# Understanding health system funding

## The challenges and opportunities for local VCSE organisations

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VCSE health & wellbeing alliance

locality
the power of community

# Contents



# Executive summary

**Following recent structural changes in the NHS, a new commissioning regime comes into place at the start of 2024. In light of this, here we explore the opportunities and challenges to date for VCSE organisations in accessing health system funding.**

There is growing acknowledgement of the role that VCSE organisations can play in health ecosystems. In theory, the new structures are designed to facilitate closer partnership working and help commissioners maximise the opportunities VCSE organisations present.

However, there remain significant barriers for many groups to access the funding they need. Without this, we all miss out on their potential: creating good health through truly preventative services that focus on the wider determinants of health and tackle health inequalities.

So as part of our work on the government's VCSE Health and Wellbeing Alliance, we have taken a deep dive into the issue with Locality members. In this report we outline some of the big challenges and provide guidance on how best to navigate the health funding landscape, accompanied by good practice case studies.

We also set out where there are opportunities for local VCSE organisations to influence the longer-term direction of local health systems.

This report is designed for VCSE organisations. It sits alongside our Keep it Local for Better Health guidance, which provides a framework for local health systems to improve how they support, invest in, and commission local organisations. The two guides have been developed to complement each other from both the local health system and local VCSE sector perspectives.

**The wider determinants of health are social, economic and environmental factors that influence health, wellbeing and inequalities.[1]**

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### Our research found four key barriers for VCSE organisations engaging with health system funding:

- **Access and engagement**, including challenges around the visibility of VCSE organisations, how to navigate a fragmented system, language and cultural barriers, building trusting relationships, and getting strategic representation right.
- **Resources**, including having the time to participate in commissioning processes, reduced funding at a time of rising demand, and impacts on long-term organisational sustainability.
- **Process and structure**, including understanding where health budgets sit and how they are distributed, inconsistent and inappropriate contract terms and sizes, social value not working for VCSE organisations, and getting the right balance between grants and contracts.
- **Data, governance, and monitoring and evaluation**, including inconsistent approaches that exclude smaller organisations, lack of support to develop robust governance arrangements, and risk aversion holding back innovation.

### Building on our findings, we have developed the following recommendations to help VCSE organisations navigate health system funding:

1. **Develop a strong strategic plan** – this will help you keep on mission and know what opportunities to go for, and what to avoid.
2. **Strengthen internal processes and governance** – there are certain baseline governance requirements for health contracts. What do you have already in place, what do you need support to develop?
3. **Look for a mixed portfolio of income streams** – there is a big risk to being too dependent on one source of income; a good mix of grant and contract funding is important for organisational sustainability.
4. **Engage with the health system** – understand the value you bring, communicate it in a language health professionals understand, and take the time to build relationships with commissioners.
5. **Explore collective action** – from the VCSE Alliances which are a formal part of Integrated Care Systems to local infrastructure to informal community networks, it is crucial to get connected and work together as a local sector.

### While maximising opportunities within the emerging system, VCSE organisations can also influence and shape it for the better by:

**Advocating for change**, such as:

- the need for flexible and inclusive commissioning with a mix of funding types.
- how contract design can best support growth and sustainability.
- what are proportionate data, monitoring and governance requirements.
- how to maximise representation and co-production.

**Harnessing the potential of collective action**, which can strengthen influence and provide coordinated input into health systems. VCSE Alliances are an integral part of Integrated Care Systems and a key route to strategic influence. Below this sit a diverse range of other networks, alliances and consortiums which can share learning, shape key messages from the sector, and identify the most effective messengers.

# 1.

# Introduction

## The wider context

The COVID-19 pandemic was a significant moment in the development of relationships between the local public sector and voluntary, community, and social enterprise (VCSE) organisations.

For local health systems, there was a greater understanding of the vital role the local VCSE sector plays in keeping local people well. The connections they have with their communities allow them to create good health through truly preventative services that focus on the wider determinants of health and tackle health inequalities. This has a vital impact on reducing the burden on urgent and acute care.

However, compounding the health and social impacts of the pandemic, the subsequent cost of living crisis continues to put individuals and communities under immense pressure.

This vastly increases dependence on VCSE organisations. Spiralling food and energy costs, and wider inflationary pressures, have seen community services overwhelmed by demand. Research of Locality members in 2023 found that 77 per cent of community organisations had seen demand for their services increase in the preceding 12 months.

Over a decade of austerity has reduced local authority finances. Staffing cuts and a high turnover of staff has significantly affected the ability for effective relationship-building. This is critical to collaboration and the effective development and commissioning of responsive, quality, co-produced services.

It is against this backdrop that the Integrated Care System (ICS) model has been rolled out, as part of the long-term NHS plan to reorganise health systems to be better able to work at a devolved level, with a range of partners. Looking ahead, the NHS is projecting 30 per cent staffing reductions in administrative and managerial positions, and innovation and efficiency are the themes that underwrite these new structures and processes.[1]

This is happening at a time when over a third of Locality members have seen their operating costs increase by more than 25 per cent. This is being driven in part by the impact of inflation on contract and grant values; 58 per cent have been impacted by this.

While this situation presents clear challenges to retain the innovation and strong relationships built during the pandemic, opportunities are arising as communities and statutory services explore new ways of working together.

## Changes to the health system

The Health and Care Act 2022 formalised the new ICSs. This included the replacement of Clinical Commissioning Groups (CCGs) with Integrated Care Boards (ICBs) supported in strategy setting by broader-based Integrated Care Partnerships (ICPs).

The goal has been to support joined-up service delivery with a focus on locally-led solutions to health and social care. This includes greater involvement of the VCSE sector in deciding and delivering on health priorities.

You can read our introduction to ICSs for more information on the changes.

