

# THE VOLUNTARY AND COMMUNITY SECTOR IN HEALTH

## Implications of the proposed NHS reforms

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First published 2011 by The King's Fund

Charity registration number: 1126980

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ISBN: 978 1 85717 621 6

A catalogue record for this publication is available from the British Library

Available from:

The King's Fund  
11-13 Cavendish Square

London W1G 0AN

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[www.kingsfund.org.uk/publications](http://www.kingsfund.org.uk/publications)

Edited by Kathryn O'Neill

Typeset by Grasshopper Design Company

Printed in the UK by The King's Fund

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# Acknowledgements

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We would like to express our thanks to all those who have given their time to support this paper, especially those who participated in the expert seminar and those who kindly provided external peer review.

Particular thanks go to Sakthi Suriyaprakasam and Belinda Pratten for their role in developing the ideas behind this work and in helping to shape the paper.

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# Executive summary

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## Background

The government's health and social care White Paper and subsequent Health and Social Care Bill (House of Commons Bill 2010–11) set out clear aspirations for the voluntary and community sector as a provider of health services, a source of support for commissioning, and a partner in tackling health inequalities. However, the proposed reforms present a number of challenges and risks.

The sector already operates extensively within health and social care, with the statutory sector spending around £3.39 billion per year on health services provided by voluntary and community organisations. Many organisations engaged in health straddle health and social care and see themselves as vehicles for integration and co-ordination of care across boundaries. In addition to integration, many organisations see their key function as tackling health inequalities through facilitating greater access to services for people with complex needs.

The sector is known for its diversity and flexibility, and develops services to meet needs that are not being met by the statutory sector. The work of voluntary and community organisations is wide-ranging, but much of the focus is on upstream preventive and wellness support, as well as advocacy and signposting. As such, the sector is an important partner for the NHS in its quest to meet the Quality, Innovation, Productivity and Prevention (QIPP)<sup>1</sup> challenge, while offering personalised care and patient choice.

There are some uncertainties over what impact the Bill will have if implemented. The main challenges likely to arise for the voluntary and community sector are set out below, along with steps the sector itself should take if it is to effectively grasp the potential opportunities offered by the reforms.

## Operating in a competitive provider market

The Bill aims to create a diverse provider market for health care where NHS, private and voluntary organisations compete for contracts. However, new funding mechanisms, exacerbated by the financial climate, will leave many voluntary and community organisations vulnerable and create barriers to new entrants to the market. There is a risk that smaller organisations will be unable to compete on

<sup>1</sup> See: [www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm](http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm) for more on QIPP.

a level playing field, leaving the market dominated by a few large providers who may not have the trust of, or knowledge about, the local community. This would severely limit patient choice and competition.

- Existing sources of support for voluntary and community organisations at primary care trust (PCT) and local authority level are being cut as public sector budgets are squeezed. New sources of support need to be developed to ensure that the sector develops the skills it requires to be able to compete on equal terms.
- Funding mechanisms that recognise social value, as well as the fact that the sector does not have access to large reserves, are required if the sector is to be able to continue to innovate and compete, and if new organisations are to be able to enter the market.
- There is a need for training for commissioners on how best to work with voluntary and community organisations, as few have a good understanding of the sector. Training and guidance should build on best practice and capacity already developed by the Department of Health and PCTs.

There is also a need for clarity over Monitor's duty to prioritise competition, and whether this will take precedence over the need for collaboration. This distinction is of vital importance to many voluntary and community organisations, whose key aim is to work in partnership with others along complex pathways of care that require collaborative approaches.

- Monitor should adopt a nuanced approach that promotes both competition and collaboration so that the voluntary and community sector is able to collaborate and develop partnerships, both within the sector and with the NHS and private sector bodies.

## Supporting commissioning

The sector has been recognised in the Bill as a valuable source of knowledge about local populations and their needs. Health and wellbeing boards and GP consortia need to engage with the sector, particularly in the Joint Strategic Needs Assessment process. However, the Bill does not require GP consortia to engage with the sector.

- Voluntary and community organisations' knowledge of local populations and their needs should be recognised by commissioners, and their advice and support remunerated fairly. The NHS Commissioning Board's authorisation process should include a requirement for GP consortia to demonstrate that they have engaged with community groups.



- Health and wellbeing boards need to ensure that voluntary and community organisations' data and knowledge about local populations is accessed and used appropriately during the Joint Strategic Needs Assessment process.
- The voluntary and community sector needs to ensure that its data is available and accessible for use by health and wellbeing boards.

## Tackling health inequalities

Health and wellbeing boards and HealthWatch will be central to tackling health inequalities – a goal they share with many voluntary and community organisations. However, they have few powers to ensure that GP consortia address health inequalities in their commissioning plans.

- The duties on inequalities outlined for GP consortia need to be strengthened through the commissioning outcomes framework, to require them to pay due attention to these issues.
- Local authorities should be given equivalent duties to tackle inequalities in health so that local priorities are aligned.
- Health and wellbeing boards need stronger powers so that they can refer to the NHS Commissioning Board any GP consortia they believe are not paying sufficient attention to the Joint Strategic Needs Assessment.

There is a lack of clarity over whether GPs are responsible only for their registered lists or for a geographical area. One of the strengths of the voluntary and community sector is that it works with groups that are socially excluded or unwilling or unable to access statutory services, and this is key to tackling health inequalities.

- The Bill needs to specify that GP consortia have a direct duty to improve the health of the population in their area.
- Giving GPs clear responsibilities for the health of their population should ensure that the pressure to make immediate financial savings will not take precedence over longer-term, upstream investment.

## Managing the transition

As PCTs are dissolved, many voluntary and community organisations are rapidly losing their key contacts. GP consortia are embryonic organisations grappling with a range of new responsibilities and their own organisational development, so are unlikely to be able to offer support to the sector.

- The sector needs to rise to the challenge and grasp the opportunities by developing its leaders, actively addressing its development needs and overcoming its internal fragmentation.
- The sector urgently needs to find better ways of measuring and demonstrating its value to potential commissioners.
- Sufficient funding and support need to be made available for organisations within the sector to help them with the transition to new arrangements. Support could take the form of key contacts at local authority level to ensure that the sector is kept informed of changes as they happen.

