A report on the voluntary, community and social enterprise sector's involvement with the health reforms.

Scoping report May 2012

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Introduction

This report summarises the findings of a scoping exercise to assess the voluntary, community and social enterprise (VCSE) sector's experiences of the new health structures and their perceptions and fears for future engagement.

It is based on a series of informal interviews with VCSE providers, their representative groups and other key stakeholders within the health sector.

It is the first output of a programme to support greater understanding of the role and value of the voluntary and community sector and social enterprises within the new health system. The programme is designed to support Clinical Commissioning Groups and Health and Wellbeing Boards to develop constructive and productive partnerships with the VCSE sector.

Section 1 of this report provides some background and context to the programme and the current health reforms. Section 2 provides an overview of the context of VCSE's role in health and social care and the new commissioning structures. Section 3 is an assessment on how these changes are or will affect the VCSE.

Section 1: Background and Context

The role of the VCSE and social enterprise sector

The VCSE plays a significant role in the delivery of health and social care. Just over a quarter of voluntary sector organisations and a third of all social enterprises are involved in the provision of adult health and/or social care. This accounts for more than £4 billion worth of public sector funding.

There is enormous breadth and diversity to the organisations that comprise the voluntary and social enterprise sectors and the roles that they play in improving health and wellbeing. They range from small community based organisations to large national organisations with multi-million pound turnovers. The roles they play include direct service provision, service re-design and innovation, training and support, patient advocacy and advice, commissioning support and medical research.

When it comes to service provision many VCSEs sit at the interface between health and social care, taking a person or placed based approach to the services they deliver. Others specialise in reaching marginalised or underserved groups including people with complex needs, often involving service users in the process. There is also a new and growing group of social enterprises that have been created from previously NHS run services.

Alongside these there are many examples of VCSEs providing services that may not necessarily be considered as health care, but offer huge benefits to improving people's overall health and wellbeing. These include community based services, social support and interaction, social prescribing, housing, employment support and parenting services – the provision of which can create considerable savings to the NHS.

Much of what distinguishes the VCSE from any other sector is their ability to engage and build trust with the communities they serve. Be it the recruitment of large numbers of volunteers, or the ability to connect with groups that have traditionally experienced discrimination or inequity by the statutory sector. The VCSE has a tradition of supporting people to help themselves – through user-led organisations, as patient advocates or through social enterprise models that involve service users in their operation and governance. Often they are established in response to the perception that the state is failing to provide for a specific group or community.

What is clear to the VSCE sector and its advocates is that with 75% of NHS costs currently being spent on people with long-term conditions, there is a need to be more resourceful. Clinical services provided in clinical settings by clinical providers are unlikely to provide the cost effective quality outcomes that patients with long term conditions need. The VCSE sector with their ability to engage with communities, to draw on a broader range of resources including volunteers, and to build the trust needed to encourage behaviour change, needs to be recognised as a critical partner in the new arrangements.

The New Commissioning Arrangements

Clinical Commissioning Groups

Duties of GP commissioning consortia to engage with the voluntary and community sector

- Commissioners will need to establish and nurture new relationships with local voluntary organisations. (Department of Health 2010e)
- GP consortia are enabled to work closely with community partners when designing joined up services. (Department of Health 2010g)
- Commissioners should consider how voluntary and community organisations can play a role in the delivery of services and, through their expert knowledge, scope the sorts of services and outcomes that communities want and need (Department of Health 2010i).
- Consortia have the freedom to buy in support from external organisations, including voluntary sector bodies (Department of Health 2012e)

At the heart of the health and social care bill is the move to put clinicians in charge of shaping services. The majority of NHS services will be commissioned by Clinical Commissioning Groups (CCGs) rather than Primary Care Trusts. They will take on these responsibilities fully from April 2013 and will hold the majority of the NHS budget, accounting for more than £60 billion of public money.

CCGs will be based on the membership of constituent general practices, and involve and empower the full range of clinical professionals. They will be responsible for commissioning the majority of healthcare for their local population. CCGs will be required to have a governing body to ensure that appropriate arrangements are in place to exercise their functions effectively, efficiently and economically and in accordance with the generally accepted principles of good governance and the constitution of the CCG. The size of each CCG varies, however, there are increasing trends in CCGs clustering together in larger groups. Each CCG is able to decide the extent to which they carry out commissioning in-house, or share or buy in support services especially from Commissioning Support Services (CSS).

