Keep it Local for Better Health

How Integrated Care Systems can unlock the power of community

February 2024

VCSE health & wellbeing alliance

locality
the power of community

Contents

KEY

Executive summary

The guidance combines the learnings of our past three years on the government's VCSE Health and Wellbeing Alliance with a decade of growing the Keep it Local campaign.

To date, the Keep it Local approach has been used successfully by local authorities across England, working with local VCSE organisations to deliver better services for local people, reduce pressure on public services, and invest in the local economy.

The Keep it Local approach entails a commitment to **six key principles** that improve local, person-centred services by unlocking the power of community:

Think about the whole system not individual service silos.

Co-ordinate services at a neighbourhood level.

Increase local spend to invest in the local economy.

Focus on prevention now to save costs tomorrow.

Commit to your community and proactively support local organisations.

Commission services simply and collaboratively so they are "local by default".

Over the last three years, we have identified how a Keep it Local approach could **support the achievement of several key Integrated Care System (ICS) priorities**:

- **A shift to prevention** – Local VCSE organisations take a holistic, person-centred approach to the wider determinants of their communities' health. This means they can create all-round good health for local people, as well as supporting the prevention of specific conditions.
- **Tackling health inequalities** – Local VCSE organisations are mostly based in disadvantaged neighbourhoods. As such, they support people from a wide range of backgrounds experiencing the most acute health inequalities. Through trusted relationships and close partnership working in their neighbourhoods, they tackle these inequalities much more effectively than the health system can do alone.
- **Broader social and economic development** – The Keep it Local approach supports this "fourth purpose" of ICSs by prioritising asset-based community development and maximising the role of local VCSE organisations as local economic multipliers.
- **Embedding the VCSE sector throughout ICSs** – The Keep it Local approach supports ICSs to embed the principle of subsidiarity – that as many decisions as possible are taken

at the most local level possible – by emphasising neighbourhood-level coordination, place-level collaboration, and system-level investment.

To produce this guide to **Keep it Local for Better Health**, we have worked with partners from councils, health bodies, and local VCSE organisations around the country.

We detail practical lessons and examples for local health systems to embed each of the six Keep it Local principles.

Think about the whole system not individual service silos requires:

- Commitment to Keep it Local as a golden thread throughout ICSs.
- Joining up the strategic, commissioning and other activities that partners are delivering in places.
- Directors of Public Health to be valued as linchpins for the Keep it Local approach.

Co-ordinate services at a neighbourhood level requires:

- A review of the alignment of Primary Care Networks to communities' understanding of "neighbourhood".
- Working with local VCSE organisations to take an approach to primary care that is integrated, preventative, focussed on population health, and informed by the wider determinants of health.
- Supporting this approach through data-sharing with local VCSE organisations as part of integrated neighbourhood teams.
- Co-locating statutory and community health and wellbeing services in trusted community spaces.

Increase local spend to invest in the local economy will apply differently depending on local maturity, as ICSs are relatively new innovations.

Clear leadership from the top around prioritising local spend is key, including the nurturing of a working culture shift towards it. As is working closely with procurement officers across the system to ensure their buy-in.

Areas with more developed thinking on this topic can:

- Think of local spend in terms of concentric circles within the ICS.
- Measure multiple relevant indicators.
- Include as much third-party expenditure as possible within local spend calculation.
- Produce ICS-wide targets for local spend to ensure accountability.
- Invest time in understanding the granular detail of ICS spend.
- Understand how to improve local spend performance based on analysis.

Focus on prevention now to save costs tomorrow can be achieved in various ways. Along with Principle 2, Principles 5 and 6, below, provide broader guidance on how local health systems can support local VCSE organisations to deliver their impactful brand of wider-determinants-led, primary prevention.

However, there are also three specific, positive models they can adopt that put these organisations at the heart of commissioned prevention services; namely:

- Peer-led health promotion
- Integrated Health and Wellbeing Services
- Social prescribing

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Commit to your community and proactively support local organisations requires:

- Cultivating a culture from the system level down that values and meaningfully supports the local VCSE sector.
- Setting (and sticking to) long-term time horizons for funding and support.
- Funding local VCSE organisations to provide the services to which people are socially prescribed.
- Using the Additional Roles Reimbursement Scheme (ARRS) to embed integrated neighbourhood team roles within local VCSE organisations.
- Supporting community ownership to strengthen local organisations and provide accessible space for co-located health services.

Commission services simply and collaboratively so they are "local by default" requires:

- Developing a joint commissioning approach between all partners within the system and ensuring shared understanding of opportunities and challenges.
- Understanding and valuing the intrinsic social value of services delivered by local VCSE organisations.
- Valuing the expertise of the local VCSE sector for what works.
- Including local VCSE collaboration in long-term commissioning and procurement strategies.
- Ensuring commissioning and procurement processes are proportionate and appropriate for the service to be delivered.
- Managing local VCSE contracts and grants effectively to measure impact and capture learnings.

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Beyond just the six principles, it is crucial to view the Keep it Local approach within the **real-world context** of the health system and the local VCSE sector. This includes:

- **VCSE capacity, capability and funding** – Local VCSE organisations are professional organisations; experts in community development with viable business models delivering effective services. However, they are operating in increasingly difficult funding environments and cannot be expected to support the health system without full cost recovery.
- **ICS finances** – Equally, it is important for local VCSE organisations to understand their health partners and the pressure they face. A relational, collaborative approach is key to tackling the limitations in funding and resource that the health system faces.
- **Shared missions and co-production** – That approach will also help with joint understanding of, and commitment to, a shared mission. This means that local VCSE organisations need to be seen as equal delivery partners; co-producing services, not just providing them.

  But is also means that the local VCSE sector needs to be able to effectively communicate to the system where they fit in and how they can support.
- **Diversity of both sectors** – Finally, there is a tendency for both the health system and local VCSE sector to view each other as homogenous. The VCSE sector within any health system, place or neighbourhood will likely be broad and complex. This diversity doesn't necessarily mean the sector is fragmented. However, it is certainly true that a more concerted effort is required to encompass all local voices in co-production.

  Again, though, this is not just a problem for health systems to solve. There is a task for the local VCSE sector in better getting to know its local system to understand its different elements and functions.

In acknowledging the proactive role that local VCSE organisations must play in ICSs, we have also produced sister guidance. This aims to help the sector understand health system funding and work strategically to influence positive change within health systems.

1.

Introduction

This report is a culmination of Locality's work over the last three years on the government's VCSE Health and Wellbeing Alliance (HW Alliance).

As the national membership network for community organisations, we've used this opportunity to work alongside NHS England and the Department of Health and Social Care (DHSC) to explore the many different facets of local voluntary, community, and social enterprise (VCSE) organisation involvement in health systems. These have included:

- Greater integration within neighbourhood health ecosystems and improved collaboration with Primary Care Networks.
- The impact of community "anchor" organisations on the wider determinants of health and the learning for the delivery of illness prevention services.
- The role of community spaces in supporting the mental health and wellbeing of children and young people.
- The importance of community organisations led by those from marginalised communities in the design of inclusive and culturally competent health services.

We have a long history of supporting the local public sector to unlock the power of community. Over the last decade, we have developed the Keep it Local approach to help local authorities deliver the highest quality people-centred services.

It is based on the simple and proven concept that local VCSE organisations know their communities best. Their long-term commitment to improving their people and place means they have the local knowledge, relationships, and connections to deliver these services in the most effective way possible.

Over the last three years, in countless conversations with local VCSE organisations, local authorities, and local and national health system partners, we have heard the appetite for a Keep it Local approach for health.

As Integrated Care Systems (ICSs) find their feet and set our their plans to achieve their four key aims in their places and neighbourhoods, it is time to turn the vision for cross-sector, joined-up health and care into reality.

The local VCSE sector is vital to this. As trusted agents delivering holistic, person-centred support, they are helping local people keep healthy and well in their neighbourhoods. These are the same people that the local NHS would otherwise be called on to treat in times of crisis or ill health.

But this support isn't free. And often it is provided despite the huge day-to-day pressures they face, the centralised systems they operate within, and a dire lack of resources. Over the last decade and more, local VCSE organisations have been forced to compete both with each other and with multinational companies and big national charities for limited public service funding.

At the same time, at Locality, we have seen our members increasingly focused

on local crisis response, providing basic necessities – food, warm space, hardship funds – to those who have fallen through the state's safety net.

This is not to blame the local public sector. Tough fiscal conditions, centralised policy-making and competitive procurement frameworks have required them to make difficult decisions to make savings wherever possible.

And the latest cost of living crisis and resulting economic fragility have not helped. Coupled with the aftereffects of the COVID-19 pandemic, these have created huge pressures on local public sector budgets.

For example, according to the NHS Confederation in 2022, the health system faced a real-terms cut in funding of between £4bn and £9bn.[1] In Spring 2023, the Department of Health and Social Care (DHSC) asked NHS England and Integrated Care Boards (ICBs) across the country to cut their running costs by 30%.[2] For ICSs, this has been exacerbated by the additional funding crises many local authorities are facing.[3]

At the same time, there is a growing understanding that the pressures on elective, urgent and emergency, and primary care will only worsen if people aren't supported to live healthier lives in their communities.