To support these structural changes, the Act proposed new regulations for procuring healthcare services in England. These have since been published as the Provider Selection Regime (PSR), coming into effect from January 2024. They will apply to ICBs, NHS England, local and combined authorities (when arranging healthcare services), and NHS trusts and foundations.

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1 HSJ, 2023, "9,000 roles will go in delayed NHS England restructure". Available at: https://www.hsj.co.uk/integrated-care/9000-roles-will-go-in-delayed-nhs-england-restructure/7034832.article

The PSR 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.

In theory, the PSR can allow for greater flexibility and allows commissioners to award contracts without using a competitive process, where appropriate. Also, where necessary, they can select the relative importance of the five key commissioning 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.

As ICBs find their feet, and with an acknowledgement that ICSs are in widely varying stages of development, resources are being developed to help guide the process of integrating services.

The NHS England Quality Development Tool, piloted in a number of areas, will be rolled out nationally.[2] It focusses on six specific elements of embedding the VCSE in ICSs:

1. **VCSE as key strategic partner and decision maker**
2. **Investment and sustainability**
3. **Service transformation, design, and delivery**
4. **Data, insight and intelligence**
5. **Leadership**
6. **Addressing the wider determinants of health and health inequalities**

Each category has quality indicators and examples of evidence and action for systems which are at stages of "emergence", "development", "maturity" and "embedded".

## Health system funding for the local VCSE sector

Despite the growing acknowledgement of the role that VCSE organisations can play in health ecosystems, and the structural changes being implemented, there remain significant barriers for many groups to access the funding needed to deliver on health objectives.

As part of our research on the government's VCSE Health and Wellbeing Alliance, we have worked with Locality members to deepen understanding on the issue. We have dug into some of the challenges and provided guidance on how best to navigate this emerging funding landscape. Beyond this, we also present opportunities for local VCSE organisations to support further, longer-term system change with local partners.

We have also provided case studies of good practice by local VCSE organisations and health systems across the country to overcome challenges and maximise opportunities.

This VCSE-facing guidance is a sister document to our Keep it Local for Better Health guidance. This provides a framework for local health systems to improve how they support, invest in, and commission local organisations. The two guides have been developed to complement each other from both the local health system and local VCSE sector perspectives.

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2 The NHS England Quality Development tool can be accessed at https://future.nhs.uk

## Keep it Local for Better Health

For a decade, Locality has been championing the Keep it Local approach to people-centred public services, which prioritises supporting, partnering with, and commissioning local sector 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 community organisations. There are now 18 councils in the Keep it Local Network.

But its principles are becoming more and more relevant to Integrated Care Systems (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".**

In Keep it Local for Better Health, we have explored how the Keep it Local principles can be applied to, and help achieve, health system priorities.

# 2.

# Barriers and challenges of engaging with health system funding

We undertook a series of workshops with Locality members and health system colleagues to identify the barriers that VCSE organisations face when trying to access health funding, as well as the barriers that health colleagues face in engaging with the VCSE sector.

Through this, we identified four key themes for the obstacles faced:

- **Access and engagement**
- **Resources**
- **Process and structure**
- **Data, governance, and monitoring and evaluation**

We begin by exploring these in more detail, before understanding how they can be overcome to help local VCSE organisations become health system ready in a meaningful way.

## Access and engagement

### Visibility of VCSE organisations

While there are many examples of the health system developing good relationships with the local VCSE sector, many health system officers don't have a good understanding of the range of active organisations. They may not understand the impact they have and their role in delivering preventative services which address the wider determinants of health.

There is a particular challenge for newer and smaller groups in "getting known". It was acknowledged by both health and VCSE colleagues that there can be a culture of working within established networks, with trusted providers, which rewards larger and more established VCSE organisations.

### Navigating a fragmented system

As ICSs develop, there may be significant variation in where budgets sit within them and how they're administered. This will depend on the nuances of individual ICSs. Navigating these structures to identify access points and key decision makers can be complex.

This is compounded by staffing cuts and high staffing turnover as systems develop, which creates a high resource burden for local VCSE organisations working to develop and maintain relationships with health partners.

### Language and culture

Information is often presented by health systems in specialist or clinical language that can be hard to access for individuals and organisations who don't have a health system background.

There can be a lack of clarity on the meaning of key terminology, such as "prevention" or "open access". This puts VCSE organisations who are smaller or new to health funding at a commercial disadvantage.

### Relationships and cross-sector working

In a funding landscape that is continually being squeezed, competition and power struggles can produce significant barriers to collaboration, quality service development, and broader strategies for addressing health inequalities.

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This can occur between VCSE sector organisations, between unaligned statutory bodies, or between preventative, community-based provision and clinical interventions. Resource pressures create significant challenges to relationship building, perpetuating uncertainty and sowing distrust.

Inconsistency in messaging and communication from health funders, including last-minute communications, further contribute to such feelings. As does the mismatch between the rhetoric of change, collaboration and integration and the reality of slowly evolving implementation mechanisms.

### Sector representation at strategic level

Formalised VCSE representation at a strategic, decision-making level (on ICPs or, sometimes, ICBs) is an important step forward. However, in many cases this translates into one formal representative at the top strategic level for the whole sector, which participants in our research identified as a challenge for reflecting the sector's myriad specialisms and experiences.

The responsibility for advocating on such a wide range of subjects is significant and requires appropriate funding and training to maximise the opportunity. Representation on such a range of issues can be fraught, particularly in terms of diversity, equity and inclusion.

NHS England has supported the development of system level VCSE Alliances in every ICB. These alliances aim to facilitate better partnership working between ICSs and the VCSE sector, as well as enhancing the role of the VCSE sector in strategy development and the design and delivery of integrated care.