Commissioning Support Services

Commissioning Support Services (CSS) are designed to support the CCGs bringing with them specialist skills and knowledge to support the clinical elements of commissioning. Commissioning support encompasses a range of functions, from transactional services such as payroll and IT services, to equipping CCGs with the complex population level data required to inform commissioning decisions. They will initially be hosted by the NHS Commissioning Board. There is much fear and uncertainty regarding the role and form these CSS will take.

NHS Commissioning Board

The NHS Commissioning Board will be responsible for authorising CCGs, allocating resources and commissioning certain services such as primary care. This will include the setting of prices or tariffs and contracts and for driving quality. The Clinical Commissioning Board will host clinical networks to advise on single areas of care and clinical senates to provide clinical advice on commissioning plans.

Health and Wellbeing Boards

Alongside the move to clinical commissioning is an expanded role in health for local authorities who will also assume responsibility for public health and health improvement. Central to this will be the development of new health and wellbeing boards (HWB) who will be responsible for overseeing the health needs of the local community. These will bring together local commissioners of health and social care, elected representatives and representatives of the new healthwatch (see below) to agree an integrated way to improving local health and wellbeing.

They will have a duty to promote integrated working, with a core purpose to drive improvements in health and wellbeing by promoting joint commissioning and integrated delivery. Their remit will extend beyond health and adult social care to include children's health and wellbeing, and wider areas that impact on health such as housing, education and the environment.

The health and social care bill sets out the core membership of the board but beyond this the constitution of boards is variable.

The Sector's role in the health improvement and inequalities agenda

The voluntary and community sector is a key partner in addressing the wider determinants of health and achieving better public health outcomes for local populations. Organisations will work alongside directors of public health, local authorities, GP consortia, the wider NHS, private businesses, early years services, and schools (Department of Health 2012b).

Duties

There are a number of processes that are critical to the future of commissioning. CCGs and Councils will have a new shared statutory duty to produce a joint health and wellbeing strategy (JHWS) and joint strategic needs assessments (JSNAs); these will inform commissioning plans prepared by CCGs involving the HWB.

Engagement with stakeholders is essential in preparing for the new duties to involve local people in the development of the JSNA and JSWS. Stakeholders include providers from all sectors including the VCSE.

Public Health England

Public Health England will be established as an executive agency of the Department of Health. By delivering concerted cross-government action through the dedicated public health cabinet sub-committee, it brings together the functions of the Health Protection Agency and among others the National Treatment Agency for Substance Misuse (NTA).

Healthwatch

Healthwatch England is the national body that will support local healthwatch organisations and advise the NHS Commissioning Board, English local authorities, Monitor and the Secretary of State. It will also have the power to recommend that action is taken by the Care Quality Commission (CQC) when there are concerns about health and social care services. It is planned to be launching in October2012.

Local Healthwatch, is due in April 2013. This will among other things take on the work of the Local Involvement Networks (LINks). Its role will include representing the views of people who use services, carers and the public on the Health and Wellbeing boards set up by local authorities. It will provide a complaints advocacy service from 2013 to support people who make a complaint about services. It will report concerns about the quality of health care to Healthwatch England, which can then recommend that the CQC take action. There will however, be some variations locally to the role each Healthwatch will play.

The VCSE Sector's role as a provider

- The voluntary and community sector is a provider operating on an equal playing field with NHS and private health care providers in the 'any willing provider' market (Department of Health 2010h).
- The sector is an important advocate for patients, supporting them to interpret information and make an increasing number of choices (Department of Health 2010f).
- As a provider of NHS services, organisations will be required to register with Monitor and the Care Quality Commission (Department of Health 2010h).
- The sector will be required to submit data to The Information Centre according to nationally defined standards (Department of Health 2010d).

