**From:** Roger Gough **–** Cabinet Member for Education and Health Reform

**To:** Kent Health and Wellbeing Board -

**Subject:** Developing the relationship between Kent's Health and Wellbeing Board and the VCS

**Status:** Unclassified


**Summary:**

The Kent Health and Wellbeing board previously raised the question as to whether it should be developing its relationship with the VCS (Voluntary and Community Sector) in Kent. Since then the review of the local health and wellbeing boards has also raised the issue of representation and developing the relationship with the VCS at a local level.

Similarly KCC has been reviewing its strategic relationship with the sector in the future and nationally the role of the VCS sector in supporting communities and individuals has been increasingly debated over the past few years. This report sets out a number of considerations for the Kent Health and Wellbeing Board (KHWB) in regards to developing its future relationship with the Kent VCS.

**Recommendation(s)**:

The Health and Wellbeing Board is asked to:

1) Comment on the content of the report

2) Consider the options for the board's strategic and local relationship with the VCS and identify next steps


## 1. Introduction:

1.1 The review of the local boards has provided an opportunity to consider the future relationship with the VCS. This report is intended to begin the conversation about how the boards can utilise their cover across a range of services and partner organisations to develop their relationship with the sector, which goes beyond service and organisational boundaries to sharing best practice and intelligence to the benefit of stakeholders and communities.

1.2 Whilst there is clearly a vital role for the VCS to play in improving the health and wellbeing of Kent's residents, we know that the majority of VCS organisations in Kent do not have a direct relationship with public sector agencies. They are not funded by the public sector to provide services but are focused on their own mission, supported by other means and driven by the needs of communities and residents.

1.3 KCC has recently developed a VCS policy, which has been informed by an in-depth 12 week consultation with the sector. Whilst the policy specifically

sets out KCC's corporate relationship with the sector in the future, some parallels can be drawn and it perhaps provides useful context for the board's discussion about its own relationship with the VCS. Equally partners around the HWB table are likely to be reviewing or re-establishing relationships with the VCS in response to changing conditions and new models of care.

1.4 A key driver of KCC's policy is that its future relationship with the sector must focus not only on those organisations it commissions but must increasingly recognise the need for a collaborative relationship with the wider sector. Similarly the infrastructure support KCC provides to the sector must ensure it continues to thrive; providing opportunities for the sector to skill share, access funding advice and business support. A criticism from the sector itself has been that KCC has had an overly paternalistic relationship with the VCS and in the future this should be one built on equal partnerships. A relationship predominantly based around funding has led to our engagement being focused on a relatively small number of organisations perhaps at the detriment of accessing the vast amounts of intelligence the wider sector holds and inadvertently limiting our view of the innovation across a vast array of organisations.

1.5 This report is intended to be a 'think-piece' to begin the Kent and local health and wellbeing boards consideration of how they develop their relationship with the VCS, what relationships are most important and how best to achieve it.

## 2. National context

2.1 The Voluntary sector nationally plays a central role in the delivery of health and social care services, The Kings Fund stated in its 2011 report entitled *'The voluntary and community sector in health- the implications of the NHS reforms'* that "The statutory sector spends £3.39 billion on health services provided by voluntary and community organisations (Clark et al 2010)[1]". Furthermore the role of the VCS in preventative services and the emphasis placed on 'social prescribing' by the Secretary of State has only increased the importance of GP's and CCG's in particular, developing a relationship with the voluntary and community sector. The Five Year Forward View is also clear that we need to design better ways for the VCS to work alongside the NHS and to engage communities and citizens in the future of health care.

2.2 A recent review commissioned by Public Health England, the Department of Health and NHS England which has been led by an advisory group including representatives from the VCSE sector, is looking into the role of the sector in health and care and the current state of collaboration and partnership working. In its interim report it has stated that the current approach to partnering, funding and commissioning the VCSE sector are not creating an environment in which better health and wellbeing outcomes will be achieved. Particular issues were also highlighted around short term funding, with some organisations feeling that their work is seen as an add-on and therefore resourced with repeated short term funding. Whilst the role of the VCSE in improving health and wellbeing outcomes is recognised within policy, it is not consistently supported in practice and very often

[1] http://www.kingsfund.org.uk/sites/files/kf/Voluntary-and-community-sector-in-health-implications-NHS-reforms-The-Kings-Fund-june-2011_0.pdf

organisations do not feel they are treated as equal partners. Whilst effective funding is required, this alone will not improve health and wellbeing outcomes. This analysis is certainly replicated in the findings of KCC's consultation on its VCS policy and has informed the future relationship this sets out.