These system level VCSE Alliances:

1. **Encourage and enable the sector to work in a coordinated way.**
2. **Provides the ICS with a single route of contact and engagement with the sector and links to communities.**
3. **Better position the VCSE sector in the ICS and enable it to contribute to the design and delivery of integrated care, have a positive impact on heath priorities, support population groups and reduce health inequalities.**

However, beyond these formal channels, participants reflected that a lack of resource to support broader VCSE representation affects the ability for the sector to be a conduit of information. This can create perceptions of gatekeeping within the sector.

Some areas are fortunate to have well developed local sector infrastructure providers and a range of experienced sector leaders to contribute at strategic level, though this isn't the case across all regions.

Case study

## VCSE Commissioning Frameworks

### Sussex ICS Commissioning Framework

Sussex VCSE Leader's Alliance (SVLA) has led the development of a VCSE Commissioning Framework, which aims to inform culture change in a transforming health and social care landscape.

The intention is that the framework is used as a tool by all partners to enable the VCSE in Sussex to be commissioned to deliver a wide range of health and care services that support and complement statutory and private sector service delivery.

The Commissioning Framework has been developed through a partnership between representatives of Sussex VCSE organisations, NHS Sussex commissioners, and local authority commissioners in Sussex during 2023.

Infrastructure providers, alliances and key leadership networks exist in each of the three places of Sussex (East and West Sussex and Brighton & Hove), liaising at varying levels on topics ranging from strategic development to grassroots delivery of support for the local community. They collaborate without formal structures to allow flexibility and partnership arrangements across county boundaries. VCSE organisations (small, medium and large) are connected at a Sussex level within the SVLA, which connects the VCSE sector at a system level with NHS Sussex through work programmes, including leading a cross sector partnership to develop the Commissioning Framework. The work is being overseen by a multi- agency Oversight Group and a dedicated VCSE task and finish group.

There was concern when the ICS came along that commissioning would become more distant from communities.

> **"We started to think "what does that look like? How can the VCSE communicate across the county with this new structure?""**

This was in an environment of existing concerns about inconsistencies and lack of flexibility in the way sector commissioning was done. A key question was how to engage smaller organisations who are not delivering across such a large geographical location.

The uncertainty of the environment, including reduced budgets and capacity, has led to a feeling of nervousness and uncertainty. Commissioners are often risk averse and are missing opportunities to commission the widest range of organisations.

**Key barriers for the VCSE to engage in commissioned services are:**

- Contract size – a scale of delivery which is often beyond the capacity of VCSE organisations to deliver.
- Participant requirements which are too onerous or beyond capacity (e.g. level of turnover or insurance levels).
- Conditions which have detrimental organisational consequences or increase risk (e.g. payment in arrears, high volume KPIs liked to payment, TUPE implications of some contracts).
- Processes that work against collaboration between providers, or which encourage collaboration that leads to inequitable treatment (such as prime contracting models).
- That approaches to measuring social value under existing contracting arrangements do not always capture the distinct social value VCSE organisations bring (eg the value of volunteering and volunteers).

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**There is therefore an understanding of the need to commission and procure differently. The exploration through the process of developing the framework has identified some critical areas:**

- Structurally embedding the VCSE in health commissioning, including a partnership approach, data sharing, investment in VCSE infrastructure that can operate at a strategic level, and processes which support provider collaboratives.

- A co-designed learning programme to support the transformation of relationships and drive the implementation of recommendations on practice in the framework.

- A combination of funding types is critical to cultivating a wide provider base and commissioning should be open to the use of grant funding. In addition, to one-off small grants, a more strategic approach to commissioning could be developed in partnership with the VCSE sector to offer a range of grant funding. Examples could include strategic grants, development grants, core funding and targeted grants.

- Contract tendering processes should be made more accessible, including: providing reasonable application timescales, contract duration, eligibility and award criteria, payment models, balance of risk, clear language, and proportionate monitoring processes.

- Co-design and co-production should be key underpinning processes which distribute power and risk across relationships placing equal value on different kinds of knowledge, including lived experience. Within this context it was acknowledged that the VCSE sector is key to engaging local communities. Co-production should include decommissioning; decisions often not taken with partners, whether changing a service specification or discontinuing a service.

- Social value was recognised as being intrinsic to the work of the VCSE and fundamental to the fabric of those organisations, but that social value may not always manifest or be communicated in ways that commissioners are familiar with. It was identified that training was needed in this area, cross-sector, to inform discussion and decisions that move beyond legislation and limited definitions of social value.

## Resources

### Time

Short notice in terms of tender windows often prohibits smaller organisations and those new to contracting from engaging with opportunities. Last minute and overdue funding decisions, often coupled with long scrutiny periods and ineffectual cross-department working, can put organisations of all sizes on the back foot in terms of quality service delivery, staffing and cash flow.

Increasingly tight capacity and staffing at local authority and NHS level continue to prevent collaborative commissioning and timely processes.

Smaller organisations are limited in their capacity to develop the complex governance and data expectations to access health contracts.

## The role of small providers

Case study

### Creative Sustainability (Gloucestershire)

Creative Sustainability CIC was established in 2010, driven by three local people with an ambition to develop project activity with a local focus. The activity areas were diverse with ambitions including urban farming, sustainable energy in schools and nature-based activities for disabled young people.

This led to the development of an organisation which was primarily values-led as opposed to services-led. The common values across all activity areas were established as empowerment, sustainability and inclusion.

The organisation has since grown and now employs twenty people. Volunteers support activities but the organisation is not reliant upon them to run. Turnover is now £500k plus and they have been able to maintain that level since 2019.

Over 50% of their income is made up of public sector contracts with the remainder coming from lottery, trusts & foundations, and earned income. They can be managing between 10 and 20 sources of finance at any one time. They have successfully delivered contract funded work in areas including support for: people in recovery after a stroke ; young people with autistic traits; disabled young people; people with mental health problems; and for Gloucestershire' s youth voice and climate action. All of these are underpinned by health and wellbeing outcome ambitions.

