

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.

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.

You may re-use the text of this document (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence/

© Crown copyright 2016

Published to gov.uk, in PDF format only.

www.gov.uk/dh

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.

Contents

| | |
|---|----|
| Contents | 4 |
| Introduction | 6 |
| Vision | 7 |
| Recommendations | 10 |
| Summary of responses | 15 |
| Promoting equality, reducing health inequalities | 15 |
| Introduction | 15 |
| Why working with VCSE organisations is valuable | 15 |
| Requirements for success | 17 |
| Partnership and collaboration | 20 |
| Introduction | 20 |
| Why partnership working and collaboration are valuable | 20 |
| Requirements for success | 21 |
| Impact and evidence | 27 |
| Introduction | 27 |
| Why VCSE organisations assessing impact and collecting evidence is valuable | 27 |
| Requirements for success | 28 |
| Funding and Commissioning | 34 |
| Introduction | 34 |
| Why improving funding and commissioning approaches is valuable | 34 |
| Requirements for success | 35 |
| Infrastructure | 43 |
| Introduction | 43 |
| Why infrastructure is valuable | 43 |
| Requirements for success | 45 |
| The future of the Voluntary Sector Investment Programme | 48 |
| Introduction | 48 |
| Why the programme is valuable | 48 |
| Requirements for success | 50 |
| Annex A: Methodology | 53 |
| Consultation | 53 |
| Online consultations | 53 |
| Face to face events | 55 |

CONTENTS

| | |
|---|----|
| Live online events | 56 |
| Other..... | 57 |
| Annex B: Advisory group and secretariat..... | 58 |
| Annex C: Glossary | 60 |
| Annex D: Co-designing local health and care systems | 63 |
| Annex E: Bibliography | 65 |
| Annex F: References | 69 |

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 2015¹. 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, whatever our long term health conditions or 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 sectors², plus at least 10,000 more social enterprises³, and tens of thousands more unregistered community groups operating below the radar⁴, 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,

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

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 be 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 sites⁵, Integrated Personal Commissioning programme⁶, Integrated Care Pioneers programme⁷ 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 guidance⁸ 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.

VISION

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,⁹ has developed six principles for implementing the NHS Five Year Forward View,¹⁰ which reflect the findings of this Review and which local health systems are being asked to build on when developing Sustainability and Transformation Plans¹¹:

- 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.

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

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 vision 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 View¹², the principles contained in the Engaging and Empowering Communities memorandum of understanding¹³, 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

VISION

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.

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

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 Principles¹⁴ and Data Standard¹⁵, 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.¹⁶ 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.

VISION

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.¹⁷ This could be modelled on the existing Justice Data Lab.¹⁸

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.¹⁹

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

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

27. Government should consider extending the market diversity duty²⁰, 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.

Summary of responses

Promoting equality, reducing health inequalities

Introduction

There is overwhelming evidence that people in England face significant health and wellbeing inequalities. Despite free access to one of the best health care systems in the world, life expectancy varies by 6 years for both men and women from different socio-economic backgrounds.²¹ There is even greater variation in healthy life expectancy and the extent to which people from different backgrounds are able to live healthy, active and social lives.²²

Health inequalities also have major economic impacts for society as a whole, not least contributing to rising costs for health and social care services. The Marmot Review²³ estimated that health inequalities account for £20-32bn per year in higher welfare payments and lost taxes, additional NHS costs of £5.5bn per year and productivity losses of £31-33bn per year.

Only with a relentless focus on reducing these inequalities will we ensure they do not get wider. Promoting equality and reducing health inequalities is a key part of the Shared Delivery Plan, mandate to NHS England, the NHS Five Year Forward View, NHS Outcomes Framework, Public Health Outcomes Framework, and local health and wellbeing strategies. As such, these goals are at the heart of existing plans for the health and social care system and should be considered a high priority.

In this chapter, we explore the contribution that VCSE organisations can make to reducing health inequalities and achieving better public health outcomes, in support of these ambitions.

Why working with VCSE organisations is valuable

Respondents believed that VCSE organisations can play a vital role in reducing the human and financial costs associated with health inequalities, often through peer- and/ or community-led activity which can achieve better outcomes at lower cost. This happens in a number of ways.

User-led

VCSE organisations involve people experiencing health inequalities and build their capacity for social action. Often organisations draw on the contributions of staff, trustees and volunteers with first-hand knowledge and experience. For example, Lancashire Women's Centres recruited women from black, Asian and minority ethnic (BAME) backgrounds to act as health mentors who could tailor advice for other BAME women, ensuring a more effective service and creating a route for individuals to progress through volunteering to paid work.²⁴

Engaging people experiencing health inequalities in social action can be extremely beneficial for their wellbeing. Putnam²⁵ found that participation in a group cuts a person's chance of dying in the next year by half, and joining two groups cuts the risk by 75%; peer support also offers a huge return on investment.²⁶ Meanwhile, DWP/ Cabinet Office research has confirmed that volunteering can improve the wellbeing of volunteers.²⁷ This is particularly likely to be beneficial for individuals from ethnic minority groups, individuals

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

who have no qualifications and those who have a disability or a long-term illness as they are less likely to be involved in voluntary associations generally, according to the national Citizenship Survey.²⁸ Additional research with those over the age of 50 suggests people who volunteer spend significantly less time in hospital.²⁹ In total, the Kings Fund estimates that there are 78,000 volunteers within NHS acute trusts and around three million in wider health, care and welfare organisations.³⁰

Community experts

VCSE organisations promote understanding of the specific and often intersectional needs of their communities. Whilst recognising the continuing value of universal services, government has accepted the risk that: “For mainstream practitioners, it can be hard to tune into the complex needs of socially excluded groups and allocate sufficient time and tailored interventions to meet the complexity of their needs.”³¹ Respondents concurred and gave examples where universal services were not always provided appropriately for those with specific religious or cultural needs, or where individuals need more support to access these services, such as translation, or where people experienced multiple disadvantages and did not neatly fit into ‘one box’.

The LGBT Foundation gave evidence that without specific advocacy, LGBT communities can find their needs rendered ‘invisible’ in universal services leading to higher long term costs:

“The common consequence of not recognising and therefore meeting these specific needs is that the issues LGBT people are disproportionately affected by – mental health issues, sexual health problems, drug and alcohol abuse, social isolation and vulnerability in old age and poor access to public services including gender identity services for trans people – are exacerbated.”³²

Trusted

VCSE organisations have “a track record of trust”.³³ Many respondents felt that individuals may be reluctant to engage with statutory services and more willing to trust VCSE organisations in their community. For example, Migrant & Refugee Community Organisations noted that, as 83% of individuals contracting tuberculosis were born outside the country, their organisations were better placed to tackle the stigma that hinders TB control, achieve case finding and contact tracing. Another indicator of trust mentioned by several respondents was the level of self-referrals to their services.

Accessible

VCSE organisations are accessible, with many operating a ‘no wrong door’ policy. As Bournemouth CVS stated: “The VCSE [sector] is better placed to achieve preventative outcomes because of the nature of the way services are provided. Access to services is easier as thresholds/ criteria do not need to be met and there is less bureaucracy. This enables us to be a first port of call for individuals.”³⁴ This is particularly helpful where people have encountered barriers to accessing statutory services. For example, Contact a Family commented: “Many parents or carers of disabled children will get in touch with Contact a Family locally or nationally to seek help with their situation. This is often after they have encountered process/ cultural barriers in accessing support from schools, local authorities or NHS providers.”³⁵

Holistic

VCSE organisations offer holistic services so that people’s needs are fully met. Many respondents felt that this was the greatest contribution of the VCSE sector: sticking with

SUMMARY OF RESPONSES

people, taking a wider view of their wellbeing and helping them to overcome personal challenges, even when these are complex or entrenched. Youth Access commented that: “The sector can work in a more flexible and integrated way as it is less bound by the ‘rules of the system’.”³⁶

“Demand relating to more complex issues has tripled in the last three years. We have gone from 30% to 70% of our client group experiencing severe and enduring mental illness which means a more intensive service is needed over a longer period of time to make what might appear to be superficially smaller steps towards a positive outcome. We really believe that longer term, more intensive and therapeutic interventions are what is needed to create sustainable change. Unfortunately this is at a time when services seem to be focussing on short-term, fixed time interventions.”³⁷

“Charities care for the ‘whole person’—whether their needs are medical, emotional or social—and provide support throughout a patient’s journey to recovery. It is not just about fixing a problem, but building resilience so individuals feel able to make positive health choices. This includes preventative action and early intervention, and work to address the social determinants of health.”³⁸

Reduce system pressures

VCSE organisations reduce the costs of ‘failure demand’. The NHS has itself recognised that “Many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, which can result in them defaulting to emergency departments.”³⁹ VCSE groups help to alleviate these pressures by helping people to navigate the system and by providing wraparound services.

“For individuals with multiple and complex needs, poor engagement with community and primary care services is recognised as leading to high use of costly emergency and crisis services, which can be significantly reduced when receiving additional support from the voluntary sector.”⁴⁰

Requirements for success

To enable VCSE organisations to maximise the contribution they make to reducing health and wellbeing inequalities, systemic and cultural changes will be necessary. These include:

Better identification of groups that face health and wellbeing inequalities

This should include but also go beyond those with protected characteristics, since many other groups of people experience health inequalities.⁴¹ Where statutory bodies do not hold the data they need, VCSE organisations may be able to provide information and estimates to assist. A key message for commissioners was to remember that people do not always fit neatly into a single ‘box’ and that they need also to consider other groups that experience health inequalities, such as families of offenders or travellers.

“The needs of many minority ethnic communities aren’t being reflected in many Joint Strategic Needs Assessments.”⁴²

“Many commissioners fail to reach beyond a narrow definition of diversity or a belief that there is a one-size solution to, for example, a range of black and minority ethnic groups. Therefore, the needs of many groups are neither considered nor addressed”⁴³

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

CASE STUDY: Calderdale CCG supported Voluntary Action Calderdale to develop networks of people who fall under the protected characteristics set out in the Equalities Act 2010. These networks were then consulted through online surveys and focus groups in order to develop the local JSNA. As a result, the JSNA better reflected the particular needs and assets of these individuals.⁴⁴

Collaborative approach

There is a pressing need for commissioners and policy makers to engage with people affected by health inequalities, if they are to reduce the human and financial costs associated with those inequalities. Yet respondents to this review commented that the health and care system is not always well-gearred towards hearing and acting upon their views. A number described poor experiences of being 'consulted':

"Each time I meet the commissioners it's like they're meeting me for the first time. They haven't taken the time to understand and respect us."⁴⁵

"Individuals and organisations have a tendency to talk to people like themselves, and this can be the case even when organisations are trying to get in touch with 'hard to reach' communities – it's easier to reach 'hard to reach' communities which are a bit like you"⁴⁶

"One BAME-led organisation described how although they were consulted, they did not feel that this consultation changed anything: 'You go to all the consultations, and almost feel quite used and abused as it doesn't feel as if it comes to anything at the end of the day. They make promises, but there's only so many times that you can go and meet in big offices, sitting round the table, and they all tend to be white males and all nodding and sometimes grimacing about things that you say. But it doesn't feel as if it comes to anything at the end of the day.'"⁴⁷

These kinds of experiences can clearly undermine people's confidence in the system and discourage their participation. Different approaches are needed, including working with and through VCSE organisations that can amplify the voices of individuals affected by health inequalities and provide evidence to strengthen the case for action. As Disability Rights UK commented, we need to: "Invest in organisations with members with direct experience of health inequalities and develop innovative ways to engage. Try to avoid relying on one organisation and recognise the diversity of the sector. People's voices are with the organisation they feel most comfortable."⁴⁸

NHS England and Public Health England are committed to improving the involvement of different sections of the community and have issued guidance on utilising participatory approaches to better facilitate their contributions:

"We are unlikely to narrow the health gap in England without actively involving those most affected by inequalities. Participatory approaches directly address the powerlessness and low self-esteem associated with structural inequalities. They also help improve access and uptake."⁴⁹

Commissioning specialist or tailored provision

Many commissioners currently favour large, generic contracts, often to provide services across a whole local area. Yet respondents gave numerous examples where universal or generic provision can be unsuitable or hard to access for people experiencing health inequalities. For example, individuals requiring more in-depth support, different access

SUMMARY OF RESPONSES

arrangements, translation, or those experiencing stigma within their own communities, such as those with HIV status, certain mental health conditions or TB. Overlooking these barriers can lead to increased human and financial costs in the longer term and often it would be more efficient to fund specialist, tailored provision in the first place. This could be done in different circumstances via grants, personal budgets, the NHS Short Standard Contract, or models of social prescribing where funding follows the patient. See the funding chapter of this report for more on these mechanisms.

National policy focus on health inequalities

Respondents felt it was critical to maintain policy leadership around promoting equalities and tackling health inequalities, particularly as public services are increasingly shaped locally, to ensure that the needs of communities of identity, such as LGBT people, are not overlooked. One option would be to focus the national Strategic Partners Programme on supporting groups that tackle health inequalities or promote equalities – who will often find it harder to fund their work via local commissioning, and who have experienced disproportionately large cuts over the last parliament.⁵⁰ The Strategic Partners will share responsibility for informing the Department of Health and other system partners on the issues and helping them work towards strategic solutions; and for sharing information and involving the wider VCSE sector in key debates.

Ultimately, a focus on equalities and health inequalities must move from being seen as a peripheral piece of work to being the core business of all health and care organisations. This would require payment systems to reward successful work with marginalised groups. The evidence base already supports approaches which are local, community-led and in which community members are employed. Conversely, we heard little evidence that large, generic contracts as currently used promote effective practice in this area. We address contracting later in the report.

Partnership and collaboration

Introduction

Many VCSE organisations develop in response to local need and are rooted in communities through the role of trusteeship and the ability to harness local voluntary action. Indeed, around 78% of UK charities⁵¹ and a similar proportion of social enterprises⁵² operate locally. Individuals are simultaneously recipients of support and are volunteers who help deliver services or oversee organisations as trustees. This embeds the principles of partnership, collaboration and co-production into the DNA of the sector.

In recent years, these approaches have also been built into key legislation, regulation and guidance for commissioners. The NHS Five Year Forward View emphasises the development of stronger partnerships and the Health and Social Care Act 2012 sets out requirements for involving individuals and their representatives in health and wellbeing boards, commissioning and through Healthwatch. The Care Act 2014 goes even further. Its statutory guidance refers to co-production in prevention, assessment, market shaping, strengths-based approaches, and developing local strategies and plans.⁵³ NHS England and Public Health England have produced a guide to community-centred approaches for health and wellbeing.⁵⁴ In addition, the Compact, last renewed by the Coalition government in 2010⁵⁵, has long promoted collaboration with the VCSE Sector.

Person-centred integration of services has been an important but elusive policy goal for successive governments. Including the VCSE sector in efforts to integrate could be seen as adding an extra layer of challenge and complexity, but we have heard that systems are far more likely to become ‘patient centred’ and think ‘whole person’ when the full range of community organisations and resources are visible and valued in local planning processes. Goals such as wellbeing, strong communities and resilience cannot be easily procured: they require collaborative planning and commissioning, with the VCSE sector able to feed community voices and expertise into the shaping of health and care systems.

In this chapter we explore the role of partnership, collaboration and co-production in health and care services, the potential benefits of these approaches and how to make their use more widespread.

Why partnership working and collaboration are valuable

Partnership working and collaboration between commissioners, VCSE organisations and individuals were seen by respondents to have a number of benefits.

Responsive to individuals

It ensures that services better reflect individuals’ needs, capabilities and goals in the context of all the resources and support available to them. Often “service users themselves are best placed to recognise what is most likely to help them and others in similar positions to have long-term positive health outcomes”.⁵⁶ Rather than a clinical intervention, it may be that a community response is more appropriate and effective. Indeed, individuals themselves may be the most effective deliverer of support (if given the right kind of help). Providing a choice of joined up, tailored and highly personalised support can help create local jobs and volunteering opportunities, enabling local money to stay local. It can also enable more effective targeting of diminishing statutory resources.

Empowering

Working in partnership can empower individuals and improve their wellbeing. Research has found that there is an “interaction between participation, well-being and agency, social

SUMMARY OF RESPONSES

interactions and cohesion”.⁵⁷ It appears that enabling people to use their assets, building on their existing capabilities, develops greater senses of self-worth and of belonging to a community. Similarly, there is a strong association between volunteering and “better health, lower mortality, better functioning, life satisfaction and decrease in depression”.⁵⁸

Utilise VCSE expertise

Collaboration allows commissioners to make use of expertise held by the VCSE sector, including its understanding of local communities. Respondents noted that VCSE organisations can have “considerable reach beyond that of statutory sector - including to underrepresented groups”.⁵⁹ Working in partnership with these organisations can ensure that the voice of marginalised citizens is reflected in strategic planning, commissioning decisions, service design and delivery. This was recognised in the Marmot Review which urged Local Strategic Partnerships to systematically engage with the VCSE sector to maximise the potential in engaging local communities.⁶⁰

As noted above, collaboration and co-production are central to the approach taken by many VCSE organisations. As such they may have expertise in particular interventions or be able to provide a frank assessment of service design and suggestions for improvements. As one submission put it, this could result in “more imaginative responses to these problems rather than just bog-standard commissioning”.⁶¹

Better use of resources

Partnership working enables more effective and efficient use of local resources. Respondents highlighted that greater collaboration can ensure that “services are complementary and support is not being duplicated”.⁶² Services provided by statutory and VCSE providers are part of the same ecosystem of support; it makes sense for priorities and approaches to be aligned. Doing so can enable commissioners to “uncover and leverage existing assets, resources and networks”.⁶³

CASE STUDY: The Age UK Integrated Care Model is currently being piloted by local health and social care partnerships across the country and brings together CCGs, local authorities, acute and community providers and local Age UKs. They work together and adopt a joint vision to improve outcomes for older people and to save money in the health and social care system, primarily by reducing avoidable unplanned hospital admissions. This model has been cited as an example of good practice in the NHS Five Year Forward View.

