and

resource management. Money is not the only resource available to good VCSE organisations and the sector has proved itself time and again to be able to achieve incredible outcomes with fewer resources. Perhaps even more important than the level of funding in the system, was the extent to which VCSE organisations are fully included in local planning, goal setting and risk management.

It is hard to see a future for many VCSE organisations and statutory services alike, if VCSE organisations remain seen as outsiders in a statutory-based system. VCSE organisations can share the risks and responsibilities of local systems but in turn need to able to share in the resources and rewards. They can bring the voices decision makers most need to hear into the system, but in turn those voices must be listened to and acted upon, even when – especially when – they are not saying what decision makers might most like to hear. All systems need the VCSE sector in their decision-making structures, but an immediate challenge is to embed our most effective, confident and community-rooted VCSE organisations into the new models of care such as the vanguard sites[v], Integrated Personal Commissioning programme[vi], Integrated Care Pioneers programme[vii] and devolution of health budgets to Greater Manchester and elsewhere. This will support integration, because effective and well-networked VCSE organisations join up responses that have previously been fractured and build relationships between public services and communities.

The new structures being developed through the new models of care vanguards and via Sustainability and Transformation Plans as set out in the latest NHS planning guidance[viii] are creating new bodies with both commissioning and provision roles. The VCSE must be central to these new collaborative processes, as well as existing JSNAs and health and wellbeing boards.

Parts of the VCSE sector have been challenged to scale up and to ‘professionalise’. They are now delivering large scale service contracts for some of the most vulnerable people in public service systems. There is only benefit in this happening where VCSE organisations can remain rooted in their communities and continue to deliver added ‘social value’, through recruiting people with lived experience or from overlooked communities as volunteers and paid staff, for instance. Professional VCSE organisations can respond to crises, deliver technical or medical care and manage challenging risks, but great VCSE organisations do not wait for crises; they think socially not medically; and they never let a clear view of risk obscure people’s potential. It would be an own goal to encourage all of our most successful VCSE organisations to become indistinguishable from statutory and private sector organisations.

Large VCSE service delivery organisations need to rise to the challenge of demonstrating the outcomes which their competitors can also demonstrate, whilst also demonstrating added social value. In turn, they need to be offered a level playing field, where the wellbeing outcomes at which they excel are recognised, valued and contracted for. Again this happens only where citizens and the groups who work directly with them have been fully involved in defining local goals and judging their achievement.

Neither ad hoc grant giving, nor contract-based procurement, appear to create a diverse, creative and sustainable VCSE sector.

Traditional contract-based commissioning can work for some large-scale VCSE provision and we saw potential in more collaborative approaches to contracting. But these do not appear to be the best way to support community development nor to build social action, and we have heard about the need for a more considered range of funding approaches to be used in every area. This should include use of co-designed, transparent grants programmes as well as personal budgets and personal health budgets, which can allow individuals and small groups to take real responsibility for shaping their care, with consistently better outcomes for people with long term conditions and their family carers. Targeted support for the very smallest social enterprises and community groups can play a large part in creating health and wellbeing, as fewer people will be left unsupported where there is a wide range of community-based and innovative interventions from which to choose.

We believe much more use could be made of the Social Value Act to level the playing field for organisations with a social mission and to create more value from public spending. We see real potential in those social prescribing models in which resources follow the prescriptions, enabling and encouraging effective VCSE organisations to sustain and grow interventions which patients and their GPs most value. Social investment has enabled some kinds of VCSE organisation to manage the risks of innovation and we see potential for it to unlock further innovation during austerity.

Helping marginalised people to have their voices heard is indisputably a key part of VCSE sector activity and this has often been recognised by government. Many organisations are born from the gaps and failures in statutory services, when for instance, a particular service cannot reach a particular group. Some in the VCSE sector are more comfortable in traditional campaigning mode, highlighting a problem, than constructing and testing pragmatic solutions and there is a view in some parts of the sector that VCSE groups have to keep their distance from government in order to remain 'true' to their mission. VCSE organisations need to consider the most effective way of influencing positive change for those they represent, considering the range of voice work approaches including advocacy, self-advocacy, critical friend roles, co-designer, co-commissioner, peer reviewer, campaigner and lobbyist.