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# Introduction

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The government's health and social care White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health 2010a), and the subsequent Health and Social Care Bill (House of Commons 2010–11) set out the most radical changes to the NHS since its formation in 1948. At the time of writing, the coalition government's 'pause' in the progress of the Bill in order that it may consider the concerns raised by a range of organisations and professionals, has just concluded.

There has been much debate about the Bill's impact on NHS staff and institutions, but far less focus on its impact on the voluntary and community sector (*see* Appendix 1 for definitions). As a substantial provider of health and social care and support, as well as a valuable partner to primary care trusts (PCTs) in commissioning and tackling health inequalities, the proposed reforms present a number of challenges and opportunities for the sector in the coming years. The King's Fund and the National Council for Voluntary Organisations (NCVO) held a joint expert seminar in November 2010 to discuss these issues, bringing together leaders from the NHS, local authorities, and voluntary and community sector organisations (*see* Appendix 2 for list of organisations represented at the seminar).

This paper discusses the potential impact of the proposed reforms as they have been presented in the White Paper and Bill in order to stimulate further debate and action at both a policy and practical level. While the pause and listening exercise is likely to result in some changes to the proposals, we believe that the broad vision and themes explored in this paper will remain important in the months and years ahead. We do not claim to offer a comprehensive summary of all the issues, but we do offer some recommendations for those in the voluntary and community sector, commissioners and policy-makers, as to how the transition to the new arrangements might best be approached.

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# Context

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## The sector's current involvement in health

The voluntary and community sector already operates extensively within health and social care. Just under a quarter (39,340) of England's 171,000 voluntary and community organisations are involved in the provision of adult health and/or social care and support services (Clark *et al* 2010). The statutory sector spends £3.39 billion on health services provided by voluntary and community organisations (Clark *et al* 2010). Many organisations engaged in health already straddle health and social care, and see themselves as vehicles for integration and co-ordination of care across boundaries. In addition to integration, many organisations see their key function as tackling health inequalities through facilitating greater access to services for marginalised groups and people with complex needs (The King's Fund and the Richmond Group of Charities 2010; *see also* information on the GlaxoSmithKline IMPACT Awards (The King's Fund 2011b) for examples of charities working in health).

The type of health work that voluntary and community organisations do is hugely varied, reflecting their broad range of technical and professional skills and expertise. The sector is known for its diversity and flexibility, ranging from large organisations with significant income and staffing to small community groups run largely by volunteers. The work of the sector falls mainly into four categories:

- provision of services (including information, advocacy and advice, in addition to health and social care)
- advice to commissioners, planners and funders
- medical research
- policy and campaigns.

This paper focuses on the first two categories, although we recognise that medical research and campaigns are substantial areas of activity.

### Focus of provision

The health work undertaken by the sector ranges from specialist clinical provision, where it often dominates the market (eg, the hospice movement), to disease-specific advice services (eg, Diabetes UK) and general wellness support and advocacy. However, much of its work has traditionally focused

on upstream prevention aimed at promoting healthy lifestyles and reducing high-risk behaviours so that people stay well and independent. Voluntary and community organisations have actively supported greater self-management for people with long-term conditions such as HIV, diabetes, multiple sclerosis (MS), motor neurone disease, depression, and rheumatoid arthritis, to name but a few. They have also taken a holistic approach to tackling social, environmental and health challenges (Office of the Third Sector 2010). There are many examples of services that are not directly health-related, but which have a positive impact on health outcomes and people's well-being, such as community centres providing opportunities for social interaction for older people. A key function of many of these organisations is to integrate and co-ordinate care and support across organisational and professional boundaries. They therefore play an important role in managing people with complex or long-term conditions and needs. Some organisations provide an alternative to statutory services; many people prefer to access services provided by voluntary or community organisations over statutory services – for instance, people with mental health and substance misuse issues or young people seeking sexual health advice.

For many organisations, advice, information and advocacy are also key areas of work. The aim is to support people and their carers/families to better understand their condition and the services they can access. According to the Department of Health, the most common health care service provided by the sector is advice (37 per cent) (Department of Health 2007).

## Commissioning support and intelligence

Because voluntary and community organisations are rooted in local communities, they are a valuable source of knowledge about local needs and gaps in services. Local Government Improvement and Development (formerly the Improvement and Development Agency or IDeA) has commented that 'the voluntary and community sector are... a key vehicle for engaging communities as they have strong links with local people at a grass roots level' (IDeA 2009). As such, the sector provides a collective voice for particular groups or communities, highlighting the needs of people who find it difficult to access mainstream services (for instance, homeless people, or those facing cultural or linguistic barriers to accessing services). The sector also plays a key role in tackling inequalities in access to health care. Organisations have started to get more involved in local strategic planning and setting of priorities, particularly through the Joint Strategic Needs Assessment process. This process formally began in 2006 and has been a statutory requirement since April 2008.

## The financial and demographic context

For the past decade, the NHS has been grappling with rising demand as a result of demographic and epidemiological changes that have seen greater numbers of people living longer and with multiple long-term conditions. Poor management of long-term conditions can, and does, result in regular emergency hospital admissions, which are costly for the system and distressing for patients. In recognition that this is unsustainable, health policy over the past decade has attempted to shift the NHS from a service that treats people when they are ill to one that promotes prevention and wellness. The broader policy of shifting care closer to home aims to help people live independently for longer and avoid the use of expensive acute services (Department of Health 2004). Efforts to improve the management of people with long-term conditions have taken the form of case management, disease management and self-management programmes. The voluntary and community sector has contributed to these efforts by offering self-management support, wellness programmes and health promotion initiatives within local communities. However, there has been a continued increase in emergency admissions (Blunt *et al* 2010).

