NECA/NHS Joint Commission for Health and Social Care Integration

Exploring the Role of the VCSE Sector in Health and Wellbeing

30th June 2016

Background

The joint NECA (North East Combined Authority) / NHS Commission was established as part of the proposed devolution deal agreed between NECA and central government in October 2015. This recognised that despite having strong health and care services across the region and life expectancy increasing faster than other parts of the country, there are still too many residents suffering from poor health and wellbeing, with many unable to work and trapped in a cycle of poverty. In January 2016 Duncan Selbie, chief executive of Public Health England, was appointed to chair the Commission and he was supported by four members who are national experts in their own fields in health and social care.

The Commission met for the first time in February 2016 and met a further three times up to the end of September 2016. They identified three core themes to shape their work:

- A shift to prevention
- Health, wellbeing and productivity
- System leadership and governance

Members of the Commission worked closely with local stakeholders, seeking views from across the region through a call for evidence, which resulted in more than 150 documents being submitted from over 80 individuals and organisations and conversations with hundreds of people with an interest in health and social care. 7 Listening Events were arranged in each of the local authority areas and a specific event for the voluntary, community and social enterprise sector was arranged working with VONNE (Voluntary Organisations Network North East).

This report sets out the key themes and discussion points from the VCSE (Voluntary, Community & Social Enterprise Sector) event.

VONNE Event: 30th June 2016

On behalf of the Commission VONNE arranged an engagement event on 30th June providing an opportunity for the voluntary sector to inform the Commission's recommendations and to identify the issues associated with what needs to happen to ensure the VCSE is enabled to be a key design and delivery partner of health and wellbeing in the future.

Guest speakers included:

- Tom Wright, Commission Member and Chief Executive of Age UK England and Chair of the Richmond Group of charities, who provided an update on the role of the Health and Social Care Commission and work undertaken to date.
- David Gallagher, Chief Officer, Sunderland Clinical Commissioning Group presented an overview of the emerging work on the Sustainability and Transformation Plans (STP) and described the work being undertaken to align this work with the work of the commission.
- Jane Hartley Chief Executive, VONNE, provided an overview of the recently published report: 'Joint review of the role of the VCSE sector in improving health, wellbeing and care outcomes & partnerships'. Department of Health, Public Health England, and NHS England

The above presentations were central to setting the scene for the table discussions which followed. The focus of the group discussions was to encourage voluntary sector representatives to play an active part in the work of the commission, and the event sought feedback from the participants in relation to 2 questions:

- How does the system need to change to enable the voluntary sector to play its part?
- How is the sector going to change to deliver the NECA/NHS ambitions for a shift in focus to improving health and wellbeing?

One table (Group 5) specifically focused upon capturing the issues for voluntary, community and social enterprise (VCSE) organisations "led by and for" equality or identity groups (such as women's, black and minority ethnic, disability, faith, young people or older people's VCS organisations). This group also looked at three case studies which demonstrated the complex needs and marginalization of some individuals.

A summary of the feedback received from each of the table discussions is attached as Appendix 1. A full feedback report on the Group 5 discussion including the case studies is attached at Appendix 2

Plenary Session

The event included an interactive plenary session with an opportunity for the participants to briefly summarise some of the key issues raised, to provide an opportunity for the guest speakers to emphasise what had been highlighted over the course of the event and to provide a synopsis of the next steps for the commission over the next few months.

The key issues and statements raised at the plenary session in response to the two questions are captured in the following section.

Question 1.

How does the system need to change to enable the voluntary sector to play its part?

System changes

- Be clearer about fewer objectives so that different parts of the system can demonstrate what their part is in achieving these objectives
- Reach agreement on a small number of key objectives to ensure all moving in the same direction (consistency of language used across sectors and services)
- Simplify data collection/improve data sharing and resolve information governance issues