The Department of Health, NHS England and Public Health England have been at the forefront of working with the VCSE sector to ensure patient and citizen voices are heard at the highest level. For example, the People and Communities Board, part of the governance of the NHS Five Year Forward View,[ix] has developed six principles for implementing the NHS Five Year Forward View,[x] which reflect the findings of this Review and which local health systems are being asked to build on when developing Sustainability and Transformation Plans[xi]:

- Care and support is person-centred: personalised, coordinated, and empowering
- Services are created in partnership with citizens and communities
- Focus is on equality and narrowing inequalities
- Carers are identified, supported and involved
- Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
- Volunteering and social action are recognised as key enablers

The central grants programme (the Innovation, Excellence and Strategic Development fund and the Health and Social Care Volunteering Fund) and the Health and Care Voluntary Sector Strategic Partners Programme have developed closer relationships between the sector and Department of Health, Public Health England and NHS England. There is real value in this, achieved through many years' work by all involved. Through the grants and Strategic Partner Programme, government and the sector have co-designed and co-implemented policy priorities.

There is overwhelming support in the sector for these programmes' continuation, but also a belief these programmes could contribute more to transformation. The grants programme has enabled many promising approaches to be tried out and evaluated; now it should have a clearer focus on sustaining successful approaches and embedding culture changes.

Below we set out a recommendation for central government's activity and investment in which a combination of grants, policy work, academic input and the work of Strategic Partners, come together into one 'wellbeing programme', with fewer goals but more demonstrable outcomes, focusing on the transformation goals to which the VCSE sector can make the biggest contribution, and issues such as health inequalities and infrastructure.

The work of central government and its partners is a relatively small, but vital part of the whole picture. The Strategic Partners and Central Grants Programmes are the ways in which government has role modelled long term commitment to the VCSE sector, not only as delivery vehicle, but also as policy co-designer and implementer.

At both national and local level, the VCSE and statutory sectors need each other. Each brings its own kind of expertise and its own kind of resources. Each has much more to do to ensure citizens are included and empowered from the earliest stage and throughout. It is time we brought our sectors together to create the local and national health and care systems which we all need to achieve wellbeing.

To achieve this vison we make the following recommendations.

Recommendations

Health and care services are co-produced, focussed on wellbeing, and value individuals' and communities' capacities

1. Promoting wellbeing is already central to the goals of the health and care system, in line with the Five Year Forward View and the Care Act. The Department of Health, NHS England and Public Health England should explore opportunities to further embed this goal, including identifying, measuring and commissioning for key wellbeing outcomes for all.

2. There should be greater co-production with people who use services and their families at every level of the health and care system. NHS England should update its guidance on Sustainability and Transformation Plans (STPs) to require local health and care systems to draw upon the six principles created to support the delivery of the Five Year Forward View[xii], the principles contained in the Engaging and Empowering Communities memorandum of understanding[xiii], and

Think Local Act Personal's definition of co-production.

3. NHS England should issue revised statutory Transforming Participation in Health and Care guidance in 2016 on working with the VCSE sector as a key way to meet CCGs' Health and Social Care Act duty to involve.

4. When preparing their joint strategic needs assessment (JSNA), Health and Wellbeing Boards should ensure that it is a comprehensive assessment of assets as well as needs based on thorough engagement with local VCSE organisations and all groups experiencing health inequalities. The Department of Health should consider including this when next updating the Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

Commitment to the Compact

5. The government, led by the Cabinet Office, should demonstrate its support for the Compact principles as a framework for effective collaboration between VCSE and statutory sectors.

VCSE organisations are involved in strategic processes

6. Any future transformation programmes (e.g. Integrated Personal Commissioning) should only be approved if proposals are included for involving the full range of local VCSE sector, taking its views into account in strategic decisions and utilising its delivery expertise. Existing transformation programmes should also be issued guidance to support better involvement of the VCSE sector.

7. Health and Wellbeing Boards should work closely with local VCSE organisations to ensure that their strategies are co-designed with local citizens, particularly as they try to reach those groups and communities which may be under-represented or overlooked. Local and national government should consider how to support and facilitate HWBs to achieve this goal.

Social value becomes a fundamental part of health and care commissioning, service provision and regulation

8. Social value should be better embedded in the commissioning approaches of local authorities and NHS commissioners. The NHS Sustainable Development Unit and Cabinet office should explore the benefits of using social value within the NHS and how to identify and incentivise its creation through their regulatory frameworks and good practice models, building an evidence base to address the gaps identified by Lord Young's review of the Public Services (Social Value) Act, which should inform a further review by 2018. NHS England and the Cabinet Office should work in partnership to ensure that training and resources provided to NHS and local authority commissioner and procurement teams support and encourage them to commission for social value.

9. CQC should review its Key Lines of Enquiry and ratings characteristics across all sectors to include the value of personalisation, social action and the use of

volunteers, based on the evidence of their efficacy in achieving improved quality of care.