This model was originally piloted in Cornwall where it has so far achieved:

- 34% reduction in non-elective admissions in comparison to a matched cohort**
- 20% increase in wellbeing for older people**
- 8% reduction in the use of social care⁶⁴**

Requirements for success

To ensure that the benefits above are realised, a number of conditions must be in place. Although actions are required by both VCSE providers and communities, there is a particular onus on commissioners due to the decision making powers (and attached resources) that they have responsibility for. Indeed, there was a sense from respondents

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

that commissioning practice must be based on the principle of partnership in order to be effective.

Effective Communication

In order to effectively work together, respondents felt commissioners, VCSE organisations and individuals need to communicate well. This requires a shared language. As one respondent noted, there is even “a wide variation in local understanding and interpretation of ‘co-production’”, suggesting that it would be “helpful to agree (co-produce?) some clear definitions”.⁶⁵

To this end, the Richmond Group of Charities, in partnership with Public Health England and other voluntary sector organisations, has developed a set of frameworks with a shared language for charities to describe their work and its value. Using language that resonates with both VCSE organisations and statutory partners, the frameworks provide commissioners with a way to identify the aspects of VCSE organisations' work that most clearly match their needs and priorities.⁶⁶

Poor communication can result in low levels of mutual understanding between different health and care stakeholders. VCSE organisations will benefit from understanding the various financial, regulatory and organisational constraints that commissioners are under. Similarly, it is valuable for commissioners “to actually get out into the communities they serve to see the positive impact of the VCSE and gain an appreciation of what the community itself has to offer in terms of peer support, co-production and social value”.⁶⁷ One respondent suggested local job shadowing as an effective way to do this.⁶⁸

Respondents emphasised the importance of communicating with and involving VCSE providers and the community at all stages of the commissioning process. Such communication needs to be fully embedded in working practices, rather than a “tokenistic”⁶⁹ extra, and should start at the strategic level. Effectively this means commissioners moving beyond simple communication to systematic stakeholder engagement. For example, the LGA and NHS Clinical Commissioners have identified that a key characteristic of effective health and wellbeing boards is “the use of systematic engagement with the full range of providers of community, primary, secondary, acute and non-acute health and care, to enable an exchange of information and views to plan commissioning which will have the most impact on health outcomes”.⁷⁰

Formal representation

According to respondents, VCSE engagement with health and wellbeing boards is currently patchy as it is not a statutory requirement for boards to have a VCSE representative.⁷¹ 86% of recently surveyed CEOs of local infrastructure bodies reported that there is VCSE representation on boards.⁷² However, only 37% of surveyed hospices are currently involved with theirs⁷³ and many VCSE respondents didn't know whether they had a representative on the local health and wellbeing board or who that was. While some respondents were happy with the feedback provided by VCSE representatives on board activity, others said they did not receive any information unless they sought it out directly.

Even those who do attend health and wellbeing board meetings can find the experience disempowering. In response to a survey by VONNE, VCSE representatives said the discussion often involves just “rubber-stamping” decisions made “outside of, and before, the meeting”.⁷⁴ This suggests that health and wellbeing boards alone cannot fulfil the need commissioners have to undertake systematic stakeholder engagement with the VCSE sector. This conclusion is reinforced by the latest NHS planning guidance⁷⁵ which asks

SUMMARY OF RESPONSES

local areas to develop Sustainability and Transformation Plans which are much wider in scope than health and wellbeing boards.

Some respondents suggested amending the legislation to make VCSE representation on health and wellbeing boards a statutory requirement but this is very unlikely to happen in this Parliament. Equally, whilst this would undoubtedly improve the representation of the sector in many areas, it would not necessarily address the wider issues around the lack of VCSE engagement in strategic decision making.

Assets approaches and community leadership

There is a need for more effective and ongoing use of JSNAs as a number of respondents did not know when they took place or how to feed in. As discussed in the infrastructure chapter, there is an important role for local infrastructure in facilitating VCSE engagement in JSNAs. We heard that a JSNA, in order to effectively guide the work of health and wellbeing boards, should be a “continuous process”.⁷⁶ This process, which should be jointly agreed with local VCSE organisations should focus on “wicked issues”⁷⁷ i.e. complex, ongoing social problems which present in unique ways and for which there is no agreed solution. Respondents were clear that this should include assessment not just of community needs, but also the assets available to meet these.

Such an approach requires commissioners to listen and take on board what the VCSE sector says, rather than adopting a “tick-box”⁷⁸ approach. Respondents were clear that this cannot just mean talking to sector leaders. Whilst there was wide-spread recognition of the good work of infrastructure bodies, including as members of health and wellbeing boards, others said that it is “not possible for one representative to effectively represent the diversity of the VCSE sector”.⁷⁹ Commissioners need to reach out to smaller organisations and marginalised communities in order to get the full picture. Respondents understood that this is not easy to do and that imaginative communication approaches will be required. One effective route is through resourcing effective local infrastructure, as noted in the chapter below.

CASE STUDY: Bexley Voluntary Service Council has been involved in the local multi-agency JSNA Steering group as well as a number of engagement events, one specifically aimed at the VCS. With the support of statutory partners, they have established an on-going process for the VCSE sector to contribute to local data, needs assessment and priority setting. They are currently exploring a more asset based approach to seek to understand community resources and capacity alongside more formal delivery of public services.⁸⁰

We also heard from respondents that there is potential for collaborative commissioning and provision approaches such as consortia and alliance contracting to identify complex goals and involve a wide range of statutory and VCSE organisations in tackling them.

Data sharing

In addition to supporting strategic planning, we heard that data sharing can act as an important driver for service improvement and that this “is particularly the case when different agencies provide tailored services to individuals with multiple and complex needs”.⁸¹ There are, however, significant barriers. A May 2015 survey of senior staff in local authorities, NHS providers and clinical commissioning groups (CCGs) found that 61% thought data protection rules were limiting progress on health and social care integration.⁸² Even if there are ways to navigate legislative and technical blockages, cultural barriers and confusion around what is allowed can heighten resistance to data sharing.⁸³

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

This was echoed by respondents who identified it as an issue, including for social prescribing projects, as VCSE organisations are unable to access the case file data of their clients, held by GPs that would enable them to evidence outcomes. Equally, it can also be difficult for health and care bodies to access VCSE data. As one respondent recalled, “Our biggest struggle was aligning our open source database with the NHS computer system that the GPs use. After a lot of technical support, GPs can now directly access our VCSE social prescribing database from the NHS computer at their desks.”⁸⁴

The LGA and NHS Clinical Commissioners⁸⁵ have identified some solutions developed by health and wellbeing boards to enable local data and intelligence sharing. These include:

- Developing JSNAs as flexible, living and frequently updated resources which all health and wellbeing boards representatives contribute to
- Agreeing information-sharing protocols
- Agreeing common datasets and parameters for collecting information (for example on patients’, service-users’ and carers’ experience of services)
- Agreeing common reporting mechanisms and performance measures.

Culture of Collaboration

We heard that health and care systems are better designed when individuals' and their carers' voices, including those from minority and overlooked groups, are fully heard and listened to from the beginning and throughout planning, commissioning and review. VCSE organisations are essential for achieving this co-produced approach. This requires engaging with a broad range of groups as no single VCSE organisation can reach every community. Too often the presence of a single VCSE organisation is considered to have ticked the 'involvement' box.

We heard from respondents that the deficit/ needs based model and expert/ medical model are deeply ingrained within the culture of the NHS, and many other organisations. These are based on a traditional view of individuals as passive recipients of support. As such, they are very different from the asset based model which underpins co-production. This seeks to bring about positive change in people's lives by harnessing their existing skills, knowledge and lived experience. Adopting the asset based approach more widely cannot be done as a “bolt on” to existing methods but will require “fundamental organisational culture change in relation to values and attitudes at both strategic and frontline levels”.⁸⁶ The VCSE sector has led on the adoption of asset-based approaches and community leadership but this is not consistent. Even organisations which draw on volunteers and social action, do not always include a focus on recruiting volunteers from the same communities and groups which they serve.

In addition to valuing the contribution of individuals, we were told of the need for a more equal relationship between commissioners and the VCSE sector. Currently, in some areas, there is not parity of esteem, with GPs and other medical professions not valuing VCSE organisations, either as providers or as a voice for communities. Respondents were clear that true partnership requires “recognition of the value and legitimacy of the sector as an equal partner”.⁸⁷ This included a CCG, which said that partnership requires “mutual respect between commissioners and VCSE organisations”.⁸⁸ Compact principles can act as a firm basis for such partnerships, either using the national standards or through the development of Local Compacts.⁸⁹ As noted in the funding and commissioning chapter, better integration of social value principles, including through the Social Value Act, in commissioning can support this process.

SUMMARY OF RESPONSES

With regard to the Compact specifically, there was a request from the sector that the current government renew its commitment to it as a demonstration of its continued support for the Compact principles.

CASE STUDY: St Helena Hospice has entered into a joint commissioning agreement with North East Essex CCG for end of life care services. The agreement recognises the hospice as a lead provider and significant funder of these services in the community. The relationship aims to utilise the social value benefits of a joint NHS and VCSE-led approach to planning for, and meeting, the increasing demand for non-acute palliative and end of life care services.

The benefits of this innovative approach include: improved patient experience; significant cost savings per annum; the delivery of the local End of Life Care strategy; and it has enabled a key contribution to the local Keogh Action Plans. For example: more people being cared for, and dying, in their place of choice; the phased reduction in unmet need in the community; and greater patient choice and person-centred care.⁹⁰

Respondents stated that trust is fundamental to valued partnerships. VCSE organisations need to trust that their views are being taken on board by commissioners if they are to commit the necessary time and energy. They need to “see evidence of the impact of the contribution” and believe that there is “a real, ongoing commitment to co-production, and it is not just a fad or a ‘fashionable’ approach to policy development”.⁹¹ Similarly, we heard that commissioners sometimes need to take a leap of faith as it can be difficult for VCSE organisations to ‘prove’ they are trustworthy. Attendees at our Stockton event spoke warmly of Hartlepool and Stockton-on-Tees CCG which they said had started with trust, leaving it to VCSE organisations to prove them right, rather than having to build that trust before being able to bid for contracts.

As noted in the impact and evidence chapter, when VCSE organisations operate as service providers, trust is also vital for overcoming concerns about sharing information about their approach and performance. Respondents told us that commissioners need to develop a culture of collaboration to overcome fears about intellectual property being lost to competitors. Similarly, worries that commissioners may cut funding can prevent VCSE organisations from being open about how services could be improved. This requires the development of a positive error culture, which focusses on learning rather than blame. A culture of measuring negative as well as positive outcomes of health and care services (see impacts chapter below) could aid this.

We also heard from VCSE respondents that commissioners can sometimes feel unable to collaborate with VCSE sector providers in the development of innovative service solutions due to legal concerns that this might represent an unfair competitive advantage. It was suggested that the new innovation partnership procedure, introduced in the Public Contract Regulations 2015, may provide a route for overcoming this issue in some cases.

Respondents understood that collaboration is difficult. Fundamental culture change and the development of inter-sector trust will inevitably take time. Senior buy in and commitment is needed to see through such a transformation. Public Health England say that making “partnership working with communities a part of the mainstream business of public health... will require local leadership”.⁹² The King’s Fund gave the example of Sheffield where “the CCG and local authority have established an executive management

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

group jointly chaired by both organisations” to lead delivery of their integrated commissioning work.⁹³

Resource

We heard throughout the consultation that partnership working, and co-production in particular, “takes time and it can be challenging but the results are worthwhile”.⁹⁴ Although there is an upfront cost, this is likely to result in a long term cost saving and better tailored services. Respondents were keen to engage in collaborative work but many highlighted how difficult it can be, one noting that VCSE organisations “have limited management resource to spend hours at meetings”.⁹⁵ An example was given of a planning meeting that involved 12 VCSE leaders and two public health staff. Although the meeting was only two hours long, the estimated cost to the sector of attending was at least £600.⁹⁶ Similarly, the Health and Care Partnership Conference held in January 2016, which brought together key stakeholders to inform national health policy, had over 30 VCSE attendees. Given the seniority of those participating from the sector, this is likely to represent a staff cost of over £10,000.

Equally, engaging the local community as volunteers is not free: recruitment, training and supervision costs must all be considered.

Collaboration between VCSE organisations, such as through consortia, can also be time and resource intensive. Some VCSE organisations, including small community groups and social enterprises which have a vital role in developing community capacity and reaching marginalised groups, are too small to engage in consortia, but this is not always recognised. There was a strong view that partnerships should be developed around intended goals and outcomes rather than imposed upon the sector as a general good.

Respondents appreciated that taking the time to engage with VCSE organisations and the communities is increasingly difficult for commissioners too due to pressures on funding and headcount. They emphasised though the risk of “squeezing out the smaller, less-resourced”⁹⁷ groups from partnership working if funding was not provided. This can be a particular loss for JSNAs which may, as a result, fail to fully reflect the needs of marginalised communities.

Infrastructure organisations can, as discussed in more detail in the infrastructure chapter, be an efficient way both for commissioners to access smaller organisations and for smaller organisations to feed in their expertise to strategic planning. Unfortunately, “voice and representation work is often unfunded or poorly resourced by statutory bodies”.⁹⁸

Impact and evidence

Introduction

Nothing is more important than a person's health and wellbeing. Good quality care can, quite literally, be the difference between life and death. Advancements have come through the repeated testing of hypotheses, collection of evidence and assessment of outcomes. It is unsurprising, therefore, that health and care commissioners should expect high standards of VCSE organisations.

As funding has got tighter, there has been an increased expectation that commissioning will be done on the basis of outcomes and that providers will be held to account for what they have achieved, often financially through payment-by-results contracts.

The language of outputs has been replaced by that of outcomes and impact. Qualitative assessments have been augmented with quantitative methods. Whereas once VCSE organisations providing public services would be asked to report on the number of sessions run or people seen, increasingly they seek to assess people's outcomes and reductions in use of hospital resources.

It should be noted, however, that demonstrating consistent achievement in contributing to long term impact, such as the achievement of wellbeing and resilience or reduction in social isolation, is a challenge for all sectors. This does not diminish the importance of these goals but it does mean that we should be realistic when setting expectations for VCSE organisations. Measurement of clinical and care outcomes is best understood within the wider context of the positive and negative effects of all health and care interventions on wellbeing, resilience and informal networks of support.

In this chapter, we explore the importance of evidence and impact assessment, and how both can be used more effectively in health and care services.

Why VCSE organisations assessing impact and collecting evidence is valuable

There was, unsurprisingly, broad agreement on the importance of effective care that is high quality, innovative and person-focussed. Respondents identified three specific reasons why the collection of evidence and assessment of impact is vital.

Self-improvement

VCSE organisations need to know that their interventions are worthwhile. Being mission-driven, the ultimate metric of their success is the impact that they have. Solvency is necessary but not sufficient for ensuring organisational aims and objectives are being met. VCSE organisations do not need to be interested in delivering public services in order to want to improve the quality of their work with communities. Respondents stressed that service improvement is a journey, rather than a destination: that failure is acceptable as long as lessons are learnt and changes made. Indeed, failure is inevitable when new innovative services are being developed. Echoing the mantra of Silicon Valley, one submission advised "Accept failure, but fail fast".⁹⁹

Accountability

Providers need to be accountable to funders, whether they are the public, charitable foundations, commissioners (who themselves are ultimately also accountable to the public) or National Lottery distributors. As noted above, statutory funders in particular are increasingly interested in the social, economic and fiscal benefits that will accrue as the result of a successful intervention. In order to secure funding, VCSE organisations must

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

provide evidence that the service will do what they say and what the commissioner wants. A respondent gave the following example:

“We have recently been able to secure additional investment from one CCG by presenting benchmarked figures from similar commissioned services in palliative and end of life care nationally.”¹⁰⁰

Individuals, who are increasingly buying services either with their own money or with direct payments, may require very different types of evidence. Rather than thinking in terms of ‘successful interventions’, they are more likely to judge a provider on the basis of its ability to enable the living of a more comfortable and ‘good’ life.

Better commissioning

Better evidence and assessment of impact leads to better commissioning. As one submission put it: “Good commissioning uses evidence about what works; using a wide range of information to achieve quality outcomes for people and communities”.¹⁰¹

Respondents highlighted the importance of JSNAs making use of the data gathered by specialist VCSE organisations. As discussed in the promoting equality, reducing health inequalities chapter, this is critical for meeting the needs of marginalised groups whose experiences are often not reflected. Commissioners should also learn from the experience of other areas. Although every locality is different, they are not so different that they can’t benefit from each other’s knowledge.

Requirements for success

To maximise the contribution that assessment and evidence can make to health outcomes, a number of key building blocks must be in place. At the core of each, is a shared understanding between commissioners, providers and individuals on aims, methods, importance and proportionality.

Measuring what matters

There was a clear message from respondents that assessing many of the services provided by VCSE organisations is inherently difficult for two reasons. Firstly, the sector tends to take a holistic, person-centred approach, focussing on long-term wellbeing. It can take many years for the results of an intervention to materialise in terms of cost savings, particularly when working with those with complex needs and a positive outcome will inevitably look different depending on an individual’s assets, objectives and needs. The evidence collected will need to reflect the variation of both this and the requirements of the funder: an individual will likely have a very different approach to a local authority or CCG. Following individuals’ journeys is often the most effective way to identify system waste resulting from so-called ‘failure demand’.

As noted in the funding and commissioning chapter, statutory funding agreements, tend to be relatively short term. As a result, it is unlikely that the full impact of a service will be known by the end of a contract. Indeed, given that evidence collection will generally stop at the same time as the money does, it may never be known. A key factor is the choice of metric; whereas the NHS will measure reductions in emergency admissions, a VCSE organisation may focus on quality of life improvements.