Commissioning and Procurement

- Educate Commissioners –they need to understand the sector/what it can do and what it is able to deliver
- Awareness of Sector – Raise knowledge/educate Commissioners
- Voluntary Sector need a place at the table – Co-Production at the right time in the process (use the sector to inform the design of services/ specifications)
- Proportionality – the same documentation has to be used when bidding for funding whether the organisation is large or small
- Traditional contracting isn't the only way to fund – consider grant funding and other contracting mechanisms eg alliance contracts too
- Meaningful effort to consult with voluntary sector is needed – Commissioners should come to us in future as time out from service delivery becomes an overhead to the sector
- Where does social value sit in the overall evaluation of value added by different service models?
- Change process to ensure that sector is involved in the development phase and focus on outputs required rather than specifying inputs and service requirements (e.g. service available 2 to 5 each day)
- Recognise the diversity of the providers in the sector – they are not all large organisations with resources to support bid/meeting the requirements of a procurement process
- Simplify contracts and extend beyond 12 months (could deliver savings/free up resources if procurement cycle occurs less frequently)

Evidence/Impact

- Change how different types of evidence are valued in the procurement and evaluation processes (a lot of evidence is case study/financial/scientific and based on medical model and decisions on services are primarily based on this type of evidence rather than exploring other outcomes / types of evidence)/ ways of measuring benefits of services
- Invest in projects that will generate evidence to support change
- Have evidence of VCSE services that can be commissioned

Asset based approaches

- Asset based approach in communities – be "bullish" move away from acute care to care in communities (if you wait for evidence to prove benefits of new delivery methods before closing acute beds they will be filled with patients with other healthcare issues)
- Engagement with the sector – asset based/working with the community

- Need to make better assessments of people/service users – more cooperative/humility
- Voluntary Sector looks at people holistically - this must not be lost going forward (value the knowledge the sector has in relation supporting individuals)
- Recognition of value of volunteers – Not a substitute for paid employees

Funding

- Need more secure core funding
- Invest in infrastructure to enable collaboration across the sector
- Funding is needed to sustain core services, along with funding for innovation which has a risk factor built in – accepting that some innovation fails.
- Need funding for capacity to enable better joint working to exploit the strengths of the sector

Question 2

How can the Sector change to deliver the NECA/ NHS ambitions for a shift in focus to improving health and wellbeing?

- Collaborate more to meet the requirements of a service – The procurement process prevents this.
- Clarify the definition of the Sector – Use common language
- Be bold and transformational
- How do we share/reallocate funds across the system/sector?
- If the voluntary sector says it can deliver and deliver it better, it has to be able to otherwise caught with “egg on our faces”
- We work better together rather than in our own ways/silos – need more focus/pathways when consulting/bidding
- Bigger organisations need to protect the smaller organisations as they can damage the smaller ones in the way they do business
- Be innovative but be allowed to fail
- More joint working between groups/play to the diversity across the sector
- Voluntary sector is data rich but needs to feed into the system better with a coordinated approach
- Where there are new approaches and innovation we may need to develop the evidence as we go – more R & D. VCSE can access other sources of funding e.g. for pilots
- Voluntary sector needs to be engaged at a strategic level where the decisions are being made and be ready to step up to do this - Voluntary sector needs to be better at working strategically and learn how to better position themselves.

Appendix 1

Summary from the table discussions.

Group One

Q1. How does the system need to change to enable the voluntary sector to play its part?

- Dementia quality of journey
- Anecdotal evidence base.
- Evidence base differs between different sectors i.e. health/social
- Language/structure is different.
- Large pharmaceuticals employ people to go/work between sectors to understand evidence.
- Look at consistency
- Advertised through a health process which often excludes VCS.
- What are fundamental tasks?
- What are the key things we are looking to do? Fewer objectives?
- Every VCS then feeds in on a specific objective and how they work
- Outcome based commission on key areas.
- The system delivers what we think people need, change to regional based outcomes are often same but with different terminology.
- Use VCS more to pilot/test (R+D Wing) out different things rather than set in 5-year plan.
- Wakefield project.
- VCS can tap grant funding; system can approach VCS to do so
- External Liverpool homes environmental health put forward some ideas 'cross fertilisation' and historically encourage a competitive environment.
- Interest in link work navigation. A simpler system would be more efficient with firewalls between delivery/infrastructure

Q2. How is the sector going to change to deliver the neca/NHS ambitions for a shift in focus to improving health and wellbeing?