Contract values range between £10k and £160k. Different size contracts present different challenges. Smaller contracts require disproportionate time and effort needed to apply, manage and report on them and lack of security this gives to staff, along with lack of an adequate contribution to overheads. Larger contracts however bring a higher burden of risk which can be hard to manage.

However, keeping the money flowing from multiple pots lowers the risk for Creative Sustainability, if any source is withdrawn or comes to an end.

One challenging example has been the recent Shared Prosperity Fund (SPF) funded initiative overseen by the district council. This would not pay providers until funds had been received from the government, so VCSE organisations were asked to take on the risk of starting their project without payment. The first year of SPF funding was disbursed in the second year of the programme, and for the second year it was three months late.

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In another recent Department for Work and Pensions contract, quarterly payment was target driven, and the 18 month the contract could be terminated with one month's notice and staff employed specifically for this project would be left without funding. Creative Sustainability is challenging contracts being managed in a similar way by public sector bodies, including Local Authority and NHS, and working with their community sector partners to ensure collaborations and partnerships have better practices embedded in consortium bids for tenders. Local authorities arrange tenders in large lots that require very established organisations and scale to manage, and historically these have not delivered effectively for people and communities. Combined with the challenges of delivering across a large geographical county with urban centres and sparsely populated areas, this can result in resources being used on paths of least resistance rather than where they are most needed. The challenge for a smaller provider like Creative Sustainability is to get a seat at the table, to be able to shape delivery and associated appropriate resource for smaller providers.

This uncertainty has led to a more direct and targeted approach with commissioners, and better communication of their mission, outcomes and participants' needs more widely. Creative Sustainability's growing reputation in the county is leading to direct approaches from both large community organisations and commissioners, and being invited to be part of decision making processes. They are aiming to influence on proportionate applications and reporting, as well as expectations of delivery against funding, and to enable better shared understanding of the VCSE by local authority commissioners and the county's Integrated Locality Partnership, including the need for full cost recovery on all funding.

Creative Sustainability also describe a situation locally of tension between the political right and left which creates uncertainty – a drive to outsource against a drive for councils to deliver services directly. They describe the need for a strong local infrastructure at both a district and county level to properly represent the needs of the sector and ensure resources go where they are most needed, equitably and inclusively for those with the least power and unheard voices.

Creative Sustainability remains a small organisation in the public sector contract ecosystem, meaning the CEO and administrator cover all management functions – finance, HR, strategy, business development and fundraising. It is therefore highly challenging to continue to drive organisational change in this context and decide whether to take the risk of investing in staff to undertake fundraising activity or to develop a pipeline of new opportunities.

To overcome the challenges in the system, they would like to see more involvement in shaping where the money is going and ensuring they get the financial support needed to participate properly in that process.

> **"We need more capacity to work on making this change – a strategic development grant would enable us to spend more time and energy on system change, to take the next jump towards becoming an infrastructure organisation for our district."**

More facilitated conversations between commissioners and providers would be very welcome and enable contract opportunities to be shaped and guided for more mutual satisfaction. In addition for more shared formative learning and evaluation that influenced delivery, would be extremely useful, giving all partners a more realistic, useful and true understanding of what can be achieved with resources.

## Funding

Reduced funding in contracts and for services more broadly, including annual uplifts not built in at a time when demand for services is increasing, is a significant barrier for VCSE organisations with a commitment to delivering quality, impactful services.

Many groups reported local contracts to which no tenders had been submitted due to perceptions that they were 'undeliverable'. Many groups identified challenges with building in full-cost recovery, particularly with the possibility of being undercut by low-cost, lower-quality tenders.

Funding in arears is a significant barrier for many smaller groups and has cashflow implications for providers of all sizes. Many VCSE groups and health system colleagues reflected that it is quite typical for community organisations to lack the liquidity required to cover upfront delivery costs. This isn't an indication of financial unsustainability, but rather part and parcel of the nature of VCSE funding landscapes.

In many areas, local authorities are the main distributors of health funding, but due to their own reduced funding and capacity, contribute to slow and late distribution of payments.

A small number of large contracts increases risk for the contracting authority as well as the contract holder. It prevents smaller groups from contributing to the provider market; groups who are best placed to reach those who most need support and are experts in preventative work.

## Sustainability

Time, capacity and funding has a considerable effect on the ability of the sector to develop and maintain a strong workforce who can deliver quality and sustainable services. Short-term contracts, late decisions and delayed contract payments compound the problem, as does a lack of funding for "core costs" for the sector.

Putting VCSE organisations on the back foot financially has a detrimental effect on leadership in the sector. These individuals can be caught in a "hamster-wheel" to counteract this financial uncertainty, taking them away from other important operational and strategic priorities.

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Whether or not the Additional Roles Reimbursement Scheme (ARRS) will be extended beyond March 2024 is an example of financial uncertainty for the sector, which was raised by many of the groups. ARRS was introduced in England in 2019 to enable Primary Care Networks (PCNs) to claim reimbursement for the salaries (and some on-costs) of 17 roles within multidisciplinary teams. 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, in roles such as Social Prescribing Link Worker and Health and Wellbeing Coach.

Contracting authorities are working with increasingly reduced budgets and, although not all, many seem open "doing things differently". However, the challenge of allocating resources to exploring what that could look like is hard won when capacity is so stretched.

## Process and structure

### Health system structure

As outlined above, understanding where health budgets sit and how they're being distributed can be hard to navigate, with variation in structure, ethos and mechanisms across ICBs, NHS England and local authorities.

Groups report that there can be a real difference in culture as to whether councils perceive themselves, or external providers, as being best placed to deliver particular services.