We heard, however, that temporal problems can be overcome. Proxies for long term goals, such as resilience, reduced social isolation and the confidence of family carers can be measured. Approaches based on logic modelling, theories of change and synthesising intervention-specific outcomes evidence from a number of existing evidence bases have

SUMMARY OF RESPONSES

shown great promise in enabling useful measurement of outcomes which are likely to be tied to long term impact and savings.

Secondly, health and care outcomes will usually have many intertwined contributing factors. Respondents said that this makes demonstrating causality difficult, especially for early action work. As one put it: “VCSE organisations struggle to demonstrate counterfactuals robustly, particularly in preventative work (e.g. attributing a reduction in A&E or GP access to an intervention)”.¹⁰²

Given the difficulties associated with thoroughly assessing long term impact, respondents emphasised the need to make greater use of qualitative evidence. Case studies, stories and quotes can all provide a powerful insight into an individual's experience and wellbeing. There was concern though that such evidence is not routinely being looked at by commissioners and that this is having a detrimental effect on JSNAs, one stating:

“Public health teams need to become more open to the potential of qualitative information to inform a JSNA. Quantitative data and statistics simply indicate a problem exists, and often do not give any insight into causes of problems (and therefore what is needed to solve problems). This means that JSNAs can be quite short-sighted and focused on fire-fighting rather than prevention.”¹⁰³

This is part of a wider shift in what is valued in health and care. Questions have been raised about whether the focus on clinical outcomes and service utilisation is sufficient given changing social attitudes to notions such as wellbeing, the growing number of people living with long-term conditions, and the increased focus on individual assets and interests, rather than just needs. If society increasingly values person and community focused outcomes, then the health care system that serves it may need to reflect this.¹⁰⁴

Clarity

Throughout the consultation we heard about the need for clarity on the outcomes and impact being sought. Sally Cupitt of NCVO Charity Evaluation Service commented during an online live chat that:

“Very often [organisations] come to us with fairly vague statements about the changes they wish to achieve, and we spend time helping people break these down into something specific, clear and measurable. This needs to be done before measurement systems can be put in place.”¹⁰⁵

A theory of change plus an understanding of the wider evidence and literature can help organisations to identify early, intermediate outcomes as well as the long term impact being sought.¹⁰⁶ There is a role here for good commissioning which can help connect providers and practitioners to the evidence base. This could be particularly valuable if undertaken by CCGs or local authorities to support providers of services purchased directly by individuals (either with their own money or through direct payments).

Commissioners too must be clear about the change they are seeking. At an event hosted in Leeds we were told that evaluation goalposts can be moved even after work has commenced. Greater clarity at an earlier stage can ensure that only information that is going to be used is collected, saving time and effort for both commissioners and providers alike. This can also increase individuals' confidence in data handling. In some cases, there may be a need for developmental evaluation in the early stages of a programme to help refine the delivery model.

Respondents also highlighted that the lack of a standardised approach to assessment and evaluation across health commissioners can be challenging:

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

“It is unclear which approach is most useful to public health commissioners, so deciding how to evaluate our interventions (and subsequently present it to commissioners, to best meet their needs) is difficult. Commissioners also adopt different approaches to assessing the value of interventions, so what may be considered appropriate in one geographical area may not be useful in another.”¹⁰⁷

It was suggested that VCSE organisations might be more willing to invest in developing skills if they could be sure that their approach would be valued by more commissioners.

There was, however, recognition that a “one size fits all approach is unlikely to work”¹⁰⁸ due to the need to take account of local context. Whilst a standardised tool would be difficult, respondents thought that there could be scope for a national “standardised development framework” that supported local areas to create their own outcome measures.¹⁰⁹ Such a framework would need to account for the fact that support and services are increasingly commissioned by the person and their family.

Finally, respondents highlighted the importance of shared language. A lack of clarity over what is meant by terms such as impact and outcomes can lead to misunderstandings between commissioners, VCSE providers and individuals. It can also prevent effective dissemination of findings. Evidence and research need “to be translated into accessible, understandable and timely resources for practical use”¹¹⁰ if their value is to be maximised. An accessible common language is particularly important given increased use of personal budgets.

Access to data and sharing of results

“Transparency of information and open data are a powerful means to support accountability, to empower patients and the wider public and to drive improvement and innovation. In the health sector our starting point should always be to make data and information available unless there are good reasons not to do so.”¹¹¹

This sentiment was supported by other respondents to the VCSE Review, who identified access to data as crucial for organisations seeking to evidence their own impact and learn from the experience of others. There are many types of data. Of particular interest in the health system are:

- Generalised anonymised data about NHS systems e.g. average wait time for GP appointments
- Specific data about individual patients e.g. number of hospital admissions for those involved in a specific VCSE project
- National survey data
- Data from other VCSE projects and services

As noted in the partnership and collaboration chapter, data protection issues around the second of these can hamper partnership working between statutory and VCSE sector bodies as providers are often unable to access the data showing outcomes of people they have worked with. For example, a respondent stated that they “would welcome timely access to wider systems data e.g. GP appointments/ hospital admissions to enable us to deduce and evidence the wider impact of our services”.¹¹² Whilst legislative and technical changes may resolve some blockages, in other cases cultural barriers and confusion around what is allowed will need to be overcome.¹¹³

SUMMARY OF RESPONSES

"Agreeing information governance and data sharing protocols is key in enabling organisations to work together more effectively by facilitating shared knowledge about what works and what delivers the best outcomes for different groups of people."¹¹⁴

With regard to organisational data, particularly assessments and evaluations, respondents identified commercial considerations as the primary block to better sharing. Firstly, VCSE providers may be "scared to report bad findings to their funders" out of fear that they will not be funded again, despite the fact that some funders "are really positive about transparency and usually see the sharing of such findings as a sign of a learning organisation."¹¹⁵

Secondly, the competitive public service tendering environment has the "potential to erode previously high levels of trust and communication between organisations, and ultimately a reluctance to share learning and good practice which organisations have invested in developing."¹¹⁶ VCSE respondents were concerned that sharing their intellectual property could leave them vulnerable to large, private sector competitors. Others noted that a funder focus on "rewarding innovation rather than imitation"¹¹⁷ may deter sharing of information. Suggested solutions to these problems included commissioners giving a higher priority to partnership meetings between providers and greater use of grants which, because organisations are not competing to deliver the exact same specification, facilitate greater collaboration.

In addition to results, it was felt that sharing of processes would also be beneficial. For example, "which measures and data are being used for which types of service would be of practical help. This could enable collection of similar data over larger areas (England) and thus confidence would grow in use and interpretation of these measures."¹¹⁸

This could enable all stakeholders to share a common understanding of appropriate validated measures, rather than using locally developed ad hoc measures.

Finally, respondents noted that the volume of evidence available can make it difficult to navigate, one stating that "there are so many different places for evidence gathering across PHE, NHS England and local JSNAs and other projects. I find it difficult to know where to access what, and I work in this kind of area every day."¹¹⁹ Curation and targeted dissemination are therefore essential. Funders and strategic partners were identified as well placed to undertake this role. For example, VCSE organisations have been working in partnership with NHS England over the last year to develop an Insight Strategy which amongst other things aims to create easier routes to data from surveys and national datasets.

Diversity

Respondents noted the importance of involving a wide variety of stakeholders when developing evaluation frameworks. Developing objectives collaboratively, they suggested, would help to ensure they are fit for purpose and that all parties have a shared understanding of what is important. This means commissioners should have an inclusive dialogue not only with providers but also with individuals, who may have very different priorities. NICE's community engagement guidance recommends involving "members of the community in the planning, design and, where appropriate, the implementation of an evaluation framework."¹²⁰ Their views on what makes a good service should be central to the development evaluation frameworks, not just an add-on.

Similarly, respondents were clear that JSNAs need to make better use of evidence provided by a range of VCSE organisations. As discussed in more detail in the partnership and collaboration chapter, many JSNAs are perceived to be missing key data on

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

vulnerable groups; data which the VCSE sector is well placed to provide. Commissioners were urged to seek out the evidence (both qualitative and quantitative) of specialist groups which have particular expertise with marginalised communities but whose voices are often not heard at a strategic level. This could be facilitated by local infrastructure bodies. Equally, smaller VCSE organisations themselves will need to become more skilled at using and presenting evidence. Again, this may be best achieved through local infrastructure organisations, which are well placed to provide training and support.

Resource

Respondents highlighted that the collection of evidence, measuring of outcomes and learning from best practice all require time, money and expertise. One submission reported that:

“Increasingly, places lack capacity to evaluate best practice and build robust business cases for adopting the models that are already ‘out there’. This is unsurprising given the pressures on public service agencies to reduce what they might see as back office support. But, there is a danger that, without the capacity to learn from best-practice, places continue to ‘re-invent the wheel’, and miss opportunities to implement transformational change in a low-risk manner.”¹²¹

This is a particular problem for smaller VCSE organisations. According to recent research by Community Action Southwark, fewer than half of Southwark VCSE organisations are seeking to demonstrate their impact with evidence. While smaller organisations are less likely to have systems in place for measuring and analysing impact, they are only slightly more likely than larger organisations not to believe they need to do so – indicating that this is a problem of capacity rather than will.¹²²

“As competition for funds increases, funders are asking for more evidence of impact. Having the capability and capacity to provide the evidence and spend the time on fundraising at the same time as working on the frontline to support clients are big challenges for small charities like ourselves.”¹²³

Respondents were clear that smaller organisations would need more support, including financial support, in order to provide outcomes data, one CCG stating “our smaller providers often need a lot of help to understand outcomes and put in place simple measurement tools”¹²⁴. Commissioners, whether CCGs, local authorities or even individuals with personal budgets, can support VCSE organisations by setting proportionate data collection requirements that are not too onerous. The publication in 2014 of a cost benefit tool for public service transformation is a promising approach. This provides indicative per person figures for the financial cost to government and wider society for issues such as depression, domestic violence and A&E attendance. This tool can help VCSE organisations to estimate the financial benefit of their service.¹²⁵

There is also a role for VCSE infrastructure organisations which can facilitate access to universities and Academic Health Science Networks to broker partnerships to deliver robust research and impact evaluation across the local sector.¹²⁶

If provided, there is evidence that capacity building support can have a long term impact. An evaluation of the Health and Social Care Volunteering Fund found it had helped develop a “culture that supports and embraces measuring impact of services, with staff more able to fulfil data collection, measurement and evaluation tasks” and supported “development of bespoke evaluation frameworks with supporting systems and data collection processes”¹²⁷.

SUMMARY OF RESPONSES

There is considerable consensus around the outcomes which VCSE (and other) organisations should aim to achieve in health and care, with a great deal of read across between legislation, outcomes frameworks and measuring tools but this has not translated into either a small number of widely used and recognised affordable (or free) tools, nor standards for data collection and generation which would allow easy comparison between datasets produced by the plethora of different tools in use.

CASE STUDY: Age UK Lancashire has the ability to generate quality impact data for their programmes and services following investment in a bespoke CRM system and the employment of a full time Information Manager. They also utilise the Short Warwick-Edinburgh Mental Well-Being Scale (SWEMBS) and New Economics Foundation assessment tools to measure the impact and effectiveness of their service delivery.¹²⁸

Funding and Commissioning

Introduction

Health and care commissioners are important funders of VCSE organisations. Although the VCSE sector as a whole receives the majority of its funding from other sources, including individuals, charitable foundations and the National Lottery, many of the key health and care services it provides are only able to operate at scale due to funding provided by CCGs, local authorities and other commissioning bodies.

While the amount received to deliver these services is important, so too is the mechanism used to commission them. Over time, the value of grants provided to the sector has fallen significantly and the vast majority of its statutory income is now in the form of contracts.¹²⁹ This is, incorrectly, seen by some commissioners as being necessary to comply with EU procurement rules.

There are a wide variety of procurement options including using an open process, spot purchasing from an approved provider list or calling-off from a framework contract. Commissioners may want to encourage greater collaborative working by funding a consortium, entering into an alliance contract or developing an innovation partnership. Some may choose to link up with other commissioners by pooling budgets.

Many commissioners are seeking greater value for money and accountability through payment-by-results contracts, which can cause financial difficulties for VCSE organisations. In some cases combining this with social investment through social impact bonds can work better. Others are choosing to try and maximise the social value generated (social prescribing, which is discussed in more detail below, is one potential approach). Others may not contract with VCSE providers directly at all, providing individuals with direct payments that allow them to purchase their own care directly from providers. Individuals will also often use their own money to buy in preventative services.

Recent years have also seen significant changes in commissioning responsibility. The Health and Social Care Act 2012 abolished primary care trusts, with their powers passed to newly created CCGs. At the same time, local authorities and Public Health England took charge of public health spending, with NHS England having responsibility for leading the NHS and for commissioning some services, including primary care and specialised services. The Care Act 2014 significantly expanded the use of personal budgets, placing a duty on local authorities to assign a personal budget to all people eligible for support. As a result, in 2014/15 £1.4bn was spent through personal budgets.¹³⁰ Further changes to commissioning came through the Social Value Act 2012 and the Public Contract Regulations 2015.

This chapter explores why commissioning practice is so important and identifies a number of key principles that should underpin the funding relationship between public sector bodies and the VCSE sector.

Why improving funding and commissioning approaches is valuable

Improving funding and commissioning practice was seen by respondents to be essential for a number of reasons.

Value for money

Better commissioning can ensure health and wellbeing services are delivering better value for money. Total health spending in England is projected to rise by £4.5bn in real terms between 2015/16 and 2020/21.¹³¹ Although this is an increase of around 0.9% per year,

SUMMARY OF RESPONSES

according to Nuffield Trust, The Health Foundation and The King's Fund, "the NHS will struggle to maintain services, let alone invest in new models of care and implement seven-day services".¹³² As a result, there will be a continued emphasis on finding £22bn in efficiency savings by the end of this parliament (2020).

Spending on social care is harder to gauge due to uncertainty about how much will be raised through the new council tax precept. Nuffield Trust, The Health Foundation and The King's Fund predict spending will be broadly flat in real terms but highlight that this "will not be enough to meet projected cost pressures of 4 per cent a year."¹³³

A coalition of organisations, including the NHS Confederation, the Association of Directors of Adult Social Services and the Care and Support Alliance, have warned that reduced resources and growing demand mean that "the social care sector is in danger of a deepening crisis".¹³⁴ This further emphasises the importance of achieving better value for money.

Realising these savings will require maximising the contribution of community assets. A joint focus on providing public benefits means that the objectives of government and the VCSE sector are broadly aligned. Both are part of the wider system of health and care support relied upon by people. Taking time to understand and value what is already being done, recognise community priorities and where small amounts of careful investment can have maximum impact – will save money but will also, and more importantly, help strengthen community structures and activities and focus intervention on what is needed.

This will often include greater emphasis on early action. As noted by one CCG, "The VCSE sector has particular value in preventative work and in reaching those people in communities who are unwilling to engage in statutory sector provision".¹³⁵ Improved investment and commissioning can support the required shift of focus from managing symptoms to resolving root causes, delaying or stopping altogether the onset of preventable conditions, thereby reducing demand and leading to cost savings for government.¹³⁶

Market diversity

Better commissioning will also lead to a more diverse supplier market. Diversity in the market is beneficial for "providing choice and saving money, it prevents the standardisation of services, promoting independence as opposed to dependence. It allows for the right provider in the right circumstances."¹³⁷ This diversity is particularly important given the increased use of personal budgets which is likely to see demands for a much greater variety of services as individuals seek to tailor support to their individual assets, interests and needs.

Requirements for success

Respondents recognised that commissioners "face a daunting task"¹³⁸ and provided a number of examples of good practice. The overwhelming message, however, was that much commissioning is characterised by short term thinking, disproportionate processes, opaque decision making and limited understanding of community needs. The following principles were suggested as the basis for a more effective and efficient approach to commissioning. Underpinning each is a clear message that good funding and commissioning requires greater collaboration.

Long term approach

Respondents emphasised the importance of commissioners taking a long term approach, whilst recognising the short term funding pressures that can make this challenging. We

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

heard from both commissioners and VCSE organisations that longer contracts provide better value. One CCG, for example, “recognised that the best efficiencies are often developed over time, as well as providing a more stable funding base for contracted providers over the life of the contract”.¹³⁹ Such contracts enable investment, innovation and are more likely to support positive outcomes for those with multiple and complex needs. Others suggested that short term contracts have a place but only with untested providers and as a stepping stone to long term funding agreements.¹⁴⁰ It should also be noted that long term contracts can have break clauses which can provide flexibility for both commissioners and providers.

The electoral and budget setting cycles have been cited as insurmountable barriers to taking a long term approach. There are, however, numerous examples of long term contracts being used where there is a will to do so, including PFI and other buildings and infrastructure contracts which run into decades.

Respondents called for a greater focus on long term savings, rather than short term cost reductions. Currently, contracts are often “awarded on the basis of lowest upfront price as opposed to the greatest combined social and financial return”.¹⁴¹ Yet we heard that commissioning for social value can have many potential benefits including creating jobs or volunteering opportunities; increasing community involvement and cohesion; addressing social isolation; generating apprenticeships and education pathways; facilitating neighbourhood improvement schemes; reducing environmental degradation; and fostering local economic growth.¹⁴²

Embedding social value in commissioning practice can also support a greater focus on prevention activities, particularly when combined with long term contracts. As one submission noted, established approaches “can often make it hard to fund the sort of prevention initiatives that involve up-front public spending but do not deliver cost savings for many years”.¹⁴³ The Social Value Act has been an important tool for spreading implementation of social value principles but, according to the review undertaken by Lord Young¹⁴⁴, uptake has been patchy.