- Are there resources to take this development research forward?
- Should make it simpler for commissioners to interact but too much simpler would lose diversity of VCS.
- Simplify leads in consortiums
- INTEGRATED
- Do infrastructure organisations have a match making function?
- Unable to see others who are interested in bidding for tender. Tenders are maybe over specific and could be simpler? Procurement officer's culture is too specific and stifles innovation.
- Open book development. Include procurement officers and protect diversity.

Key Points:

1. Setting out the priorities so all VCS would be aware of them.
2. Permission to set our own outcomes.
3. Help to shape it more before you procure.
4. R + D Testing new ways of working, access to grant

Group Two

The world is changing!

- Language between services and provision
- Recognition of service provision in the voluntary sector. Small organisations competing with large (national) organisations
  Identifying and applying for funding – enabling access for smaller providers.
- Encourage, acknowledge volunteering, lived experience and co-production.
- Recognising voluntary sector can be responsible and trusted to share information relevant to provision for individuals.
- Involvement in sharing 'grass roots' experiences- in developing service needs.
- More collective view
- Voluntary sector needs to be more forward thinking.
- Standardised measures of the impact and "difference we make" proportionate to money and provision.
- Consortiums and partnership working – governance

Q1. How does the system need to change to enable the voluntary sector to play its part?

- Primary/ Secondary care need to accept that the voluntary sector has a role to play.
- Move away from the medical model for delivery.
- Importance → relevance to outcomes
- System of funding, Contracts are too big and often short term. There isn't the right range/type of funding models.
- It's all about trust and relationships and a lack of understanding of the VCS.
- Too much flux in statutory sector – Relationships need to be developed which is made difficult by the high turnover of staff in the sector.
- Need more access to funding for non-medical models.
- Focus on increasing numbers of participants in projects, rather than placing too much emphasis on scaling up.
- Need to gather an evidence base to gain trust with CCG. Data needs to be gathered, but first need a better data gathering system.
- Alliance contracting- need to be more open to different contracting models.
- Need to look at grants rather than contracting.
- Can't comply with TUPE- Voluntary sector can't compete with this.
- Is there any way of getting around legislation without breaking the law?
- Commissioning processes get in the way.
- Confidentiality/data issues: information governance.
- System change: the voluntary sector needs to have clear terms of reference.
- Voluntary sector is data rich but needs to feed into the system better with a coordinated approach.
- System needs to be more flexible and more open to partnership working.

Q2. How is the sector going to change to deliver the NECA/NHS ambitions for a shift in focus to improving health and wellbeing?

- Need to work together more.
- Voluntary sector is being pushed into a more competitive arena.
- Representation: Who knows what's going on locally?
- Voluntary sector needs to be engaged at a strategic level where the decisions are being made.
- Assumption that the voluntary sector are amateurs.

- How can the voluntary sector join up – need to look more at co-production.
- What's the role of VONNE to help facilitate this work?
- Look at Catalyst Stockton and their relationship with the CCG.
- Concern group: need to look at information sharing across health, social care and the voluntary sector.
- Clarity - what is the ask for the voluntary sector in terms of expected outcomes? All seems to be centred on the medical model.
- Voluntary sector need not to be shy – Voluntary sector need to add value and ask questions.
- Recognition is needed at a national level.
- Social return on investment- added value that voluntary sector is offering and not just focused on health issues.
- Joint commissioning will health a) health and social care commissioning b) across a larger geographical area. We need to join up – one route in and one route out.
- System change: central investment in data share across the whole system.
- Voluntary sector doesn't get the information because of trust.
- Is this something that the commission need to look at? Unlocking data/ information governance issues.
- How does the voluntary sector compete in tendering processes etc.? First needs investment into the infrastructure organisations to add value.
- We have a fantastic voluntary and community sector which the statutory organisations don't recognise.
- How can commissioners help?
    - Shared resources within infrastructure organisations.
    - Voluntary sector is embroiled in trying to compete against very experienced bid writers.
    - Should only have three-year contract.
    - Voluntary sector needs to be better at working strategically and learn how to better position themselves. Need to work differently and cleverly.
    - Need to be aware that the voluntary sector is working in a competitive market.
    - Social value- need to build this into health/social care processes.
    - Voluntary sector needs to educate commissioners as an opportunity to explain their role and build a relationship.
    - Is the voluntary sector aware of who is the 'commissioner'?