If we can create healthy people in healthy communities, we can significantly reduce the cost and resource pressures on the NHS to provide treatment later down the line.

But doing so will only be possible if people – particularly those least likely to access primary care, experiencing the worst health inequalities, and requiring costly acute care when they reach crisis – can access local, trusted, personalised, and high-quality support across the wider determinants of their health.

This is the role of local VCSE organisations. They hold the power of community to transform people and place. And the Keep it Local approach is the way to unlock it.

Our research

This report draws on the rich learning from all of our work to date on the HW Alliance and from our Keep it Local programme of work with local authorities across the country over the last ten years.

To translate this effectively into a **Keep it Local for Better Health** guide, we convened a series of roundtables with Keep it Local councils, local VCSE organisations, and local and national health system partners from across the country.

These began by exploring the challenges and opportunities for taking a Keep it Local approach in the health system, from the perspective of each set of stakeholders.

We then brought them all together to co-produce shared solutions and strategies for making the approach work.

Once we'd analysed and developed those findings, we tested the guidance below with the same cross-sector group to make sure it would be as relevant, helpful, and effective as possible.

The guidance has been developed to support and build on recent reports and recommendations from both The Kings' Fund[4] and NHS England on better integration of the VCSE sector within ICSs.[5]

Through our conversations, we drew out strong examples of where elements

of the Keep it Local approach are already being delivered in health systems up and down the country. We have threaded these throughout this guidance to show how it can be done and what it can achieve.

Guidance for local VCSE organisations

The commitment of the health system is just one side of the Keep it Local for Better Health coin. The other is the preparedness of the local VCSE sector. The two must be aligned to make the approach as successful as possible.

To support this, we have produced sister guidance for the sector – Understanding health system funding. This explores the current challenges and opportunities for VCSE organisations around health system funding. These include: access and engagement; resources; process and structure, and; data, governance, and monitoring and evaluation.

It then aims to help local VCSE organisations to understand health system funding and work strategically to influence positive change within health systems.

2.

What is Keep it Local?

Over the last decade, Locality has been championing the Keep it Local approach to people-centred public services.

The movement can be traced back to a ground-breaking piece of research we conducted in 2014 – "Saving money by doing the right thing". This demonstrated how the shift to outsourcing at scale in the wake of austerity measures had led to "diseconomies of scale" – big contracts inevitably leading to tick box, one-size-fits-all services that don't deal with people's problems at source.

Ultimately, this is what puts such pressure on local services. Rising demand is the price of this "scale fail". This, in turn, has been amplified by growing pressures, like the COVID-19 pandemic and the cost of living crisis.

Instead, the Keep it Local approach prioritises supporting, partnering with, and commissioning local VCSE organisations. As providers, these organisations produce high-quality, people-centred services with intrinsic social value.

Since its inception, the campaign has focussed on local authorities as the most common point of connection between the public sector and local VCSE sector. There are now 18 councils in the Keep it Local Network.

But its principles are becoming more and more relevant to ICSs.

The six Keep it Local principles:

1. **Think about the whole system not individual service silos.**
2. **Co-ordinate services at a neighbourhood level.**
3. **Increase local spend to invest in the local economy.**
4. **Focus on prevention now to save costs tomorrow.**
5. **Commit to your community and proactively support local organisations.**
6. **Commission services simply and collaboratively so they are "local by default".**

We have seen how the network of Keep it Local councils has embraced these principles and developed innovative ways to bring them to life. As such, we've also built understanding of the positive impacts they produce for local areas, including:

- **Better services for local people** – a distinct approach to service provision driven by deep-rooted connection to people and place means local organisations can have a transformative impact of people's lives.
- **Reduced pressure on public services** – decreased long-term demand on the public sector by addressing the root causes of people's problems.
- **Investment in the local economy** – harnessing local VCSE organisations' potential as local economic multipliers.

There is now huge potential for the approach to deliver the same benefits for the health system.

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3.

Why to Keep it Local for Better Health

Over the last three years, our research has highlighted how the Keep it Local principles can help achieve several key priorities for the health system.

A shift to prevention

The local VCSE sector – particularly well-established, place-based community "anchor" organisations (CAOs) – deliver their prevention work through an approach that combines multiple types of healthy living and wellness support.

This support takes a holistic, person-centred approach to the wider determinants of health that impact an individual's ability to, for example, quit smoking, manage their alcohol consumption, or maintain a healthy weight.

It goes beyond just tackling specific conditions, though. Through helping people to, for example, find good work, get out into green space, or build their social networks, community organisations actively create good health for local people.

Tackling health inequalities

Local VCSE organisations tend to exist in more disadvantaged areas – places where the state has failed to meet people's needs and the private sector has abandoned after struggling to turn a profit. Sixty-one percent of the organisations in Locality's membership are based in the top 30% most deprived neighbourhoods.[6]

As such, the local people they support are often those experiencing the most acute health inequalities. On average, they serve 13 different population groups, with most supporting, for example: refugees and migrants; people from racially minoritised communities; disabled people; long-term unemployed people, and; people living in poverty.

They tackle the health inequalities these groups face – both in accessing healthcare and in their experience of the wider determinants of health – in many different ways. They invite statutory health services to co-locate in their safe community spaces, increasing accessibility for those least likely to visit purely clinical settings due to stigma and mistrust.

Particularly when led by and serving people from marginalised communities, these organisations also work to adapt health guidance and services to make them inclusive and culturally competent. This is key to ensuring that those most at risk of the health inequalities these activities aim to tackle are actually able to benefit from them.

Broader social and economic development

This "fourth purpose" of ICSs is key to long-term health creation for people and places. It is predicated on the importance of the wider determinants of health, and the role that the health system itself must play in nurturing them.

The Keep it Local principles encompass two approaches that achieve the purpose – asset-based community development (ABCD) and the local multiplier effect (LME).

ABCD is central to the way local VCSE organisations work – by focussing on "what's strong, not what's wrong", they use the existing strengths of local people and place to build social capital, increase community resilience, and create economic opportunity.

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They can then measure the impact of this approach on the wider determinants of health, including: making healthy lifestyle choices, access to green and open spaces, levels of loneliness and social isolation, and emotional wellbeing.

Local VCSE organisations also act as local economic multipliers. By employing local people and using local supply chains, we have seen returns for the local economy of over £2.50 for every £1 spent with a local VCSE organisation.[7]

Embedding the VCSE sector throughout ICSs

A key element of each of the 42 ICSs is the VCSE Alliance. These are formal mechanisms for engaging and embedding diverse VCSE representation in system-level governance and decision-making arrangements.

Involvement of the VCSE sector at this system level is strategically important. However, NHS England guidance also emphasises the importance of partnerships at the two lower tiers of ICSs – place and neighbourhood.

In fact, a key tenet of the ICS model is the principle of subsidiarity – that as many decisions as possible should be taken at the most local level possible. This means that, to have meaningful input into how services are designed and delivered, the VCSE sector needs to be represented at place and neighbourhood too.

The Keep It Local emphasis on whole-system thinking, neighbourhood coordination of services, and collaborative commissioning provides a sound basis for this approach.

4.

How to Keep it Local for Better Health

After several years of working with colleagues from local authorities, local VCSE organisations, ICSs, Primary Care Networks (PCNs), NHS England, and the Office of Health Improvement and Disparities, we have developed the following guidance for implementing the Keep it Local approach in health systems.

Here we present our learnings for each of the six Keep it Local principles, illustrated along the way by case studies of good practice already happening in these areas.

Think about the whole system not individual service silos

Too often, local services exist in silos. This is particularly true where they are commissioned by different bodies, narrowly targeted at one aspect of a person's needs and working to their own internal logic and organisational priorities.

This creates a disjointed service landscape that can be hard to navigate and can't respond to the range of factors that impact people's lives. Keep it Local recognises the complex nature of social problems and the need to work as a whole system to address them.

There are several ways this principle can be followed within health systems:

- **Commitment to Keep it Local should be a golden thread throughout ICSs**

  Keep it Local is less a method of delivering public services, and more a philosophy to unlock community power and the benefits to local health and wellbeing that come with it.

  As such, it requires mobilisation on the ground with a supportive culture from the top. It requires neighbourhood-level coordination, facilitated by place-level collaboration, driven by system-level investment. Across all levels, meaningful decision-making powers for VCSE representatives are essential:

  - At **neighbourhood level**, PCNs should work closely with local VCSE organisations to understand not only the needs and inequalities faced by those they support, but also the assets on offer locally to improve people's health.

    Key to this is involvement of local VCSE staff in "integrated neighbourhood teams" alongside statutory service representatives. They will often have the closest and most trusted connections with local people, increasing the effectiveness of interventions.