In addition to demographic pressures, the NHS is facing unprecedented financial constraints following the coalition government's decision to cut public spending by £81 billion over four years as part of its deficit reduction programme (HM Treasury 2010). Although no direct cuts have been made to the NHS budget (in line with a commitment to increase real-terms spending), the projected increase in inflation means that the NHS's spending power is likely to decline next year (Appleby 2010). Even before the budget settlement, the NHS was faced with finding £20 billion in efficiency savings by 2014/15. Local authority budgets have seen real cuts and councils have announced substantial reductions in services – a situation that is likely to result in further pressures on the NHS (Humphries 2011). In recognition of the interdependency of health and social care budgets, the Comprehensive Spending Review allocated an extra £1 billion by 2014/15 to NHS commissioners specifically for services that support social care and improve health (Department of Health 2010c). However, this money is not ring-fenced, so there is no guarantee it will be spent on social care.

These funding cuts are now filtering down to the voluntary and community sector, which faces further financial challenges because of the global recession and associated reductions in charitable giving. As a result, many organisations are struggling to survive, with diminishing reserves.

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## The Health and Social Care Bill

The Health and Social Care Bill is one element of a wider political discourse that has, at its core, the devolution of power from Whitehall to local communities and a greater reliance on the market as the main mechanism for delivering public services. The Big Society, described as a ‘bottom-up vision’ aimed at creating the ‘largest and most vibrant social enterprise sector in the world’, encompasses aspirations to empower communities, boost social action and volunteering, and open up public service provision to charities, social enterprises, private companies, and employee-owned co-operatives (Department of Health 2010a, p 36). The shift in power to communities and individuals will be supported by a Localism Bill, which is also progressing through parliament (House of Commons 2010).

The Health and Social Care Bill sets out proposals for an ambitious reorganisation of the NHS. Some of its themes – for example, choice and competition – are not entirely new policies, but the Bill seeks to significantly extend the focus on market mechanisms. There remains great uncertainty over the likely impact of the reforms, and the pause in the passage of the Bill for the ‘listening exercise’ has heightened this uncertainty. However, what is clear is that the government envisages a key role for the voluntary and community sector, not only as a provider of services in competition with NHS and private organisations, but also as a potential source of commissioning support and a key partner in addressing public health challenges and inequalities. The main elements of the Bill are described briefly below. Specific references to the role of the sector are presented in boxes.

*New commissioning structures:* At the heart of the Bill is the plan for GPs to take on new responsibilities. Practices are required to join together in commissioning consortia, which will take over from primary care trusts (PCTs) as the main commissioners of health services by April 2013. Consortia will be responsible for the health of their registered populations as well as the budget to meet their needs. While the Bill specifies that GPs have a duty to provide services for non-registered individuals, it is not clear whether GPs will be required to become guardians of population health (The King’s Fund 2011a). Size and geographical coverage of consortia have not been prescribed, and there is no requirement for them to have co-terminous boundaries with local authorities. Strategic health authorities (SHAs) and PCTs will be abolished, and GP consortia will be held to account for their commissioning outcomes by a newly formed national NHS Commissioning Board. The board will have responsibility for setting budgets and also for some commissioning of specialist services.

### Duties of GP commissioning consortia to engage with the voluntary and community sector

- Commissioners will need to establish and nurture new relationships with local voluntary organisations (Department of Health 2010e).
- GP consortia are enabled to work closely with community partners when designing joined-up services (Department of Health 2010g).
- Commissioners should consider how voluntary and community organisations can play a role in the delivery of services and, through their expert knowledge, scope the sorts of services and outcomes that communities want and need (Department of Health 2010i).
- Consortia have the freedom to buy in support from external organisations, including voluntary sector bodies (Department of Health 2010e).

*An expanded role in health for local authorities:* Local authorities will have a new and enhanced role, assuming responsibility for public health and health improvement. They will have a duty to establish health and wellbeing boards, which will be responsible for overseeing the health needs of the local community and for co-ordinating commissioning across a local area. The Bill states that, beyond minimum membership, local authorities are free to determine the membership of health and wellbeing boards. It also makes provision for GPs to work with health and wellbeing boards to exercise their functions (which include developing Joint Strategic Needs Assessments and health and wellbeing strategies). But it remains unclear how compliance with these duties will be monitored, and what the penalties will be in the event of failure to comply (Maybin *et al* 2011). Local authorities will also be responsible for establishing local HealthWatch, which will take over from current arrangements for public involvement and will hold local services to account for their commissioning and delivery decisions.

### The sector's role in the health improvement and inequalities agenda

- The voluntary and community sector is a key partner in addressing the wider determinants of health and achieving better public health outcomes for local populations. Organisations will work alongside directors of public health, local authorities, GP consortia, the wider NHS, private businesses, early years services, and schools (Department of Health 2010b).



*On the provider side:* Competition, choice and information will be the key drivers of quality in the new system. NHS markets will be opened up to alternative providers under an extension of the ‘any willing provider’<sup>2</sup> policy, enabling consortia to commission services from any licensed provider. It is intended that providers (be they from the NHS, the private sector or voluntary sector) will compete on a level playing field for NHS contracts. The policy of any willing provider is intended to increase competition (and therefore, it is hoped, innovation, improvement and productivity) while reducing barriers to entry to the market. Tariffs are to be extended to many community services so that money follows patients around the system to enable stronger competition between providers.

The competitive market is to be underpinned by an ‘information revolution’ whereby patients are empowered to make decisions about their own health, treatment, and provider. The provision of information and data about services will also be opened up to the market.

Any provider of NHS services will be required to be registered with the Care Quality Commission (CQC) and be licensed by Monitor. While the CQC’s role will continue to focus on maintaining quality standards, Monitor’s role will change as it becomes an economic regulator. The Bill states that Monitor’s key duties will be to promote competition and ensure continuity of services. The ‘listening exercise’ has raised questions about the role of Monitor and its duties may be amended as a result. Failing providers will be dealt with by the market (ie, be taken over by other organisations, be put into administration or, if they become failed organisations, exit the market).

A set of national outcomes frameworks will be used to measure performance: one for the NHS, one for social care, and one for public health. Any provider of NHS services will be required to provide data to The NHS Information Centre against the framework(s). The three separate frameworks overlap to enable joint working, but they are not fully aligned.

<sup>2</sup> At the time of writing, the government had changed its terminology to any ‘qualified’ provider. Throughout this report, we have used ‘any willing provider’, as this was the term originally used in the Health and Social Care Bill.