Commissioning boundaries can be unaligned to the geographical boundaries of communities and the organisations serving them. This means that although a group has significant expertise and relationships in a particular district, they might not be best placed to deliver wider than that. Whether commissioning is happening at the "system level" via the ICB, or the subsidiarity principle - that as many decisions as possible should be taken at the most local level possible - means it has been devolved to the "place level", it can still be happening on a much larger footprint than the work being delivered 'on the ground'.

### Contract types and terms

Contract terms can be inconsistently implemented and disproportionately onerous to the amount of funding available. Many groups mentioned stock terms and conditions being implemented across contracts of vastly different sizes. The expectations around data governance for instance, were regularly mentioned as considerable pieces of work to undertake in order to be "contract ready", putting much health funding out of reach for smaller providers.

A number of smaller groups described the challenge of working in consortiums with larger providers where negligible delivery costs have been allocated; they aren't large enough to tender for the contracts on their own, but aren't allocated enough in partnerships to deliver packages of work the way it needs to be.

### Social value

Social value is routinely flagged up as a challenge for the VCSE sector, with many groups citing that it isn't always clear what the expectation is or how it can be measured.

Social value is intrinsic to the VCSE sector; delivering social value is inbuilt into the fabric of VCSE organisations. But groups might not highlight or communicate the value in ways that commissioners are familiar with. Equally,

existing contract arrangements might not capture the types of value that VCSE organisations provide. For instance, apprenticeships aren't suitable due to the size or scope of many smaller providers, and the added value of volunteering is often not measured.

### Grants vs contracts

The mechanisms for distributing funding, via grants or contracts, was a key theme in the workshops. Grants can provide VCSE organisations with more autonomy in terms of innovation and provide real opportunities to develop test and learn approaches. Contracts can provide greater stability, helping organisations to grow their sustainability. The importance of using both mechanisms according to delivery need is critical and many groups noted that there can be a lack of confidence in implementing these flexibly. The overuse of contracts can in fact stifle the innovation that VCSE organisations offer.

## Data, governance, and monitoring and evaluation

### Data sets and data sharing

VCSE and health partners can focus on different measures of impact and use varying terminology, data points and methods of analysis. Considerable work is being undertaken to create a common data set for the whole system, though until that happens expectations for the sector to demonstrate impact can often be unclear.

There can be preferential differences between health systems and VCSE organisations on the use of quantitative and qualitative data use. While case studies are often accepted by health partners, they might not be integrated into health data sets or given as much weight. Not all case studies move beyond

the anecdotal to making the broader case about VCSE interventions and the wider determinants of health.

Dataflow into and out of the health system into communities is being done well in small pockets, though not across the board. Many VCSE organisations need to access secure ethernets or in-person at sites with servers in order to report data into health systems. In many cases, community-health collaborations result in elaborate and time-consuming reporting in multiple locations because reporting and data collection for the two partners is unaligned.

Smaller VCSE organisations report that they are unsure as to where they can access relevant health data, which is crucial to them aligning their work with health priorities.

## Governance

The "start-up" resource requirement to get governance "contract-ready" is often not funded. While the majority of VCSE organisations have either formal or informal policies and procedures in place for finance, HR, safeguarding and health and safety, they may not meet the level of expected detail set out in procurement processes.

Developing the requisite detail on this, particularly on cyber security, delegation of authority, codes of conduct and unfair dismissal, takes considerable time for smaller groups who don't have a delegated member of staff to develop and monitor, ultimately taking their time away from service development and delivery.

## Risk

Perceptions of risk for both VCSE organisations and health commissioning authorities was identified as a key theme in the workshops, particularly as a barrier to innovation.

Many VCSE groups discussed the challenges of lengthy and onerous tender processes, target-based payments, payments in arrears and late payments as being potential sources of risk. Health partners identified the challenge of building trust with smaller "unknown" providers, when time and capacity is at a premium, as well as the scope for engagement and co-produced commissioning with the VCSE sector in terms of the rules around fair market engagement.

One group identified a co-produced commissioning process in which they helped to shape the specification, but when they weren't listed as a named partner, felt that they had relinquished valuable intellectual property and ultimately their competitive edge.

# 3.

# Getting health system ready

Building on our workshop findings, we have developed the following recommendations for VCSE organisations to help navigate health system funding.

## A strong strategic plan

Vision and values are central to quality VCSE service development and delivery. Theory of change approaches, which place need and impact at the forefront, ensure that delivery remains person-focused, rather than "service-focused".

Developing an organisational strategy requires time and capacity, but empowers VCSE organisations to make decisions about which funding to pursue and the confidence to let others pass by. Many groups reported that they had a clear sense of an "ideal" contract size and length for what they want to deliver, which helped them identify realistic opportunities.

Having a clear understanding of the broader VCSE landscape and your organisation's work within it is critical to identifying opportunities for development and partnership working, as well as how to communicate that.

Being able to communicate how the services that are being delivered contribute to health system priorities, such as prevention and health inequalities, puts VCSE organisations in a strong position to advocate for funding.

Developing this core narrative for the organisation ahead of time as stock text that can be adapted, with a focus on community need, outputs and impact, enables groups to respond to tender opportunities at short notice.

## Strengthening internal processes and governance

Reviewing governance processes, including human resources, finance, volunteer management support, safeguarding, health and safety, cyber-security and data-protection (GDPR), is a required part of accessing health contracts. Groups reported that formalising these policies and procedures takes time, but that guidance from expert sources (such as local infrastructure organisations, larger VCSE providers, or paid-for specialists) helps to streamline the process.

Linking these policies and procedures to a central risk register and allocating leads for key areas of work were noted amongst good practice, to reinforce quality service delivery.

## A mixed portfolio of income streams

VCSE organisations know that a diverse range of income streams is critical to sustainability. Groups noted the risks identified with becoming overly dependent upon one source of income, particularly when engaging with contracts that can be cancelled if funding runs out or targets aren't met.