    This close working is also vital for effective social prescribing – local VCSE organisations will often have been delivering activities in this area for a long time, but need health system funding to keep up with the increasing number of referrals they receive. **See more on coordinating services at neighbourhood level on p. 22.**

  - At **place level**, place-based partnerships should bring together colleagues from local authorities (from multiple departments, as well as from different tiers of council where relevant), local VCSE infrastructure bodies, wider representative VCSE organisations, the ICB, and local PCNs.

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Collaboration between all parties should ensure that services join up local, community-led activity. This should facilitate population health management that focusses on prevention and the wider determinants of health to tackle inequalities.

Case study

The **Medway and Swale** Health and Care Partnership (the term used for place-based partnerships in Kent and Medway) has agreed a Voluntary and Community Sector Strategic Framework.

The Framework builds on an existing Memorandum of Understanding between the local health system and VCSE sector. It is signed by a wide range of cross-sector partners, including the ICB, local NHS trusts and PCNs, Healthwatch, local authorities, and local VCSE infrastructure bodies and networks.

It was developed after partners realised the true value of the VCSE sector to the health and wellbeing of local people and communities during the COVID-19 pandemic.

It commits to "radically rethink how we support our communities' health and wellbeing through an authentic commitment to working together to build capacity in our communities".

This includes by, among other things:

- Working to "level up" local VCSE infrastructure funding.
- Working with the VCSE to build capacity and identify areas for market development to help local VCSE organisations to be "business ready".
- Supporting the development of smaller local VCSE organisations and their involvement in service delivery.
- Engaging with the local VCSE sector at all stages of the commissioning cycle to shape the approach taken by commissioners.
- Identifying solutions to mitigate the risk of unfunded social prescribing referrals to local VCSE organisations.
- Gathering and using the valuable information on service user need and views held by the local VCSE sector, incentivising the sector to experience insights and developing ways to share data.
- Valuing the employment of local people, use of volunteers, and partnership with local VCSE organisations, aiming to incorporate these factors in commissioning strategies.
- Developing a system to capture the intrinsic social value produced by local VCSE organisations.
- Recognising the evidence-based approach and professionalism of the VCSE and working to address diversity, deprivation and inequality.
- Working to maximise financial opportunities as a system to support the preventative agenda.

Medway and Swale is also one of only a few places to put all of its health inequalities funding towards supporting the VCSE to, for example, ensure it hears from the most seldom heard communities.

All of this represents an excellent basis for delivering a Keep it Local for Better Health approach at place level and should be a template for others around the country.

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- At **system level**, the approach must be endorsed by the Integrated Care Partnership (ICP) as part of the Integrated Care Board's (ICB) strategy to encourage a culture of community-led health and wellbeing. This will often be supported by the presence of local VCSE sector representatives on the ICP who may best understand, and be able to champion, the value of the approach.

  A similar commitment from local and, where relevant, combined authorities within the ICS footprint will also be important. This should involve individual commitment to the Keep it Local approach, as many councils have already done. This can ensure that it is adopted even in public service areas that aren't within the purview of the ICS, but which still impact the wider determinants of health.

  This could fulfil the advice of The King's Fund to develop a common, system-wide vision for the VCSE sector within an ICS.[8] The ICB should use its convening power to achieve this – particularly of the ICS VCSE Alliance, which will be key leaders for the approach.

  This is particularly important when, despite the relatively low cost of shifting budgets upstream for a prevention-first approach like Keep it Local, there is high demand for additional money to support stretched acute services. ICBs should nurture support for the approach across all such services, highlighting the long-term impact it will have on reducing the strain they experience.

  Commitment at this level also supports consistency and security in commissioning and procurement across the board and supports a system-wide approach to tackling health inequalities.

  However, attention should be paid to how this manifests itself – a system-wide commissioning framework may help to foster a culture of VCSE involvement but may not necessarily provide as good an understanding of process, opportunity, and possibility locally as at place and neighbourhood level.

Case study

In **Bristol, North Somerset and South Gloucestershire** (BNSSG), there is strong involvement of, and demonstrable commitment to, the local VCSE sector at the place and system level.

There are eight places for sector organisations on the ICP, plus the local infrastructure body. Locality Partnerships (the term used for place-based partnerships in BNSSG) are either co- or vice-chaired by a VCSE representative.

The South Gloucestershire Locality Partnership, for example, is co-chaired by the CEO of Southern Brooks, a CAO working across the area.

In addition, Bristol City Council and South Gloucestershire Council have both signed up to the Keep it Local principles.

- **Join up the strategic, commissioning and other activities that partners are delivering in places**

  Place-based partnerships provide a great opportunity to coalesce partners around a Keep it Local approach. By planning for how they support and work with the local VCSE sector, they can ensure activities are joined up and complementary. For example, by knowing what each partner is commissioning locally, they can make the most of their resources, avoid duplication, and plug gaps.

  The Better Care Fund presents an opportunity to do this – establishing

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pooled budgets between the NHS and local authorities to reduce the barriers often created by separate funding streams. This helps to tackle a common problem faced by local VCSE organisations – dependency on one local commissioner acting independently, creating significant risk should that funding stream end.

There should also be close working between place-based partnerships and local Health and Wellbeing Boards to support a Keep it Local approach. For example, a Joint Strategic Needs Assessment could be accompanied by a Joint Strategic Assets Assessment. This would ensure that local authority-led Joint Health and Wellbeing Strategies are asset-based – inspired by the existing strengths, skills, spaces, and connections in local communities to create good health from the ground up.

Finally, overly jargony or clinical language can make it hard for local VCSE organisations to work collaboratively with health systems. The use of different terminology for the same approach also creates confusion and duplication. This is particularly true of terms such as "population health", "prevention", "community approaches", "social prescribing", "health creation", "anchor work" etc. Clarity and consistency of language between all parties is key.

- **Directors of Public Health can be linchpins for a Keep it Local approach in ICSs**

Local authority Directors of Public Health can play a key role in making the Keep it Local approach work across health systems.

They and their teams are already well versed in early intervention and prevention, with a strong focus on the wider determinants of health. They also have the data to measure and demonstrate the value of the VCSE in these areas.

They have reach across health systems to act as navigators for other parties. This is particularly true for connecting other local authority departments that impact the wider determinants of health – housing, environment, communities, social care etc – with health decisions being made at place level.

As part of local authorities, they and their teams are also likely to have better understanding and relationships with local VCSE organisations at place and neighbourhood level.

However, it is important to recognise the existing demands on public health teams and not to place an excessive burden on them to fulfil this role without proper resource.

Case study

Well Doncaster is a strategic partnership of the city's local authority, NHS, and VCSE sector. It was launched in 2015 with funding from Public Health England and the Better Care Fund.

It aims to improve health and wellbeing, kickstart community-led regeneration, and support a thriving VCSE sector. It uses evidence-based, community-centred approaches in the way it works with local people and organisations to co-produce a programme of work focused on health, wealth, and social inequalities.

It supports all 88 neighbourhoods in the city, but with a deeper, hyperlocal "neighbourhood plan" for the top 30 most deprived. The approach has fostered £21m of investment into Doncaster from a wide range of sources.

The programme is multi-faceted, delivering, among other things:

- Strategic local commissioning, with 10% of all tenders scored on social value and resources to help commissioners work with local VCSE organisations. It has so far invested in 65 organisations this way.
- Work with PCNs to facilitate one-to-one support for local people to affect deep-rooted behavioural change to improve their health outcomes.
- Growth, connection, and infrastructure support for local VCSE organisations.
- Community wealth building activities, eg, helping local people to set up social enterprises that create social value.

While led by City of Doncaster Council's public health team, the programme has a strong relationship with South Yorkshire ICB. It recently supported the co-production of the ICB's five-year plan.

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Co-ordinate services at a neighbourhood level

It is at the neighbourhood level where services can be most effectively joined up around people's distinct needs and where the strengths of communities can be fully realised.

As Anna Hartley, Executive Director of Public Health and Communities at Barnsley Council, puts it:

> **"Working at a neighbourhood level with communities who understand both the challenges they face, and the strengths and assets that can help meet those challenges, can help find creative solutions to seemingly insurmountable problems. It seems an obvious point, but neighbourhoods are where people spend most of their time. So by working in them and with them, we can have greater reach and impact."**[9]

This underpins the ICS principle of subsidiarity – where as many decisions as possible are made at the most local level possible. Making decisions in partnership with the local VCSE sector can ensure that services are driven by the vital knowledge, skills, and connections of local communities.

CAOs (community anchor organisations) – those larger, more established organisations usually owning assets and delivering multiple services – can play a significant role in supporting PCNs with this approach. Locality research has found that these organisations on average deliver 13 different services to 13 different population groups within their areas. In doing so, they address on average 91% of the wider determinants of health.[10] This means they can support the PCNs with population health management, tackle health inequalities, and create good health in their neighbourhoods.

Key to this is their role as local "cogs of connection". As previous Keep it Local research has shown, they connect residents to other local people and the place they live, as well as other services and organisations.[11] Their high level of innovation, creativity and flexibility helps them build trusting relationships, often with people furthest from statutory support. It means they are skilled at dealing with complex cases. It also means they are continually investing in the people and spaces of their neighbourhoods.

