Voluntary Organisations Disability Group

Representation to NHS England and NHS Improvement consultation on *Integrating care Next steps to building strong and effective integrated care systems across England*

January 2021

About VODG

The Voluntary Organisations Disability Group (VODG) is the national infrastructure body representing organisations within the voluntary sector who work alongside disabled people. Our members' work is focused on enabling disabled people of all ages to live the lives they choose. VODG believes that an ambitious, trusted and vibrant voluntary sector that works together plays a unique role in achieving this aim.

VODG welcomes the opportunity to submit this representation to NHS England and NHS Improvement (NHSE/I). In submitting this response, our aim is to represent our membership and the perspectives of voluntary sector providers of disability and social care services. VODG is also supportive of the response submitted by National Voices[1], particularly the emphasis on a need for a requirement for integrated care systems to work with places and the voluntary, community, and social enterprise sector as well as the need for the strengthening of provisions for meaningful co-production with communities.

Context

There are approximately ten million disabled people in England. That is 18 per cent of the population.[2] Disabled people are more likely to have poorer outcomes in relation to education and employment and have fewer household resources compared with the general population. Disabled people also experience stark health inequalities.

The provision of high-quality health and social care services to disabled people is a hallmark of a fair and equitable society that seeks to enable disabled people to have full choice and control over their lives, and to be included in society.

[1] www.nationalvoices.org.uk

[2] Office for National Statistics (2015) *Nearly one in five people had some form of disability in England and Wales.* www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/nearlyoneinfivepeoplehadsomeformofdisabilityinenglandandwales/2015-07-13

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VODG members support people over one million disabled people with social care needs associated with learning disability, autism, mental ill health, and physical and sensory impairment and employ more than 85,000 staff. Together, these organisations deliver in excess of £2.8 billion in state-funded services each year. In addition, the voluntary sector support millions more through volunteering, information, advice and advocacy. Above and beyond the delivery of contracts, voluntary services are supporting local communities.

Introduction

VODG supports the policy focus for more integrated health and social care services. As part of this, the ambitions of Integrated care systems (ICSs) to strengthen partnerships, develop provider collaboratives, develop strategic commissioning and harness the use of digital and data are to be welcomed.

However, *Integrating care: Next steps to building strong and effective integrated care systems across England* is clearly a document written by the NHS, for the NHS. It looks inward to how the NHS wants to organise itself and in doing so fails to engage with the wider agenda of working with the voluntary sector and social care community providers. The current proposals are at risk of repeating previous mistakes in looking internally, and not externally to fully realise shared policy ambitions for integrated services.

The Joint Voluntary Community and Social Enterprise (VCSE) Review[3], which has been endorsed by NHSE/I, sets out how the system should:

• place a clear expectation on leaders to co-design services with individuals and families,

• make wellbeing a core outcome for health and social care,

• make the most of the voluntary sector by nurturing small organisations.

There is a clear need for NHSE/I to focus on the co-design of its systems with the voluntary sector and people who use services. There should be strong ambitions to forge greater collaboration and partnership working between the NHS and the VCSE sector. In addition, and in specific reference to the document being consulted upon, the following overarching points must also be acknowledged:

- The document is right to highlight the significant challenges faced by health and social care as we progress through and recover from the coronavirus (COVID-19) pandemic, as outlined in points 1.7 and 1.8, but there needs to be greater detail around how the voluntary sector and community social care will be integrated into the different ICS models. It is misleading to think that the voluntary sector and adult social care will be integrated solely by involving local authorities. Local

[3] Joint Voluntary Committee & Social Enterprise Review (2019) https://vcsereview.org.uk/

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authorities are only the commissioners of services and cannot 'speak' for these sectors. Furthermore, the voluntary sector is delivering services that are not only commissioned by local authorities, often using their own investment or through fundraising to tackle unmet need and to support local communities.

- If partnerships are to be meaningful, "others" referenced in the consultation document must be carefully defined and – crucially – resourced to enable active participation. Governance and budget arrangements must allow partners to direct resources jointly.

- Achieving good health outcomes for all requires an equal emphasis in collaborative arrangements for the promotion of public health and tackling health inequalities alongside empowering and enabling people, and those who support them, to take responsibility for improving and maintaining their own health.

- Enabling people to stay well will also require the engagement of those working in housing, environmental health, economic development and the social welfare and benefits system. These should be more closely involved than implied in 1.16 of the *Integrating care: Next steps to building strong and effective integrated care systems across England document.*

- Compelling evidence and substantial and genuine engagement with the VCSE sector and the general public will be required for the proposal to be accepted at a local level and not regarded as a process of cost-cutting re-organisation.