### The sector's role as a provider

- The voluntary and community sector is a provider operating on an equal playing field with NHS and private health care providers in the 'any willing provider' market (Department of Health 2010h).
- The sector is an important advocate for patients, supporting them to interpret information and make an increasing number of choices (Department of Health 2010f).
- As a provider of NHS services, organisations will be required to register with Monitor and the Care Quality Commission (Department of Health 2010h).
- The sector will be required to submit data to The Information Centre according to nationally defined standards (Department of Health 2010d).

### The sector's future involvement in health

In the White Paper and subsequent Bill, there are explicit aspirations for the sector in the future health and social care system: as a provider of services, as a partner and source of support and information for commissioning services, and as a partner in tackling health inequalities. Both the White Paper and the Bill are clear about the expectation for GP commissioning consortia and health and wellbeing boards to work with the sector to commission services to meet the needs of local populations and tackle the wider determinants of health. Building on the sector's historical involvement, successes, and learning in health care, the reforms place renewed emphasis on its potential to engage with the NHS, helping it to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge and deliver greater patient choice.

#### As a provider

The opening up of NHS markets to a plurality of providers potentially offers considerable opportunities to the voluntary and community sector. These include expanding existing service provision, breaking into markets previously dominated by monopoly providers, and entering areas of the market it has not previously had access to. The sector is recognised for its ability to reach parts of the community that the statutory sector finds difficult to access and for developing services to fill gaps left by statutory provision (Office of the Third Sector 2010). This suggests that it is well placed to continue, and extend, this role.

The rising number of people with long-term conditions suggests a growing need for self-management support and health promotion, and the devolution of budgets to GPs should incentivise investment in upstream preventive services. The sector is well established in this area of service provision, and the shift towards making the NHS a service that supports wellness rather than treats illness suggests there should be growing demand for services provided by voluntary and community organisations.

The information revolution may also open up new opportunities for the sector, in terms of providing advocacy and signposting services to individuals trying to navigate the system and make complex choices about who provides their treatment and where. In a system potentially made up of multiple providers, the voluntary and community sector – with its social and user-centred approach to care – could play a crucial role in co-ordinating care and helping people bridge organisational and professional divides. This co-ordination and integration of services can reduce fragmentation and duplication of health care, which can lead to poor patient outcomes, inefficient service and wasted resources (MacAdam 2008).

### As a commissioning partner

Devolution of commissioning powers is intended to ensure that the needs of local populations are better met than they would be by a commissioning body operating at a higher level (eg, at a PCT or regional level). The theory is that GPs, who know their patients well, are best placed to design and commission services to meet patients' needs. However, while GPs will be familiar with their registered lists, few will have an in-depth knowledge of the wider community. While the requirements for them to take account of the needs of the wider resident population are unclear, it is hoped that these duties will be strengthened. In order to effectively commission services for this wider population, GPs will need to engage with organisations that have an in-depth knowledge of local communities. There are already frameworks in place, such as Local Compacts, that can facilitate this. The White Paper gives GP consortia a duty to work with community partners and encourages them to consider the role the sector could play in scoping services.

It is particularly important that GP consortia, local authorities, the voluntary and community sector and other providers work together to ensure that disadvantaged or under-served groups are properly catered for (eg, people who are not registered with a GP, homeless people, and those facing linguistic or cultural barriers to access, as well as those with relatively rare conditions). The sector has a wealth of information and knowledge that it could contribute to health and wellbeing boards to help them tackle health inequalities.

In addition to the sector providing information about local populations and needs, it also has the potential to offer commissioning support and advice to GP consortia. This is likely to be of particular value in relation to specialist conditions where consortia members may not have the requisite knowledge to develop effective care pathways. One recent example of such a model is Neurological Commissioning Support (NCS) Ltd. This is a joint initiative by the Multiple Sclerosis (MS) Society, Parkinson's UK, and the Motor Neurone Disease (MND) Association to offer support and advice for those who are planning and commissioning care for people with chronic neurological conditions (Zollinger-Read 2011). Whether or not this emerges as a widespread approach is yet to be seen, but what it does underline is the fact that voluntary and community organisations are well placed to support or even take on elements of commissioning.

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# Can the aspirations for the sector be realised?

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The previous section reviewed the current involvement of the sector in health and its potential role if the proposed NHS reforms are realised. While the skills and experience within, and characteristics of, the sector mean it is well placed to play this new role, the reforms pose a number of challenges and risks. Some of these are explored in this section, which is structured around the key considerations and concerns that were raised at the expert seminar organised by The King's Fund and the National Council for Voluntary Organisations (NCVO) in November 2010. Our aim is to highlight the issues that require the most development and/or further research and thinking by policy-makers and organisations within the sector itself.

1. How will the sector be able to operate in a competitive market in terms of:
  - the financial sustainability of existing organisations
  - market entry among new and emerging organisations, and existing organisations expanding into new areas
  - the regulatory and reporting requirements
  - the need for organisations to demonstrate value?
2. How will the sector be able to engage with the right partners in the new system in terms of:
  - forging new relationships as existing ones are altered
  - the need to work across boundaries
  - engaging in commissioning?
3. Will the sector be able to support the health inequalities agenda in terms of:
  - playing a role in health and wellbeing boards
  - engaging with other key bodies?
4. What can the sector do to succeed in the new system in terms of:
  - its internal structure
  - its development needs?

## How will the sector be able to operate in a competitive market?

The NHS reforms put greater emphasis on competition, and the sector is expected to compete on a 'level playing field' with other organisations within the sector, as well as the private sector, the NHS, and newly formed social enterprises. While the sector has become accustomed in recent years to bidding for, and winning, contracts with commissioners, the new system raises a number of concerns and challenges. Some of these are discussed in more detail below.

### Financial sustainability

Financial sustainability is a major concern for many voluntary and community organisations; this stems not just from the NHS reforms but also from a general tightening of public sector spending and diminishing donations as a result of the recession. However, the NHS reform programme has brought concerns about financial sustainability to the fore.