2.3 The role of the sector is not simply as a service provider and since the introduction of the Health and Wellbeing Boards the sector has been attempting to establish their relationship with the boards and its role in developing key documents such as the JSNA and JHWS. The local intelligence the sector can offer in terms of identifying local needs and gaps in provision has been often highlighted nationally but the extent to which this has been utilised has differed greatly and many in the sector would argue it is underused and underrepresented in the development of strategic priorities.

2.4 Regional Voices[2] was awarded funding from DoH to support effective VCS engagement with health and wellbeing boards; in the South East this is led by RAISE[3]. They work with the VCS by giving them up to date information on HWB'S and identifying ways of influencing the boards. They have developed a range of models for engaging the VCS on HWBs ranging from a single voice, to multiple representatives or sub groups which support the development of key documents such as the JSNA and health and wellbeing strategies.

2.5 A national survey by Regional voices in 2015[4] found that only 9% of respondents felt they were linked with the work of the HWB. Where there was representation from the VCS on the boards only 31% of respondents felt they were able to discuss the activity of the health and wellbeing board with the VCS representative and 42% of respondents did not feel that the VCS rep on the HWB was accountable to the wider sector. However VCS reps on the boards felt that they were able to influence the JSNA and JHWS so that it reflected community needs compared to the wider sector that did not.

## 3. The voluntary sector in Kent

3.1 There are approximately 4,658 registered charities active in Kent, of which, 3,631 operate at a local level[5]. 43% of these charities have an income under £10K.

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[2] Regional Voices are "are a voluntary sector Strategic Partner of the Department of Health, NHS England and Public Health England and work with other partners, supporting voluntary and community organisations to understand changes within the NHS and support organisations to influence these changes, in order to achieve better outcomes" *They support the voluntary sector to influence local strategic decision making in health and social care. http://www.regionalvoices.org/health-wellbeing*"

[3] RAISE aims to help the voluntary and community sector in the South East be as effective as possible. They provide information, advice, connections and practical ideas for voluntary and community organisations, particularly in the area of health and social care. RAISE collaborates with 8 other regional networks to form Regional Voices to build the capacity and capability of the voluntary and community sector to engage with the health and social care agenda and act as a critical friend to health decision-makers by providing a coordinated response to consultations and programmes

[4] http://www.regionalvoices.org/hwb-reps/survey

[5] NCVO and Big Society Data based on UK Civil Society Almanac definitions http://data.ncvo-vol.org.uk/areas/kent

3.2 In 2013/14 KCC's total spend with Kent based VCS organisations for the provision of services was £123m, (this does not include all grant funding). Whilst KCC is a significant funder of the VCS in Kent, District Councils and NHS partners equally provide significant investment into the local VCS. However public sector contributions to the sectors income as a whole should not be overestimated as nationally, income from individuals is the largest proportion of income for organisations of all sizes. For small organisations this is particularly significant with 56% of their income coming from individuals.

3.3 The sector brings in significant investment to Kent; research by NCVO and Big Society Web found that the 3142 charities in Kent[6] with a reported income have an income of £398.7m[7]. We should also not underestimate the sector as a significant employer, as well as the significant social and economic value of the many volunteers who provide the backbone to a range of VCS organisations. In 2012/13 the largest charities in Kent (those with an income greater than £500K) employed 6489 staff (FTE)[8]. In the same year these charities also had 11,386 volunteers within their organisations[9].

3.4 The largest group of charities in Kent fall within Education/Training with 1795 charities operating in this area[10]. The largest group of beneficiaries is Children and Young People with 1969 charities supporting these. 942 charities are supporting elderly and older people and 808 people with disabilities.

3.5 Housing Associations, (where registered charities) and NHS charities, whilst not considered in the general charities figures above, must also be recognised for the considerable role they play in supporting individuals and communities in Kent and the important relationship they have with a range of public sector partners. The future relationship with the VCS should consider the wider VCS in this context.

## 4. Current relationship with the VCS in Kent

4.1 At present the VCS is not represented on the KHWB. Nationally there has been some confusion about the role of Healthwatch in relation to the VCS with some boards believing that it represent the sector, however it is clear that its role is to promote and support the involvement of the public in the commissioning and provision of local services. Furthermore where VCS representatives are at the HWB table, the level of engagement of the wider sector still remains a challenge.

4.2 That said, many partners around the health and wellbeing board table have existing relationships with the VCS, although these are often specific to a service or geographical area and most often developed through a funding arrangement. What appears to be missing is a mechanism for the VCS to

[6] This is based on the "general charities" definition. This definition takes all registered charities as a base, but excludes certain categories of charity to produce a tighter definition. The general charities definition excludes independent schools, faith charities, those controlled by government and others.