Membership of integrated care systems

Charities have a legal duty to create public benefit and this is clearly aligned to the mission of the NHS. Voluntary sector services, including user and patient-led organisations alongside social care and mental health providers, have a vital role to play in working together with the NHS to deliver shared ambitions of the long-term plan.

Voluntary sector disability organisations are at the heart of the communities they support and their contribution to society is significant. As providers of not-for-profit care and support services, they predominantly serve people who rely on the state to pay for their care. Furthermore, these organisations can be seen to go above and beyond service delivery to improve health and social care outcomes for the people they support and the local communities within which they work.[4]

Voluntary sector providers also have a track record of innovation and enterprise and are an integral part of the solution to improving outcomes in public services. One example is to re-provide care for disabled people, and those experiencing mental ill-health, out of expensive long-stay hospitals and into their own homes supporting by

[4] Voluntary Organisations Disability Group (2019) *Above and beyond: how voluntary sector providers of disability support add value to communities* https://www.vodg.org.uk/wp-content/uploads/2019-Above-and-Beyond-web.pdf

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local community services.[5] By partnering with the voluntary sector to build community provision and move people out of long-stay hospitals, the system can move away from its reliance on expensive and outdated forms of institutional care to community provision at, or close to, home. In doing so this also saves public funds.

If the commitment to partnership is to be truly meaningful, voluntary sector leadership should be 'consistently involved' in 'place' leadership arrangements as opposed to 'flexibly' as stated in section 2.31 of the document. It is not enough for the voluntary sector to be represented by local authorities, who are the commissioners and therefore not genuine representatives. Put simply, voluntary sector engagement must be a requirement and not a suggestion.

To make this real there are number of solutions the NHS can embrace.[6] Alliance contracting offers an established approach through which the NHS can work with the voluntary sector. The voluntary sector can not only deliver more community services, but also can offer as individual specialist organisations, or as consortia, significant capability and capacity.[7]

Greater incentive through collaboration

Collaborative arrangements must include diverse providers of different sizes avoid remote and unaccountable concentrations of power. Collaboration should also break down false barriers between commissioners and providers and include a drastic overhaul of commissioning, which has significantly failed to achieve improved health outcomes for the population as a whole. For example, to tackle health inequalities, the NHS must seek wider engagement with the voluntary sector. Such work cannot be carried out in isolation and there are inherent risks if the NHS seeks to drive collaboration only within those organisations it can control.

To make this real, the NHS should embrace principles and practice that enable genuine collaborative arrangements. The VCSE Review[8] contains plenty of suggestions. Looking across government, the Department for Work and Pensions Merlin Standard adopts a model to encourage excellence in supply chain management.[9] Given the primary role of the NHS, the Merlin Standard offers a set of values and practices that will be provide a workable and fair framework for

[5] Voluntary Organisations Disability Group (2019) *A time for action: ending the reliance on long-stay inpatient units.* www.vodg.org.uk/wp-content/uploads/VODG-A-Time-For-Action-ending-the-reliance-on-long-stay-inpatient-units-FINAL.pdf

[6] Voluntary Organisations Disability Group (2016) *What can the voluntary sector do to encourage greater engagement and collaboration with the health system?* www.vodg.org.uk/wp-content/uploads/2016-VODG-What-can-the-voluntary-sector-do-to-encourage-greater-engagement-report.pdf

[7] ACEVO (2019) *Alliance contracting.* www.acevo.org.uk/wp-content/uploads/2019/07/Alliance-Contracting.pdf

[8] Joint Voluntary Committee & Social Enterprise Review (2019) https://vcsereview.org.uk/

[9] Department of Work and Pensions (2013) *Merlin standard guide for providers.* www.gov.uk/government/publications/the-merlin-standard-guide-for-dwp-providers

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collaboration. For example, the Merlin Standard pays particular attention to the requirements of smaller organisations involved in delivery.

Making a success of provider collaboratives

VODG welcomes the provider collaboratives approach being adopted, especially as it relates to specialist disability and mental health provision. VODG believes that approaches that bring together local partners from a range of backgrounds to take control of funding, the design and delivery of community services are much more likely to succeed in the long-term when compared with traditional 'commissioner/provider' relationships. To ensure success of the new provider collaboratives, a number of key points need to be considered:

- Provider organisations can play an active and strong leadership role in provider collaboratives insofar as provider organisations are made responsible for the allocation of resources. Checks and balances will be required to manage situations where the needs of providers might conflict with the needs of the public.