Social prescribing is given greater support

10. We recommend that NHS England, working with key partners such as the Department of Health and NICE, should publish good practice guidance on social prescribing which includes advice on different models and recognition that prescriptions should be appropriately and sustainably funded. NHS England should promote this guidance, provide implementation support to health commissioners and evaluate uptake and impact on outcomes, including for those people experiencing inequalities.

The skills of those involved in health and care commissioning are improved

11. Government should consider how they can support and encourage health and care commissioning bodies to access skills development training for their workforces, including from the Commissioning Academy, particularly on the co-commissioning of services.

12. The Cabinet Office and the Department of Health should consider providing support to build the capacity of VCSE organisations to compete for and win health and care contracts, particularly where infrastructure is limited, and coordinate this support with the Commissioning Academy and the commissioning plans of local health and care systems.

Long term funding as standard

13. Moving away from short-term pilot funding, NHS commissioners, local authorities, charitable funders and National Lottery distributors should provide core and long term funding with capacity building support, particularly to smaller and/ or specialist VCSE organisations.

Health and care bodies fund on a simplest-by-default basis

14. Health and care commissioners should, by default, use the simplest possible funding mechanism (that which best balances impact and transaction costs). The Department of Health, with support from NHS England and the Cabinet Office, should continue to develop shorter model contracts and grant agreements, and consider commissioning research on the transaction costs and relative impact of different funding mechanisms for a variety of services and circumstances. This should include but not be limited to grants, fee for service contracts, payment by results contracts, social impact bonds, social prescribing models, personal budgets and personal health budgets.

Greater transparency

15. Government should consider fully implementing the Open Contracting Partnership's Global Principles[xiv] and Data Standard[xv], and introducing a public contracting disclosure baseline, so that full details of contracts, including awards, amendments, termination and financial flows to subcontractors are available

through the Contracts Finder website.

16. The Department of Health should consider commissioning NICE to develop an indicator of VCSE engagement for NHS and other public health and social care commissioners.

Volunteering is valued, improved and promoted

17. All NHS settings, with strategic leadership from NHS England through the Active Communities and Health as a Social Movement programmes, should develop more high-quality, inclusive opportunities for volunteering, particularly for young people and those from disadvantaged communities. All NHS settings, not just trusts, should also comply with the second and third recommendations made by the Lampard Review on volunteer recruitment, training, management and supervision.[xvi] This should include consideration of whether to apply for accreditation under the Investing in Volunteers scheme.

Dormant funds are used for good

18. NHS Charities (including their linked and/or successor charities) with support from the relevant sector bodies, should develop links with their local Community Foundations and the wider VCSE sector in the area, to explore the possibility of using funds for the benefit of the NHS and to achieve broader health outcomes within the wider community, and share learning and good practice in this area.

Evidence underpins health and care

19. Service objectives should be developed in partnership with funded organisations and service users and include a focus on the health, wellbeing and experience of service users. Standard tools to support credible outcome measurement should be adopted. Providers should be supported to effectively undertake evaluations, measurement of social value and cost-benefit analysis of savings. For NHS commissioners, this may include giving providers full access to anonymised patient data in order to aid impact assessment.

20. Government should consider funding the What Works Centre for Wellbeing to set up a wellbeing data lab service for all sectors.[xvii] This could be modelled on the existing Justice Data Lab.[xviii]

21. NHS commissioners, local authorities and independent funders should publish the evaluation methodology and results for all grant and funded projects where an evaluation is undertaken, in line with the government's open data principles.[xix]

22. The National Institute for Health Research (NIHR) should use existing research to identify and develop tools to help measure preventative outcomes, using suitable proxies as necessary and having regard to what works for different communities.

23. VCSE organisations should engage further with the evidence base, contributing to and drawing on resources such as the What Works Centre for

Wellbeing, Social Care Institute for Excellence, Think Local Act Personal and guidance on 'Community-centred approaches for health and wellbeing' developed by Public Health England. Strategic partners and national infrastructure bodies should promote greater engagement with this evidence base.

A sustainable and responsive infrastructure

24. Government, local infrastructure and independent funders should consider the recommendations set out in Change for Good and subsequent work from the Independent Commission on the Future of Local Infrastructure.

25. NHS commissioners and local authorities should consider providing funding and guidance for suitable infrastructure to better connect personal budget and personal health budget holders with a range of providers, including small and start-up organisations, and facilitate the development of a more diverse range of services accessible by and co-designed with local communities.