Just under half of the sector's income for providing health services comes from statutory sources, with the rest being funded through individual donations, private sector contributions, National Lottery grants or internally generated incomes (Clark *et al* 2009). Much of this statutory funding comes from primary care trust (PCT) public health or community commissioning budgets via grants and contracts (Clark *et al* 2009). During the past decade, there has been a shift away from grants towards contracts, which now account for around 80 per cent of statutory income (Clark *et al* 2009). This shift in funding mechanisms has highlighted the need for organisations to be more 'business-like' to enable them to win statutory contracts. Taking a business-like approach is sometimes felt to be at odds with the ethos of volunteering and communitarianism (Coule 2007); this debate is likely to become increasingly prominent as the sector strives to compete with other providers for contracts.

Many voluntary and community organisations are already feeling the impact of public sector budget cuts. NCVO's *Charity Forecast* for the first quarter of 2011 suggests that 35 per cent of organisations are decreasing their service offers and 55 per cent have already decreased staff numbers (NCVO 2011). Councils have started to cut budgets available to the sector and some organisations have claimed that the vision of the Big Society is being undermined by 'draconian' cuts (Boxell *et al* 2011).

Budget cuts are compounded by the fact that many organisations have few reserves. This is partly a result of struggling to recover the full costs of their activities due to downward pressure on prices from commissioners (Association of Chief Executives of Voluntary Organisations (ACEVO) 2009).

But it is also because many funders are reluctant to support organisations with large reserves. The government's own Big Society Transition Fund will only consider organisations with 'free reserves... for no more than six months' total expenditure' (Ricketts 2010), creating real tensions for organisations trying to develop a sustainable business model.

In addition to budget cuts, the NHS reform programme has raised further financial concerns for the sector. One key concern is around the availability of grants in the new system. Despite the shift from grants towards contracts mentioned earlier, grants still play a key role, enabling commissioners to fund innovative projects and help organisations become established to fill gaps in statutory provision. The Bill states that GP consortia will have the power to award grants, but there is uncertainty about how widespread this practice will be and, indeed, whether GP consortia will have the skills and expertise to assess proposals and award grants effectively. There is a risk that the new system will stifle innovation and severely restrict the emergence of new voluntary and community organisations which (unlike the private sector) are unable to raise high levels of capital investment.

Another concern centres on the shift from block contracts towards Payment by Results for many community services. Under this system organisations within the sector, which typically have few reserves, will be paid for services in arrears, based on achievement of outcomes set by commissioners in advance. Contracts that pay in arrears restrict organisations' ability to manage cash flows effectively as they do not guarantee a minimum income (HM Treasury 2006). Additionally, there is uncertainty over how payments will be made under tariff for services for complex populations, whose needs span the boundaries of health and social care and primary, secondary and community care. Furthermore, there is concern that the transition to the new arrangements would leave organisations vulnerable if there is a gap between grant-funding and block contracts and the development of new funding mechanisms.

Many services provided by the sector focus on wellness and prevention and, although in theory GP consortia should be incentivised to keep their populations well, the pressure to make immediate financial savings may take precedence over longer-term upstream investment. Similarly, although advocacy and signposting will arguably be more important in the new system of choice and competition, budget constraints, rising real costs and social care cuts may mean that resources are diverted to 'essential' acute and crisis services.

There is a risk that some organisations will not survive the transition to the new system unless sufficient support is put in place. There are doubts that transition funds will be sufficient to ensure that voluntary and community organisations

survive, particularly smaller organisations that might be less visible to GP consortia. There is also a risk that organisations retreat into ‘survival mode’ instead of taking a strategic approach, focusing on day-to-day operational issues and shedding staff, thus compromising their ability to pursue opportunities and foster new relationships. The new system should include a range of different funding mechanisms that continue to encourage innovation. There is an urgent need for the sector and national policy-makers to work together to explore innovative funding mechanisms, including models of social investment. Social Impact Bonds are one such example that is being developed in the public sector.

## Market entry

There are also concerns about the ability of voluntary and community organisations to enter or expand in a competitive market.

Historically, the statutory sector has preferred to work with larger voluntary and community organisations, partly because the procurement costs of contracting with lots of small organisations can be prohibitive, and because of the perception that smaller organisations are high risk (Baines *et al* 2009). The result is that many small local organisations that are well connected to their communities can find it difficult to secure contracts. As commissioners strive to make efficiency gains, it is possible that they will pursue even fewer, larger contracts, further excluding smaller organisations. It is, as yet, unclear whether GP commissioners will be more prepared than their PCT predecessors to award contracts to smaller organisations; this is likely to vary locally. The shift to Payment by Results for many services will also limit the ability of some organisations to enter the market, without the help of a grant.

There is, therefore, considerable concern that the new system will be anything but a ‘level playing field’ – that larger organisations within the sector, as well as private sector organisations and newly formed social enterprises emerging out of NHS provider organisations, will crowd out smaller organisations because of their ability to invest in new markets, innovate, take risks, invest in marketing, and carry financial losses. Unless there is deliberate support for a diverse provider market, organisations that are already vulnerable are likely to fail, and those not yet in the market may be discouraged from entering it. In addition, organisations within the sector need to be more proactive in building partnerships with each other in order to share risk and benefit from economies of scale. They could also seek out partnerships and joint ventures with private and NHS organisations (*see* ‘Internal structure’ for further discussion). However, such collaboration raises questions about the role of Monitor and its duty to promote competition (*see* ‘Working across boundaries’).



## Regulatory and reporting requirements

In the new system, a voluntary or community organisation that wins a contract to provide NHS care will be subject to the same accountability and governance requirements as an independent sector provider – that is, they will be contracted by the commissioner, they will have a regulatory relationship with the Care Quality Commission (CQC) and Monitor, and be subject to scrutiny by the local authority (Maybin *et al* 2011). They will also still be accountable to the Charity Commission. The requirements of CQC and Monitor are not yet known, but these multiple lines of accountability may present a substantial burden for some smaller organisations, sufficient to discourage them from entering the market or seeking NHS contracts.

In addition to the regulatory framework, all providers will be required to report outcomes data to The Information Centre. Since 2009, providers are also expected to produce quality accounts – a form of annual report to the public about the quality of their services (Foot *et al* 2011). Although some organisations will be well able to meet these requirements, many – particularly the smaller ones or those run largely by volunteers – will struggle, compromising their ability to compete in the market.

