



Thought  
Leadership

**What can the voluntary sector do to  
encourage greater engagement and  
collaboration with the health system?**

**V O D G**

Bernadette<sup>1</sup>, who has dissocial personality disorder and recurrent depression, now has a place called home. She enjoys walking, cooking and looking after her flat. Supported by her personal assistant, the 58-year-old from Lambeth, in south London is now living a life she never thought possible. In the 13 years she spent on secure wards (in five different hospitals) the maximum unescorted leave Bernadette was granted was for three hours a day. Bernadette has in fact spent most of her life in institutions including a period in prison, a very difficult and traumatic time in her life. Bernadette now lives in her own flat in south London and employs a personal assistant whose sense of humour and ability to respond when things do not go to plan are just what Bernadette needs.

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<sup>1</sup> Not her real name

<sup>2</sup> <http://lambethcollaborative.org.uk/>

Bernadette's higher quality of life and lower care bill are the result of a major change in how her support is commissioned and delivered. Her care is provided by Lambeth Living Well Collaborative<sup>2</sup>, a partnership of organisations that co-produce support with people who use mental health services.



Bernadette is one of 200 people with mental health needs supported in this way under an “alliance contract” since April 2015 operated by Lambeth council, the clinical commissioning group (CCG), voluntary and community-sector organisations Thames Reach and Certitude, and service provider, the South London and Maudsley NHS foundation trust.

The single contract, single performance framework incorporates shared objectives and risks, shifting provision away from high cost, bed-based settings and towards supporting people at home, at a lower cost. The programme is on track to achieve a 20% saving in two years. Personalised recovery packages include social housing, personal budgets, and intensive care and support. Contract incentives are focused on rehabilitation and recovery, so all the partners have an equal stake in boosting – and maintaining – people’s health.

Alliance contracting was among the collaborative approaches to health and care support debated at a recent VODG meeting of chief executive and senior directors. As one practitioner said: “We feel it’s the future – not just in treating mental illness, but potentially for commissioning all adult care services.”

The VODG event, held under the Chatham House Rule enabling a full and frank discussion, investigated the barrier to and opportunities for greater partnership between health and the voluntary sector. This paper, based on that debate, is the latest in a series of thought leadership publications from VODG.



The need for better partnership between health and the voluntary organisations - and for a stronger, collective stance on the issue within the voluntary sector itself - is clear. As well as ongoing funding cuts<sup>3</sup>, there are now Brexit-related uncertainties relating to workforce, funding, policy and legislation<sup>4</sup>.

The need for relationships between statutory organisations and the voluntary sector to be reframed and for the two to become much more closely aligned was underlined in a recent joint review of partnerships and investment in voluntary organisations in the health and care sector<sup>5</sup>. That review, produced in partnership by VCSE representatives and the Department of Health, NHS England, and Public Health England, stated:


It is hard to see a future for many voluntary, community and social enterprise (VCSE) organisations and statutory services alike, if VCSE organisations remain seen as outsiders in a statutory-based system.

*Joint VCSE Review<sup>5</sup> calls for the sector to be recognised and valued both as a key provider of community-based, cost effective care and health services, but also as a key partner in designing effective health and care systems. The Review recommended that health and care systems be reframed around the goal of helping people to achieve and maintain wellbeing, in place of narrow, more medical goals and that tools are developed to measure and pay for the achievement of wellbeing and resilience goals. Local areas should base their plans on a clear view of all the assets and resources in an area, including VCSE organisations, and should use a range of funding approaches strategically to achieve a range of goals, including use of contracts, grants, personal budgets, social prescribing and social investment, on a 'simplest by default' principle, avoiding unnecessary bureaucracy. It called for greater use of the Social Value act and for statutory organisations to support the sector to embed social action and volunteering in health and care provision.*

<sup>3</sup> Association of Directors of Adult Social Services (2016) *Budget survey 2016*. Available: [www.adass.org.uk](http://www.adass.org.uk)



<sup>4</sup> VODG (2016) *Post-Brexit: what next for voluntary sector disability organisations*. Available: [www.vodg.org.uk](http://www.vodg.org.uk)

<sup>5</sup> VCSE sector and the Department of Health, NHS England, and Public Health England (2016) *Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector*. Available: [www.gov.uk/government/publications/review-of-partnershipsand-investment-in-the-voluntary-sector](http://www.gov.uk/government/publications/review-of-partnershipsand-investment-in-the-voluntary-sector)

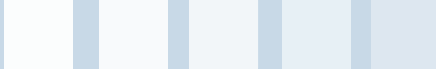


There have long been hopes that the kind of collaborative work in Lambeth could be replicated elsewhere. The vanguard sites under NHS England's Five Year Forward View<sup>6</sup> aim to deliver more integrated services while Greater Manchester and Cornwall are among the first areas to win devolution and the chance to reshape local and regional health, care and support.


A report published last year by the Association of Chief Executives of Voluntary Organisations (ACEVO), *Alliance Contracting: Building New Collaborations to Deliver Better Healthcare*<sup>7</sup>, argues that alliance contracting between the third sector and the public sector in health and social care is necessary if future NHS crises are to be avoided. Such "collaborative approaches", says ACEVO, should be the dominant commissioning model for relationship-based services.



"Collaboration is the golden thread that runs through successive policy platforms for health, social care and community development", according to a recent report from policy and practice community interest company Collaborate. The report, *The anatomy of collaboration*<sup>8</sup>, says collaboration is "the subtext of current NHS reform, the enabler of social action, and the means through which many stretched local authorities are thinking about the sustainability of their social care services."