<u>Provider side developments</u>

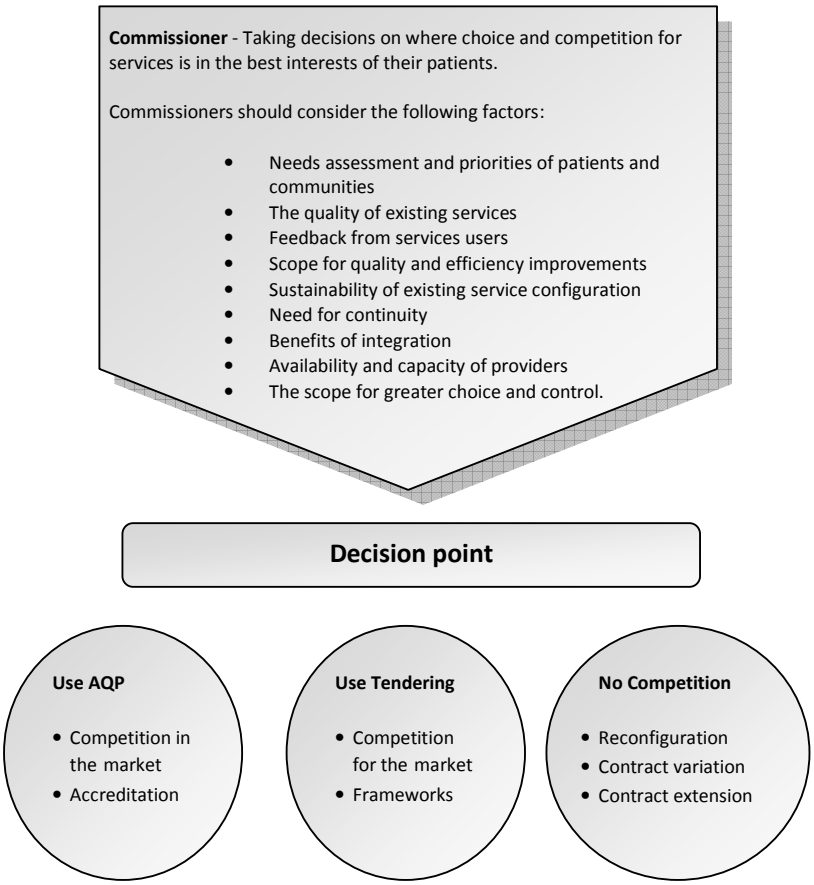
Commissioning models

Competition and choice are the two guiding principles that underpin the reforms. NHS markets will be opened up to a broad range of providers. One of the new commissioning tools will be use of the 'any qualified provider' (AQP) model. This will allow CCGs to commission services from licensed providers. This move is designed to open up markets and level the playing field between providers.

AQP is to be used when patients are referred by their GP for a particular service, patients will be free to choose from a list of *'qualified'* providers which meet NHS service quality requirements, prices and standard contractual obligations. Initially AQP will be implemented for a choice of eight "service lines". Each PCT cluster, supported by pathfinder clinical commissioning groups must select up to three services for implementation in 2012/13. From April 2012 providers were asked to register to provide services. AQP however, is just one tool alongside, competitive tendering, framework agreements and non

competitive processes. Figure 1 sets out the decision making process available to commissioners.

Figure 1: Commissioner choices



Regulation

When it comes to regulation providers will no longer be performance managed by the Strategic Health Authority. The Care Quality Commission will ensure services meet safety and quality requirements while Monitor will promote efficiency with power to set prices to ensure competition works in patient's interest and supports service continuity. For the first time the Bill enshrines a fair-playing field in legislation.

Public Services (Social Value) Act 2012

Under the Public Services (Social Value) Act, for the first time, all public bodies in England and Wales are required to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the area. It is a piece of legislation that will require commissioners to look beyond the price of each individual contract and looking at what the collective benefit to a community is when a public body chooses to award a contract.

Section 3: The voluntary, community and social enterprise sector and the current arrangements

The health reforms have been dominated by the role of the private sector in delivering previously NHS run services. Far less attention has been given to the role of VCSEs, rendering the sector anxious and uncertain about the implications of reforms on their futures. While the health and social care bill and the discourse that surrounds it talks of "plurality of provision" and "creating level playing fields", this is dominated by discussions of opening up markets to private sector providers, creating a level playing field between private and public sectors. It seemingly fails to take account of the role of the VCSE.