## Demonstrating value for money

The need for voluntary and community organisations to better measure and demonstrate their value has been identified and debated previously (Muñoz 2009). However, the shift from block contracts and guaranteed income to a focus on outcomes and competition arguably makes this even more vital. Organisations need to find better ways of measuring and demonstrating what they offer, both in terms of cost-effectiveness and wider social value. The sector needs to demonstrate its value, as a provider and a commissioning partner, to commissioners, patients and – depending on contracting arrangements (*see* ‘Internal structure’ for further discussion) – to other providers. Meeting the £20 billion ‘NHS efficiency challenge’ of the next four years will heighten pressures to demonstrate value and cost-effectiveness. Organisations within the sector will need to be adept at marketing their services to commissioners, who will want to see evidence of value for money.

The complexities of quantifying the financial value of organisations delivering impacts that do not have a market value (often referred to as ‘social value’) have been identified by the government<sup>3</sup> and in literature (eg, Muñoz 2009). Although

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<sup>3</sup> In 2009, the government released the Social Return on Investment approach to quantifying the financial value of organisations delivering impacts that do not have a market value. More about this approach, and how it is being used, can be found at: [www.thesroinetwork.org/content/view/31/1/](http://www.thesroinetwork.org/content/view/31/1/)

there is a great deal of anecdotal evidence about the value of the sector and its impact on the NHS (The King's Fund 2011b), there is little empirical evidence. This is partly because of the complexities of quantifying this sort of evidence but also because commissioning bodies have not always required information in this format. There is, therefore, a considerable challenge for the sector in terms of articulating its value, and for commissioners in recognising 'social value' when procuring services.

There is concern within the sector that its 'social value' model represents a fundamentally different approach to the 'medical' model that GPs may prefer, and that this will make it difficult for the sector and GP consortia to agree on the value of services or, as some seminar participants put it, to 'talk the same language'. GP consortia are likely to need support and guidance to be able to commission effectively from the sector. Commissioners, public health teams, health and wellbeing boards, and the voluntary and community sector would all benefit from working together in setting standards and expectations at a local level to ensure that social value is recognised.

## How will the sector be able to engage with the right partners?

In order for the system to operate as envisaged, with the dissolution of PCTs and GP consortia becoming fully functional by 2013, it is essential that new relationships are forged quickly. However, there are concerns that the Bill does not fully facilitate the development of relationships between voluntary and community organisations and others.

### Forging new relationships

The extensive changes to the architecture of the NHS and local authorities will have far-reaching implications for established relationships between voluntary and community organisations, the NHS and local authorities. Established relationships will inevitably change as PCTs are dissolved and responsibilities are shifted to local authorities and GP consortia. Some organisations within the sector have reported that they are already seeing a breakdown in key relationships with their PCTs, and that it is not clear who they should be in contact with during the transition period. This presents significant problems for the sector in terms of managing existing contracts and grants; it may also be difficult to develop relevant service offers if commissioning intentions for the near future are unclear.

The sector will need to develop key relationships with GP consortia, health and wellbeing boards, and HealthWatch. Individual organisations will need to develop relationships (whether collaborative or competitive) with others in the

sector, as well as other providers from the private sector, primary, secondary and community NHS organisations, and newly formed social enterprises. The development of GP pathfinders suggests there will be significantly more consortia than there were PCTs. In many places, voluntary and community organisations will need to forge links with multiple GP commissioners, where previously they dealt with one PCT.

However, GP consortia will no doubt be grappling with the demands of their new responsibilities, including internal matters of organisational development (Imison *et al* 2011), and there are concerns that engaging with the sector may be a low priority for them. There are existing mechanisms, such as Local Compacts, that consortia could draw on in the new arrangements to prevent them having to reinvent the wheel. Many organisations within the sector are calling for a central or local point of contact (perhaps at the local authority) to help keep them up to date with, and engaged in, changes during the transition.

### Working across boundaries

One major strength of the sector is that it helps to integrate and co-ordinate care across organisational and professional boundaries for people with complex needs. But the reform programme has given rise to concerns that the loss of co-terminous boundaries between the NHS and local authorities may create complexities for those organisations working across health and social care, resulting in a more fragmented experience of care for patients. In the new system, a voluntary and community sector provider that is contracted by one consortia may be working across two or more local authority areas, each with its own set of priorities and requirements for information. This may present certain difficulties in terms of building relationships and integrating with social care, housing, education, and so on.

The duty of Monitor to promote competition also raises concerns for the ability of organisations in the voluntary and community sector to collaborate and integrate care across pathways. Critics of the Bill have called for a more nuanced approach to competition that would allow and enable collaboration where there are benefits to patient care. Since the conclusion of the 'listening exercise' the government has indicated that changes to Monitor's duties are likely (Cameron 2011). This will be extremely important to the sector if it is to continue to deliver seamless, co-ordinated care to people with complex needs. It will also be important if the NHS is to rise to the QIPP challenge as evidence suggests that integrated care can offer a range of benefits, including a more efficient system (Curry and Ham 2010).

## Engaging in commissioning

Despite the aspirations of the NHS reform programme, there are uncertainties as to whether the Health and Social Care Bill will facilitate the sector's engagement in commissioning. There are already concerns that the sector is not engaged as widely as it could be (White 2010), and it is not clear that the new set of arrangements will rectify this situation.

While the Bill specifies that GP consortia will be able to work with community groups to design joined-up services, there is no *requirement* for them to engage with or involve these groups, or representatives of patients and the public, on their boards. This raises questions over whether GP consortia will actively seek to engage with voluntary and community organisations. The voluntary sector has submitted evidence to the House of Commons Health Committee, and has called for a requirement for GP consortia to make it clear what channels voluntary providers can use to play a part in service redesign (House of Commons Health Committee 2011). These channels need to deal head-on with the issue of conflicts of interest that might be seen to stem from the sector playing a dual role as both provider of services and adviser in the commissioning cycle. Although this is not a new debate, it is important that local-level arrangements include robust and transparent mechanisms for governance and accountability to ensure that concerns about conflicts of interest do not hinder progress. Similar concerns about GPs under practice-based commissioning led to a stagnation of progress in many areas (Curry *et al* 2008), and lessons learned from that experience need to be applied to the new system.