We have identified four key learnings for health systems to effectively coordinate services at a neighbourhood level. These build on the findings and recommendations of the Fuller Stocktake report, commissioned by NHS England in 2022, on the next steps for integrating primary care.

- **Review the alignment of PCNs to communities' understanding of "neighbourhood"**

  The Fuller Stocktake made a brief but important reference to a significant issue with the assumption of PCNs as the primary co-coordinators of health services at the neighbourhood level. It highlighted the need for "full alignment of clinical and operational workforce from community health providers to neighbourhood 'footprints'".

  Our research has found this to be a substantial obstacle to the effective involvement of local VCSE organisations in primary care. The understanding of the "neighbourhood footprint" within places often differs greatly between local sectors.

  PCNs may have often formed – and continue to operate – primarily on the basis of corporate or financial expedience, rather than a joint connection to local communities.

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This means that the neighbourhood footprint they delineate does often not correspond to that commonly understood by local communities (based on human geography, areas of deprivation, population demographics, or community infrastructure). This creates difficulty for local VCSE organisations to work with PCNs to support local people, particularly from a population health management perspective.

For example, one organisation described how they often receive social prescribing referrals from their PCN for individuals who live in a completely different area of the city, with no connection, relationship, or means of travelling to the location of the service. As such, those people do not receive the support they need.

Where this is the case, the ICB should consider how best to strategically realign the coordination of services at the neighbourhood level. This could include devolving budgets to the place level to coordinate services across their neighbourhoods. The remainder of the recommendations in this section suggest ways of managing this realignment in line with the Fuller Stocktake.

Case study

In **Bradford District and Craven**, the issue of highly variable PCN-community footprint alignment was creating issues with the effective coordination of services for communities.

Thirteen "Community Partnerships" (CPs) were established across the districts. These brought together each PCN with officers from other local agencies (community pharmacies, social care services, community nurses etc) and, critically, representatives from neighbourhood VCSE organisations.

Each CP supports a PCN population cohort of 30,000 to 60,000 people, with the mission to enable health creation activities that address the wider determinants of health.

Annually and collectively, each CP agrees local health priorities, commissions health creation activities, and identifies opportunities to add value to, or complement, existing or city-wide initiatives.

When first established in 2017, each CP was assigned a pot of £60,000 to commission work locally. They had free reign to use this for any activity as long as it focused on health creation by addressing the wider determinants. This pot is now made up of national Core20PLUS5 funding. This has refocussed priorities slightly but has doubled the amount of money available.

The local VCSE sector is represented on each CP Leadership Team by a nominated CAO. Each has a commitment to understanding and developing the breadth and diversity of the sector in their neighbourhood. This includes through ongoing health asset mapping and outreach and support by the CAO to their local health creation "ecosystem" of groups and activities.

Local partners report satisfaction with how the CPs are functioning. However, they do recognise that some neighbourhoods are better served by local VCSE organisations – including CAOs – than others. As such, they see a role at system level for the VCSE Alliance and commissioners to support connection and infrastructure for smaller groups to build capacity and capability in these underserved areas.

KEY

- **Work with local VCSE organisations to take an approach to primary care that is integrated, preventative, focussed on population health, and informed by the wider determinants of health**

  As the Fuller Stocktake recommends, PCNs should evolve from top-down coordinators of healthcare at the hyper-local level into integrated neighbourhood teams.

  As well as bringing together general and specialist primary care clinicians, secondary care consultants and local mental health teams, they should include local VCSE staff. These staff have a resource that is hard to create in the NHS: the trust and connection to reach and engage local people, working through complex issues and attending to the wider determinants of their health. However, that resource is not free, and must be supported by local, long-term funding arrangements.

  This position within communities allows such organisations to deliver prevention services that tackle health inequalities through a holistic and person-centred approach. This approach complements NHS England's Core20PLUS5 approach, more so than one limited to individual conditions.

  They can also do so at a level even more local than the PCN footprint. They can understand the granularity of health inequalities in, for example, Middle Layer Super Output Areas (MSOAs) – around 8,000 people on average.

  It also allows them to support individuals to access clinical services from which they may otherwise be excluded, reducing missed appointments and facilitating appropriate discharge. As such, is it vital that PCNs work closely with local VCSE organisations to co-create the care pathways available to individuals.

  It is particularly important that those smaller VCSE organisations that often support the most marginalised communities are involved and supported as part of this approach. They are key to tackling the health inequalities these groups face – connected to both their community of place and community of identity – and can ensure that appropriate services reach all those that require them.

  For more information on how local VCSE organisations support the development of inclusive and culturally competent health services, see our website.

Case study

In the **Wirral**, local VCSE organisations are working with the NHS and local authority to deliver a new "Neighbourhood Model". This a community-led approach to supporting the wider determinants of health and tackling health inequalities.

The model will allow a focus on health priorities as outlined by the communities living in different neighbourhoods. These will be supported by population health data and local intelligence to provide focus and deep local insight.

The borough has been divided into nine geographic "neighbourhoods", with two chosen as trailblazers for the initial phase; Birkenhead A and Wallasey C.

A "Core Group" will be established in each neighbourhood, led by local community leaders. This will ensure that the voice of the community is heard, with residents supported to develop different approaches to tackling their health inequalities.

Representatives from a range of sectors and services will sit on each Core Group. These will be the vehicle for agreeing local priorities and testing out new ways of improving health outcomes, with £20,000 available to each to do so.

Learning from the initial phase will support the expansion of the Neighbourhood Model across the remaining seven neighbourhoods.

Three local VCSE organisations – The Positivitree, Citizens Advice Wirral, and Utopia Project – have been part of the multidisciplinary steering group convened to set up the model.

- **Support this approach through data-sharing with local VCSE organisations as part of integrated neighbourhood teams**

  The Fuller Stocktake rightly prioritises the need for shared data on population health, local wider health determinants, and patient records to help integrated neighbourhood teams operate effectively. This should include the impact of interventions to ensure learning is captured and shared.

  As part of these teams, local VCSE organisations should have access to this data, and be able to feed in their own relevant data from the deep knowledge and close relationships they have with local communities.

  They should be equally able to read and write into single patient records to support local system understanding of the day-to-day health and wellbeing profiles of individuals.

  As Fuller suggests, this will require local systems to implement data governance frameworks and work closely with partners and patients to co-produce data sharing agreements where appropriate.

- **Co-locate statutory and community health and wellbeing services in trusted community spaces**

  The Fuller Stocktake emphasised the need to address and rethink the way that primary care uses space. It stresses that this is about more than just the number of buildings in the estate; it is about finding ways for those spaces to facilitate the integration of health services.

  In doing so, it highlights the need to make use of, among other things, VCSE spaces and community assets, as worked so successfully in rolling out the COVID-19 vaccination.

KEY

Our previous research has indicated how valuable this approach can be.[12] We know, for example, that delivering statutory health services from familiar, community-led spaces increases their trust and relevance for different communities. This is particularly true for those least likely to attend purely clinical settings. The reduction of stigma is an important factor – an individual could be attending a community space for many reasons and can therefore be more anonymous in accessing healthcare where that is stigmatised.

But community organisations across the country face a challenge in finding and maintaining appropriate space. Buildings aren't free and resource is required to keep them in community control, particularly during financial crises. By supporting them to gain and keep community ownership of assets, local health systems can invest in physical assets of truly integrated healthcare.

This can include providing the match funding required for CAOs to bid into the Community Ownership Fund. Beyond this, ICSs and NHS Property Services should proactively identify existing community-run spaces in which clinical services can be co-located.

Increase local spend to invest in the local economy

As referenced in the introduction, we know that the health system is currently operating in a precarious financial environment.

It is therefore vital to maximise the value of precious health system resources. We must ensure they invest in the local economy rather than being allowed to leak out, and that they have as low a carbon impact as possible. This is key to achieving the "fourth purpose" of ICSs; to support broader social and economic development within their areas.

KEY

Commissioning local VCSE organisations is a meaningful way of doing this. Indeed, previous Keep it Local research has shown how they act as local economic multipliers.[13] They ensure the wealth they generate is redistributed in their neighbourhoods, by employing local people in good quality jobs, using local supply chains, and providing training opportunities so local people can become economically active. This local focus also reduces their carbon footprint.

As such, investing in them builds wealth in the local economy and reduces climate impact far more effectively than when contracts go to multinational companies or big national charities. Whether through grant funding or commissioning, increased spend with local organisations can make a significant impact in developing an inclusive, sustainable, and green local economy. This, in turn, acts as a key determinant of health, supporting community wellbeing and resilience.

It is important, though, that changes in local spend within an ICS do not destabilise existing funding arrangements for VCSE organisations. This is particularly true where there isn't a shared level of current investment between places. It should be done thoughtfully, intentionally, and in close consultation with the sector to avoid organisations losing precious sources of funding.

