

Let's ask for three wishes of this review

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....If DH/PHE/NHSE* and their local friends in CCGs†/Local Authorities and LHWBs‡ were genies

.....and we were in Aladdin's cave – what might our 3 wishes be?

The NHS remains the darling of the public. Health is never far from the top of our personal or Political agendas.

But we need to redefine what 'health' means for the needs of the 21st century. And whilst the centre calls for this ever more stridently and often – from [The NHS Plan](#) (2000) to [Derek Wanless](#) (2002) to the [Five Year Forward View](#) (2014) – the VCSE[§] sector quietly gets on doing it.

We saw this in the 1990's with the shift in the focus of effective chronic disease management: this began with Arthritis Care bringing ideas from the USA to introduce self-management. When I was at Diabetes UK we plagiarised this and models from Germany to create *DAFNE*** the patient education programme centred on supported peer learning. Then came asthma, osteoporosis – the list goes on. This thinking is now widespread across chronic disease management with an understanding of the expert patient. And now even cancer with the focus on survivorship and the work of Macmillan. It has even begun to flip over into elective care through the growing interest in shared decision making, which reduces demand through a focus on patient over clinical preference.

There are many more examples. End of life care has been transformed through the hospice movement. The Alzheimers Society has led thinking on dementia friendly communities and dementia friends: still in its infancy but creeping up as mainstream. The list is almost endless.

What all of these have in common is a subtle but clear paradigm shift: usually centred on listening hard to those on the receiving end and driving innovation *up* through the eyes of consumers, rather than *down* through providers. DAFNE is the example par excellence: it turned conventional thinking on its head with the strapline '*eat what you like, like what you eat*' an anathema to (then) diabetes management.

But because none of these were initiated or planned from the centre and have often been achieved quietly without the brouhaha of the next miracle drug cure, we rarely reflect back on their profound impact.

* Department of Health, Public Health England and NHS England

† Clinical Commissioning Groups

‡ Local Health and Wellbeing Boards

§ Voluntary Community and Social Enterprise Sector

** Dose Adjustment for Normal Eating

A powerful VCSE national advocate or movement has often been critical. Prepared to be tenacious against the grain of current thinking with independent funding to put their money where their mouth is and create leverage.

But the 21st century challenges health faces often don't have organised and independent advocacy.

If we look at many of the avoidable health costs we see drivers that often don't sit in 'health' at all and which affect the most disenfranchised in our society: drugs, alcohol, mental health, social isolation in older people, domestic violence, and homelessness. These are the bread and butter of A&E.

But they are also the bread and butter of the VCSE.

Usually this is local and often small scale with a focus on good relationships as a central philosophy: outwards between the VCSE and its community, and inwards in the relationship formed with those it serves – a physical manifestation of *Think Local/Act Personal* rather than a strategic wish-list.

But whilst many of the large national charities which drove innovation in self-management are independently funded, most local VCSE services, whether provided by small charities or national branches of larger charities, rely on a degree of public funding to survive, albeit often alongside funding from people like us at the Foundation.

NCVO data shows that public funding is both rapidly declining *and* shifting from a focus on holistic support of complex needs to one of contracting, scale and single outcome.

This is particularly problematic when the 'spread' model that works for chronic disease – VCSE pilots/proof of principle to an NHS which picks up the tab – doesn't cut it for these issues. Success here is often founded on trust based relationships with people who have little faith or trust in public institutions which have often affected their lives so adversely. Effective reach will always require trusted independent agents – the VCSE will always be central.

At the Foundation we are becoming very concerned that these critical organisations are under real threat. Many of the larger foundations like us rely on what we have called the '*fruitcake*' model: as we can only afford to be the icing and marzipan, we often rely on a public funded fruitcake. Both are critical but they are symbiotic: without one the other will not thrive. Recent ESRC^{††} research demonstrates that this ecology is especially fragile where the need is greatest. What we have called *triple jeopardy*: the inverse relationship between need and VCSE capacity; and the direct relationship between areas with high public sector investment in the VCSE, high benefit dependency and high needs. NCVO data shows that at a macro level between and within regions. We see it ourselves: looking at London with the concentration of good VCSE's in the centre and near The City, and the scarcity in the outer suburbs where the need is greatest, or in the north east between Durham city one of the wealthiest areas, and Redcar – one of the poorest.

^{††} Economic and Social Research Council

The implication is those most at risk are often supported by a VCSE infrastructure which is also most at risk. It is not hard to extrapolate what that might mean for health and social costs right across the board and where the greatest impact will be felt if it continues.

So this really matters.

If we are brave the review is an opportunity to turn the tide. And a new electoral cycle is the right time to ask for our three wishes.

So here are three wishes to the DH/PHE/NHSE and their local partners in CCGs, Local Authorities and LHWBs: each in order.

The **first wish**: a more rounded view of where 'health' begins and ends. To the NHS it may end in A&E, the elective surgery table, long term care or blocking beds, but it starts with people, the lives they lead and the communities they live in.

The **second wish**: match the recognition of the strategic value of the VCSE intended in this review with the need for well placed national and local funding to those best equipped to tackle these issues. This is hard at a time of fiscal constraint with little new money. It will mean diverting funds from what isn't working, or from where we are funding the costs of failure, to funding community based prevention and support.

The **third wish**: take a more flexible approach towards *how* that support is provided with a determined focus on *purpose*, centred on people as they present with their complex lives and wishes – rather than the service silos we pigeon hole them into. This probably means a radically different approach to how to achieve 'scale' and a big rethink of whether contracts are fit for purpose.

If you agree let us know.

Then, once our wishes are granted – we need to hear:

- examples of how the VCSE *is* the answer to some of these intractable health problems so we can make a robust case for a strategic and central role, and
- practical suggestions about what DH, NHSE and PHE and their local system partners need to change or do, to enable that to happen

This is not an easy ask and there are no easy answers. We need scale – and yet part of the solution lies in retaining the essential 'localness' of many small/local organisations. We will need to turn current orthodoxy of reach through scale up on its head – to create a presumption of achieving reach through replication, collaboration across boundaries and 'spread'. So this time we need paradigm shifts on how to deliver, how to 'commission' and what constitutes 'scale'.

Tough stuff.

But, as with self-management 20 years ago, the answers will come the 'bottom up'; from us and those we serve, turning existing orthodoxy on its head.

So ... give us a hand and, like Aladdin, we might even live happily (or at least purposefully) ever after.