## Will the sector be able to support the health inequalities agenda?

The Bill envisages that the sector will continue to be a partner in tackling health inequalities and the wider determinants of health. It is recognised as having particular strengths in reaching parts of the community that the statutory sector finds difficult to access (Office of the Third Sector 2010), and therefore plays a crucial role in tackling health inequalities. Voluntary and community organisations are often formed in response to needs that are not being met by statutory services and, in this way, they enable community members to exercise choice and voice (Office of the Third Sector 2010). However, whether the sector will be able to operate effectively as a partner in the health improvement agenda depends to a large extent on whether the rest of the system operates as intended.

## The role of health and wellbeing boards

Much of the success in advancing efforts to tackle health inequalities will rest on how effective health and wellbeing boards are in garnering the support and involvement of all those involved in health in their local area. Some within the sector are concerned that health and wellbeing boards will struggle to engage effectively with the breadth of organisations in a local area, and will only engage with larger, better-resourced organisations that may not represent the full diversity of the sector. While it will not be practical to invite representatives from all organisations, health and wellbeing boards need to be aware of the diversity of the sector, and should develop channels to engage with smaller organisations to ensure that the needs of all population groups are considered.

There are also widespread concerns that health and wellbeing boards lack the necessary authority to ensure that GP consortia take account of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (House of Commons Health Committee 2011; The King's Fund 2011a). The Bill states that GP consortia should 'have regard to the Joint Health and Wellbeing Strategies', but it is not clear that health and wellbeing boards will be able to ensure that consortia actually do take account of the needs of their populations (Maybin *et al* 2011). There is concern that the needs of some groups – particularly those who face barriers to accessing services – may go unmet, and inequalities will therefore widen, if GP consortia fail to take into account their needs in commissioning plans. This risk is likely to be even greater for groups that are dispersed across more than one consortia, for whom services may previously have been provided across a single PCT area. Consortia should have to give due regard to these issues rather than just relying on the local authority and health and wellbeing boards to intervene (The King's Fund 2011a). Health and wellbeing boards also need greater powers to refer to the NHS Commissioning Board any consortia that they feel are not engaging with the health inequalities agenda.

## Roles and responsibilities

There is still a lack of clarity over the alignment of responsibilities between GP consortia and local public health departments, particularly in terms of who 'owns' the health inequalities agenda, and this also affects the sector's ability to play a role. It is not clear from the Bill whether GP consortia will have a direct duty to improve the health of the population in their area. It specifies that GPs will have a duty to *provide* services for non-registered patients, but there is no requirement for GPs to become *guardians* of population health. Without such a requirement, there is a risk that GP consortia will not engage fully with the public health agenda (The King's Fund 2011a) and will fail to invest in the preventive wellness

services often run by the sector. There is also concern that local authorities have no specific duty to tackle inequalities. There is an urgent need to align the roles and expectations of local authorities and GP consortia with respect to tackling inequalities. This is a significant issue for the sector, as many organisations work with the most disadvantaged and excluded groups with a view to reducing inequalities. Without this clarity around roles and responsibilities, the sector will face considerable difficulties in identifying and building relationships with key bodies.

## What can the sector do to succeed in the new system?

While some of the challenges facing the sector stem from the government's health reform programme, and require support to be addressed and overcome, the sector itself also needs to be proactive in managing the transition to the new system. The reforms set out in the Bill present a number of opportunities for the sector to take a central role in meeting the health challenges of the future. But in order to do so, it needs to address two main issues: its internal structure and its development needs.

### Internal structure

The sector's diversity is one of its key strengths, but it can also mean that it struggles to communicate and represent itself to commissioners (IDeA and IVAR 2009). Poor communication and fragmentation within the sector can prevent it from properly demonstrating its impact and cost-effectiveness to statutory commissioners (Office of the Third Sector 2010) – qualities that will be vital in the new system. Although this is not a new issue for the sector, the reforms add an element of urgency to the debate.

Research has shown that existing PCT commissioners have gaps in their awareness and understanding of the sector (IDeA 2008). The sector will therefore need to give considerable thought to how it can actively engage with GP consortia – many of whom will have had little contact with voluntary and community organisations – so that it is seen as a legitimate, long-term commissioning partner. It also needs to give thought to how it can best survive in a cold financial climate. The question for the sector is: how can it best organise in order to operate most effectively through the reforms, and in the post-reform NHS, while still retaining its strengths, flexibility and values?

One emerging model is that of consortia of voluntary and community providers forming in order to share back-office functions, provide joint services, and streamline communication with commissioning bodies and local authorities. However, there is real tension within the sector between the need to streamline

communication and concerns that one organisation would be unable to effectively represent the breadth of the others within its consortia. Some worry that this would result in the larger, more well-known organisations crowding out the voice of the smaller and more specialist organisations, thus undermining the key selling-point of the sector.

There are various contractual structures that could be explored. For example, a lead provider from the sector could win a contract and subcontract to member organisations in order to offer a pathway or package of care. An alternative model might see a private sector organisation taking the position of lead contractor. This would be advantageous in that the private sector brings economies of scale and investment potential, while the voluntary and community sector partner brings knowledge of local communities and needs. However, there are obvious tensions within the sector about whether such a model would compromise the organisation's values, and whether volunteers would be willing to offer services to an organisation that is part of a wider, private sector provider arm. In some instances, voluntary and community organisations may seek to merge in order to make efficiency gains. But some organisations that have taken this route in recent years emphasise that such an approach takes time and can be resource-intensive before it delivers the intended efficiency gains.

It is essential that the sector undertakes an urgent and honest debate about how it can best organise itself to respond to the challenges of the transition and the new system. Developing new structures will inevitably take time, and could incur additional one-off costs, so it is crucial that a long-term strategic approach is taken and that tensions and challenges are debated openly. Existing infrastructure bodies could play a crucial role in supporting this process.

## Skills and capacity

In order to ensure it has sufficient capacity and appropriate skills to rise to the challenges presented, the sector needs to engage in a significant skills development agenda.