A mixture of grant and contract funding was identified as critical for developing innovative solutions and sustainable, long-term delivery. A number of groups identified that contracts funded from pooled budgets, across health and public health for instance, helped to support sustainable delivery, particularly when extended funding was required.

Groups noted that having a clear sense of the type of funding (grant or contract), scale of delivery and funding required in order to best deliver service

objectives, was important to avoiding mission drift.

## Engaging with the health system

Developing that clear understanding of the value that individual VCSE organisations offer to health systems is a key first step: the value of hyper-local service delivery, the rich network of established relationships and trust that VCSE organisations have, all of which are critical to creating long-term change and to address health inequalities.

Communicating this value using "health-facing" language such as "prevention" and "early intervention", the "wider determinants of health", and aligning with health priorities such as CORE20PLUS5 is important. In many instances groups identified that further clarification is often needed on definition of terms, and there is scope for real co-production in terms of developing a better shared understanding on these between health systems and the VCSE sector.

Understanding individual ICS processes and structures also takes time, but is critical to identifying the key stakeholders and developing these relationships into trusted partners and champions for the VCSE sector. VCSE Alliances are a key means to do this, so it is important to find out who they are and get connected.

Engaging with commissioners early on, to contribute to the spec before it goes out to tender, often provides organisations with the greatest opportunity to affect change. Having those relationships in place is critical to achieving this; knowing who the health system champions are to advocate behind the scenes and to steer health colleagues towards you when they are ready to engage.

## Exploring collective action

The importance of a strong VCSE ecosystem was identified as critical not only to the delivery of quality, impactful, person-focused services, but also the health, success and strength of the individual organisations that contribute to a diverse and robust provider market.

Opportunities for collaborating with smaller and larger providers to access health funding, particularly to access larger contracts, is a real strength of the VCSE sector. Groups outlined the many ways in which smaller and larger VCSE organisations each provide key pieces of the overall "jigsaw".

As above, VCSE Alliances are a crucial first port of call, and there will be a range of other local VCSE networks, such as VCSE leaders networks and Community Anchor Networks. These provide opportunities for networking and developing partnerships, for sharing knowledge and expertise, to strengthen collective action, and to act as a conduit for health partners, commissioners and other potential partners.

Identifying the skills, knowledge and expertise in your own organisations as well as those that could further enhance your work was noted as the first key step. Identifying the key strengths of potential partners, working to build trust and shared goals with these groups ahead of time, creates the foundation needed for open and robust discussion and working. This trust and transparency is central to being able to have honest and challenging conversations, as well as managing and sharing risk. Groups noted the importance of being able to be open about areas that need strengthening as critical to collaboration, in terms of ensuring strategies are put in place to balance this risk, as well as developing strategies for development and sustainability.

KEY

By establishing these relationships ahead of time, co-production can be achieved early on in consortium building. Groups identified that understanding the value of all contributing partners is central to a strong collaboration, as is strong leadership to hold space throughout the process for the range of voices and expertise to shape the project. Ensuring that smaller providers can contribute to developing tenders from the earliest point ensures that the detail needed to budget for quality delivery is central to the proposal.

Case study

## Partnership and Consortia Bids

### CB Plus

CB Plus is an independent infrastructure and community development organisation operating within London. It was originally a Council for Voluntary Services established in 1979 serving predominantly the London Borough of Barnet. They now provide services across London including Barnet, Brent, Enfield, Hillingdon, and Newham.

They deliver a broad range of services including those funded by local authorities, ICBs and Lottery funders. An example is Barnet Wellbeing Service, a mental health service commissioned by North Central London ICS with additional funding from other sources. CB Plus is the lead contractor and manages a partnership of community organisations with expertise in mental health. The Wellbeing Service provides a wellbeing hub (physical space enabling the co-location of multiple services) and through this supports residents with emerging or complex mental health conditions, including asylum seekers, young people and those in need of befriending. Their regular events connect residents, statutory services and medical/clinical staff.

As a larger provider, they provide support to smaller partners with less capacity. CB Plus believes that the basis for any partnership is both an understanding of the needs of the community alongside an understanding of the value which each partner brings – the mix of expertise, skills, knowledge, and experience.

Regular partner meetings and appropriate lead-in time are critical to a successful partnership. These create space for relationships to develop in a way which enhances delivery. Networking can be a starting point, and provides a foundation for a future collaborative relationship, allowing a quick, direct route, to establishing a consortium when opportunities emerge. CB Plus's origins and experience as an infrastructure support organisation for the sector enables them to support this process.

> **"You might not feel like things are moving on, but relationships get stronger and healthier, the partnership becomes more resilient, and everyone knows what is happening on the ground. Understanding the small details and nuances is critical to building that trust and operational working."**

Having techniques and structures in place to help partnerships manage disagreements and conflict is also important. Delivering together in a transparent way, where all partners understand what each is doing helps to prevent conflict, and can enable open and honest conversations to take place when needed.

Those leading on collaborative contract delivery processes are often perceived to hold the power, but as lead organisations, they often have significantly greater responsibilities and effectively act as a guarantor for the other partners.

KEY

Therefore, having frank conversations about potential weaknesses or risks, enables all parties to build trust and have the confidence to engage.

CB Plus identifies that a blend of partners, a combination of local community-based organisations with expertise, pre-existing relationships and local bases, working alongside organisations with specific specialisms, can create a strong offer to commissioners.

Commissioners are facing significant challenges in the current environment with reducing budgets and increasing demand, particularly in relation to services focussed upon early intervention. In response to this, many commissioners have created larger contract values. Without collaboration, many smaller providers would completely miss out or the contract would no longer be delivered by the VCSE.