Given the relative youth of ICSs, it is likely that most will not have well-developed policies or processes for maximising and measuring local spend. As a starting point, clear leadership from the top around this way of working, and the nurturing of a working culture shift towards it, is key. As is working closely with procurement officers across the system to ensure they understand the value of this approach and feel supported to take it in their individual roles.

For those that do wish to explore a more in-depth approach to increasing local spend, we have developed the following tips through working on the Keep it Local approach with councils over the years.

- **Think of local spend in terms of concentric circles within the ICS**

  The first circle will be the footprint of the neighbourhood areas. The second will be the places within the system – usually local authority districts. The third will be the boundaries of the whole ICS. Beyond this, the next may be the region, and the fifth would be national.

  Recording spend against these geographies can help provide a more nuanced view of where ICS money is going. Creative judgement may need to be used for suppliers with distant head offices, depending on whether the delivery of a spend occurs through a local office.

- **Measure multiple relevant indicators**

  This can bring further nuance and allow ICBs to really understand the impact of their spend and set priorities to go further. ICBs may already measure local spend with small and medium enterprises (SMEs), but it's important to also measure both total and local VCSE spend.

- **Include as much third-party expenditure as possible within your local spend calculation**

  Apart from salary expenditure, payment for goods, works, services and grants that go through the ICS's ledger should be included and measured.

- **ICS-wide targets for local spend are important to ensure accountability**

  They should be stretching but achievable and reviewed according to trends in overall ICS spend. Targets should be included in both ICS forward plans and procurement strategies.

- **Invest time in understanding the granular detail of ICS spend**

  This will have an exponential impact

on the ability to maximise local spend. Without a more qualitative understanding of changes in local spend – for example, the effect of different departmental approaches, how services are designed, and how contracts are awarded – it is difficult to understand how to move the dial on local spend in an intentional and sustainable way.

- **Understand what happens next**

  This level of analysis will support a better understanding of the impact of local spend, and whether the money stays locally. Providing training and capacity for contract managers to develop a 'circular economy' approach, including understanding how services are sub-contracted, is valuable here.

Key to the success of a local spend strategy is investment in the procurement monitoring system. The more sophisticated the functionality of the system, the more accurately ICSs can measure and target local spend. Tagging suppliers by geography, size, and sector, and spend by type (as in the third point, above) will greatly increase an ICS's ability to set, and reach local spent targets and understand their impact.

Whatever stage an ICS is at in this approach, taking steps towards it will start to bear real benefits. This can also be supported by closer discussions with local authorities to understand their approach.

Focus on prevention now to save costs tomorrow

As The Hewitt Review emphasised in 2023, we cannot wait any longer to shift to a prevention-first approach in healthcare.

The pressures on elective, urgent and emergency, and primary care will only worsen if people aren't supported to live healthier lives in their communities.

The Keep it Local approach is ideally suited to primary prevention, keeping people healthy by improving the wider determinants of their health and tackling the health inequalities they face.

We know that local VCSE organisations – particularly CAOs – take a person-centred, holistic approach to supporting individuals' health and wellbeing. On average, they support 13 different population groups, addressing 91% of their wider health determinants as described in the Office of Health Improvement and Disparities' Inclusive and Sustainable Economies Framework.[14]

As such, supporting, partnering with, and commissioning these organisations is vital for any health system attempts to truly put prevention first.

This can not only complement the NHS's overarching Core20PLUS5 approach to tackling health inequalities, but strengthen it too. It ensures that the approach is rooted in the wider determinants of health as key to primary illness prevention and health promotion. This is a more impactful and sustainable view of Core20PLUS5 than the alternative – a more conditions-focussed, medical model that prioritises secondary prevention (eg, testing and screening).

Case study

In **Wakefield**, national Core20PLUS5 funding has been pooled with local public health funds to run a three-year programme to invest in the district's 10 most deprived neighbourhoods. The programme aims to reduce health inequalities and prioritise prevention through co-produced, asset-based, wider-determinants-focussed working with local people.

This has been delivered through the council's Big Conversation initiative, taking an appreciative inquiry approach to understand what local people want to see and do to make this happen.

This began with a series of co-produced workshops in four of the 10 areas. These sought to understand who the local stakeholders are, how the programme relates to existing activities, what the local community strengths and assets are, and, importantly, which communities are not adequately represented.

These were followed by a final workshop to explore how to work in a different way – not only through use of funding, but also better ways of working and local collaboration. Health system partners were then brought into community-led conversations to help create the change people wanted to see.

These have included interventions across the wider determinants of health, like housing, employment, poverty, community infrastructure, and local transport. Importantly, they have also involved work to build trust between communities and public authorities on to tackle priority issues for local people (eg, anti-social behaviour). This commitment to long-term presence and support is key to building sustainable, health-creating partnerships locally.

Along with Principle 2, Principles 5 and 6, below, provide broader guidance on how local health systems can support local VCSE organisations to deliver their impactful brand of wider-determinants-led, primary prevention.

Below, however, we detail three specific positive models they can adopt that put these organisations at the heart of commissioned prevention services. Importantly, the design and commissioning of these services should be done collaboratively with local VCSE organisations. This can help to ensure that they are based on, and benefit from, the wider determinants of health focus of these organisations.

Peer-led health promotion

However health messaging is disseminated, it is unlikely to influence groups most impacted by health inequalities if it comes directly from statutory bodies.

Instead, local health systems should invest in "peer-led health promotion".[15] The "community health champion" model is the most common form of this approach. But whatever form it takes, it should have a common, asset-based characteristic at its heart – using the knowledge and connections of local people to reach communities the health system has otherwise struggled to engage.

In fact, NHS England has begun its own community health champion model. The Core20PLUS5 Community Connectors pilot has funded several ICBs to recruit, mobilise and support peer influencers to help engage local people with health services. This is coordinated by local VCSE organisations seen as "pivotal" delivery vehicles. Connectors are local people with unique insight into the barriers faced by those in their communities. As well as offering health advice to community members, they also advise local NHS providers on how to reduce barriers and design accessible services.

KEY

As the Community Connectors programme develops, our research suggests that CAOs are ideally placed to adopt the coordinator role in communities across the country. Indeed, the programme's designers see a wider determinants approach as key to its success. For example, Connectors can move beyond simply sharing health messaging to also support peers around income, transport, mental wellbeing, and access to the natural environment.

Where ICSs do involve local VCSE organisations in peer-led health promotion, either through the Community Connectors programme or in another form, they should consider some key factors that may affect delivery locally:

- While effective, this type of community engagement comes with a cost for VCSE organisations. The more localised or targeted it is, the better the results will be. But organisations need funding to engage, grow, develop, and train such peer networks.

- A one-size-fits-all approach to this peer-led health promotion will not work in all places. Every marginalised community will have its own unique needs and will need to be approached in a way that works best for them.

- Labelling any such interventions as "health" related may have a negative impact on engagement. The wider determinants should be addressed as issues that come before health, are shared among the community, and do not carry stigma or judgement.

Integrated Health and Wellbeing Services

The Integrated Health and Wellbeing Service (IHWS) model has been adopted in several places across the country.[16] It is often commissioned by local authorities as a single point of access for health and wellbeing services, supported by local organisations. They may involve a single adviser supporting an individual to change multiple behaviours. Or they may refer clients to one or more single behaviour change activities.

Less formally, this is what CAOs do every day – taking a holistic, person-centred approach to provide or connect individuals with services to improve the wider determinants of their health.

Existing evidence highlights areas where a greater involvement of CAOs could help overcome issues with, or add further value to, the delivery of IHWSs. For example:

- **Trust for provider, service, and staff** – Where the service is provided by the local authority or a national provider, there is evidence of potential service users being uncomfortable with unfamiliar staff they don't know or trust. They suggested this could be overcome by promoting the service through, for example, trusted voluntary sector organisations and existing community networks.[17]

  Better still would be for the service to be provided by those organisations and their staff with whom service users already have a connection. This could help overcome the challenges of another practice – using statutory service branding in an attempt to gain service user confidence.

  Our previous primary research suggests the opposite could in fact be true, particularly for communities more likely to distrust government health institutions due to historic marginalisation or discrimination. Instead, endorsement and provision by local, trusted CAOs may provide a better chance of increasing engagement with an IHWS.

- **Remit of support** – Evidence suggests that a focus on the wider determinants of health (as promoted effectively by CAOs) is a sensible approach for IHWS commissioners to take.[18] This can increase the sustainability and long-term impact of such programmes by supporting individuals with the areas of their life that have the most fundamental impact on their health (eg, building skills, accessing good work, or connecting with their communities).

- **Long-term support** – It is debatable whether a time-limited service of, for example, 12 weeks, provides sufficient support for all service users to reach their goals.[19] The inherent nature of CAOs as deep-rooted, community-led organisations committed to their place means they are better suited to providing long-term support to individuals.