[7] This total income figure is based on the latest income of charities in the population, so does not reflect the total income in one financial year http://data.ncvo-vol.org.uk/areas/kent/income

[8] http://data.ncvo-vol.org.uk/areas/kent/workforce Figures based on 103 charities who returned data

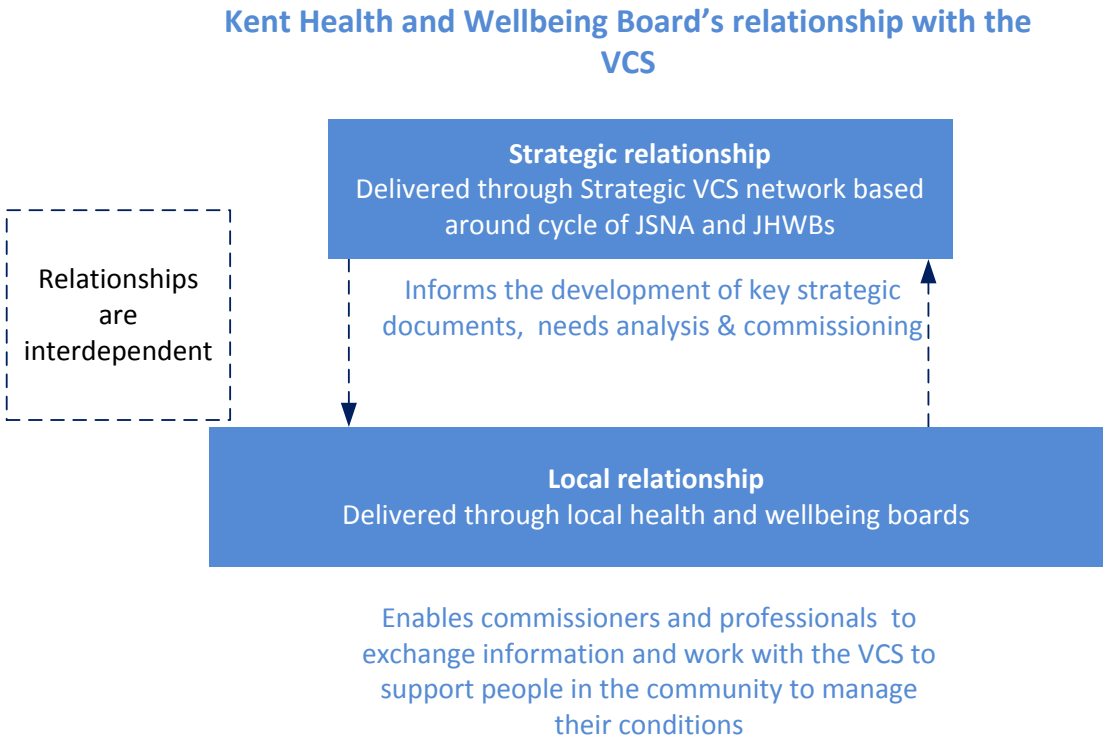
[9] http://data.ncvo-vol.org.uk/areas/kent/workforce. Charities are not required to record this, and measurement can be inconsistent, results should be treated with caution. Only 65 charities returned data on volunteers.

[10] NCVO and Big Society data http://data.ncvo.org.uk/areas/kent/classification

engage with public sector partners collectively or indeed a conscious decision as to whether such a mechanism is required, to establish an ongoing and mature relationship for the benefit of all stakeholders

4.3 The HWB does not need to duplicate relationships with the VCS where they already exist but a strategic relationship with the sector which helps to identify the needs of communities and assess the capacity of the sector, could be beneficial to all stakeholders around the health and wellbeing board table. Similarly at a local level developing a more in-depth understanding of the sectors ability to contribute to meeting the health and wellbeing needs of the population could be particularly beneficial.

## 5. Future relationship with the VCS




5.1 **Developing a strategic relationship- influencing local health and social care commissioning**
Whilst KCC has begun to address its strategic relationship with the VCS, the principle of moving towards a more collaborative relationship, where the VCS is recognised as a key strategic partner is one that could be equally developed across the HWB agenda.

5.2 The VCS whether funded by public sector agencies or not, plays an important role in the health and wellbeing of communities and perhaps more importantly because of its position rooted within local communities is a valuable source of knowledge about local needs and gaps in provision. Embedded in local communities, VCS organisations often play a role in demand management; supporting those who may otherwise require health or social services. Many of these organisations are likely to be micro or small in size however the impact of any of these organisations 'falling over' is likely to be significant to public sector organisations.