Key points:

1. Social value in contracting.
2. Investment in infrastructure.
3. Data/ information
4. Collaboration and sharing
5. Education about the VCS – including social prescribing.

Group Three

Q1. How does the system need to change to enable the voluntary sector to play its part?

- The Proving value added is becoming more and more difficult and quality is often not part of this process/evidence base
- Cultural differences between sectors needs to be taken into account when requesting evidence in the process
- Where/when do you engage with health – right person at the right time is critical

- Language and jargon is a barrier – NHS don't recognise the VCSE language around prevention
- Definition of evidence is required
- Greater consistency in definitions of evidence and value added
- Greater clarity about the objectives we are trying to get behind together – Clearer about fewer objectives so that different parts of the system can demonstrate what their part is in achieving these objectives
- Think about different stages of any development and sustainability. Is the sector too complicated/complex for the statutory sector to engage with?
- No informed commissioners working in the sector
- How can the system work with the procurement process to enable this to happen?
- Change the approach to procurement to be less specific on how more on what.

Q2. How is the sector going to change to deliver the NECA/NHS ambitions for a shift in focus to improving health and wellbeing?

- What organisations are expected to deliver?
- Role for umbrella organisations – infrastructure organisations to translate and promote the VCSE offer
- Greater recognition of diversity of VCSE
- Consistency across the region on outcomes required would help – Devo could help here to enable a focus on fewer outcomes.
- Where there are new approaches and innovation we may need to develop the evidence as we go – more R & D. VCSE can access other sources of funding e.g. for pilots
- Get better at collaboration across organisations to meet requirements of procurement/commissioning.
- Alternative contracting/special procurement vehicles e.g. alliance contracting

Group Four

Q1. How does the system need to change to enable the voluntary sector to play its part?

- There was a very limited understanding and acceptance of the costs associated with operating a voluntary sector organisation. Attending events to contribute and keep up to speed with initiatives and developments was an overhead so it proved difficult to find time and resources to cover this overhead.
- The Commissioners needed to understand/have their awareness raised of the costs associated with operating a voluntary sector organisation, especially the costs associated with complying with NHS procurement and contracting rules. The commissioning process needed to be improved to enable greater participation at an earlier stage of the process.
- Voluntary Sector input was required in the design and delivery of services however the costs associated with the procurement process and running a contract were becoming a bigger and bigger overhead.
- The proposed Anti-Advocacy Clause could impact on organisations that are funded through the public purse. The progress and impact of this legislation if enacted would have to be monitored carefully.
- The development and roll out of Personal Health Budgets was a good example of where the Sector had only been invited to be involved in the process after it had been designed and developed for roll out. A Project Manager had now been appointed and it was felt that it would now just "happen" with little influence from the sector. The CCG just went straight to NECS for procurement without any reference to the Sector.

It was considered that they did not understand the role and input the voluntary sector had in this service area.

- The CCG and service providers in the Voluntary sector needed to change their views on those working in the Sector. They must not be seen as replacements for full time, paid roles.
- Better Commissioning/More Informed Commissioners
- The Sector brought in at an early state in the commissioning process
- Challenge Commissioners to move cash out of acute care to asset based model. Potentially lose asset based resources unless funding issues resolved.
- Newcastle Elders had discussed this and it appeared that the voluntary sector was trying to fill gaps in services/activities relating to wellbeing. They had connections with the link workers. How do you measure success of this type of activities? Having a strict, standardised methodology for measuring success created issues as there were various ways to measure success depending on the type of the project/activity/ service e.g. difficult to measure impact on visits to a& e/acute beds etc.
- Volunteers are not just a replacement for paid workers – Their work adds value!

Q2. How is the sector going to change to deliver the NECA/NHS ambitions for a shift in focus to improving health and wellbeing?