Respondents understood why contracting with the cheapest provider may appear attractive to commissioners but noted that this will not ensure value for money and in the long term can be detrimental to the diversity of the local provider market. Such an approach will generally favour very large, national providers which may subsidise a service in the short term in order to undercut local providers and gain a foothold in a new market.¹⁴⁵ Small VCSE organisations which are more closely linked to communities and understand their needs will struggle to secure funding and may not be there or operating at sufficient scale when later needed by commissioners. As NHS England stated, investment in a range of local VCSE organisations is also needed “to enable greater choice to be available to those using personal health budgets and personal budgets”.¹⁴⁶ This may also require support for the development of new co-produced enterprises.

Size of contracts and proportionality

Respondents were clear on the importance of proportionality, no matter which funding approach is selected. Contract sizes, bidding processes, monitoring and risk transfer were all identified as elements that must be appropriate and proportionate to the service being commissioned.

We heard from respondents that there is a clear trend, including in the vanguard sites, towards the aggregation of services into a smaller number of larger contracts. This has been driven by a desire to reduce the transaction costs of procurement exercises and achieve economies of scale in service delivery. Both of these assumptions were

SUMMARY OF RESPONSES

questioned, in particular by Locality, the national network of community-led organisations, which presented evidence of “diseconomies of scale” i.e. that smaller contracts are more likely to improve outcomes and provide better value for money. The VCSE Review consultation identified that it is often not clear whether transaction costs have genuinely been reduced by consolidating contracts, or simply shifted onto prime providers or elsewhere in the system, nor what the overall effect is upon achievement of outcomes and therefore cost-effectiveness.

This was supported by other respondents who suggested that there is a commissioner preference for large contracts from known providers and a tendency towards risk aversion which “means that local innovation is often lost”.¹⁴⁷ Although some smaller providers are able to act as sub-contractors or form consortia, respondents suggested that contracting directly with them can have significant advantages. Providers reported using scarce resources to enter into intricate contracting arrangements with prime providers only to find that little or no work resulted. Smaller VCSE organisations can also often lack the back office capacity which would enable them to form or join consortia, the development of which can be complex and time consuming.

The value of proportionate funding application processes was also emphasised in submissions. As one noted, “complex bidding processes are frequently impenetrable for smaller charities that don’t have the skills and capacity to compete against professional bid writers”.¹⁴⁸ Reducing complexity can ensure organisations with less capacity for bid writing and business development – many of whom may represent better value for money and deliver added social value – are able to compete for contract opportunities. It is also important that funders “set firm parameters and communicate clearly and transparently to avoid undue competition and funding streams from being oversubscribed”.¹⁴⁹

“The majority of procurement practice is stifled by process and bureaucracy, what appears to be text book practice in reality translates into overly complex, process focused exercises. Such exercises demand a huge input from providers and commissioners and often miss the point of the intended outcome. Tenders now typically require 30,000 word submissions, and the majority of tendering organisations now support sizable bid teams.”¹⁵⁰

Whatever the process chosen by commissioners, they must ensure that VCSE organisations are given sufficient time to apply. Very short timescales will again favour larger organisations with greater in-house bid writing capacity. Respondents told us that this is particularly important when commissioners encourage bids from partnerships or consortia as these can take significant time to develop.

Proportionality should also apply to monitoring. The Nuffield Trust has suggested that the NHS “has become fixated with the use of targets, micro-incentives and punitive approaches”.¹⁵¹ As a result, respondents told us that many VCSE organisations are struggling to meet “excessive monitoring requirements which neither reflect the value of the contract nor the focus on those they exist to support”.¹⁵² We heard that contracts for a few thousand pounds carried risk management processes better suited to a few million. Such an approach can be counterproductive. Instead, it was suggested that commissioners should focus on the end-to-end cost and impact of service provision, rather than unit costs and performance against proxy measures. Doing so would enable them to differentiate between ‘failure demand’ and real demand: identifying waste and areas for improvement.¹⁵³

Risk was another area suggested by respondents where proportionality is required. We heard that “a culture of risk transfer, rather than risk sharing”¹⁵⁴ predominates. This is due

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

to the traditional use of vertically structured contracting models and that, as a result, “commissioners often lack experience of developing such arrangements.”¹⁵⁵ Inappropriate transfer of risk, either from commissioners to providers or from prime-contractors to sub-contractors, can lead to increased bureaucracy, manipulation of results and a reduction in the pool of VCSE organisations able to provide high quality services.¹⁵⁶

Appropriate funding mechanisms

As set out in the introduction, there are a wide variety of funding mechanisms available to commissioners. We heard that some of the most valuable work done by the VCSE sector is not easily funded by contracts and that a more thoughtful approach to choosing the best funding route should be taken.

Although there is a clear trend towards greater use of payment-by-results contracts and an emphasis on social investment, particularly through social impact bonds, respondents emphasised that these are not always the most effective or efficient way of achieving commissioning objectives.

In payment-by-results contracts, all or part of the payment depends on the achievement of specified targets. Doing so is intended to increase accountability and provide direct financial incentives for providers to improve their practice. We heard from respondents that this can be a sensible contracting approach, particularly where there are clear and easily measurable outcomes that can be attributed to the intervention of a single provider or supply chain. However, ‘results’ in reality often means ‘outputs’ and particularly for work with those who have complex and multiple needs, it is unlikely to be suitable “due to the complexity of factors which would influence the outcome, and the risk of prioritising a particular outcome dictated by the contract rather than listening to what is most important to the service users.”¹⁵⁷ Such contracts can also provide an unfair advantage to large organisations with the capital required to manage cash flow risks.¹⁵⁸ This tallies with a recent NAO report, which found payment-by-results schemes are difficult to get right, costly, risky and lacking in evidence supportive of claimed benefits.¹⁵⁹

Social investment is another funding mechanism currently popular with government as well as some VCSE organisations. The benefits of drawing social investment into health and care organisations was set out clearly in a submission by Catch22, which stated that it can help VCSE groups:

“to scale up successful projects, allowing them to maximise the impact of effective interventions. It can provide the working capital and financial guarantees that are needed to satisfy procurement requirements for running large public services contracts, particularly payment by results contracts. It also provides an opportunity to align incentives of commissioners, funders and providers to improve outcomes.”¹⁶⁰

However, support for social investment was not widespread amongst VCSE respondents. Similar results were found by the Health and Care Voluntary Sector Strategic Partnership 2015 survey.¹⁶¹ This asked participants to identify which funding approaches were best for different types of work e.g. prevention, social prescribing, advocacy (multiple options could be selected for each answer). Less than a third of respondents identified social investment as a good funding tool for 18 of the 19 listed work types. The exception was ‘community enterprise’ which 58% thought was appropriate for social investment.

A focus on outcomes, as well as the opportunity to transfer risk to investors, has driven government interest in social impact bonds. Indeed, there was notably more enthusiasm for this approach in submissions from government and think tanks than in the responses received by VCSE organisations. The principal concern raised was that social impact

SUMMARY OF RESPONSES

bonds “are hugely complex and out of the reach of most local voluntary organisations and smaller national organisations because of the high set up costs and levels of administration.”¹⁶² For example, the Ways to Wellness social impact bond, the UK’s first focussing on health issues, took three years to set up, with one stakeholder describing the delays as “deeply frustrating”.¹⁶³ Respondents queried whether social impact bonds were appropriate for the majority of health and care providers. Commissioners were encouraged to think very carefully about whether social impact bonds are workable and use the six tests identified by the Cabinet Office.¹⁶⁴

VCSE respondents, in particular, were significantly more supportive of the continued use of grants as a key component of funding. Grants were seen as very effective for promoting innovation, amplifying people's voices, development of local solutions, enabling collaboration, building capacity and engaging the community, with lower transaction costs for both commissioners and providers. They are also, as one submission put it, “an effective way of investing in organisations that carry out activity which achieves social outcomes that are desired by commissioners, but which might be difficult to measure or define in a contract.”¹⁶⁵ Such an approach was thought to be particularly beneficial for small VCSE organisations. Respondents also welcomed NHS England’s bite sized guide to grants.¹⁶⁶

Widespread support for grants was also found in the Health and Care Voluntary Sector Strategic Partnership 2015 survey¹⁶⁷. Of the 19 services listed, grants were the most popular funding method for 14 types of services and the second most popular choice for a further three. Grants were seen as particularly effective for funding work which engages with overlooked groups. Further examples of the benefits of grants are now also being collated through the Grants for Good campaign.¹⁶⁸

Respondents were also generally very positive about the potential of social prescribing. Although the model is still relatively new, some encouraging evidence has emerged. For example, the evaluation of the Rotherham Social Prescribing Project found “a clear overall trend that points to reductions in patients' use of hospital resources” and “positive economic benefits”.¹⁶⁹ The Rotherham example highlights two factors identified by other respondents as essential for success. Firstly, funding needs to be attached to the patients that are referred to social prescribing projects. This approach was only used in some such projects; others expected to be able to refer people to VCSE organisations without funding those organisations to carry out the increased work, which is not an approach which would be applied to the private or statutory sectors and is perhaps indicative of a view that the VCSE sector is, or should be, ‘free’. Secondly, commissioners need to allow time for savings to show in complex systems subject to multiple demand factors.

Social prescribing is a form of micro-commissioning. This is where support is commissioned “at an individual level, usually through an assessment and support planning process undertaken by the local authority. It is often referred to as setting up individual packages of care.”¹⁷⁰ An increasingly widespread way of setting these packages up is through personal budgets. Respondents had mixed views on this development. On the one hand, they recognised the potential for more flexible, innovative person-centred models of care to result from enabling “people to make their own choices about the care they need and where to get it”.¹⁷¹ Personal budgets can act as a powerful lever for joining up support across services used by people. A survey by Scope found that “63 percent of social care users surveyed who feel they have choice and control when planning their care said that using a direct payment or alternative personal budget has helped.”¹⁷² Personal budgets can also enable VCSE organisations to secure statutory income whilst maintaining a strong link with individuals.

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

There were, however, also concerns. One submission raised an issue of principle, suggesting that the personalisation agenda is about the marketisation of health services and as such “may be anathema to many organisations with social purpose”.¹⁷³ More organisations raised practical concerns. We heard, for example, that VCSE providers, particularly small organisations, can struggle to get information about their service out to those with personal budgets¹⁷⁴, that the funding available does not cover the full service cost¹⁷⁵, that there is a lots of paperwork involved¹⁷⁶ and that people are not getting a real choice due to immature supplier markets not providing a diverse range of services.¹⁷⁷ Underpinning a number of these issues is the need for suitable infrastructure to support suppliers and link them with personal budget holders. A good example of where this has been successful is Harrow.

CASE STUDY: Harrow Council developed the online social care market place shop4support three years ago. This offers choice and control over the services that individuals receive. Harrow developed My Community ePurse to enable a shift from commissioning to easy, direct purchasing between an individual and provider. Harrow now has the highest percentage of cash personal budgets in the country.¹⁷⁸

Some respondents were very supportive of greater use of consortia as a way for smaller organisations to come together to successfully bid for and deliver larger contracts. Others cautioned that “complex governance issues”¹⁷⁹ can mean that consortia are time consuming and sometimes expensive to set up. Similarly, there was a belief that alliance contracting is an effective way to build “co-production, collective ownership and shared risk”¹⁸⁰ into funding agreements. Evidence was submitted suggested that alliance contracts can support a spectrum of organisations, including specialist groups with niche skills, to contribute¹⁸¹ though concerns were again raised about whether the smallest providers will be excluded.

The overall message from respondents was that there is no single funding approach which is best for all kinds of work and sizes of organisation. Although most areas are moving towards increasing reliance on outcomes-based contract funding, there is no evidence that this is the best way to achieve the long term impact which health and wellbeing strategies require. We could only find a handful of examples of areas taking a strategic view of their funding and investment approach mix.

CASE STUDY: In Hull the CCG and local authority jointly commissioned a piece of research mapping the total statutory funding and investment in the local VCSE sector, including contracts, grants and service-level agreements. This identified that combining a number of existing small grants programmes would reduce duplication and enable more targeted and impactful grant giving. It also highlighted the need to develop a common approach to social value measures across the public sector in partnership with local VCSEs. This work has only gone ahead because of longstanding partnership between the public and VCSE sectors in Hull and the strong relationships that have developed.

Julia Weldon, Director of Public Health, Hull City Council said: “Our health and wellbeing board’s vision is to nurture sustainable communities in Hull where barriers to participation are removed and local people feel connected, involved and valued. To do that we need to understand how much money is invested in communities, where that money is spent and

SUMMARY OF RESPONSES

what works well so that we can build on those assets, and promote and maximise the investment so that we can decide what is needed in the future.”¹⁸²

Expertise

Designing, procuring, bidding for and delivering health and care services for communities with diverse needs is difficult. Respondents believed that both commissioners and VCSE organisations require further training and support, if best use is to be made of limited resources.

Good commissioning is well led¹⁸³ and the consultation identified a number of areas where commissioners need help to improve their practice. Firstly, we heard that there is “often a disconnect between commissioners and procurement”¹⁸⁴, with attempts at creative commissioning stifled by rigid procurement processes. In many cases this appears to be due to risk aversion and misapplication of the public contract regulations. Although, as noted below, a lack of bidding expertise in small VCSE organisations can cause problems, VCSE respondents suggested in some cases the best solution would be to use simpler funding approaches, including grants, rather than tie up VCSE resources in bidding teams. There was a clear call for further guidance in this area.

Secondly, as noted above, there are a wide variety of funding mechanisms available to commissioners, many of them relatively new and poorly understood. Commissioners need access to “information, advice and training”¹⁸⁵ on alternative funding models if they are to make best use of them, choosing the right model from the range available. There is likely a role here for national government in developing evidence banks and examples of best practice.

Thirdly, there has been significant turnover amongst commissioning staff over the last five years. This is a result both of the restructure brought on by the Health and Social Care Act 2012 and public sector funding constraints. At an event, a former commissioner said they were disheartened that commissioning has become generic and so much expertise has been lost.¹⁸⁶ Respondents recommended that through better mapping of VCSE sector assets in JSNAs and working with local infrastructure, commissioners could build up their local knowledge.

Respondents also identified skills gaps in the VCSE sector. Firstly, as with commissioners, support is needed to enable organisations to better understand and manage alternative funding models. This is particularly important for smaller groups which “may not have the financial or legal capacity”¹⁸⁷ necessary.

Secondly, as set out in the impact and evidence chapter, many VCSE organisations need to get better at demonstrating their impact. One respondent suggested that the sector “needs to develop understanding about what evidence is useful to commissioners and how to present it, to place greater focus on evaluating and articulating social value. It needs to develop capacity to measure impact of services provided.”¹⁸⁸ It was noted that the Inspiring Impact programme, which is part funded by the Cabinet Office, has a goal of making high quality impact measurement the norm for VCSE organisations by 2022.¹⁸⁹

Thirdly, there is a need to improve the overall commercial skills of much of the sector but especially smaller organisations. Greater expertise in writing funding bids, how to negotiate and marketing would all help to level the commissioning playing field. There is a clear role for infrastructure in delivering such support.

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

Finally, a number of respondents made clear that although many VCSE organisations can improve their skills, not all want or need to develop their expertise in commissioning. Only 25% of charities¹⁹⁰ and 59% of social enterprises¹⁹¹ receive any funding from government. Although some assume that all VCSEs want to scale up through winning statutory contracts, this is not the case. Much local provision delivered by the sector is rooted in local culture and relationships, and as such does not naturally lend itself to expansion.

Accountability and transparency

Respondents told us that there is a need for greater transparency around funding decisions made by commissioners at all levels. As the LGA has put it: “Transparency in commissioning is fundamental to delivering better outcomes.”¹⁹² From the perspective of VCSE organisations, it can be difficult to understand who is responsible for commissioning which services. This is not helped by the use of confusing terminology and jargon. For example, one organisation stated that there is “a lack of transparency about how to apply and how decisions are made”.¹⁹³ There was also a call for commissioners to be clearer about the marking criteria used to assess bids and the scores achieved by applicants.

Commissioners were urged to hold to account large providers that name smaller VCSE organisations in their supply chains but don’t actually sub-contract with them. We heard that in some cases, VCSE groups are named in bids without their knowledge or approval.

Respondents also noted a lack of transparency around overall spend with VCSE organisations. One submission noted that “local authorities often don’t know how much they are contracting to the voluntary sector”.¹⁹⁴ Although there is some aggregate data available at prime-contractor level, there is almost nothing on the amount of public funding that is being passed to VCSE groups operating as sub-contractors. Similarly, the weakness of central government data on contracting with small and medium-sized enterprises, which includes the vast majority of the VCSE sector, was recently highlighted by the National Audit Office.¹⁹⁵ This significantly limits both public accountability and the ability of commissioners to effectively shape provider markets.

Infrastructure

Introduction

With an estimated 900,000 civil society organisations in the UK¹⁹⁶, including 160,000 voluntary organisations¹⁹⁷ and 15,000 social enterprises¹⁹⁸, it is natural that they should seek to coordinate and amplify their efforts to improve health and wellbeing through collaboration. Over time, an infrastructure of support organisations and representative bodies has emerged. Sometimes these are focussed on a particular locality, other times on specific communities of interest. Sometimes the concept of 'infrastructure' bodies is contested, as these organisations move into direct service delivery or act as 'prime contractors' with a role in coordinating and funding smaller groups.

Notwithstanding these issues, infrastructure bodies are often well placed to facilitate VCSE partnerships and act as a conduit for their engagement in policy and commissioning processes.

In this chapter, we explore the role of infrastructure bodies and how best to enable their future contribution to the health and care system.

Types of infrastructure organisations¹⁹⁹

- national and regional representative bodies
- specialist national bodies such as Clinks, the Women's Resource Centre, Voice4Change England and Children England
- local councils for voluntary service
- rural community councils
- volunteer centres
- social enterprise networks
- community foundations
- networks and forums for specific communities of interest e.g. Black, Asian and Minority Ethnic; Lesbian, Gay, Bisexual and Transgender; and faith
- parent bodies/ national headquarters, such as Age UK
- VCSE peer-support groups and specialist training providers

Why infrastructure is valuable

The support provided by infrastructure bodies was highly valued by the vast majority of respondents. There was also a view that infrastructure organisations will need to continuously adapt in order to develop the kinds of support which are most needed in a rapidly changing environment. Respondents highlighted the following vital roles for infrastructure.