<sup>6</sup> NHS England (2016) *New care models - vanguard sites*. Available: [www.england.nhs.uk/ourwork/futurenhs/new-care-models/](http://www.england.nhs.uk/ourwork/futurenhs/new-care-models/)



<sup>7</sup> ACEVO (2015) *Alliance Contracting: Building New Collaborations to Deliver Better Healthcare*. Available: [www.acevo.org.uk/sites/default/files/ACEVO%20alliance%20contracting%20report%202015%20web.pdf](http://www.acevo.org.uk/sites/default/files/ACEVO%20alliance%20contracting%20report%202015%20web.pdf)

<sup>8</sup> Collaborate (2016) *The anatomy of collaboration: a resource for leaders in health, social care and beyond*. Available: <http://collaboratei.com/2016/06/the-anatomy-of-collaboration/>



However, there is a huge gap between the theory of collaboration and the reality on the ground; many voluntary sector chief executives and senior directors who joined the VODG's debate that sparked this paper, cited their frustration at getting access to health commissioners. "How do you join the table?" one speaker asked. Another added: "You need the headspace and capacity to put yourself out there, maybe the bigger charities are able to do this better – it's the big charities that dominate, but it's also the medium to small size charities doing the work."

Another participant described health commissioners as something of a closed shop: "They don't think about how to involve people [who use services, as well as VCSE]. There's an internalisation attitude from the health side." Others echoed this observation: "We have much more discussion with social care commissioners – health feels very internalised." Another speaker added: "We don't understand the CCGs...we're good at getting to the local authority, knowing what they want and how to meet that need... I can't quite do that with CCGs."

When it comes to considering new services and providers, the debate heard, health commissioners focus on the traditional "medical model". In contrast, "local authorities are broader thinking and the innovations are driven by lack of money, so [the feeling is] "we've got no money therefore we've got to think differently and do something radical."

There was disappointment at the wildly different commissioning practices that exist. As one senior director said: "Some places are forging ahead [with commissioning collaboratively] and some are in the dark ages." There was widespread agreement that "it will be different in different areas. It's about spotting the Lambeths of this world, and thinking beyond the medical model."

Commissioners, it was felt by some, discourage collaboration and focus instead on competition: "That environment isn't conducive to having conversations with not for profit organisations."

What compounds health commissioners' reluctance to engage with VCSE, according to one speaker, is the fact that financial pressures mean that organisations themselves are focused on "just surviving" as opposed to innovating. This "can prevent us from doing new work... because of external factors."



## What can the voluntary sector do to encourage greater engagement and collaboration with the health system?

To shape the commissioning approach, one participant suggested, “the easiest way to get to CCG is to sit in on their public meetings and ask questions”, this however, it was acknowledged, “is very resource intensive.”

One common idea was to focus on breaking down the barrier through simply changing the language used. “Does the voluntary sector talk the wrong language?” as one commentator asked, “are we not getting the message across ourselves [about a willingness for joint work]?” Talking to health colleagues “in their language” was of paramount importance: “It’s about how you express it [the voluntary sector’s ability to meet local health need], and understanding pressures for CCGs or A&E... can we talk in their language about the benefits we can bring?”

Building relationships and investing time in creating allegiances, it was agreed, was vital. “We know so little about each other”, as one speaker said of the contact with health peers. Another added: “We need to get our act together and think about how we can collaborate in a proactive way – being clear what our message is in simple and focused ways.”

There was also an acknowledgment that, because the voluntary sector consists of diverse organisations of varying sizes, health professionals see it as something of a fractured group. “Part of the problem with the voluntary sector is that if you tell health they have to liaise with ‘the voluntary sector’, we aren’t a single entity and to some extent we’ve been set up to compete with each other. We’re not necessarily a collaborative entity, and not always a local entity.” Others agreed: “It’s about getting our house in order and saying we can work collaboratively.”



The Social Value Act<sup>9</sup> offers an opportunity here, the debate heard. The Act, which requires public authorities to take into account social and environmental value when choosing suppliers, is “a mechanism [for health] to think more about the community.” A focus on social values, it was agreed, might lead to health thinking more innovatively about developing commissioning.

There is also potential for work on the image of social care as provided by the voluntary sector. “Social care’s been hit so hard [by funding cuts], yet it has no profile – the public doesn’t ‘get it’. People relate to disability or old age, but not to social care.”

Some suggested that other ways to raise the profile of social care and the voluntary sector included attending public events and encouraging trustees to take a more proactive role in building bridges with health partners. A focus on the learning and development needs of managers on the subject of health was also deemed important: “Maybe managers aren’t as proactive about promoting what they do, and the impact it has?” Another speaker concluded: “We need transparency about

what we have to offer. We need to build leadership capability and capacity in the frontline manager workforce to realise future opportunities.”

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<sup>9</sup> Cabinet Office (2016) *Social Value Act: information and resources*. Available: <https://www.gov.uk/government/publications/social-value-act-information-and-resources/social-value-act-information-and-resources>

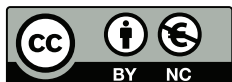




Funding cuts, the aftermath of Brexit, public service reform and new models of service delivery under the Five Year Forward View are radically and swiftly changing the landscape in which health and care operates. It is an unsettling time. However, a spotlight on the well-established and positive outcomes from innovators in the sector – and the stability that this approach can lend communities – could help encourage health to widen its horizons and embrace its voluntary organisation partners.

As one speaker concluded:

The voluntary and community sector needs to co-design the healthcare system. People who have long-term relationships with services and their families and communities need to be more actively involved. The voluntary and community social enterprise sector is the only one that has experience of doing that.



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