- The success of relationship-based approaches is likely to be predicated on local people and communities, alongside voluntary sector organisations, being brought in from the outset to co-produce and co-design approaches.

- Arrangements must ensure that smaller providers are also able to enter collaboratives whilst maintaining their autonomy and independence.

- Checks and balances will be required to ensure that excessive power and influence is not concentrated in the hands of any such fewer and larger providers.

- This strategy should explicitly encompass social care and the voluntary sector in order for it not to benefit one part of the health and social care system at the expense of another.

- The success of provider collaboratives can be significantly enhanced by harnessing the collective expertise of voluntary sector providers, co-ordinating the delivery of services and working across organisational boundaries. However, transformational change with common purpose and collaborative leadership is required.

Taking a fresh approach to commissioning the voluntary sector

Health-based commissioning should be all about quality and meeting the clinical needs and choices of individuals. The ambitions of ICSs to develop strategic commissioning with a focus on population health outcomes is to be welcomed. The voluntary sector can support effective commissioning through the co-design and co-production of services, especially as a means of forging new integrated health, social

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care and community services. But there are challenges involved which must prompt a fresh approach to how the NHS approaches commissioning and it must refocus based on outcomes and not price alone.

Health-based commissioning activities that do not support effective delivery with the voluntary sector should be abandoned – such as competitive tendering and narrow procurement rules – in favour of genuine partnership building. Grants and contracts should not be overengineered nor over-prescriptive and should be tight on outcomes rather than process. The NHS has the opportunity to take a fresh approach and co-design of services, as set out in the VCSE review, drawing upon the expertise of people who use services and voluntary sector providers to actively involve them in oversight and governance.

Short-term competitively tendered contracts are a barrier to sustained long term involvement by providers in the partnerships with health services. The ICS proposals should go further and explain how it will deliver a transformed approach to ensure longer term partnerships with the voluntary sector are maintained.

As such, VODG would encourage NHSE/I to consider including commissioning policies and practices that ensure:

- the full breadth of voluntary sector provision, whether or not directly commissioned, is identified and mapped locally, and understood.

- there is genuine engagement between voluntary services in health-based place-shaping, policy development, budget decisions and strategic commissioning.

- strategic commissioning is a partnership made up of people who use the services, their families and carers, the voluntary sector and statutory sector in equal numbers with a joint responsibility to produce plans that are genuinely co-designed.

- strong governance is in place involving local stakeholders including user-led groups and providers.

- voluntary sector services are valued when they complement statutory agencies.

- activities that do not support relationships with the voluntary sector are abandoned – for example, removing competitive tendering and replacing with relational partnerships, using grants and whilst recognising that accountability will often involve contracts – though these should not be over-engineered nor over-prescriptive.

- when used, procurement processes are simple and proportionate, but this use should be minimal.

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- services are always fully funded (including all delivery costs, overheads and a surplus for investment and development in services and the workforce).

- providers are encouraged to respond to need in ways in which people who use services are able to determine; and consequently, to take managed risks and to innovate.

- recognise how social value and wider public value can be delivered through genuine partnerships with the voluntary sector when the objectives and targets are jointly determined.

- there is investment in voluntary sector capacity building.

Legislative proposals

The recommendations outlined in 3.3 of the consultation document are a helpful recognition of the failures of the existing competitive commissioning regime. However, if commissioning by health partners continues to be largely driven by competition, a significant part of local systems will remain disadvantaged and the offer of the voluntary sector unexplored.

In terms of the proposed options, while legislation will certainly accelerate the process and set an accountability framework, there also needs to be a transformative change in behaviour, relationships, and culture, which will not be driven by legislative change alone and to which much consideration will need to be given.

Of the proposed options, it appears that with Option 1 there is more of a chance of the voluntary and social care sectors being 'heard' and involved in ICSs, but with a risk of challenges around accountability and clarity of leadership. The risk with Option 2, however, is that the 'voice' of the voluntary and social care sectors will be lost.

Regardless of which option NHSE/I decide to take, there are fundamental principles that need to be integrated into the implementation of ICSs. If striving for great care (as well as health) outcomes, we need a system that actively involves and engages disabled people and the voluntary sector. By including mandatory membership for the voluntary social care providers, as well as a commitment to co-production, the risk of simply rearranging the existing systems can be avoided and genuine transformative change can be achieved.

Ends

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