Single point of access

Given the plethora of frontline VCSEs, having a single access point for individuals looking for support, or to volunteer or donate, was seen as extremely helpful. Infrastructure bodies

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

typically signpost or directly link individuals with organisations that can then provide support or utilise their contributions. Traditional models for this ‘single point of access’ include volunteer centres and community foundations; emerging models include social prescribing services based in GP practices and online mapping of local VCSEs. Public sector respondents also valued the single point of access, helping them to readily access and navigate the VCSE sector’s expertise.

“Prescribers need to have as simple a system as possible, and this can be achieved by instilling a brokerage service through CVSs or other infrastructure organisations, which will allow prescribers to ring just one number and pass on the details of the person who requires the service, so that the broker can then match a service to need. It is important that the brokers do not just use the same services all the time, but that they understand and use the most appropriate service to meet the needs of each individual.”²⁰⁰

Connector

Infrastructure was seen as ‘the glue that holds things together’,²⁰¹ connecting VCSE organisations to each other and strengthening their efforts. Many VCSE respondents valued being put in touch with their peers, for example, to develop new or complementary services. They also valued having a central information resource, for example, about changes in the health and social care landscape or welfare provision. Many had accessed training and specialist expertise from infrastructure bodies such as legal advice, business development, volunteer management, recruitment and fundraising training. The Cabinet Office has acknowledged that organisations accessing support from infrastructure have “a substantially higher likelihood of success in grant applications and bidding for contracts”.²⁰²

Strategic champion

Infrastructure organisations are valued for their strategic contribution at a national and local level, helping to: identify the needs and assets of their communities (for example, contributing to JSNAs), represent the perspective of small organisations and amplify the voices of people at the margins (for example, as representatives on health and wellbeing boards), provide timely insights from the frontline (for example, advising CCGs about gaps in provision), and provide feedback to and from the sector to shape policy and redesign services (for example, collaboratively developing new specifications or social value indicators). The national health and care voluntary sector Strategic Partner Programme, discussed in more detail in the future of the Voluntary Sector Investment Programme chapter, is an excellent example of infrastructure bodies playing a strategic role at a national level.

CASE STUDY: Castlepoint Association of Voluntary Services and Volunteer Centre (CAVS) established a reference group for Castle Point and Rochford CCG, embracing the ‘no decision about me, without me’ philosophy. The reference group includes existing GP based patient participation groups, partner organisations, schools, health providers and Healthwatch, as well as groups representing, for example, people with Alzheimer’s. There are 12 residents involved, six from each district covered by the CCG, and a cohort of young people, to inform prevention work within that demographic.

The reference group has been able to investigate issues such as why young people and mums attend A&E departments when there are other options available or when A&E is not appropriate and this has informed steps to reduce this.²⁰³

SUMMARY OF RESPONSES

Facilitator of commissioning

Different models are emerging for how infrastructure organisations can best support public service delivery. From a ‘hands on’ model - acting as a prime contractor, consortia lead, micro-commissioner or social prescriber - to an ‘honest broker’ model - convening partnerships, providing support for tendering, and resolving difficulties from a position of neutrality. An example of the latter is Community Action Southwark (CAS): “Southwark CCG will be moving towards alliance contracting to serve local populations, using a multi-speciality provider approach to create a holistic, person-centred approach to health and care. CAS holds information about, and can access, VCSE organisations providing health services in the borough, and can help bring them together to form alliances.”²⁰⁴

Steward of resources

Infrastructure organisations can help marshal the assets of local communities and help them be used in the most efficient way. This includes training volunteers, distributing funding (for example, via a community foundation), sharing of back office functions, hosting other VCSE organisations in their building, and producing briefings to keep VCSE organisations abreast of policy developments (whereas it would be expensive for each organisation to monitor separately).

Learning hubs

Infrastructure bodies are well placed to share ‘what works’ across different organisations and to develop useful evidence and insights to inform practice locally. This can include supporting the development of emerging community innovations and initiatives. Playing such a role “takes time and effort, but delivers results in terms of cultural shifts, understanding and practice”.²⁰⁵

CASE STUDY: Hospice UK promoted a number of poster presentations detailing how hospices had used capital grants to improve their care environment. A number of innovative projects such as Men’s Sheds and Step Down/ Self Enablement Lodges have since been replicated within other hospices.

Local infrastructure organisations were seen as particularly important to the smallest organisations and to equalities organisations and community groups. Ironically, cuts to infrastructure organisations were often seen as being made in order to protect those front line groups.

Requirements for success

To facilitate this contribution from infrastructure bodies to the health and social care landscape, there are some key conditions for success. Some of these conditions must be met by VCSE organisations themselves; others are about the creation of an enabling environment by local government, CCGs and other statutory partners.

Anchored in communities

In order to mobilise the VCSE sector effectively, respondents felt that infrastructure bodies need to be firmly rooted within the communities or sectors they serve. This involves understanding the communities’ needs as well as VCSE organisations’ needs, so they can anticipate how best VCSE provision and capacity could be developed. In doing so, infrastructure bodies need to ensure they engage with the diversity of these groups. For example, one respondent commented:

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

“The challenge for infrastructure is to marshal resources in areas where the capacity for social action is likely to be weakest so that all communities are able to influence decisions and maintain services, not simply the best connected and most affluent.”²⁰⁶

Other respondents echoed this and felt that given the strategic role that many infrastructure bodies play, it is particularly important for them to reach out to groups that experience health inequalities and poor health outcomes. Infrastructure bodies are generally well placed to do this, and sometimes benefit from a greater level of trust and access to these communities. Infrastructure bodies that lack the capacity to do this should recognise their limitations and work with others to fill the gaps. As one event attendee put it, to achieve coverage of their communities they “need to network the networks”.²⁰⁷

Developing expertise and adding value

Infrastructure organisations can offer a unique contribution to their communities and to the health and care system – drawing on their knowledge and connections across the VCSE sector. They are often well-placed as a repository of data and information about the community they serve, a point of access to VCSE networks, and to offer views on how the ‘market’ as a whole is functioning.

For example, NHS England guidance has recommended to local commissioners that: “[Infrastructure bodies] can be a rich source of expertise about the sector in your area and will be happy to help you to identify local voluntary organisations and co-design fair and effective grant making processes.”²⁰⁸

However, respondents suggested that infrastructure bodies need to constantly review whether they are adding value or there is a risk that they can crowd out or cannibalise the voices of other VCSE organisations. There was particular sensitivity about local infrastructure bodies bidding for funding that would previously have gone to frontline VCSE organisations, and needing to be sure that where they did so, this was the best option to secure these resources for the sector.

Proving their worth

Respondents felt that infrastructure bodies needed stronger evidence to overcome a perception (especially among funders and commissioners) that their services are ‘nice to have’ rather than integral and potentially cost-saving. A common concern was that funders and commissioners wanted to see immediate benefits for the public when the improvement journey is often a longer, and slower process over many years. Another issue was that infrastructure bodies’ evaluations described change, but did not quantify it sufficiently.

Different approaches may be needed. Several respondents felt that cost-benefit analysis would be useful. This could include savings made to the health and care system, for example, due to the benefits of volunteering, as well as an assessment of the opportunity cost if infrastructure organisations ceased to exist. For example:

“What they could instead be evaluated against is the value that they have delivered to their local VCSE and what the cost of not funding them would be. So for example if individual services all had to recruit their own volunteers rather than the CVS sourcing them, the added cost to individual service budgets should be projected and weighed up.”²⁰⁹

Infrastructure bodies could also familiarise themselves with the legal duties on health and wellbeing boards to engage with communities, and on local authorities to tackle health inequalities, so that they can better articulate and quantify their contribution towards these goals.

SUMMARY OF RESPONSES

Resource

To facilitate the fullest contribution of VCSE organisations to the health and social care system, respondents emphasised the need for sustainable funding of infrastructure bodies.

Some infrastructure bodies have successfully secured new public funding, particularly through engagement with CCGs and the development of social prescribing services, where they have been able to evidence the added value of helping people to access community-based interventions instead of medical ones. One such example is Voluntary Action Leicestershire which has been commissioned by West Leicestershire Clinical Commissioning Group to manage and deliver a social prescribing pilot based at the Rosebery Medical Centre in Loughborough.²¹⁰ Others have received funding to support the commissioning and public engagement process locally. There is a strong case for considering these models elsewhere, given the potential to mobilise community resources and assets more effectively, and inform smarter commissioning decisions.

Meanwhile, many infrastructure bodies have already adapted their business models to deal with changing circumstances: for example, by charging membership fees, charging for training and support, or acting as a prime contractor/managing agent for bids. There have been mixed results: some are flourishing with these new models, but a number are struggling or have closed. Overall funding for umbrella charities fell by a third between 2008/09 and 2012/13.²¹¹ Generally, respondents valued the transitional support programmes sponsored by the Cabinet Office and Big Lottery Fund, though these have not been universally successful.

Some respondents felt strongly that there was a risk of mission drift for infrastructure bodies engaging with new business models, whereas others believed this was an inevitable response to the changing external context and would still deliver a net increase in resources for the voluntary sector (compared to these bodies closing down).

A key concern was for smaller organisations and marginalised communities who may not be able to pay for the support and representation they have previously accessed for free: “those most at risk are often supported by a VCSE infrastructure which is also most at risk.”²¹² This is an area of clear market failure that funders such as the Lloyds Bank Foundation for England and Wales have already identified for further investment and more support may be needed in future.

The future of the Voluntary Sector Investment Programme

Introduction

The Department of Health, NHS England and Public Health England (collectively referred to as the 'system partners') have long recognised that the voluntary sector has a key role to play in promoting health and wellbeing in communities. They have stated that: "The assets within communities, such as the skills and knowledge, social networks, local groups and community organisations, are building blocks for good health."²¹³

Grant schemes administered by the Department of Health have existed for many years and since 2008 the system partners have run a joint Voluntary Sector Investment Programme (VSIP) which has given out around £23m in grants annually. The programme had three strands: Health and Care Voluntary Sector Strategic Partners Programme; Innovation, Excellence and Strategic Development Fund; and Health and Social Care Volunteering Fund.

In the context of a challenging Spending Review settlement, all non-protected budgets across the Department of Health and other system partners were subject to significant scrutiny. Consequently, the VSIP grants budget has been reduced to £13.5million for 2016-17 then £11.5million from 2017-18 onwards, although the facility for specific work programmes to make grants to the sector still exists. The latter accounts for the largest amount of Department of Health grant funding to the sector.

This reduction will require a more streamlined approach to the programme and the funding will need to be tightly focused towards achieving the necessary impact.

In this chapter, we set out the value of the VSIP programme and recommendations for its future focus.²¹⁴

Why the programme is valuable

Strategic engagement and recognition of the VCSE sector

Many respondents believed that the VSIP – particularly the Strategic Partners Programme - was critical in facilitating the involvement of VCSE organisations in policy development. Respondents also felt that the programme was an important signifier of the government's support for VCSE organisations.

"The VCSE sector has made an immense contribution to achieving the Government's key health goals, including through system resilience and demand management (e.g. in the recent winter pressures work); supporting people with dementia and mental illness; implementing the Care Act and promoting more personalisation and choice; and integrating health and social care and reforming out of hospital care." - National Council for Palliative Care (current strategic partner)²¹⁵

"Without a specific programme of funding for VCSE, the System Partners would be less able to engage with the VCSE sector and valuable opportunities for collaborative working would be lost. In the case of our own partnership, without the resources provided by the programme, several valuable pieces of work would not have been able to take place or would have been significantly scaled back. These include feeding into the development of The Accessible Information Standard, the Better Care Project, an extensive Autism Strategy consultation and the provision of Transforming Care resources for families and people with a learning disability." – Disability Partnership (current strategic partner)²¹⁶

Addressing health inequalities

SUMMARY OF RESPONSES

Respondents believed that one of the strongest rationales for the VSIP was to help address health inequalities. This was seen as a strength of the VCSE sector and the VSIP an opportunity to tap into this expertise. For example, the charity Sense commented that Strategic Partner and IESD funding had enabled it to engage deafblind people in decision-making and co-production and carry out awareness-raising among statutory partners.²¹⁷

Respondents also noted that it is increasingly difficult for equalities-focussed organisations and smaller national organisations that serve a community of interest (for example, those with a particular health condition) to access funding via localised health and care commissioning arrangements.

“A key role for the VCS is tackling inequalities – it is core to its existence. One of the significant contributions made by the VCS is its reach to people the statutory system may struggle to connect with. The VCS should, where it works well, be more person-centred and holistic in its approach and offer a platform for the voice of more disadvantaged groups to be heard. In terms of young people, the VCS particularly works across age gaps that are created by the system. Here the VCS acts as the safety net where Health and the wider public sector operate in ways that may reinforce inequalities e.g. creating unhelpful age barriers (unintentional or otherwise) that deny access to help and treatment.” – Youth Access²¹⁸

Supporting learning and strengthening the evidence base

Respondents believed that the VSIP enabled VCSE organisations to develop and share learning with each other and with system partners. Many felt that in light of financial constraints, it was more important than ever for system partners to know and disseminate ‘what works’ in support of the goals it has set out, for example, around prevention, reducing inequalities, and holistic community-based care.

“In the current economic climate it is essential that public authorities are investing in projects that are proven to be effective.”²¹⁹

“[the VSIP] represents one of the very few ways of enabling local and specialist learning from the VCSE to be scaled up and shared, offering the possibility of sharing learning rather than constantly repeating both good and bad practice. In the current funding climate it is more essential than ever that [the Department of Health] and other system partners locally and nationally are able to harness the reach, knowledge and, equally importantly, expertise of the VCSE to support delivery, improve health and health and care quality and address health inequalities. This partnership should be developed to support best practice and evaluation, too often, work which is done is not built on or followed up.”²²⁰

Supporting partnerships

Respondents felt that the future of the health and care system would be dependent on effective partnerships at all levels. As one CCG stated, “We recognise the importance of working with and commissioning services from the VCSE sector. With the economic constraints and pressures there are even more reasons.”²²¹ The VSIP makes an important contribution in facilitating some of those partnerships and networks, but could arguably do more to strengthen this aspect in the future.

“VSIP is invaluable to Mind as a means to develop capacity and capability in our network of 146 local Minds by developing projects with strong evidence of impact, with the potential to scale up nationally, while sharing best practice across the sector and informing our campaigns to influence government policy more widely. It gives us the necessary flexibility to respond to evolving needs among beneficiaries, as well as changes in the external

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

landscape, and is a lifeline at a time when local authority funding for mental health has received significant cuts.”²²²

“[LVSC] are in position to build on and collect good practice through case studies and mapping exercises (e.g. social prescribing). Through the programme, we are able to keep abreast on the key issues for the sector which we feedback to the Regional Voices health coordinators. This process ensures a feedback loop up to the key decision makers within the systems partners. As we are a member of Regional Voices, the programme has also enabled us to share intelligence and knowledge with the other regions which has been invaluable in terms of sharing skills, ideas and expertise and driving the programme forward.”²²³

Requirements for success

The VSIP should continue, with an emphasis on promoting wellbeing of communities

The overwhelming majority of respondents valued the programme highly, with 96% of respondents agreeing or strongly agreeing that it should continue. There was a strong desire to focus on promoting wellbeing in communities, particularly building on the wealth of expertise the voluntary sector has in providing preventative and upstream services. By promoting wellbeing, the VSIP would contribute to improving people’s health outcomes, overcoming inequalities and reducing demand for costlier interventions.

Strategic partners should demonstrate their reach into communities

Many respondents recognised the value of a strategic partner programme. It has enabled numerous opportunities for the Department of Health and its partners to draw on the expertise of the voluntary sector as it has been developing policy and practice guidelines.

“[The Strategic Partners programme] gives DH and system partners unique insight and understanding from the sector, adding voice and personal experience into engagement, to improve services and with long term thinking to inform and influence government policy and practice.” – Carers UK (current strategic partner)²²⁴

CASE STUDY: Producing national tools which improve local practice and support government policy priorities. National Voices produced five narratives, each comprising a series of “I” statements, which define what good coordinated care looks like from the point of view of people and their carers. They were co-produced with individuals, health charities, system leading organisations and practitioners.

Under the umbrella of the strategic partner programme, the original narrative was commissioned by NHS England and has been adopted by all 13 system leading organisations in health and social care as the definition of the goals of integration to which they are committed to working. It forms an explicit basis for the integrated care pioneer programme and informs the implementation of the Better Care Fund and of the NHS Five Year Forward View new care models programme (through guidance developed on person centred care). It is being used by CCGs, local authorities and provider trusts across England. It forms the basis for the CQC’s approach to developing cross-system regulation and has been used in its thematic review of older people’s coordinated care.

Following the positive impact of the narrative, NHS England funded the production of four further narratives covering the interests of different groups: older people, people using

SUMMARY OF RESPONSES

mental health services, people near the end of life, and children and young people with complex lives.

The end of life care narrative, *Every Moment Counts*, has formed the vision for new national Ambitions for palliative and end of life care. It has been used as a key source in CQC's thematic review of end of life care.²²⁵

A concern from several local organisations was that the strategic partner programme was focussed on national organisations and their relationships with government. To some extent, this is the nature of a strategic partner programme. However, an opportunity for the next iteration of the VSIP would be to ensure that national strategic partners have strong networks that enable them to draw on local intelligence and disseminate information and evidence to frontline partners across the country.