- **Local accessibility** – In rural areas with low population densities, IHWSs may require consultation and triage to take place over the phone, rather than face-to-face, due to poor transport links.[20] If such services were designed to be less centralised and more neighbourhood-based, they could benefit from delivery by CAOs in smaller, local, more accessible community spaces.

Case study

In **Suffolk**, before releasing the tender for their IHWS, the council undertook a period of intense market engagement. By involving hundreds of organisations, potential bidders, communities, residents and the VCSE sector, the process itself was used to iteratively design the service.

The net effect was that both the commissioner and the successful provider could resolve any teething problems early on and embed partnership working from the start.[21] This approach corresponds closely to the Keep it Local approach to local commissioning **(see Principle 6 on p. 37)**.

As the IWHS model grows in popularity as a holistic model of prevention, commissioning bodies – ideally place-based partnerships working collaboratively – must be aware of the very similar work CAOs are already doing every day in local communities. As such, they should be prioritised as providers for IHWSs that are trusted, impactful in their support for the wider determinants, long-lasting, sustainable, and accessible to all.

Social prescribing

The standard model of social prescribing within the NHS is through Link Workers. These staff are employed by either the PCN or a VCSE organisation and aim to support individuals following referral from one of numerous possible sources, including self-referral.

However, it is important to recognise that local VCSE organisations have, by their very nature, been delivering forms of social prescribing for many years before the introduction of Link Workers. Equally, such forms may correlate with the IHWS and peer-led health promotion models described above. As such, there is much to be learned by local health systems from the experiences of their local organisations – particularly CAOs – in this area.

Different models of social prescribing will have value based on the existing structures and assets within different communities. This will determine whether the Link Worker model is the most suitable.

Health systems should embrace the different potential models of social prescribing in different places. As with IHWSs, CAOs have many years' experience of what we now call social prescribing and will have found various ways to tackle local health inequalities. Where the Link Worker model is suitable, commissioners should work with CAOs to understand the scope for embedding these roles within them.

CAO staff will often already have the knowledge and connections to play the Link Worker role better than anyone and can be resourced as such. This approach can also maximise the sustainability of the social prescribing model. It invests in community development that supports long-term improvement of the wider determinants of health locally, rather than focussing purely on sign-posting to individual services to tackle the specific issues a person faces.

However, without the grass-roots funding to provide activities, there will be nothing for CAOs to prescribe to and/or deliver. As anchors, they are able to use funding to both deliver services themselves and to channel it to other local groups to support wider community infrastructure. Such steps would help to overcome two key recurring issues with the current system:

- Duplication of work, excessive meetings, and confused points of contact between the VCSE and the health system.
- The need for greater parity of esteem between VCSE prevention services and NHS clinical services.

For more information and examples of these models in practice, see our previous research, "Creating health and wealth by stealth: Community anchor organisations, prevention services, and the wider determinants of health".

KEY

Commit to your community and proactively support local organisations

Local community organisations are facing huge financial pressures as they tackle deeply entrenched social challenges in their communities, particularly as the cost of living crisis continues to bite.

But if this work didn't get the recognition it deserved in the past, the COVID-19 pandemic showed just how vital it is. Councils and local health systems now have greater understanding of the immense value of their local VCSE sectors. They had the networks and agility to reach and support communities and individuals most at risk from the disease.

The NHS England Board has already identified the need to build on this approach to strengthen wider prevention services to benefit the same at-risk communities.[22]

But local VCSE organisations cannot be expected to serve as the public sector's crisis response unit, to be switched on and off as needed. A strong and resilient VCSE sector that supports the local health system through wider-determinants-based health creation requires investment in its capacity and capability to act.

We found, however, that the likelihood of local health systems providing this support, and following Keep it Local principles more widely, is driven by their perception and understanding of the VCSE sector in their areas:

- Where it's good, there are examples of systems mapping local VCSE services and making this publicly available, supporting its connection and infrastructure, and funding their involvement in neighbourhood-based approaches.
- Where it's "OK", there are examples of some engagement and consultation, but that can be unilateral, tokenistic or involve a limited number of representatives from the local sector.
- Where it's bad, there is little engagement, no commissioning, and no understanding of the sector's intrinsic social value, ability to build community wealth, or important role in taking an ABCD approach.

In fact, we heard an unfortunately common scenario in which local health systems not only failed to support the capacity and capability of their VCSE sector, but actively damaged it too (if not intentionally). PCNs are known to attract staff from local VCSE organisations with better pay offers, despite those organisations having spent much of their own time and money skilling the staff up. While this can mean more champions for the VCSE sector within the local health system, it is costly for the organisations and the continuity of their service.

So, there are several key steps local health systems can take to commit to their communities and proactively support local organisations:

- **Cultivate a culture from the system level down that values and meaningfully supports the local VCSE sector**

  There needs to be a shift in thinking and practice at all levels of the ICS, inspired by the ICB, from basic VCSE sector engagement or consultation towards genuine co-production of services accompanied by sustainable funding, training and resourcing.

  This should include funding for involvement in formal channels at different levels of the system; the ICS's VCSE Alliance, place-based partnerships, and integrated neighbourhood teams. Local VCSE infrastructure bodies and community

CAOs are particularly well placed to engage at more strategic levels. Particular attention should be paid to ensure local organisations led by and serving marginalised communities have seats at the tables and are resourced to take them.

This co-production should be based on a clear, shared understanding of the wider determinants approach to health. It will also require a relinquishing of control by statutory bodies and an alignment of the system to support the VCSE sector to create good health. In doing so, it should move away from using the sector as a crutch to respond to crises or deliver basic support to those the health system otherwise fails to reach.

Such a mindset is particularly important for commissioning. Smaller local organisations will often be best placed to deliver an impactful and person-centred service, but may lack the time and technical know-how to complete a tender.

Reducing these barriers, for example through training, extensive pre-market engagement, or the removal of unnecessary and prohibitive technical specifications, is crucial to ensuring as fair a process and as high-quality a service as possible. **You can read more on collaborative commissioning under Principle 6 on p. 37.**

Case study

Buckinghamshire, Luton, and Milton Keynes ICB is currently producing a VCSE Market Management Strategy to support the challenges of sustainability and short-term funding faced by the sector. Along with the new NHS Provider Selection Regime **(see yellow box on p. 37)**, this will support the development of more integrated services.

The ICB is working on plans to deliver this through a range of activities for local VCSE organisations. These could include, for example, training workshops on ICB structures, responsibilities and personnel, opportunities for VCSE involvement, and procurement processes, systems, and tools.

These sessions will also include inviting such organisations to share insight on the experiences of patients and the efficacy of current services. From there, partners will work together to develop better processes for service delivery by the sector. The ICB is testing the strategy through work on non-emergency patient transport in the first instance.

- **Set (and stick to) long-term time horizons for funding and support**

  Investing in the sustainability of local VCSE organisations is not just about increasing the size of the funding envelope at the neighbourhood level. It's also about providing long-term certainty for that funding, through multi-year arrangements.

  These allow for the proper planning of activities, particularly of core community engagement and development work. This is vital to build and sustain the knowledge, relationships, and networks necessary to take a holistic, person-centred, health creation approach.

  This unique approach allows them to focus on primary illness prevention that is based on the wider determinants of health and tackles local health inequalities.

Case study

In **Bradford**, the local VCSE sector, council, and health system have worked together to develop the "Community Investment Standard". This commits the system to shifting one per cent of the local health budget to community-led prevention.

- **Fund local VCSE organisations to provide the services to which people are socially prescribed**

  Possibly the most common involvement local VCSE organisations have with their health system is through social prescribing. This is usually in the form of receiving referrals of an individual from a GP or Link Worker to take part in an activity or receive a service that is considered to be helpful for their health and wellbeing.

  However, we have heard time and again that, in most cases, there is no money attached to these referrals. Instead, organisations are expected to find the capacity to support additional clients for free.

  Organisations will usually do their best to accommodate this, but it soon becomes impossible to service all the additional demand. This leaves the individual without the support they need and have been prescribed, can damage the standing of the VCSE organisation in their community, and strains their working relationship with the PCN.

  Instead, whether the social prescribing service is delivered by the PCN itself or, preferably, a local CAO, the contract should include sufficient funding to ensure that local organisations are able to deliver on the additional demand at a full-cost-recovery rate.

  It should be recognised that this approach needs national as well as ICS-level support to facilitate. To the extent that it relates to the broader funding picture for local community organisations, it will require a cross-governmental approach involving, among others, NHS England, the Department of Health and Social Care, the Department of Levelling Up, Housing and Communities, and other national funding bodies.

- **Use the Additional Roles Reimbursement Scheme to embed integrated neighbourhood team roles within local VCSE organisations**

  The Additional Roles Reimbursement Scheme (ARRS) was introduced in England in 2019 to enable PCNs to claim reimbursement for the salaries (and some on-costs) of 17 roles within multidisciplinary team. PCNs can employ these additional roles to address the specific needs of the local population, increase capacity, improve access, and widen the care offer.