5.2 A better understanding of the VCS and how the sector contributes to the priorities of the KHWB could be both beneficial to stakeholders but through an ongoing dialogue could also provide the VCS with a better understanding of commissioning priorities. With a consistent criticism from the sector that there should be more information available about commissioning intentions and better market engagement, this is an area where arguably a future relationship should focus. In addition, an ongoing dialogue between the sector and the KHWB partners could enable the refinement of commissioning processes, to make them more accessible and where appropriate the development of grant funding pots where it is considered a more appropriate mechanism to meet identified needs.

5.3 However, representation at the KHWB perhaps falls short of forming a meaningful relationship between stakeholders at the board and the VCS; the sector is vast and in many ways is not one sector but a range of organisations which come together under the not-for-profit and charitable banner. To form a relationship with such a sector through one representative is perhaps unrealistic and the capacity in which the VCS would be represented would need consideration; if this is a commissioner provider relationship then providers more generally should be represented.

5.4 The establishment of a VCS network which could be opened up to a wide range of VCS organisations could be more effective if run alongside the cycle of reviewing the JHWS, the JSNA and setting strategic priorities of the KHWB. In this capacity the VCS relationship would be focused on identifying need, demand and the strategic 'system' issues rather than simply a funder, provider relationship. Furthermore a mechanism such as this would support the Terms of Reference of the Kent Health and Wellbeing Board *to develop and implement a communication and engagement strategy for the work of the HWB; outlining how the work of the HWB will reflect stakeholders' views and discharge its specific consultation and engagement duties (…).*

5.5 However, establishing a strategic relationship between the board and the VCS will only be successful if the local relationships and understanding of the VCS are also strengthened. Local networks will need to feed into the strategic overview of the Kent Board and arguably it is those local relationships which will be most important to commissioners given that most VCS organisations will not be pan Kent but embedded in local communities.

**5.6 Understanding and accessing the local VCS market**

Stakeholders from across District Councils, health, public health and social care have varying relationships and understanding of the local VCS sector and how it is supporting local communities and individuals. With increasing emphasis on people managing their own health, set out in the Five Year Forward View, clinicians will need to be able to work alongside and access the VCS to help support people to manage their own health and conditions.

5.7 Representation at the local health and wellbeing boards is perhaps a good mechanism for developing local intelligence and information exchange, however to date this has varied across the CCG areas, as identified in the recent review of local health and wellbeing boards. Furthermore the capacity in which VCS representatives attend the local boards needs to be clarified; ultimately representation at the board should be on behalf of the wider VCS with a responsibility to sharing information and acting as a

local conduit, if it is to be successful. Representation in this way could help to identify gaps in the market, unmet need and enable commissioners to develop local solutions to navigating the VCS sector and understanding the support available to patients/service users in their area. Development of this local relationship would also provide vital intelligence to feed into the strategic overview of the Kent Board.

5.8 Further consideration of Healthwatch is perhaps also required, with the possibility of establishing a more effective engagement mechanism between Healthwatch and the VCS. Whilst some work is being undertaken to identify a Healthwatch representative within VCS organisations arguably the interface between the two could be better articulated or formalised in the future.

**6. Conclusions:**

6.1 The review of the local health and wellbeing boards and the work which will evolve as a result has provided an opportunity to rethink the relationship with the VCS through both the Kent and Local Boards. Perhaps though a wider question for the board, that requires further consideration is the level of engagement boards should have with providers. If the VCS is to be engaged in this capacity then the debate will need to be broadened out.

6.2 However, representation on local boards could certainly provide the foundations for better local relationships with the VCS, as has been highlighted in the review of the local boards and could help to develop local solutions to navigating the vast array of services the VCS has to offer. However, the capacity in which VCS representatives attend local boards needs defining and the responsibility that representatives have in providing a conduit for information to the sector must be clearly set out for it to be an effective mechanism for engaging a diverse and changing sector.

6.3 Given the localised nature of the VCS and the subsequent diversity from one geographical area to the next, developing local networks and relationships will be vital. If issues of accessing the VCS and navigating through a complex but vitally important sector are not dealt with locally, then a strategic relationship will simply be another engagement mechanism without any real impact; that is unable to focus on the 'bigger picture' bogged down in the detail of local issues. However, developing a strategic relationship to run in parallel to local engagement would provide the Kent Board with intelligence on collective demand and pressures- aggregating locally held intelligence into a strategic view and an opportunity to share good practice.

6.4 The development of both a local and strategic VCS engagement mechanism is perhaps a timely piece of work to be taken forward given the recent review of the relationship between the local and Kent Board. As work to improve this evolves it would be pertinent to consider how a more developed and mature relationship with the VCS can further support the health and wellbeing agenda in Kent.

**7. Recommendation(s)**:

**The Health and Wellbeing Board is asked to:**

1) Comment on the content of the report

2) Consider the options for the board's strategic and local relationship with the VCS and identify next steps

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