"We've seen too many national programmes with little impact at local level - Strategic Partners who are London-based & highly visible to Central Government are often invisible in local neighbourhoods."²²⁶

Recognition and appropriate support for volunteering should be integrated into the VSIP

"Volunteers are the golden thread running through the vast majority of service delivery."²²⁷

A number of respondents highlighted the importance of maintaining support for volunteering through the VSIP. It was felt that volunteers contributed significantly to many existing VSIP projects and would continue to be integral, particularly as a means of mobilising individuals and communities in promoting health and reducing inequalities. Where a VSIP application includes volunteers, it should be recognised that they are a valuable 'in kind' resource, but that volunteers will often require training and management and that these are legitimate costs.

"While [volunteering] should be encouraged, should not become essential as some service delivery models will require professional/ paid roles to ensure compliance with standards of management and delivery."²²⁸

"Volunteering and social action are at the heart of a community based response to better health and social care. Encouraging people to be active citizens and play a role in improving the health of those around them underpins the wider objectives of the Voluntary Sector Investment Programme: social action often involves creating innovative solutions to tackling health inequality, and volunteers can also be key in scaling up projects and helping organisations to grow. Furthermore volunteering benefits not only those the volunteer is helping but the volunteer themselves: Join In's Hidden Diamonds research demonstrated that those who volunteer in sport have higher self-esteem, emotional wellbeing and resilience than those who have never volunteered"²²⁹

Managing demand

Managing demand for the VSIP will be critical to its future success – as there was a concern from respondents and system partners alike that it was unfair to applicants if they had very low chance of success. Many respondents urged greater focus and clearer eligibility parameters.

Smaller organisations tended to prefer limiting eligibility to smaller organisations; other respondents felt there should be different strands of the resulting programme for local and regional/ national organisations. Several suggested a sliding scale approach – so smaller

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

organisations could bid for small grants, without directly competing with larger organisations.

“The limits should reflect the need and what the design of the funding programme is looking to achieve”²³⁰

Evidence about ‘what works’

Greater consideration should be given to existing evidence about ‘what works’. A tension in the current programme is that, while supporting innovation is valuable, many respondents felt that their main funding constraints were around how to scale up already-effective practice. They didn’t want to have to jump through ‘innovation’ hoops unnecessarily. Although the “Excellence” strand of the IESD programme was intended to enable scaling up, the level of evaluation required from existing work was potentially prohibitive to some organisations and this strand has been under-utilised in comparison to the other two strands since its inception.

This concern needs to be balanced with a realistic sense of what the VSIP can achieve. It is a relatively small pot of grant funding, and so not well-suited to scaling up effective practice, other than by facilitating networks to share learning.

Efficiency

An efficient application and assessment process will be important, as ever, for engaging voluntary organisations.

“I found the form quite hard going, which put me off considering it again. The new proposals sound more accessible.”²³¹

“Small to medium VCSEs who engage with small-sized patient groups need to know their applications for funding are considered proportionately.”²³²

Annex A: Methodology

Consultation

Following an initial consultation in early 2015, the advisory group published an interim report in March 2015²³³. The findings of this report informed a more comprehensive consultation process which ran from August to November 2015 and had three main elements: online consultations, face to face events and live online events.

Online consultations

Two consultations, one for each of the elements listed above, were hosted on the NHS England Consultation Hub. These were both open from 7 August 2015 to 11 November 2015.

Challenges and solutions to better investment in and partnership with the VCSE sector²³⁴

In total this consultation had 94 respondents, the vast majority of which were from the VCSE sector.

| Type of respondent | Number of respondents |
|---|-----------------------|
| Charity (frontline) | 37 |
| Charity (infrastructure) | 29 |
| Social enterprise | 6 |
| Grassroots community group or microenterprise | 2 |
| Other VCSE organisation | 4 |
| University | 3 |
| Clinical Commissioning Group | 3 |
| Local authority | 2 |
| Non-departmental public body | 1 |
| Sector skills council | 1 |
| Consultancy to VCSE sector | 1 |
| Funder | 1 |
| Individual | 2 |
| Anonymous | 2 |

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

Of those respondents that indicated their size, a plurality had an annual turnover between £100,000 and £1m.

| Size of respondent | Number of respondents |
|----------------------------------|-----------------------|
| Micro (income less than £10,000) | 5 |
| Small (£10,000 - £100,000) | 8 |
| Medium (£100,000 - £1m) | 27 |
| Large (£1m - £10m) | 24 |
| Major (over £10m) | 14 |

Of those organisations that indicated their geographical reach, the majority operated nationally.

| Geographical reach of respondent | Number of respondents |
|----------------------------------|-----------------------|
| National | 24 |
| National with regional branches | 23 |
| Regional | 10 |
| Local | 30 |

Voluntary Sector Investment Programme²³⁵

In total this consultation had 77 respondents, the vast majority of which were from the VCSE sector.

| Type of respondent | Number of respondents |
|---|-----------------------|
| Charity (frontline) | 35 |
| Charity (infrastructure) | 19 |
| Social enterprise | 8 |
| Grassroots community group or microenterprise | 3 |
| Other VCSE organisation | 4 |
| University | 1 |
| Clinical Commissioning Group | 2 |
| NHS Trust | 1 |

ANNEX A: METHODOLOGY

| | |
|--------------------------------|---|
| NHS Commissioning Support Unit | 1 |
| Sector skills council | 1 |
| Consultancy to VCSE sector | 1 |
| Individual | 1 |

Of those respondents that indicated their size, a plurality had an annual turnover between £100,000 and £1m.

| Size of respondent | Number of respondents |
|----------------------------------|-----------------------|
| Micro (income less than £10,000) | 1 |
| Small (£10,000 - £100,000) | 12 |
| Medium (£100,000 - £1m) | 29 |
| Large (£1m - £10m) | 16 |
| Major (over £10m) | 13 |

Of those organisations that indicated their geographical reach, a plurality operated only locally.

| Geographical reach of respondent | Number of respondents |
|----------------------------------|-----------------------|
| National | 14 |
| National with regional branches | 14 |
| Regional | 17 |
| Local | 25 |

Face to face events

The VCSE Review secretariat ran six bespoke consultation events across the country which were attended by a total of 112 people.

| Location | Date |
|-----------|-------------------|
| Bristol | 15 September 2015 |
| Leicester | 5 October 2015 |
| Stockton | 14 October 2015 |

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

| | |
|------------|-----------------|
| Manchester | 15 October 2015 |
| Leeds | 22 October 2015 |
| London | 2 November 2015 |

In addition, members of the VCSE Review advisory group spoke and ran workshops at the following events.

| Event | Location | Date | Contribution |
|--|-------------|-------------------|---------------------|
| Future Focus | Leicester | 7 September 2015 | Workshop |
| South Central Leadership Forum | Swindon | 14 September 2015 | Workshop |
| The Shape of Things to come | Newcastle | 29 September 2015 | Speech and workshop |
| Rethinking the Future of the Sector | Manchester | 7 October 2015 | Speech and workshop |
| National Children and Adult Social Services Conference | Bournemouth | 15 October | Workshop |
| NAVCA Core | Manchester | 15 October | Workshop |
| ACEVO Annual Health and Social Care Conference | Leeds | 21 October | Speech |

Live online events

The VCSE Review secretariat ran five live online events which 107 people took part in.

| Topic | Type | Date |
|-----------------------------------|------------------|-------------------|
| Grant funding for health projects | Webinar | 10 September 2015 |
| Strategic partnership programme | Online live chat | 17 September 2015 |
| Partnership and infrastructure | Online live chat | 20 October 2015 |
| Impact and evidence | Online live chat | 21 October 2015 |
| Funding and commissioning | Webinar | 29 October |

ANNEX A: METHODOLOGY

Other

A shorter version of the online consultation was produced by Community Catalysts on behalf of the advisory group. 12 community organisations responded.

There were also 11 submissions from academics (either via the online consultation or in direct response to a call for evidence). This was supplemented by research and background papers from think tanks and academic institutions.

There were no responses using the easy read version.

Annex B: Advisory group and secretariat

| | |
|--------------------------------|--|
| Current advisory group members | |
| Mark Winter | ACEVO |
| Lindsay Marsden | Big Lottery Fund |
| Daria Kuznetsova | Big Society Capital |
| Renée Smith-Gorringe | Cabinet Office |
| Sian Lockwood | Community Catalyst |
| Flora Goldhill | Department of Health |
| Helen Walker | Department of Health |
| Paul Streets | Lloyds Bank Foundation |
| Caroline Howe | Lloyds Bank Foundation |
| Charlotte Ravenscroft | National Council for Voluntary Organisations |
| Jeremy Taylor | National Voices |
| Anu Singh | NHS England |
| Olivia Butterworth | NHS England |
| Rachel Pearce | NHS England |
| Catherine Davies | Public Health England |
| Jabeer Butt | Race Equality Foundation |
| Carol Candler | Regional Voices |
| Alex Fox (chair) | Shared Lives Plus |
| James Butler | Social Enterprise UK |
| Nick Temple | Social Enterprise UK |
| Ben Smith | Voluntary Action LeicesterShire |
| Rhidian Hughes | Voluntary Organisations Disability Group |
| Former advisory group members | |

ANNEX B: ADVISORY GROUP AND SECRETARIAT

| | |
|----------------------|--|
| Dr Ravali Goriparthi | Barking and Dagenham CCG |
| Matt Smith | Big Lottery Fund |
| Aigneis Cheevers | Cabinet Office |
| Alex Ankrah | Cabinet Office |
| Louise Beatty | Cabinet Office |
| Sarah Mitchell | Local Government Association |
| Ruth Driscoll | National Council for Voluntary Organisations |
| Giles Wilmore | NHS England |
| Bev Taylor | Regional Voices |
| Jane Hartley | Regional Voices |
| Charlotte Augst | Richmond Group |
| Richard Paynter | Vinspired |
| Arraba Webber | Vinspired |
| Secretariat | |
| Alison Powell | Department of Health |
| Andie Michael | Department of Health |
| Howard Chapman | Department of Health |
| Angie Macknight | National Council for Voluntary Organisations |
| Nick Davies | National Council for Voluntary Organisations |
| Emma Easton | NHS England |
| Amy Sinclair | Public Health England |
| Judith White | Public Health England |

Annex C: Glossary

Clinical Commissioning Group (CCG)

Clinical Commissioning Groups (CCGs) commission most of the hospital and community NHS services in the local areas for which they are responsible. CCGs are overseen by NHS England, which retains responsibility for commissioning primary care services such as GP and dental services, as well as some specialised hospital services. All GP practices now belong to a CCG, but groups also include other health professionals, such as nurses.

Services CCGs commission include:

- most planned hospital care
- rehabilitative care
- urgent and emergency care (including out-of-hours)
- most community health services
- mental health and learning disability services²³⁶

Co-design

When individuals are involved in designing and planning services, based on their experiences and ideas. They may be invited to work with professionals to design how a new service could work, or to share their experiences in order to help a service improve.²³⁷

Co-production

When individuals are involved as an equal partner in designing the support and services they receive. Co-production recognises that people who use social care services (and their families) have knowledge and experience that can be used to help make services better, not only for themselves but for other people who need social care.²³⁸

Direct Payment

Direct payments are local authority payments for people who have been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly from the local authority.

Individuals have responsibility for accounting for how the budget is spent to ensure it is meeting their needs, and additional responsibilities if they decide to become an employer and hire a personal assistant with the direct payment.²³⁹

See personal budgets.

Failure demand

Demand placed on the health and care system due to failures in the system rather than in direct response to people's needs. For example, an individual attending A&E for an issue that could be resolved more cheaply elsewhere because they were not signposted correctly.

Health and wellbeing board

Every council area in England has a health and wellbeing board to bring together local GPs, councillors and managers from the NHS and the council. Their job is to plan how to improve people's health and make health and social care services better in their area. Members of the public have the chance to be involved in the work of their local Health and Wellbeing Board through your local Healthwatch.²⁴⁰

Impact

The longer-term, broader or cumulative and sustained effects of an organisation's outputs and outcomes.²⁴¹

Joint strategic needs assessments (JSNAs)

JSNAs are assessments of the current and future health and social care needs of the local community. These are needs that could be met by the local authority, CCGs or NHS England. JSNAs are produced by health and wellbeing boards, and are unique to each local area. The policy intention is for health and wellbeing boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory data set to be included.²⁴²

Outcomes

Outcomes are the changes, benefits, learning or other effects resulting from an organisation's activities.²⁴³

Personal budget

A personal budget is the amount of money allocated by a local authority for an individual's care, based on its assessment of their needs. Individuals can be put in charge of this "budget" either by telling the local authority how they would like it spent, or by the council giving them the money so that they can directly pay for their own care (a direct payment).

It could also be given to a separate organisation (such as a user-controlled trust) that will spend the money on an individual's care according to their wishes. These are commonly known as Individual Service Funds.

Individuals may choose a combination of the above (for example, a direct payment with some council-arranged care and support), often called a mixed package.²⁴⁴

Personal health budget

A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local CCG. The aim is to give people with long-term conditions and disabilities greater choice and control over the healthcare and support they receive.

The plan sets out the individual's personal health and wellbeing needs, the health outcomes they want to achieve, the amount of money in the budget and how they are going to spend it. Individuals can use a personal health budget to pay for a wide range of items and services, including therapies, personal care and equipment.

Personal health budgets work in a similar way to the personal budgets that are used to manage and pay for their social care.²⁴⁵

Social determinants of health

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.²⁴⁶

Social impact bond (SIB)

A SIB is a financial mechanism in which investors pay for a set of interventions to improve a social outcome that is of social and/ or financial interest to a government commissioner.

If the social outcome improves, the government commissioner repays the investors for their initial investment plus a return for the financial risks they took. If the social outcomes are not achieved, the investors stand to lose their investment.²⁴⁷

Social investment

Social investment is the use of repayable finance to achieve a social as well as a financial return²⁴⁸.

Social prescribing

Social prescribing is a way of linking patients in primary care and their carers with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being²⁴⁹.

Annex D: Co-designing local health and care systems

This guide has been developed to inform discussions between the voluntary community and social enterprise sector (VCSE) and local councils, Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards (HWBs). It is an entirely optional resource which we hope local areas will find useful and which you may edit or adapt as you wish.

What role can the VCSE play in public services during austerity?

A broad range of activities are provided by the VCSE sector, such as advocacy, community engagement, complex service provision, infrastructure support and volunteering. The sector's strength lies in its holistic, community-embedded and personalised approaches.

The diversity, flexibility and level of innovation within the VCSE sector enables it to meet the needs of communities that the statutory sector may find more difficult, many of which are experiencing the greatest health inequalities. However, this also means that the sector is different in each locality and that there is no one-size-fits-all approach.

Increasing budget pressures and rising demand are impacting on both the statutory and VCSE sectors. Statutory guidance on Joint Strategic Needs Assessments (JSNA) and joint health and wellbeing strategies, suggests commissioners and their partners will wish to:

- build a comprehensive understanding of all sections of the community, with particular focus on groups which are often overlooked or experience health and wellbeing inequalities
- develop an understanding of what solutions the local area has to offer to health and wellbeing challenges (the area's assets)
- develop an understanding of the VCSE sector in their area
- engage with and recognise value of VCSE organisations in developing strategic plans and when commissioning services.

Suggested discussion questions for local areas

Identifying local assets and needs

How can we build on our JSNA to develop a fuller picture of our community's resources and assets (including charities, social enterprises, community groups, volunteers etc.) as well as its needs?

Are there any local communities whose health and care needs are being overlooked? What could be done to address this and which organisations are well-placed to do so?

How can commissioners and VCSE organisations better work together in co-producing our health and social care plans for this area?

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

How could we actively engage a wider range of citizens and local communities?

Understanding your local market

What are the size, scope and capabilities of VCSE and other providers in the local market?

What currently works well in forming effective partnerships between the VCSE and statutory organisations?

Are certain kinds of VCSE activity currently being affected more by cuts and does anything need to be done to minimise the impact of any disparities?

Which funding approaches will best enable VCSE organisations to achieve desired outcomes?

Do statutory partners have a clear policy for selecting between different funding approaches? (e.g. grants, contracts, service level agreements, personal budgets, social impact bonds)

Procurement

Do your commissioning processes encourage the involvement of VCSE providers e.g. in designing tender specifications?

How could commissioning processes enable the involvement of a wider range of VCSE providers?

Are tender requirements clear and proportionate to the size of contract opportunity?

What use is made of the Social Value Act (2012) and what more use could be made of it?

Outcomes

What kinds of outcomes and impact do you currently require in monitoring and evaluation?

What resources might the VCSE sector need to measure and demonstrate outcomes?

What support is available to develop skills and capacity in this area?

How could learning from funded work and projects be better shared and disseminated?