  This provides a good opportunity to resource local VCSE organisation staff to play a direct role in the neighbourhood health system. Roles such as Social Prescribing Link Worker and Health and Wellbeing Coach

KEY

are best provided by local VCSE staff, based out of their community spaces, who have the existing knowledge, trust, and connections with local people and services.

Case study

In **Leeds**, Hamara Centre developed a successful relationship with the lead practice manager at one of their PCNs to do just this.

> **"Trust is so important: they trust us to know the best way to reach our community, so the Link Workers, our 'patient ambassadors' as we call them, are based with us here in the heart of the community. The leadership team meet monthly, discuss needs on both sides and discuss how we can deliver on these. It's flourishing."**

Not all partnership working with PCNs has been successful for Hamara, though, with another insisting that the ARRS staff be based at GP practices.

Engagement rates were much lower for those Link Workers, and Hamara struggled to create the same impact for the PCN.

- **Support community ownership to strengthen local organisations and provide accessible space for co-located health services**

As detailed under **Principle 2, on p. 22**, above, co-locating health services within trusted community spaces can have a significant impact on their uptake by local people.

However, buildings aren't free, and a lot of resource is required to keep them in community control. By supporting local community organisations to gain ownership of assets, local health systems can invest in the bricks and mortar of truly integrated healthcare.

This can include providing the match funding required for CAOs to bid into the Community Ownership Fund. Beyond this, ICSs and NHS Property Services should proactively identify existing community-run spaces in which clinical services can be co-located.

In the long-term, owning physical assets can provide a strong and stable basis for community organisations to generate independent income and deliver services. It also ensures that local spaces remain dedicated to community development, increasing the ability of local people to stay happy and healthy in their neighbourhoods.

Commission services simply and collaboratively so they are "local by default"

The Keep it Local movement began in response to the trend towards scale in public service commissioning. Local VCSE organisations, who had created innovative local services and developed huge experience in supporting local people, suddenly found themselves crowded out of the local service landscape. Big contracts and bureaucratic processes were automatically putting services in the hands of mega outsourcing companies and big national charities.

The Keep it Local approach aims to turn this on its head by making services "local by default". This doesn't mean giving unfair advantage to local organisations or suggesting local community organisations should win every single contract.

It means recognising that, historically, commissioning and procurement processes have promoted short-term, competitive tendering, ultimately favouring big providers. These processes don't create good results and make local VCSE organisations act like businesses, ignoring their intrinsic social value and holding them to unfairly high evidence burdens compared to other providers. They are even less appropriate for smaller value contracts, often resulting in unnecessarily complicated procurement processes that cost more than the contract itself.

Instead, processes should encourage and enable smaller local providers, so they are supported to show what they can do and the benefits they can bring. This will mean commissioning looks local first, with a focus on collaboration over competition. This can help manage and overcome historical funding dynamics within the local VCSE sector. Organisations have often been asked to compete with each other for funding one week, and collaborate the next.

The new **Provider Selection Regime** (PSR) – the rules for procuring health services in England – provides an opportunity to pursue this approach. It sets out three commissioning processes – "direct award" (with three sub-routes), "most suitable provider", and "competitive". The process adopted will depend on, among other things, the number of capable providers available, the scope for people to choose different providers, and the need and likelihood of continuity for a service.

As such, the PSR allows for greater flexibility and allows commissioners to award contracts without using a competitive process, where appropriate. Where the direct award process is not applicable, commissioners may still be able to avoid a fully competitive process by instead using the most-suitable-provider process. Here, as well as in the competitive process, they can select the relative importance of the five key criteria – quality and innovation; value; integration, collaboration, and service sustainability; improving access, reducing health inequalities, and facilitating choice, and; social value.

This means that they could increase the ability of local community organisations to successfully bid for service contracts. They could put greater emphasis on their ability to improve access and reduce health inequalities within their communities or generate their intrinsic social value **(see more on social value on the next page).**

The key to collaborative commissioning is in-depth, long-term, strength-based engagement with communities, including the perspective of local VCSE organisations and the populations they support. Here, we lay out how to do his within local health systems:

- **Develop a joint commissioning approach between all partners within the system, and ensure shared understanding of opportunities and challenges**

  For this principle of collaboration to succeed, it is vital that all parties at the place and neighbourhood levels are pursuing shared outcomes, co-producing local services and interventions designed to achieve these.

  As discussed under Principle 1, this approach should also ensure shared understanding of what each other is commissioning, who with, and why. This is particularly important from an NHS perspective, as their activity is not always well understood locally. Place-based partnerships offer this, as does the "Community Partnership" model at the neighbourhood-level (see Bradford case study on p. 35).

  A truly collaborative commissioning approach – that prioritises a wider determinants approach to tackling health inequalities – can empower the local VCSE sector and allow them to deliver the full impact of their services. This is particularly true when different models of commissioning and service delivery are explored, such as alliance contracting, that take into account existing relationships and the history of local service delivery.

  Collaborative budget pooling presents an opportunity for more effective working. The Better Care Fund, as described under Principle 1, is one option for this. But any approach requires strong principles of participatory budgeting to allow local communities to have their say and what is spent where.

  Equal partnership is important in these relationships, but this can be difficult to achieve when there is a clear power and funding imbalance between commissioners and delivery organisations. At the place level, there may be a role for the local VCSE sector infrastructure body to be the go-between in brokering this collaboration.

  However this issue is tackled, it is also vital that there is a wide representation of voices from the community, including local organisations led by and supporting marginalised communities at the highest risk of health inequalities.

  A deep, shared understanding of local community and health assets also supports a joint approach to commissioning the right services to be delivered by the right people in the right places.

  Similarly, shared understanding of the challenges that both VCSE and statutory partners are facing in commissioning, particularly around capacity and funding, is important for healthy and productive relationships.

- **Understand and value the intrinsic social value of services delivered by local VCSE organisations**

  Traditional approaches to measuring social value – where it is seen as additional to the value of the service being commissioned and scored as such – is unsuitable for person-centred health and wellbeing services that aim to reduce inequalities.

  For these, the social value runs right through the service. It is at the very core of the procurement and should be at the core of the provider's ethos. Asking providers to demonstrate additional

social value – on top of the social service they are already seeking to provide – risks diverting resources away from their core social purpose.

As such, health commissioners should seek to make social value inherent to the quality element of tenders for person-centred services. This can be supported by writing the Keep it Local principles into commissioning frameworks.

- **Value the expertise of the local VCSE sector for what works**

The long-term presence of local VCSE organisations in their communities, and the knowledge and relationships that come with this, means they understand what intervention will work best for the health and wellbeing of local people. As such, commissioners should speak to them early and often when seeking to tackle a problem. Solutions should not just be imposed on communities.

Indeed, the health system should commission for health outcomes and let community organisations propose the most effective solution to achieve them. This will support the health system to understand which services are best delivered by local community organisations, and how best to facilitate that.

Importantly, commissioners should take the time to understand the value of the work already being done by the local VCSE sector. It should avoid the temptation to simply fund the shiny "emperor's new clothes" of a big new bidder.

Case study

In **Kent and Medway**, the ICB were given a small pot of funding from NHS England's Personalised Care Fund to support people with blood pressure management at home.

They immediately saw the value of giving it to the local VCSE sector to design a programme that would achieve this as effectively as possible. This required the confidence to hand the money over and understand that the sector knew how to make the most of the limited resources to reach the communities most affected.

Ek360 – a social enterprise delivering community engagement services – was chosen to manage the funding. They developed the "Hypertension Heroes" programme, recruiting and training peer health promoters in places with high rates of blood pressure and within seldom heard groups. The programme supports communities to understand the importance of blood pressure, how to measure their own, and how to interpret the readings.

These "Heroes" are now managed and coordinated within the local VCSE sector, by groups like Youth Ngage, Rethink Sahayak, North Kent Caribbean Network, and Folkestone Nepalese Community Centre. The trust between the community and the volunteers and spaces is key. In Maidstone, for example, Fusion Healthy Living Centre is able to extend the initiative to a wide range of residents alongside its foodbank and community café.

The success of the project has led to it being shortlisted as a finalist in the "Innovation and Improvement in Reducing Healthcare Inequalities" at the Health Service Journal Awards 2023.

KEY

- **Include local VCSE collaboration in long-term commissioning and procurement strategies**

  Long-term commissioning relationships are very important – embedding relationships at an organisational level is key to ensure that the inevitable churn of individuals on both sides does not detriment the delivery of quality services.

  It is equally important that such relationships include not only commissioners but procurement colleagues too. This can ensure that everyone involved at each stage of the service cycle understands the rules of engagement, the commitment to the local VCSE sector, and, importantly, the move away from competition to collaboration. This will be particularly important as the practicalities of the PSR become apparent, including the likely differences in interpretation between parties.

  For procurement colleagues, this may require the training and freedom to explore the breadth and depth of opportunities to work differently and become less risk-averse. The Art of the Possible in Public Procurement can be a good place to start.

  On the point of long-term thinking, funding agreements should be designed to be as long as possible. This helps VCSE providers to plan in what is often otherwise an uncertain financial environment.