How engaged are the VCSE with the current changes to the commissioning structures?

Much of the evidence surrounding good commissioning practice recognises good relationships as essential to successful commissioning. Many VCSEs report that they would not have been commissioned to deliver the services they currently deliver, had it not been for the strong and trusted relationship they developed with their commissioners. Recent research carried out by Voluntary Sector North West looked at five highly successful health programmes being delivered by either voluntary sector or social enterprises. These were unanimous in their recognition that the relationships and trust between the commissioners and providers were critical factors in the co-design and co-production that led to a successful service. Similar evidence was reported as a key finding from the Partnership Improvement Programme.

The scoping highlighted conclusively that many VCSEs feel excluded from the new commissioning developments. It was reported by a number of VCSEs that in this period of transition they felt there is no clarity who they should be engaging with. Many VCSEs are reporting people within PCTs moving on and no replacements being appointed before the replacement structures have the staff and capacity to pick up these roles.

One organisation reported that "*the rate of staff turnover is rather alarming – I am having to rebuild relationships with new commissioners, even though I know they are only going to be around for another year*"

Lack of clear roles and responsibilities

VCSE reported that many of the forms of services they provide, straddle the boundaries between health and public health – focussing on overall wellbeing or early intervention and prevention. While previously such services would be commissioned by the PCT – it is not clear to many VCSEs where responsibility for commissioning services contributing to the reduction in health inequalities lies. They recognise that the duty may lie with the Health and Wellbeing Board but are not clear who their future commissioners will be and whether they will be in the local authority or in the CCG.

One interviewee described it as "*having to look in 3 directions at the same time – my current commissioner is the PCT and will be for another year, but my service straddles health and*

well-being so I have to engage with both the CCG and the local authority. It is a huge resource drain."

Competing for space

It was voiced by many interviewees that the accelerated timeframes have resulted in competing demands particularly on CCGs; it is felt that the VCSE is simply not seen as a priority yet. Many VCSEs reported having been hesitant in engaging with CCGs for this reason, but now fear that decisions are being made without considering them.

The one exception from the research is the experience of the larger social enterprises that have recently emerged from the NHS through the Right to Request policy. These organisations are often major providers of community services in their locality and are being consulted more widely in the developments as they progress.

This reinforces the fear that commissioners are engaging with the large providers but not the full breadth of the VCSE.

Representation

In addition to engagement with the VCSE there is also inconsistency in their formal representation in the new structures. Early implementer boards appear to be taking two main approaches: Commissioner-focused or mixed membership, which includes representation from the VCSE. Boards that have decided not to include provider representatives as members, generally because of conflict of interest issues, are looking at other ways of ensuring their involvement. VSNW reported that only half of Health and Wellbeing Boards have VCSE representation on them. When the VCSEs are not represented often the reason given is due to there being a conflict of interest as the VCSE are providers of services – not recognising the multiple and often complex role of the VCSE.

Levels of awareness and understanding of the sector among commissioners.

Previous research conducted as part of the National Programme for Third Sector Commissioning highlighted fragmented understanding of the breadth of the VCSE sector among PCT commissioners. However, in recent years VCSEs have reported positive changes occurring. This scoping exercise however, suggests that there is a real need to build this understanding again among CCGs. Many GPs had previously had little contact with the VCSE. One interview reported the CCGs referring to the VCSE as Diabetes UK or the local volunteering groups, not yet seeing the breadth in between or the sector as a long term commissioning partner.

Understanding the breadth and diversity of the sector in both scale and function is essential to be able to engage in the more sophisticated commissioning that allows the comparative advantage of VCSEs to be taken account of.

Alongside the basic level of awareness is a lack of knowledge of how to begin to engage with the

sector. Given the accelerated time pressures facing the new structures they feel the complexity and diversity of the sector is a challenge to successful engagement and would welcome means of simplifying this process.

How well will the VCSE sector be able to compete in the new structures?

How the VCSE is currently commissioned?