Annex E: Bibliography

- ADASS, VONNE. The Care Act - A Commissioner's Perspective presentation. The Shape of Things to come conference. 29 September 2015
- Aiken M. Patient Participation Groups: challenges, reflections and actions presentation. January 2015
- Association of Public Health Observatories, The Marmot Review. Fair society healthy lives – Framework of indicators post 2010. UCL Institute of Health Equity. <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> (accessed March 2016)
- Attend Academy. Health and Social Care Volunteering Fund Support Package - Evaluation of Impact. April 2015
- Austin T. Mapping Clinical Governance in Voluntary Sector Organisations. National Institute for Mental Health in partnership with the Mental Health Providers Forum. 2004
- Baylin E. Clinical Commissioning Groups - Beyond authorisation. Hosted conversations of CCG projects involving VCSE. Bradford CVS
- Benson A. Inquiry into the future of voluntary services: summary report. NCIA. January 2015
- Bertotti M. et al. Key barriers to community cohesion: views from residents of 20 London deprived neighbourhoods. Institute for Health and Human Development, University of East London. GeoJournal 2011. 47(2). Pp. 168-183.
- Brown A., McAllister, A. Ready, willing and able. An interim review of investment and contract readiness fund. Boston Consulting Group. April 2014
- Carlin J. The growing demand for volunteering support. Public Service bulletin. NCVO. 19 February 2015
- Catalyst Stockton on Tees. IPC Briefing. VONNE. 30 September 2015
- Chapman T. Third sector trends presentation at Durham County Council VCSE Working Group. Durham University. 12 May 2015
- Chapman T, Robinson F. Key findings from the Northern Rock Foundation Third Sector Trends Study in North East England. Northern Rock Foundation. August 2015
- Citizens Advice. A very general practice: How much time do GPs spend on issues other than health? Policy briefings. Citizens Advice. May 2015
- Community Voluntary Action Tameside. Engagement with Tameside and Glossop residents on phase 3 of the Care Together programme. For Tameside and Glossop Clinical Commissioning Group. September 2015

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

Coyle A. Whole systems change: coproducing new models of health and care presentation at LVSC & Community Voices for Health event. Greater London Assembly. 16 April 2015

Crow R, Crawshaw P. Briefing Note: Methodology used to Calculate Health Economic Impact of CATALYST Health Improvements' Programme. Social Futures Institute, Teeside University. May 2015

Cultural Commissioning Programme. Overview evidence of impact: sources. NCVO. October 2015

Cultural Commissioning Programme. Summary of further examples of measuring impact. NCVO. October 2015

Cultural Commissioning Programme. Summary of evidence measures requested by commissioners from arts and cultural organisations. NCVO. October 2015

Dadson C. et al. Growing the local social economy with place based investment. CSEP Conference. SIB Group. 2014

Daneshvar S. H. et al. Future of Social Media in Health and Care with Coproduction. School of Informatics, University of Edinburgh. 2014

Defend NHS Sussex. Third sector and the NHS – the Trojan horse? NCIA. January 2015

Derges J, Clow A, Lynch R. et al. 'Well London' and the benefits of participation: results of a qualitative study nested in a cluster randomised trial. BMJ Open 2014. 4:e003596. doi:10.1136/bmjopen-2013- 003596.

Eckley B. et al. Fullness of life together. Reimagining Christian engagement in our communities. Church Urban Fund. October 2015

FSI. Taking the Pulse of the Small Charity Sector. June - August 2015. 9th Edition.

GLA, Public Health England, London CCGs, London Councils, NHS England. Better Health for London: Next Steps. Greater London Authority. March 15

Hartley J. North East Third Sector Trends and National Almanac data presentation. VONNE. 2015

Health Inequalities National Support Team. How to Develop Voluntary Organisations, Community Groups, Charities and Social Enterprises as Strategic Partners. Department of Health. 2011.

<http://www.institute.nhs.uk/images/documents/wcc/HPHL/HINST%20resources/VCS.pdf>

Health Inequalities National Support Team. How to develop and implement a strategic framework for community engagement to support achievement of health and social care goals: the 'Five Elements' model. Department of Health. 2010.

<http://www.institute.nhs.uk/images/documents/wcc/HPHL/HINST%20resources/The%20Five%20Elements%20Model%20-%20community%20engagement.pdf>

Henwood M. Empowering communities: community skills development and neighbourhood workforce planning. An evaluation of the early adopter programme. Skills for Care. November 2012

Hill M. Executive summary interim report – Evaluation of the volunteering in care homes project. Institute for Volunteering Research. May 2015

Hutchinson L. et al. Alliance contracting. Kings Fund. March 2014

Impetus. Building the Capacity for Impact. Impetus, Private Equity Foundation. September 2014

Institute For Government. Public sector local delivery Landscape 13. IFG. 2015

Institute For Government. Timeline joining up local public services. IFG. 2015

#Iwill. Youth Social Action in Health and Social Care. Step Up To Serve. September 2015

Kamerāde D, McKay S. Is There a Subjective Well-Being Premium in Voluntary Sector Employment? International Society for Third-Sector Research and The Johns Hopkins University. 10 December 2014

Kamerāde D. Impact review - Third sector impacts on human resources and community: a critical review. TSI working paper no. 3/ TSRC working paper no. 134. Seventh Framework Programme (grant agreement 613034), European Union. Brussels: Third Sector Impact. 2015

LGA, ADASS, CfPS, Solace. Shared Principles for redesigning the health and care landscape. LGA. 2015

LGA, NHS Clinical Commissioners, NHS Confederation. Making it better together - A call to action on the future of health and wellbeing boards. LGA. June 2015

LVSC. Whole systems change: co-producing new models of health and care, event report. LVSC. April 2015

LVSC. Whole Systems Change think piece. LVSC. 2015

McKenzie F. Engaging with NHS structures presentation at LVSC event. UCLPartners. April 2015

Murdock A. The example of Mindapples in promoting good mental health. November 2015. Submission to the VCSE Review consultation. August – November 2015. London Southbank University.

NCVO, Compact Voice. Background Paper for VCSE Health Review. March 2015

NCVO. Financial Sustainability Funding Review. NCVO. 2015

NHS European Office. Matching health with growth. NHS Confederation. Briefing Issue 21. March 2015

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

Nuffield Trust. Health and social care priorities for the Government: 2015 - 2020.

Nuffield Trust. Policy Briefing. June 2015

Oldham J, Kendall L. People not body parts: How do we achieve whole person care.

New Statesman. Person Care Supplement. December 2014

Phillips G. et al. Well London Phase-1: results among adults of a cluster-randomised trial of a community engagement approach to improving health behaviours and mental well-being in deprived inner-city neighbourhoods. *J Epidemiol Community Health* 2014. 68: 606–614. doi: 10.1136/jech-2013-202505.

Royal Voluntary Service. Avoiding unhappy returns: radical reductions in readmissions, achieved by volunteers. RVS. December 2013

Scotland Funders' Forum. Harmonising reporting: working group report to the Scotland Funders' Forum. Scotland Funders' Forum. 2010

Shared Lives Plus. A shared life is a healthy life: health report. Shared Lives Plus. October 2015

Social Impact Investment Taskforce. Impact Investment: The invisible heart of markets. SIIT. Sept 2014

Skills for Care. Valuing what matters: Commissioning citizens and communities to provide social care services. A guide for commissioners. Skills for Care. 2014

Stuffins C. Open public services experiences from the voluntary sector. NCVO collective response. 2012

Tinker R. Making case for public spending. TUC Touchstone extra. 2015

Volition. Leeds Strategy Notes from 20 April event. 2015

Volunteering Matters. Toolkit Youth Social Action in Health and Social Care. Volunteering Matters. 2015

Annex F: References

- ¹ VCSE Review Advisory Group. VCSE Review. <https://voluntarycommunitysocialenterprisereview.files.wordpress.com/2015/05/vcse-review-interim-report.pdf> (accessed February 2016)
- ² Civil Society Almanac. NCVO. 2015
- ³ 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.
- ⁴ 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.
- ⁵ NHS England. New Care Models - Vanguard sites. www.england.nhs.uk/ourwork/futurenhs/new-care-models/ (accessed February 2016)
- ⁶ NHS England. Integrated Personal Commissioning (IPC) Programme. www.england.nhs.uk/commissioning/ipc/ (accessed February 2016)
- ⁷ NHS England. Integrated Care Pioneers. www.england.nhs.uk/pioneers/ (accessed February 2016)
- ⁸ 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
- ⁹ National Voices. Five Year Forward View People and Communities Board. www.nationalvoices.org.uk/fyfv (accessed February 2016)
- ¹⁰ National Voices. Five Year Forward View People and Communities Board. www.nationalvoices.org.uk/fyfv (accessed February 2016)
- ¹¹ 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
- ¹² 1. Care and support is person-centred: personalised, coordinated, and empowering
2. Services are created in partnership with citizens and communities
3. Focus is on equality and narrowing inequalities
4. Carers are identified, supported and involved

5. Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers

6. Volunteering and social action are recognised as key enablers

National Voices. Five Year Forward View People and Communities Board.

www.nationalvoices.org.uk/fyfv (accessed February 2016)

¹³ Think Local Act Personal, forthcoming publication 2016

¹⁴ Open Contracting Partnership. Global principles. <http://www.open-contracting.org/get-started/global-principles/> (accessed March 2016)

¹⁵ Open Contracting Partnership. Implementing the Open Contracting Data Standard. <http://www.open-contracting.org/data-standard/> (accessed March 2016)

¹⁶ 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)

¹⁷ 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)

¹⁸ 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)

¹⁹ Gov.uk. Government Service Design Manual. Open data. <https://www.gov.uk/service-manual/technology/open-data.html> (accessed March 2016)

²⁰ 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)

²¹ Office of National Statistics. Life Expectancy at Birth and at Age 65 by Local Areas in England and Wales, 2012 to 2014. 04 November 2015

²² Public Health England London Knowledge and Intelligence Team. Understanding inequalities in London's life expectancy and healthy life expectancy. Public Health England. 24 January 2014

²³ The Marmot Review. Fairer Society, Healthy Lives. Strategic review of health inequalities in England post-2010. February 2010

²⁴ Clinks. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

²⁵ Putnam R. Bowling Alone: the collapse and revival of American community. New York: Simon and Schuster.

-
- ²⁶ National Voices, NESTA. Peer Support: What Is It and Does It Work? A summary of the evidence. National Voices, Nesta. 2015
<http://www.nationalvoices.org.uk/publications/our-publications/peer-support> (accessed March 2016)
- ²⁷ Fujiwara D, Oroyemi P, McKinnon. E. Wellbeing and civil society. Estimating the value of volunteering using subjective wellbeing data. Department for Work and Pensions, Cabinet Office. Working paper No 112.2013.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/221227/WP112.pdf
(accessed February 2016)
- ²⁸ Kitchen S. et al. 2005: Citizenship Survey: race and faith topic report. Department for Communities and Local Government. 2006. and Low, N. et al. Helping out: a national survey of volunteering and charitable giving. London: Cabinet Office. 2007
<http://www.ivr.org.uk/component/ivr/helping-out-a-national-survey-of-volunteering-and-charitable-giving>
(accessed March 2016)
- ²⁹ Kim E. Volunteering is prospectively associated with health care use among older adults. Soc Sci Med. 2016 January. 149: 122-9. Academia online:
https://www.academia.edu/19753044/Volunteering_is_prospectively_associated_with_health_care_use_among_older_adults (accessed February 2016)
- ³⁰ Galea A. et al. Volunteering in acute trusts in England: Understanding the scale and impact. Kings Fund. November 2013.
<http://www.kingsfund.org.uk/publications/volunteering-acute-trusts-england> (accessed March 2016)
- ³¹ Social Exclusion Task Force. Inclusion health: Improving the way we meet the primary health care needs of the socially excluded. Cabinet Office, Department of Health. March 2010
<http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf> (accessed February 2016)
- ³² LGBT Foundation. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ³³ LVSC. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ³⁴ Bournemouth CVS. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ³⁵ Contact a Family. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ³⁶ Youth Access. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ³⁷ Lloyds Bank Foundation. Expert yet Undervalued and on the frontline: the views and voices of small and medium sized charities. Lloyds Bank Foundation. July 2015. P 5.

³⁸ Bull D, Joy I, Bagwell S. Supporting Good Health: the role of the charity sector. NPC. 30 October 2014

³⁹ London Office of CCGs, NHS England (London). Transforming London's health and care together. NHS England. March 2015

⁴⁰ Revolving Doors Agency, Centre for Mental Health. Comprehensive Services for Complex Needs: A summary of the evidence. Revolving Doors Agency. 2015

⁴¹ Protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation Equality and Human Rights Commission. Protected characteristics. www.equalityhumanrights.com/private-and-public-sector-guidance/guidance-all/protected-characteristics (accessed February 2016)

⁴² LVSC. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁴³ Nacro. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁴⁴ NAVCA. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁴⁵ A BME charity quoted in Alex Fox. Gathering thoughts ahead of 2nd March. Blog. Originally posted February 2015, reposted June 2015
<http://vcseview.org.uk/2015/06/14/gathering-thoughts-ahead-of-2nd-march/#more-125> (accessed March 2016)

⁴⁶ Addaction. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁴⁷ Clinks. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015. Quoting More than a provider research (http://www.clinks.org/sites/default/files/basic/files-downloads/clinks_more-than-a-provider_WEB_FINAL_0.pdf) (accessed February 2016)

⁴⁸ Disability Rights UK. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁴⁹ Public Health England, NHS England. A guide to community-centred approaches for health and wellbeing. Public Health England. 11 February 2015

⁵⁰ Centre for Human Rights in Practice. Page list of reports on the Impact of Public Spending Cuts on Different Disadvantaged Groups within the UK. University of Warwick
<http://www2.warwick.ac.uk/fac/soc/law/research/centres/chrp/projects/spendingcuts/resources/database/reportsgroups/> (accessed February 2016)

⁵¹ Civil Society Almanac. NCVO. 2015. Local is defined as operating at regional level or below

⁵² State of Social Enterprise Survey 2015. Social Enterprise UK. 2015. Survey allowed multiple responses. Neighbourhood/locally – 13%, local authority – 15%, several local authorities – 15%, region – 17%, Scotland – 11%, Wales – 11%, Northern Ireland – 8%.

⁵³ Social Care Institute for Excellence (SCiE). Coproduction in social care: What it is and how to do it. www.scie.org.uk/publications/guides/guide51/what-is-coproduction/policy-and-legal-context.asp (accessed February 2016)

⁵⁴ Public Health England, NHS England. A guide to community-centred approaches for health and wellbeing. Public Health England. 11 February 2015

This includes a helpful diagram, Figure 2, which shows the family of community-centred approaches for health and wellbeing.

⁵⁵ Cabinet Office, Compact Voice. The Compact. Cabinet Office. 2010. www.gov.uk/government/uploads/system/uploads/attachment_data/file/61169/Theme_20Compact.pdf (accessed February 2016)

⁵⁶ Mind. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁵⁷ Derges J. et al. 'Well London' and the benefits of participation: results of a qualitative study nested in a cluster randomised trial. Group.bmj.com. April 6 2014.

⁵⁸ Public Health England, NHS England. A guide to community-centred approaches for health and wellbeing. Public Health England. 11 February 2015

⁵⁹ The National Council for Palliative Care. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁶⁰ The Marmot Review. Fairer Society, Healthy Lives. Strategic review of health inequalities in England post-2010. February 2010

⁶¹ LVSC. Whole Systems Change: co-producing new models of health and care. Event report. LVSC. April 2015 http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Whole_Systems_Change_event_report_160415.pdf (accessed February 2016)

⁶² Regional Voices. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁶³ Nesta, Innovation Unit. By Us, For Us: The Power of Co-Design and Co-Delivery. Nesta. 2013

⁶⁴ Age UK. Personalised Integrated Care Programme.

<http://www.ageuk.org.uk/professional-resources-home/services-and-practice/integrated-care/integrated-care-model/> (accessed March 2016)

⁶⁵ Regional Voices. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁶⁶ Bull D, Bagwell S, Weston A, Joy I. Untapped potential: Bringing the voluntary sector's strengths to health and care transformation. NPC. Forthcoming publication 2016

⁶⁷ OPAAL. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁶⁸ Spectrum CIC. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁶⁹ Spectrum CIC. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁷⁰ LGA, NHS Clinical Commissioners. Making it better together: A call to action on the future of health and wellbeing boards. LGA. 30 June 2015

⁷¹ Respondents were clear that Healthwatch representatives on boards should not be expected to represent the views of local VCSEs

⁷² NAVCA. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁷³ Hospice UK. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁷⁴ Cowan R. Survey of VCSE Reps on 'Supporting Influence on Health and Wellbeing Boards'. VONNE. 5 February 2015

www.vonne.org.uk/resources/supporting-influence-health-and-wellbeing-boards-survey-vcse-representatives (accessed February 2016)

⁷⁵ 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

⁷⁶ LGA, University of Birmingham, ADASS, Department of Health, TLAP. Commissioning for Better Outcomes: a route map. LGA. 2015

⁷⁷ Gamsu M. Working with the local voluntary sector to tackle inequality and exclusion: a better JSNA. Local democracy and health. 06 May 2014. <http://localdemocracyandhealth.com/2014/05/06/working-with-the-local-voluntary-sector-to-tackle-inequality-and-exclusion-a-better-jsna/> (accessed February 2016)

-
- ⁷⁸ Community Action Southwark. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ⁷⁹ Greenwich and Bexley Community Hospice. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ⁸⁰ LVSC. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ⁸¹ Independent Public Service Transformation Panel. Bolder, braver, better: why we need local deals to save public service. Department for Communities and Local Government, HM Treasury. 26 November 2014
- ⁸² Dalton R. Integration: Local government and health leaders prefer a whole system approach. Health Service Journal. 9 June 2015. www.hsj.co.uk/resource-centre/supplements/integration-local-government-and-health-leaders-prefer-a-whole-system-approach/5086572.article#.VhKmJvIVhBc. (accessed February 2016/ 5 October 2015)
- ⁸³ Wilson S. et al. Joining up public services around local, citizen needs. Institute for Government. 04 November 2015
- ⁸⁴ Dave Forrest, Director, Bradford Volunteer Centre. Contribution to live chat discussion. Impact. 21 October 2015
- ⁸⁵ LGA, NHS Clinical Commissioners. Making it better together: A call to action on the future of health and wellbeing boards. LGA. 20 June 2015
- ⁸⁶ Nacro. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ⁸⁷ VANL. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ⁸⁸ North Derbyshire CCG. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ⁸⁹ Compact Voice, NHS England. Bite sized guide to the Compact. NHS England. Forthcoming 2016
- ⁹⁰ Hospice UK. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015 Hospice UK
- ⁹¹ Community Action Southwark. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁹² South J, Stansfield J, Fenton K. Putting communities at the heart of public health. *Perspectives in Public Health*. November 2015 vol. 135 no. 6 291-293

⁹³ Humphries R, Wenzel L. Options for integrated commissioning: Beyond Barker. King's Fund. 09 June 2015

⁹⁴ Alzheimer's Society. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁹⁵ Cambridge CAB. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁹⁶ YMCA Plymouth. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁹⁷ Nacro. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁹⁸ NAVCA. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

⁹⁹ The Creating Health Collaborative. A report from the Collaborative's first meeting on July 22nd 2014, 10 November 2014

¹⁰⁰ Voluntary sector respondent who asked to be anonymous.