The broader knowledge and skills to be developed for partners through collaboration is also significant:

> **"It's like going on an MBA for the charities sector. You just absorb and learn from your partners."**

CB Plus identify their value as a "go-between" – a conduit between the sector and commissioners, and a vehicle which supports wider sector development. CB Plus believes they have played a valuable role creating understanding among partners about the importance of reporting performance. This is often in the context of being asked by commissioners to provide data and insight, which are outside the original terms of the contract, or while liaising with partners who want to push back on requests.

> **"Sometimes there can be confusion about the onerous reporting burden and frustrations such as "why don't they trust us?". We can take the time to explain the value of these requirements and help to develop tools that make them more proportionate to the group's resources... We know groups often feel like pushing back on these requests - which might risk the relationship or funding - so we can help with that."**

Engaging with partners throughout all stages of the process is critical to a successful partnership. For that reason CB Plus encourages involvement by prospective partners at an early stage, which can include attending provider engagement events with commissioners alongside other market engagement and service design activities. This is not simply about doing the right thing by those partners. It also recognises the value that those delivering can bring to those early-stage development processes.

Partnership also represents an opportunity for capacity building, supporting smaller organisations on a development journey, which could enable them to deliver contracts independently in the future. CB Plus developed a consortium of five small organisations, supporting racialised communities. Together, they achieved a Lottery grant, through which staff and volunteers are trained in mental health services that are now provided for communities who did not have access previously to culturally sensitive support. Larger VCSE organisations often have generous leadership and a commitment to building sector capacity because they recognise the strength to be gained from collective action.

CB Plus faces a challenging commissioning environment. There is a feeling that the structure of health commissioning has not caught up with the narrative of co-production and integrated delivery. And procurement processes do not always strike the right balance between quality and cost. But there is reason for optimism, with commissioners who have the vision of what a good community-based services look like, and local partners who are developing strong collaborative relationships.

# 4.

# Working strategically to influence health systems and create change

As well as trying to be as effective as possible in the system we have, there is also an important role for VCSE organisations to positively shape future direction.

Below we set out a number of ways VCSE organisations can seek to influence from the ground up.

## Advocating for change

### Flexible and inclusive commissioning

A mixture of funding types is critical to supporting a healthy provider ecosystem, which draws on the strengths of the whole VCSE sector. Appropriate funding opportunities to support test and learn approaches are integral to the overall funding picture, as are grants and contracts which support the sector with strategy and development, infrastructure, and overheads.

The VCSE sector is well placed to help identify how these budgets can be distributed to greatest effect.

Pooled budgets between ICBs, public health and the NHS were noted as a key way to share expertise and risk, creating a system-wide climate of collaboration and providing a robust framework to creating wrap-around, person-centred commissioning, and to address intersecting wider determinants of health.

Open conversations about quality and cost are desperately needed to address long-term, entrenched health inequalities. Many groups reported "short-term thinking" in the tender process, with a higher weighting afforded to cost rather than quality. Without a robust conversation and assessment as to the long-term cost of funding cheaper tenders, the VCSE and health systems will be hamstrung in realising their potential to create meaningful, long-term change. All providers need to be able to factor in full-cost recovery to achieve sustainable delivery.

Greater clarity on the expectations on social value, and further thinking to expand the ways in which this can be measured and accounted for by the VCSE sector, is also needed. Cross-sector collaboration is needed to drive this further, with resource support and training to embed new practice.

### Contracts that support growth and sustainability

A range of contract sizes with proportionate contract governance expectations are needed to support quality, hyper-local delivery. Consideration of and alignment to relevant geographical footprints of the target demographics and provider market, rather than to commissioning authority boundaries, would increase engagement with a wider range of providers.

Longer-term funding would enable providers to align their long-term strategies for addressing entrenched health inequalities with health system funding, supporting sustainable, consistent, quality delivery, as well as maintaining a quality workforce.

Further conversation is needed to develop flexible payment models which acknowledge the risk of funding for outcomes for the sector and the barriers which payments in arrears provide.

Many groups reported the common usage of "stock" contracts which are applied to much larger commercial tenders and much smaller public health contracts indiscriminately. Proportionate contracting, tailored to the target demographic and provider, would transform the ability of many VCSE organisations to engage with health funding.

### Proportionate data, monitoring and evaluation, and governance

A shared, and co-produced understanding of the data required by all partners to measure impact and drive quality service delivery, as well as the mechanisms and frameworks to capture these.

Systems and software are needed which enable communities and the VCSE to feed data into health systems that inform their working, resource allocation and strategic direction setting.

A broader conversation is underway to align VCSE and health systems on data. VCSE organisations need to be part of shaping how these processes operate, not only to ensure that health systems are able to draw on the critical insights from communities and the sector, but also to enable VCSE organisations to align this data capture and analysis with their own theory of change and broader organisational delivery and impact.

Resource investment will support a wider range of providers to develop the governance, policies and procedures which will enable them to support the delivery of health contracts. The role of these smaller organisations who provide hyper-local delivery is key to delivering effective services which address the wider determinants of health.

## Data, governance, and monitoring and evaluation

Case study

### Barca-Leeds

Barca-Leeds is a large, well-established, charity with its origins in the Bramley community of Leeds. It delivers across three main areas of work: children and families; complex health and housing; community and employability.

In the last financial year it had a turnover of over £5m and has significant experience of health-related contract delivery, including as working as part of large delivery consortia.

Barca is a large and complex organisation with many examples of partnership and cross matrix working in health commissioning. The examples within this case study focus specifically on experiences with Children and Families services.

Barca identify real benefits of jointly commissioned and delivered activities. These include increased connectivity between partners, more opportunities for shared learning, and shared budget responsibility.