A greater focus on equality and health inequalities

26. The VCSE sector plays a vital role in amplifying the voices of people from communities whose voices are seldom heard, helping them to engage with the health and care system. NHS commissioners and local authorities should work with the VCSE sector to enable all groups in society, especially those experiencing health inequalities, to have a say in how services can achieve better health and care outcomes for all citizens. Commissioners should be encouraged and supported to make better use of guidance, tools and resources to improve local people's access to services, experiences and outcomes by promoting equality and reducing health inequalities.

Market diversity

27. Government should consider extending the market diversity duty[xx], which currently applies to local authorities, to NHS commissioners.

A streamlined Voluntary Sector Investment Programme

28. We recommend that the three current strands of the VSIP (central grant funds [IESD and HSCVF] and strategic partner programme) are unified into one health and wellbeing programme, with project funding and strategic partner elements.

Based on the findings of the VCSE Review, project funding should be used to demonstrate effective models for supporting local infrastructure to tackle health inequalities and better embedding VCSE groups with expertise in this area into local health and care systems. Consideration should be given to sustainability and potential for leveraging other funding contributions to support this work.

A small implementation working group, comprising VCSE organisations and system partners, should identify specific health inequalities and/ or localities for the programme to ensure that it is sufficiently targeted. Outcomes measures should be developed in partnership with funded organisations and service users.

The demonstration projects should work closely with and be given national reach by the Health and Care Strategic Partnership Programme, the continuation of which has already been announced. Strategic partners should have responsibility for supporting government to disseminate learning, develop policy and identify new models for reducing health inequalities that can be rolled out nationally.

This programme should be aligned with the overall strategy of the health and care system set out in the NHS Five Year Forward and underpinned by the requirements for success set out in the VSIP chapter. This should include multi-year funding to maximise opportunities for impact and learning.

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[i] VCSE Review Advisory Group. VCSE Review. https://voluntarycommunitysocialenterprisereview.files.wordpress.com/2015/05/vcse-review-interim-report.pdf (accessed February 2016)

[ii] Civil Society Almanac. NCVO. 2015

[iii] State of Social Enterprise Survey 2015. Social Enterprise UK. 2015. There are around 70,000 social enterprises, of which 19% work in health and social care. Of these, around 20% are likely to be charities.

[iv] GMCVO's 'Greater Manchester State of the Voluntary Sector 2013' report estimated that there are 9,624 'below the radar' organisations compared to 4,968 registered voluntary groups in Greater Manchester: almost twice as many.

[v] NHS England. New Care Models - Vanguard sites. www.england.nhs.uk/ourwork/futurenhs/new-care-models/ (accessed February 2016)

[vi] NHS England. Integrated Personal Commissioning (IPC) Programme. www.england.nhs.uk/commissioning/ipc/ (accessed February 2016)

[vii] NHS England. Integrated Care Pioneers. www.england.nhs.uk/pioneers/ (accessed February 2016)

[viii] NHS England, NHS Improvement, Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE). Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21. NHS England. 22 December 2015 version 2

[ix] National Voices. Five Year Forward View People and Communities Board. www.nationalvoices.org.uk/fyfv (accessed February 2016)

[x] National Voices. Five Year Forward View People and Communities Board. www.nationalvoices.org.uk/fyfv (accessed February 2016)

[xi] NHS England, NHS Improvement, Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE). Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21. NHS England. 22 December 2015 version 2

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[xiii] Think Local Act Personal, forthcoming publication 2016

[xiv] Open Contracting Partnership. Global principles. http://www.open-contracting.org/get-started/global-principles/ (accessed March 2016)

[xv] Open Contracting Partnership. Implementing the Open Contracting Data Standard. http://www.open-contracting.org/data-standard/ (accessed March 2016)

[xvi] Lampard K, Marsden E. Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile. Independent report for the Secretary of State for Health. February 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf (accessed March 2016)

[xvii] Ministry of Justice. Guidance: Accessing the Justice Data Lab service. First published: 7 November 2014 https://www.gov.uk/government/publications/justice-data-lab (accessed March 2016)

[xviii] Ministry of Justice. Guidance: Accessing the Justice Data Lab service. First published: 7 November 2014 https://www.gov.uk/government/publications/justice-data-lab (accessed March 2016)

[xix] Gov.uk. Government Service Design Manual. Open data. https://www.gov.uk/service-manual/technology/open-data.html (accessed March 2016)

[xx] Care Act 2014, clause 5. Legislation.gov.uk. 2014 [cited 11 January 2015]. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted (accessed March 2016)