While the sector accounts for £4 billion worth of statutory health related services the ways in which these are commissioned, who does the commissioning and the types of services commissioned varies enormously. At present the majority of statutory income for health comes from PCTs, from a range of health and public health budgets. There has been a shift from grants to contracts over the last 10 years, with contracts now accounting for 80% of statutory income. However, these figures hide considerable nuances when it comes to commissioned services. When you explore the forms of contracts held by many VCSE organisations, a significant proportion were not won through competitive process. At their most basic level they are grants and Service Level Agreements that have been replaced with a contract. At best they are likely to be awarded through a more sophisticated co-production approach to commissioning.

The types of services being commissioned by PCTs also vary greatly, and these go well beyond clinical services. In a number of areas for example, PCTs fund infrastructure support for the VCSE and capacity building programmes – recognising the importance of the wider role that VCSE organisations play in improving health and wellbeing. There are many reports of such funding being cut in recent month or certainly notifications that it will not continue beyond March 2013. With the shift in boundaries, changes in responsibilities and tightened funding, it is unclear who might commission such services going forward and there is little in the way of transition funding.

Market structures - Size

Originally there was some optimism that smaller CCGs could support more locally tailored solutions and that as a result contract size would not preclude much of the VCSE from entering the market. As developments emerge regarding Commissioning Support Services and amalgamation of CCGs into clusters, this optimism is diminishing. There is widespread fear in the sector that markets are going to be designed in such a way that smaller organisations and in many cases even mid-sized organisations will simply be unable to compete.

Recent contracts put out to tender, including those for community care in Surrey and Children's services in Devon and Community services in Suffolk, are so large that only a very limited number of providers can compete. This is a trend seen in many other public service industries from welfare provision, to waste where a small number of very large private providers dominate the market and the VCSE sectors are squeezes out. In part this is due to the size of contracts limiting entry to organisations that already operate at that scale or organisations that are able to access the capital to scale.

There is also a capacity issue to note here: In most VCSEs the business development role is carried out by the CEO and they lack the capacity to engage with all structures in a way that

they feel is meaningful. This means organisations are restricted from building the relationships that are so critical to them being successfully commissioned.

Commissioning processes

Choice and competition have been cornerstones of the health reforms. Any Qualified Provider (AQP) is to be the dominant commissioning tool. It is to be used when patients are referred by their GP for a particular service, with patients free to choose from a list of 'qualified' providers which meet NHS service quality requirements, prices and standard contractual obligations.

There is considerable anxiety among the VCSE regarding the way in which AQP is rolling out. While in theory AQP could open up possibilities for the VCSE to provide services, it is likely to exclude many for a number of reasons:

- The costs of regulation and registration, with no guaranteed services or income at the end is a speculative risk beyond the capacity of most VCSEs.

- In reality there are limitations to the numbers of successful bidders to be the AQP provider in each area (on the whole 3). There is clear rationale for managing the transition in this way, however, it does limit new entrants to health markets.

- Where an organisation does qualify there is no guarantee of patients/service users i.e income. This will be dependent both on signposting from the health practitioner and on other market forces. VCSEs on the whole lack the capital to make this form of risk investment in marketing and business development.

- These forms of commissioning leave little scope for co-production and co-design or innovation. Any Qualified Provider may be a useful tool to bring in an element of competition and drive up quality but it does not support the forms of collaborative commissioning that have favoured the social enterprise and voluntary sectors.

There is widespread fear in the VCSE sectors that competition and choice are dominating how behaviours are emerging outside of AQP and that tender based commissioning will become the default approach, reliant on existing evidence to inform service specifications.

This is reinforced by the language in the bill surrounding 'level playing' fields. There are concerns that the principles of co-design and co-production that were starting to gather pace will be lost, and that if this assumption is not challenged it will reinforce a narrow approach to commissioning that will drive out innovation, weaken localism and disenfranchise further some of the most disadvantaged. And there is a fear that contracts will be too rigid to allow for the flexibility needed to respond to people's needs.

If commissioning is taken simplistically, as a large scale tendering process to encourage efficiencies from economies of scale, then the effectiveness from co-produced solutions will be lost along with their trust and reach to communities.