- There are issues with keeping up with developments and initiatives in the Sector. Concern that awareness of the devolution agenda depends on organisations/group looking for information rather than the sector having an effective information dissemination process that is accessible to all groups.
- The sector needs to wake up to the significance and positive impact the opportunities created by devolution could have.
- There is a need to keep abreast of developing issues/changes and how devolution will impact on the sector.
- There was an urgent need for everyone involved to see how the two sectors could work more effectively together. However, there was also a need for those within the voluntary sector to work together better.
- There was a need for greater collaborative working in the sector in order for organisations to survive. However, some organisations did not want to work together. New ways of maintaining connections and working in partnership needed to be developed. Events such as this one today were a key way of keeping up to speed with developments in the sector and developing connections and networks. A significant number of organisations were now in survival mode and had become quite protectionist. There needed to be some common goals created that all groups and organisations in the sector could associate with and work towards achieving.
- The Voluntary Sector is best placed to do the “voice of/local placed role” in the sector. The phrase “when commissioning think voluntary” needed to be used more in the process. Social Prescribing was a good example of the impact the voluntary sector was having on the health and wellbeing in the community and needed to be rolled out on a larger scale but it required to be adequately funded to have a significant and long lasting impact.
- There was a challenge in relation to the assumption that activities that were aimed at removing acute bed provision in hospitals would actually remove beds as they would just be occupied by the next priority service area that currently had unmet demand for beds.
- Filling the funding gap identified in the NHS STP should not be a measure of success!

Key Points

1. Small and Large Organisations needed to be at the table early
2. Make co-production a reality
3. Invest in communities, build on assets already there – move funds out of acute beds
4. Educate the Commissioners
5. Invest in Projects that will generate ideas/solutions – Not an absolute requirement that they will deliver savings/resolve issues

Group Five

Q1. How does the system need to change to enable the "led by and for" VCS organisations to play its part in addressing the barriers for these groups/ individuals?

- Stop infighting and work better together, to improve health and social care pathways and to support small VCSE organisations that are "led by and for" equality or identity groups, i.e. not sucking up all the available funding/ contracts without first thinking how these groups can be sustained and supported.
- More meaningful consultations, particularly with smaller VSCE organization – take time to make short visits (even if only for 30 minutes) rather than always expecting us to come to you.
- Don't keep talking about changing the system every six months or so and asking us about it – make the changes we ask for
- Take on board the VCSE works in a holistic/ bottom up way and with communities of interest and identity – we complement the public sector. It is really important that people have agencies to advocate on their behalf who are independent of the state
- The state and the system should stop making victims – there needs to be better assessment processes – joint assessments involving sharing, co-operation and humility
- Funding is needed to sustain core services, along with funding for innovation which has a risk factor built in – accepting that some innovation fails - With some issues we already know a fair amount about prevalence. E.g. DV, SV, and the relationships of these to mental health issues. These services in the VCSE should be grant funded. There should be a more standard range of services to grant fund from the expert, experienced VCSE service providers. (This standard list can be the subject of debate and education)

Group 5 feedback on how can we improve health and wellbeing outcomes by working in partnership?

Here are some of the solutions to these barriers:

Under the Health Act Local Authorities now have the main responsibility for coordinating and for meeting the needs of the population. They are now the gateway to information on health and wellbeing s services in the local area.

a) **Easier and different methods, for individuals to access information** about who can provide them specialist services, support and knowledge. The Independent and impartial advice, necessary to help them to make their own choices including advocacy. This is even more important for vulnerable groups.

b) **All Local authorities must now offer Advocacy,** when doing a health and social care assessment to anyone who does not family or friend to support them.

Have it is essential that local authorities explain clearly, what is meant by advocacy and how it can be helpful. This option should be available to any vulnerable person they may come into contact with, even if they have family and friends.

- General advocacy is less effective in these vulnerable identity groups, specialist support and services are needed.
- The voluntary sector is already heavily involved in providing services in particular user led groups.
- These organisations were created to support, campaign and change the system. There was a lack of awareness, understanding, and inappropriate or no provision.
- Examples include Disability North it is a user led charity, it supports disabled people and their families in the North East.
- The Angelou Centre is user led based in Newcastle, supporting black and ethnic minority women and their families including refugees.
- There seems to be a lack of support for young people
- The voluntary sector must listen to young people and help them create their own services.