- **Ensure commissioning and procurement processes are proportionate and appropriate for the service to be delivered**

  Eliciting the best local VCSE provider for a particular service requires the commissioning process to be as simple and accessible as possible. The tendering software used should be user-friendly, and the demands made on bidders around data, systems, finances, workforce, and governance should be proportionate to the type and size of contract to be awarded.

  As one health system colleague suggested during our research roundtables,

  > **"Commissioners should be made to complete their own procurement process to understand exactly what it entails and who they're missing out on!"**

  To increase the options for funding local VCSE delivery of health activities, authorities should also consider grant funding as an alternative to contracting. This could include comprehensive, co-produced evaluation to help make the case for ongoing funding.

- **Manage local VCSE contracts and grants effectively to measure impact and capture learnings**

  One of the most common areas of tension between health commissioners and local VCSE providers is impact measurement.

  Often, commissioners perceive a lack of rigour in the collection and analysis of impact data by community organisations.

  Meanwhile, the organisations lament a lack of understanding by commissioners of the preventative, wider-determinants-led nature of their work, and the inherent difficulties in measuring this by conventional evidence metrics. This can include the impact that a certain intensiveness of monitoring and evaluation can have on the providers' relationship with the client.

  As we've found in previous research,[23] the answer may well lie in flexibility, open-mindedness, and compromise on

both sides towards a "theory of change" approach to measuring health creation.

Here, impact on the wider determinants of health could be used to demonstrate longer-term impact on health promotion and illness prevention. Similarly to the Office for National Statistics' Health Index, indicators such as access to services, economic and working conditions, and access to green space could be used.

However impact is ultimately measured, the traditional commissioning cycle stages of "deciding priorities" and "designing services" present a clear opportunity to decide this collaboratively. Here, commissioners can engage early with both communities and prospective providers to co-produce not only what the service looks like but also what outcomes it should aim to achieve and how they should be measured.

This approach should be complemented by increased support and resources for local VCSE organisations to demonstrate their impact. This can help to both satisfy their funding agreement and produce learning and recommendations for improved future services.

Where this includes impact on health inequalities, commissioners could use the Health Equity Assessment Tool alongside local VCSE organisations to gain a clearer understanding of their contribution. This could even replace the need for bid exercises where health inequality reduction is the central purpose of the service.

5.

Keeping it Local in the real world

We hope that the information, ideas, and examples above provide a clear and inspiring approach for truly integrating the local VCSE sector into health systems.

However, the Keep it Local approach does not exist within a vacuum. Any adopter and their allies must consider the real-world context in which both the VCSE sector and ICSs are operating.

Here, we explore this context in more detail, including the challenges, myths, and misconceptions that must be understood to overcome the historical "them and us" attitude that often pervades, and achieve proper integration. We also allude to the reform and support needed at the national level to makes approaches like Keep it Local as effective as possible.

VCSE capacity, capability and funding

Excessive emphasis is often given to the "V" in VCSE by partners of the sector. The vast majority of the sector's workforce are paid rather than volunteers. They are experts in community development, running professional organisations with viable business models delivering effective services.

But, in truth, they are operating in increasingly difficult funding environments. The gap between the funding they receive to provide services and the actual cost of doing so has been growing year-on-year. Recent research by NCVO, the charity sector body, paints a dire picture of charities on the brink of insolvency after years of subsidising heavily underfunded local authority and NHS contracts.[24]

This is important to remember for partners in local health systems when asking local VCSE organisations for support. Particularly as, beyond just wages, they also have buildings to run and bills to pay.

On page 35, we described the classic problem of people being referred to these organisations for social prescribing activities, but with no additional funding to service the increased demand.

While this remains the case, social prescribing will never be a sustainable solution to keeping people healthy in their communities and tackling the demands on primary care. Relatedly, it is also important for the health system to understand that not all local VCSE organisations will be set up to receive referrals in the first place.

Beyond social prescribing, any funding provided to local VCSE organisations should be as long-term as possible. A six or 12-month grant or contract will not provide the financial security or quality of engagement necessary to deliver an effective service. Ideally, funding should be provided for at least three years, and preferably more.

The most effective and sustainable way to do this is through agreement at the national level for a significant shift of health system funding upstream, focussing on community-led prevention activities.

ICS finances

Keep it Local isn't a one-way relationship. There's a lot that local VCSE organisations can do to support closer working with their health systems. We have produced an accompanying report - "Understanding health system funding" - to help with the sector with this. Further guidance still can be found in our previous health and wellbeing reports.

Better understanding of their health partners, and the pressures they face, is key to the relational approach that makes Keep it Local a success.

As referenced in the introduction, estimates placed the real-term cuts in NHS funding at between £4bn and £9bn in 2022.[25] And in Spring 2023, DHSC asked NHS England and ICBs across the country to cut their running costs by 30%.[26]

This has a stark impact on the depth and breadth of services that can be delivered. It also drives understandable operational and political pressures to prioritise funding for acute services. This is seen as necessary to tackle the record-high waiting list for routine hospital care, which sat at 6.5m as of November 2023.

A shared understanding of this reality is as important as a shared commitment to a new way of working like Keep it Local. It can help all parties move towards more strategic commissioning in the face of such obstacles.

But the funding crisis doesn't just affect service delivery. It also makes it harder for health system staff to find the resources to produce and share information and learning in a systematic way. This can create confusion around the structures that the VSCE sector is expected to operate within, and the precise roles and responsibilities of their colleagues in the health system.

As in the previous point, and as emphasised in the Fuller Stocktake report, there is only so much ICSs can do to manage these issues alone. National reform and support from DHSC and NHS England is key.

Shared missions and co-production

Effective integration of the local VCSE sector within the health system requires a joint understanding of, and commitment to, a shared mission. In theory, this should be simple – the health system's patients and the VCSE sector's clients are one and the same.

But too often, as addressed by Principle 1 of Keep it Local, the two are siloed. The link is not made between the VCSE sector's work to tackle health inequalities and support the wider determinants of health and the health system's efforts to keep people well. The benefits that one has for the other, and the language used to describe them, are not shared.

Instead, more effort must be spent to understand shared motivations and drivers – this is vital to generate the cultural shift needed to make the Keep it Local approach a success.

In practice, this means that local VCSE organisations need to be seen as equal delivery partners in health – co-producing services, not just providing them.

It also requires a widening of the health system's perceptions of patient interaction – from traditional time-limited, one-to-one, subject-specific appointments, towards the long-term, holistic, person-centred approach offered by local VCSE organisations. This can be supported by providing opportunities for NHS staff to work on placements within such organisations.

The onus is not just on the health system, here, though. The VCSE sector also needs to be able to effectively communicate to the system where it fit in and how it can support.

For example, in switching the traditional role of provider to referrer, local VCSE organisations are often well placed to direct and support individuals into clinical treatment.

Diversity of both sectors

Finally, there is a tendency for both the health system and local VCSE sector to view each other as homogenous.

The VCSE sector within any health system, place or neighbourhood will likely be broad and complex. But this diversity doesn't necessarily mean the sector is fragmented. Many of them will work in partnership, building relationships with the support of local and national infrastructure bodies (like a Council of Voluntary Services, or like Locality).

However, it is certainly true that a more concerted effort is required to encompass all local voices in co-production. Not only because understanding of true co-production varies from sector to sector, but also because of a historical sidelining of organisations led by and serving marginalised communities most at risk of health inequalities.

Case study

Leicester, Leicestershire and Rutland
ICS have taken a particularly inclusive approach towards their VCSE Alliance. Any VCSE organisation within the area – regardless of size and reach – can join the Alliance by listing themselves on the VSCE Alliance Directory. This means that access and influence isn't restricted to the largest organisations or "usual suspects" in the sector.

As members of the Alliance, all organisations have access to an "Applications and Opportunities Hub", knowledge and skills-building resources, including a member forum, and a process for feeding insight into the ICS's "Insights, Behaviour and Research Hub".

This must be considered in application of each of the six Keep it Local principles. For example – who is benefitting from local spend, which organisations are being supported, and how well are services being coordinated in different neighbourhoods?

Again, though, this is not just a problem for health systems to solve. There is a task for the local VCSE sector in better getting to know its local system to understand its different elements and functions.

KEY

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Locality

Locality supports local community organisations to be strong and successful. Our national network of over 1,800 members helps hundreds of thousands of people every week. We offer specialist advice, peer learning and campaign with members for a fairer society. Together we unlock the power of community.

VCSE Health and Wellbeing Alliance

The VCSE Health and Wellbeing Alliance (HW Alliance) is a part of the VCSE Health and Wellbeing Programme (HW Programme) which is delivered by Department of Health and Social Care and NHS England and NHS Improvement (the system partners).

The HW Alliance is new network of 18 member organisations (and one coordinator) established to collaborate and coproduce to bring different solutions and perspectives to policy and programme issues. All HW Alliance members represent communities that we need to hear from as we develop health and social care policy and programmes.

VCSE health & wellbeing alliance

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