Alongside this it is feared that increasing pressures of the Quality, Innovation, Productivity and Prevention (QIPP) programme will squeeze out VCSE providers and their focus on early interventions and wellbeing.

The transition

While it is less than a year until CCGs and local authorities take on their new responsibilities the vast majority of interviewees had not been given any information on the future of their existing contract – where it would sit, would they have to compete for it. This makes it exceptionally difficult to plan.

Existing programmes to engage the VCSE

There are a number of open days that are taking place at a local level where the VCS are often invited. The DH is running considerable support for health and well being boards and specifically with regard to shaping the joint strategic needs assessment and health and wellbeing plans these include the role of the VCSEs. However, when it comes to Clinical Commissioning Groups there is little in the way of a comprehensive programme to engage with VCSEs.

Appendix 1:

Stakeholders

Locally

- Clinical Commissioning Boards
- Health and Wellbeing Boards
- HealthWatch
- Professional advice organisations
- Public Health Teams in Local Authorities
- Social Enterprises and Voluntary Sector Providers
- Emerging and existing Foundation Trusts
- Private companies

Sub regionally

- Commissioning Support Organisations

Nationally

- NHS Commissioning Board
- Monitor
- The Care Quality Commission
- Public Health England
- HealthWatch England

Appendix 2: Resource documents

Health Commissioning Programme

Kings Fund

http://www.kingsfund.org.uk/publications/future_commissioning.html
Commissioning for the future: Learning from a simulation of the health system in 2013/14
Candace Imison, Natasha Curry, Martin McShane . Looks at how the proposed changes to the health care system will work in practise, with focus on GP commissioning

http://www.kingsfund.org.uk/publications/voluntary_sector.html
The voluntary and community sector in health: Implications of the proposed NHS reforms
Natasha Curry, The King's Fund Claire Mundle, The King's Fund, Fiona Sheil, National Council for Voluntary Organisations (NCVO) Lisa Weaks, The King's Fund

BMA

http://www.bma.org.uk/images/commissioningupdate-clinicalcommsjan2012_tcm41-211462.pdf

Clinical Commissioning Groups and Effective Engagement, Jan 2012

RCGP

http://www.nhsconfed.org/Publications/Documents/Managing_conflicts_of_interest_in_CCGs.pdf

Managing Conflicts of Interest in Commissioning groups ,Sept 2011

Regional Voices

Series of briefings on the transition period and how it will impact on VCS as well as what is actually happening in various areas e.g. Tower Hamlets, Yorkshire and Humber.

http://www.regionalvoices.net/stronger-connections-for-better-health/stronger-connections-for-better-healthhealth-transition-resources/

Nuffield Trust

http://www.nuffieldtrust.org.uk/sites/files/nuffield/setting-priorities-in-health-research-report-sep11_0.pdf

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/120319_health-and-social-care-bill-commons-consideration-lords-amendments.pdf

19th March 2012 Comments on Lords amendments to the Health and Social Care Bill.

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/event_report_competition_integration_jan12.pdf

Report on Competition and integration event.

NHS Future Forum

http://healthandcare.dh.gov.uk/forum-report/

Reports on Integration, Education and Training, Information, NHS role in Public Health

NHS Confed

http://www.nhsconfed.org/Publications/Documents/putting_people_first_270312.pdf

Putting People First – Shared decision making and collective involvement.

Appendix 3:

Interviewees

Lisa Weaks - The Kings Fund

David Paynton - The Royal College of GPs –

Fiona Sheills - NCVO

Jules Actor - National Voices

Lance Gardner – Care Plus Group

Chris Dabbs – Unlmited Potential

Adrian Masters - Monitor

Dr Linda Harris – Spectrum Health care

Simone Hensby - Director of Voluntary Action Camden

Emma Easton – Regional Voices

Sarah Cowling – Health Works Newcastle

Natasha Thomas – Hale Project

Mike Cadger – Project 6

Richard Caulfield – Voluntary Sector North West

Elaine Cohen - NHS Confederation

Jo Cookes – RAISE

Lyn Bacon – Nottingham City Care Partnership

Mike Pyrah – Social Value Foundation