¹⁰¹ LGA, University of Birmingham, ADASS, Department of Health, TLAP. Commissioning for Better Outcomes: a route map. LGA. 2015

¹⁰² Lloyds Bank Foundation. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁰³ Community Action Southwark. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁰⁴ National Voices for Realising the Value Consortium. How should we think about value in health and care? Nesta. September 2015
http://www.nesta.org.uk/sites/default/files/how_should_we_think_about_value_in_health_and_care.pdf (accessed February 2016)

¹⁰⁵ Sally Cupitt. NCVO CES. Proving our impact live chat. NCVO CES. 21 October 2015. <http://blogs.ncvo.org.uk/2015/10/08/live-discussion-proving-our-impact-21-october-10-30-11-30/> (accessed February 2016)

¹⁰⁶ NCVO. Proving our impact live chat. 21 October 2015.
<http://blogs.ncvo.org.uk/2015/10/08/live-discussion-proving-our-impact-21-october-10-30-11-30/> (accessed February 2016)

-
- ¹⁰⁷ Living Streets. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁰⁸ Join In. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁰⁹ Nova Wakefield District. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹¹⁰ Leeds Beckett University. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹¹¹ Innovation and Service Improvement. Innovation Health and Wealth: Accelerating Adoption and Diffusion in the NHS. Department of Health. 05 December 2011.
- ¹¹² Greenwich and Bexley Community Hospice. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹¹³ Wilson S. et al. Joining up public services around local, citizen needs. Institute for Government. 04 November 2015
- ¹¹⁴ Age UK. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹¹⁵ Sally Cupitt. NCVO CES. Proving our impact live chat. NCVO CES. 21 October 2015. <http://blogs.ncvo.org.uk/2015/10/08/live-discussion-proving-our-impact-21-october-10-30-11-30/> (accessed February 2016)
- ¹¹⁶ Clinks. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹¹⁷ Independent Public Service Transformation Panel. Bolder, braver, better: why we need local deals to save public service. Department for Communities and Local Government, HM Treasury. 26 November 2014
- ¹¹⁸ NIHR Collaboration for Leadership in Applied Health Research and Care East Midlands (CLAHRC EM). Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹¹⁹ Rob Newton. Leeds Beckett University. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹²⁰ NICE. Community engagement guidance. 2008 currently being updated. <https://www.nice.org.uk/guidance/ph9> (accessed February 2015)

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

¹²¹ Independent Public Service Transformation Panel. Bolder, braver, better: why we need local deals to save public service. Department for Communities and Local Government, HM Treasury. 26 November 2014

¹²² Community Action Southwark. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹²³ VCSE organisation referenced in Lloyds Bank Foundation. Expert yet undervalued and on the frontline: the views and voices of small and medium sized charities. Lloyds Bank Foundation. July 2015

¹²⁴ East & North Hertfordshire CCG. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹²⁵ HM Treasury, Public Service Transformation Network, New Economy. Supporting public service transformation: cost benefit analysis guidance for local partnerships. HM Treasury. April 2014. [HM Treasury, Public Services Transformation Network & New Economy, Supporting public service transformation: cost benefit analysis guidance for local partnerships \(2014\)](#) (accessed February 2016)

¹²⁶ Age UK. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹²⁷ Attend Academy. HSCVF Support Package – Evaluation of Impact. April 2015

¹²⁸ Age UK Lancashire. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹²⁹ Civil Society Almanac. NCVO Income from Government. 26 May 2015. <http://data.ncvo.org.uk/a/almanac15/government/> (accessed February 2016)

¹³⁰ Health & Social Care Information Centre. Personal Social Services: Expenditure and Unit

Costs England 2014-15.HSCIC. 16 September 2015

¹³¹ Nuffield Trust, The Health Foundation, The King's Fund. The Spending Review: what does it mean for health and social care? King's Fund. 17 December 2015

¹³² Nuffield Trust, The Health Foundation, The King's Fund. The Spending Review: what does it mean for health and social care? King's Fund. 17 December 2015

¹³³ Nuffield Trust, The Health Foundation, The King's Fund. The Spending Review: what does it mean for health and social care? King's Fund. 17 December 2015

¹³⁴ ADASS et al. Spending Review 2015: a representation from across the care and support sector. ADASS September 2015. https://www.adass.org.uk/uploadedFiles/adass_content/news/press_2015/Spending%20Review%20Representation%20from%20Care%20and%20Support%20Sector.pdf (accessed February 2016)

-
- ¹³⁵ North Derbyshire CCG. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹³⁶ Bull D, Joy I, Bagwell S. Supporting Good Health: the role of the charity sector. NPC. 30 October 2014
- ¹³⁷ Voluntary Action North Lincolnshire. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹³⁸ ACEVO. Alliance Contracting: Building New Collaborations to Deliver Better Healthcare. ACEVO. February 2015
- ¹³⁹ East and North Hertfordshire CCG. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁴⁰ VCSE organisation. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁴¹ Mind. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁴² For example, see LGA, University of Birmingham, ADASS, Department of Health, TLAP. Commissioning for Better Outcomes: a route map. LGA. 2015
- ¹⁴³ Social Impact Investment Taskforce. Impact Investment: The Invisible Heart of Markets. Social Impact Investment Taskforce. 15 September 2014
- ¹⁴⁴ Lord Young et al. Social Value Act Review. Cabinet Office. February 2015
- ¹⁴⁵ Spectrum CIC. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁴⁶ NHS England. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁴⁷ Mind. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁴⁸ Lloyds Bank Foundation. Expert yet Undervalued and on the frontline: the views and voices of small and medium sized charities. LBF. July 2015
- ¹⁴⁹ Young People's Health Partnership. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁵⁰ Joint submission from group of large housing and care providers. Phase I. 2015
- ¹⁵¹ Nuffield Trust. Health and social care priorities for the Government: 2015–2020. Nuffield Trust. 02 June 2015

¹⁵² Lloyds Bank Foundation. Expert yet Undervalued and on the frontline: the views and voices of small and medium sized charities. LBF. July 2015

¹⁵³ Locality, Vanguard Consulting. Saving money by doing the right thing: Why 'local by default' must replace 'Diseconomies of Scale'. Locality. March 2014

¹⁵⁴ ACEVO. Alliance Contracting: Building New Collaborations to Deliver Better Healthcare. ACEVO. February 2015

¹⁵⁵ Ham C, Murray R. Implementing the NHS Five Year Forward View: aligning policies with the plan. King's Fund. 18 February 2015

¹⁵⁶ Locality, Vanguard Consulting. Saving money by doing the right thing: Why 'local by default' must replace 'Diseconomies of Scale'. Locality. March 2014

¹⁵⁷ Clinks. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁵⁸ Locality, Vanguard Consulting. Saving money by doing the right thing: Why 'local by default' must replace 'Diseconomies of Scale'. Locality. March 2014

¹⁵⁹ Comptroller, Auditor General. Outcome-based payment schemes: government's use of payment by results. NAO. 19 June 2015. <https://www.nao.org/wp-content/uploads/2015/06/Outcome-based-payment-schemes-governments-use-of-payment-by-results.pdf> (accessed February 2016)

¹⁶⁰ Catch22. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁶¹ NAVCA. Health and Care Voluntary Sector Strategic Partnership 2015 survey. Strategic Partners Programme. Due for publication March 2016

¹⁶² Carers UK. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁶³ Ecorys UK, ATQ Consultants. Ways to Wellness Social Impact Bond: The UK's First Health SIB. Commissioning Better Outcomes Fund Evaluation. 2015

¹⁶⁴ Cabinet Office. Guidance on social impact bonds. Cabinet Office. First published 2012, latest update 16 May 2013. <https://www.gov.uk/guidance/social-impact-bonds> (accessed February 2015)

¹⁶⁵ Clinks. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁶⁶ Patient and Public Voice team. A bite size guide to: grants for the voluntary sector. NHS England. February 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/02/nhs-bitesize-grants.rb-170215.pdf>

¹⁶⁷ NAVCA. Health and Care Voluntary Sector Strategic Partnership 2015 survey. Strategic Partners Programme. Due for publication March 2016

-
- ¹⁶⁸ Directory of Social Change, Charity Finance Group et al. Grants for Good campaign. <https://www.dsc.org.uk/grants-for-good-2/> (accessed March 2016)
- ¹⁶⁹ Sheffield Hallam University: Centre for Regional Economic and Social Research. The social and economic impact of the Rotherham Social Prescribing Pilot: Main evaluation report. September 2014
- ¹⁷⁰ LGA, University of Birmingham, ADASS, Department of Health, TLAP. Commissioning for Better Outcomes: a route map. LGA. 2015
- ¹⁷¹ Ham C, Murray R. Implementing the NHS Five Year Forward View: aligning policies with the plan. King's Fund. 18 February 2015
- ¹⁷² Davies A. Our support, our lives: joining up the public services used by disabled people. Scope. March 2015
- ¹⁷³ NIHR Collaboration for Leadership in Applied Health Research and Care East Midlands (CLAHRC EM). Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁷⁴ Sian Lockwood. Community Catalysts. Heart and head: The case for community micro-enterprise. Blog. 9 July 2015 <http://vcsereview.org.uk/2015/07/09/heart-and-head-the-case-for-community-micro-enterprise/#more-206> (accessed February 2016)
- ¹⁷⁵ DanceSyndrome. Submission to the VCSE Review via the Community Enterprise version of the consultation questionnaire. October-November 2015.
- ¹⁷⁶ Leeds event. Organised by Involve Yorkshire and Humber. 05 November 2015
- ¹⁷⁷ Speaker at 4 November 2015 JRF/ Disability Rights UK event on personal budgets
- ¹⁷⁸ Mayor of London, Public Health England, London CCGs, London Councils, NHS England. Better health for London: next steps. London Assembly. 18 March 2015
- ¹⁷⁹ Charity quoted in Lloyds Bank Foundation. Expert yet Undervalued and on the frontline: the views and voices of small and medium sized charities. LBF. July 2015
- ¹⁸⁰ Newcastle CVS. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁸¹ Community Action Southwark. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015
- ¹⁸² Phone interview with Jason Stamp, Hull CCG lay member for Patient and Public Involvement, February 2016 and quote from Julia Weldon, Director of Public Health, Hull City Council, March 2016
- ¹⁸³ LGA, University of Birmingham, ADASS, Department of Health, TLAP. Commissioning for Better Outcomes: a route map. LGA. 2015

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

¹⁸⁴ NAVCA. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁸⁵ Alzheimer's Society. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁸⁶ Participant at workshop on the VCSE Review consultation. Future Focus Conference. Leicester. 15 September 2015

¹⁸⁷ Lloyds Bank Foundation. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁸⁸ NCB. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁸⁹ Inspiring Impact Programme. <http://inspiringimpact.org/> (accessed February 2016)

¹⁹⁰ Civil Society Almanac. NCVO. 2015

¹⁹¹ State of Social Enterprise Survey 2015. Social Enterprise UK. 2015

¹⁹² LGA, University of Birmingham, ADASS, Department of Health, TLAP. Commissioning for Better Outcomes: a route map. LGA. 2015

¹⁹³ Respondent to consultation conducted by Bournemouth CVS. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

¹⁹⁴ The Centre for Social Justice, Something's got to give: The state of Britain's voluntary and community sector. The Centre for Social Justice. December 2013

¹⁹⁵ Comptroller and Auditor General. Government's spending with small and medium-sized enterprises. National Audit Office. 9 March 2016

¹⁹⁶ Civil Society Almanac. NCVO. 2014 <http://data.ncvo.org.uk/a/almanac14/how-has-the-number-of-civil-society-organisations-changed/> (accessed February 2016)

¹⁹⁷ Civil Society Almanac. NCVO. 2015

¹⁹⁸ State of Social Enterprise Survey 2015. Social Enterprise UK. 2015

¹⁹⁹ Adapted list from: The independent commission on the future of local infrastructure. Change for Good. NAVCA. January 2015

²⁰⁰ North Derbyshire CCG. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

²⁰¹ Participant at VCSE Review London event. 02 November 2015

²⁰² Cabinet Office. Supporting a stronger civil society. Cabinet Office. 2010. which quotes results from National Survey of Third Sector Organisations (later renamed the

National Survey of Charities and Social Enterprises) [Cabinet Office, Supporting a Stronger Civil Society](#) (accessed February 2016)

²⁰³ NAVCA. Community Engagement and Health: Examples from NAVCA members. NAVCA. 2015

²⁰⁴ Community Action Southwark. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

²⁰⁵ Carers UK. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

²⁰⁶ The independent commission on the future of local infrastructure. Change for Good. NAVCA. January 2015

²⁰⁷ Participant at VCSE Review London event. 02 November 2015

²⁰⁸ Patient and Public Voice team. A bite size guide to: grants for the voluntary sector. NHS England. February 2015.

²⁰⁹ Join In. Submission to consultation, VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015

²¹⁰ Ben Smith. Voluntary Action Leicestershire. PPG volunteers lead successful social prescribing clinic pilot. Blog. 12 January 2016. <http://vcsereview.org.uk/tag/voluntary-action-leicestershire/> (accessed March 2016)

²¹¹ Civil Society Almanac. NCVO. 2015

²¹² Paul Streets. Lloyds Bank Foundation. Let's ask three wishes of this Review. Originally posted January 2015. [Paul Streets, Lloyds Bank Foundation](#) (accessed February 2016)

²¹³ Public Health England, NHS England. A guide to community-centred approaches to health and wellbeing. Public Health England. February 2015

²¹⁴ Our recommendations for other funders, including local health partners, are included separately in the Funding and Commissioning chapters of this report.

²¹⁵ National Council for Palliative Care. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015

²¹⁶ Disability Partnership. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015

²¹⁷ Sense. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015

²¹⁸ Youth Access. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015

JOINT REVIEW OF PARTNERSHIPS AND INVESTMENT IN VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE ORGANISATIONS IN THE HEALTH AND CARE SECTOR

- ²¹⁹ Hertfordshire County Council. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²²⁰ Health Work and Wellbeing Group. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²²¹ East and North Hertfordshire CCG. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²²² Mind. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²²³ LVSC. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²²⁴ Carers UK. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²²⁵ National Voices. <http://www.nationalvoices.org.uk/publications/our-publications> (accessed March 2016)
- ²²⁶ Sheffield Cubed. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²²⁷ Imago. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²²⁸ VCSE organisation. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²²⁹ Join In. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
<https://www.joininuk.org/hidden-diamonds-true-value-of-sport-volunteers/> (accessed February 2016)
- ²³⁰ Lay volunteer. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²³¹ Maidstone special needs support service. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²³² Child Brain Injury Trust. Submission to consultation, VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
- ²³³ VCSE Review. Interim report. VCSE Review website. 2015
<https://voluntarycommunitysocialenterprisereview.files.wordpress.com/2015/05/vcse-review-interim-report.pdf> (accessed March 2016)
- ²³⁴ NHS England Consultation Hub. VCSE Review: Discussion paper on the challenges and solutions to better investment in and partnership with the VCSE sector. August - November 2015 www.engage.england.nhs.uk/consultation/vcse-review (accessed February 2016, consultation closed November 2015)

-
- ²³⁵ NHS England Consultation Hub. VCSE Review: Discussion paper on the Voluntary Sector Investment Programme. August – November 2015
www.engage.england.nhs.uk/consultation/vcse-review-vsip (accessed February 2016, consultation closed November 2015)
- ²³⁶ NHS. About the NHS. CCG outcomes.
www.nhs.uk/NHSEngland/thenhs/about/Pages/ccg-outcomes.aspx (accessed February 2016)
- ²³⁷ Think Local Act Personal. Care and support jargon buster.
www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/#Co-design (accessed February 2016)
- ²³⁸ Think Local Act Personal. Care and support jargon buster.
www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/#Co-production (accessed February 2016)
- ²³⁹ NHS. Social care and support guide. Personalised care
www.nhs.uk/Conditions/social-care-and-support-guide/Pages/personalisation.aspx (accessed February 2016)
- ²⁴⁰ Think Local Act Personal. Care and support jargon buster.
[http://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/#Health and Wellbeing Board](http://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/#Health%20and%20Wellbeing%20Board) (accessed February 2016)
- ²⁴¹ NCVO/ KnowHowNonprofit. Key terms in monitoring and evaluation
<https://knowhownonprofit.org/organisation/quality/mande/glossary> (accessed February 2016)
- ²⁴² Department of Health. Statutory guidance on joint strategic needs assessments and joint Health and wellbeing strategies. March 2013.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf (accessed February 2016)
- ²⁴³ NCVO/ KnowHowNonprofit. Key terms in monitoring and evaluation
<https://knowhownonprofit.org/organisation/quality/mande/glossary> (accessed February 2016)
- ²⁴⁴ NHS. Social care and support guide. Personalised care
www.nhs.uk/conditions/social-care-and-support-guide/Pages/personalisation.aspx (accessed February 2016)
- ²⁴⁵ NHS. Choice in the NHS. Personal health budgets.
www.nhs.uk/choiceintheNHS/Yourchoices/personal-health-budgets/Pages/about-personal-health-budgets.aspx (accessed February 2016)
- ²⁴⁶ World Health Organisation. Social determinants of health.
www.who.int/social_determinants/sdh_definition/en/ (accessed February 2016)
- ²⁴⁷ Social Finance. Social Impact Bonds
<http://www.socialfinance.org.uk/services/social-impact-bonds/> (accessed February 2016)

²⁴⁸ Big Society Capital. <http://www.bigsocietycapital.com/faqs> (accessed February 2016)

²⁴⁹ Centre for Regional Economic and Social Research. From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot. Sheffield Hallam University. December 2013