> **"This creates the best of both worlds: local and economy of scale. If done well…"**

### Example one – health commissioning

Barca are one of three preferred providers commissioned to deliver a Children and Health contract. Each provider has an independent contract, with monitoring undertaken directly by the ICB. And although there is some alignment on outcome measures between providers, there are also some differences. Under this contract, "top-ups" can be given for people who require more in-depth support which is managed differently within each service delivery area. Data gathering processes don't always capture this nuance.

At the start of the contract, providers met with the ICB separately. However, within the last year the ICB has been

successful in bringing providers together to ensure both they and commissioners benefit from shared learning and create more consistency in data monitoring. This process has been strengthened by an NHS England grant linked to addressing health inequalities, which has enabled the best methodology on data management and data sets to be explored, and for the collective learning process underpinning this to be better coordinated. Barca identify that these "test and learn" grants are extremely valuable in influencing and improving contract delivery.


A challenge in relation to delivering any NHS-funded contract is that dataflow to the NHS has to happen in a particular way. They currently use the MYMUP database, which the NHS has invested in to support provider use. It was only meant to be a temporary stopgap with a longer-term ambition to move on to MOSAIC (used by many local authorities); the hope being that this would be more usable for everyone. However, this has never been achieved due to governance challenges.

### Example two – learning from local authority commissioning

A Leeds City Council youth work contract, demonstrates some of the benefits of working at scale. Barca currently works with nine partners to deliver under three separate contracts – East, West, and South Leeds. They do not deliver across the whole city, but this structure ensures that delivery takes place in every geography.

A key aspect of this jointly commissioned activity is the centralising of data collection and monitoring and evaluation processes. This consortia approach enabled smaller delivery partners to work on this contract, through providing support with accessing data management systems and through Barca as a larger organisation having the resources to carry the majority of the risk associated with contract governance (i.e. Barca have a quality assurance officer with capacity to manage IT security requirement), often a challenging element of delivery. This collaboration brings coherence to data reporting, developing narrative alongside quantitative reporting, better linking their work to the wider determinants of health.

Challenges can remain in demonstrating the impact of their work in line with NHS requirements. For example, "reduced attendance at GPs" - current understanding of this is based upon self-reporting by beneficiaries rather than being objectively documented by the GPs or public sector.

### Knowledge and learning

Conversation pre and post commissioning has been important to the tendering process; it has helped match clinical language with VCSE language; helped the ICB and Barca/VCSE partners better share resources and find solutions; and set realistic expectations to meeting

data and governance requirements. For example, at Barca some services have access to NHS systems while others have ICB commissioned databases that flow data to NHS Digital. However, it does showcase that solutions can be found.

A particularly challenging issue when trying to form partnerships is how to make them feel equal when one organisation is leading. This often entails driving the performance of other providers and collecting management data. Barca identify that equality comes not in the roles, but in the perception and esteem in which organisations hold each other.

Practical methods to achieve this include making co-production central from the start, creating spaces for everyone to contribute and make decisions collectively. Barca identify the need for a shared values base, with the lead partner working to establish this early and embed it in the way the partnership works. This is not always easy when faced with tight timescales linked to the way services are commissioned.

Overall, partnership working is a complex and challenging area, particularly when organisations pivot between being sometimes partners, and sometimes competitors. However, Barca believes strongly in the benefits of partnership working and how as a larger organisation they can play a key role in demystifying and supporting access to contract opportunities for smaller providers.

## Representation and co-production

There could be greater VCSE representation on strategic boards, including voting rights and commensurate resourcing to support sustainable, quality contributions.

The breadth of expertise across the VCSE sector continues to be under-utilised by health systems. The process of integrating care systems has considerably moved practice forward but in many cases VCSE representation on strategic boards is limited to one space, and in many cases without voting rights.

Resources are needed to support quality collaboration; VCSE networks and alliances to support elected representatives with the challenges of representation as well as the two-way flow of information and advocacy on behalf of a complex and multitudinous sector need investment in order to maximise their potential.

Opportunities to co-produce the commissioning of services, and VCSE representation on funding and evaluation panels are further examples to draw on sector expertise and facilitate cross-sector learning.

## The role of collective VCSE action

Working collectively in alliances and networks provides opportunities for developing partnerships, sharing knowledge and expertise, strengthening collective action, and can provide a centralised point of contact for health partners, commissioners and other potential stakeholders.

Forums and alliances enable VCSE organisations to share learning and identify and shape the key sector messages collaboratively, including identifying who the best representatives and "messengers" are.

Placing equal value on different kinds of knowledge and lived experience is a key strength of the VCSE sector. There are very many examples of strong sector leadership, who help to ensure there are spaces and places for organisations of all shapes and sizes to contribute to broader strategic work on service

design and delivery. Quality consortium building requires a commitment to equal partnership, regardless of each organisation's size; that each's contributions are equally valued and integral to the health of the whole.

They provide an important role in identifying the key areas that could be collectivised across the sector, such as training, data capture and impact analysis, risk management, governance and other infrastructure considerations.

Applying for funding as alliances or consortiums, enables VCSE organisations to maximise this infrastructure development, as well as sharing the risk and resource burden between a wider group.

VCSE Alliances are embedded within ICSs and as discussed represent a key means for collective influence. However, in general, VCSE infrastructure provision varies widely from region to region, and where there is not a CVS or community anchor providing that function, networks are exploring alternative options for representation and advocacy, and alternative conduits for facilitating the flow of funding into communities (such as "special purpose vehicles").

Critically, they enable the sector to develop a stronger evidence base for the collective impact of the sector on the wider determinants of health, health inequalities and the prevention agenda more broadly.

By pooling this learning, VCSE organisations are identifying opportunities for innovation, with a view to supporting the health system by accessing novel approaches to cross-department funding (such as housing and health; green spaces and health).

In many areas this work is being developed as part of a case for social return on investment, as comparative to the cost of clinical interventions (particularly at the point of acute care).

## 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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