Some capacity building has historically been funded by the statutory sector, through jointly funded posts (PCT/local authority) that support the sector's needs. These have typically involved running collaborative strategic forums and informing the sector of policy changes and best practice, as well as representing the sector to commissioners and external evaluators. However, many of these posts are being lost because of the public sector budget cuts – something that could prove damaging at a time when platforms for strategic leadership are essential. Therefore, the sector needs to be able to build capacity from within instead of relying on support provided by the statutory sector. One of the

immediate problems arising from the current situation is that many organisations are cutting staff to address immediate budget concerns, rather than investing in their existing capacity. This will further limit the sector's capacity to adapt to the new arrangements and forge strategic relationships.

In order to operate effectively in the new system, the sector will need to be highly skilled in a range of areas. Of critical importance will be its ability to exhibit leadership skills. If it is to address the issues around its internal structure and the challenges of operating in a competitive market, it must invest in its leaders. Other critical skill areas will be marketing, tendering, negotiating, and data gathering, analysis and presentation. Some organisations will already possess these skills, but others will not. It would be neither realistic nor efficient for all organisations to develop all of these skills, so the sector needs to consider how it might best share learning and skills and develop partnerships internally to ensure the best use of the skills it has.



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# Conclusion

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The vision of the future health and social care service, as set out in the White Paper and Bill, clearly includes a significant role for the voluntary and community sector. The emphasis on the Big Society, localism and volunteerism that runs through emerging policy offers potential opportunities for the sector to develop its public service delivery and commissioning support roles. The sector has the expertise to help the NHS and social care services meet the significant financial and demographic challenges that lie ahead. But can the aspirations set out in the White Paper be realised? This paper has explored some of the challenges that face the sector, but there are still widespread uncertainties about what impact the reforms will have once implemented. It is possible to foresee a range of scenarios that might play out (*see* Dixon and Ham 2010), but here, we explore what two opposing scenarios – the best and the worst – would be.

## The best-case scenario

The sector is empowered as a real community partner by GP consortia and health and wellbeing boards. The latter provide strong leadership and oversight at a population level and drive the public health and health improvement agenda, facilitating input from relevant partners. Priorities and needs are identified across populations, and the sector is seen as a key supplier of data and knowledge about local populations as well as commissioning support, for which it is fairly remunerated. Health and wellbeing boards and HealthWatch effectively hold consortia to account for the inequalities agenda. Where boundaries are not co-terminous, good relationships enable joined-up work programmes to ensure that no groups are left unserved.

At a local level, the outcomes frameworks for public health, the NHS and adult social care are aligned, and organisations within the sector are supported by their commissioners to measure their impact and report outcomes to The Information Centre. A range of funding mechanisms enable organisations to thrive and innovate. Financial support and skills training is made available to the sector at a local authority level. A diverse provider market develops to offer patients real choice. The Big Society bank and primary care trust (PCT) clusters support organisations through the transition, and the sector bands together to take a strategic approach; voluntary and community provider consortia emerge to streamline communication and contractual arrangements with GP consortia, but are structured so as not to undermine the independence and flexibility of individual members. These consortia share back-office functions to make

efficiency gains, and develop networks to enable sharing of skills and expertise. GP consortia, sector representatives and local authorities invest time and effort in developing effective working relationships.

Nationally, support is offered to help build the skills of those in the sector and commissioners alike; national guidance and toolkits, based on existing practice and learning, are made available to those working at local level. The sector demonstrates its value and achievements and successfully competes for patients and contracts. It also collaborates with other providers to work along pathways to deliver seamless care to patients. GPs adjust quickly to their new population-wide responsibilities; they recognise the importance of upstream preventive services in maintaining the wellness and independence of their populations, and commission services accordingly.

### The worst-case scenario

The loss of co-terminous boundaries and established relationships during the transition to the new system leaves the sector struggling to achieve sufficient visibility and forge new relationships. GPs, focused on the productivity challenge, concentrate on downstream clinical services that meet the immediate needs of their populations. They do not invest time in understanding the sector and regard voluntary and community organisations as high risk, preferring to contract services from large NHS or private providers. None of the bodies involved take responsibility for stimulating a diverse provider market, so large organisations dominate, leading to failure for many smaller organisations and leaving patients with little choice. There is little funding available to support new organisations to enter the market. The sector retreats into survival mode, unable to take a strategic approach, simply trying to grasp what financial support there is available. The sector fragments further as organisations compete for scarce support, and fails to join forces to demonstrate its value and share back-office functions. The scramble for contracts undermines the essence of the sector and leaves little space for innovation. In the absence of national guidance and toolkits, each locality embarks on the same work, duplicating effort and failing to share learning.

Organisations cut their staffing to a minimum to survive financially, and therefore lack the capacity to build local relationships and respond to the requirements of Monitor and The Information Centre. GP consortia do not seek to engage with the sector, and health and wellbeing boards involve only the larger, more visible organisations, leaving little room for engagement with smaller community groups. Health and wellbeing boards lack the authority to ensure that GP consortia take account of the Joint Strategic Needs Assessment, and commissioners lose touch with their community.

Transition funding is insufficient to support all voluntary and community organisations, many of whom are left to rely on dwindling private donations already hit hard by the recession. Where services are commissioned, downward pressure on costs by commissioners who see the sector as a ‘cheap’ provider means that organisations struggle to recover full costs. The focus on competition prevents organisations collaborating to provide care along pathways, and patients experience increasingly fragmented care. Advocacy and support services are not seen as essential and, in the bid to save money, do not receive funding. The patient voice is weakened and patients lack the support they need to make informed choices about their care. Many (particularly the most vulnerable) continue to use the provider they have always used, and so choice fails to drive competition. In the absence of performance management, there is little else to drive quality and standards, which slip to the minimum levels required by the regulatory framework.

### What next?

These two opposing scenarios are very extreme, and are unlikely to unfold in their entirety in reality. But they do demonstrate that the detail of how the reforms are implemented will be crucial in determining the outcomes. It is critical that the rhetoric surrounding the Big Society, volunteerism and localism is accompanied by tangible support to ensure that the sector not only survives the transition to the new system, but thrives in it. For this to happen, there needs to be recognition of the role it plays, and could play, in delivering and commissioning health services. It is also vital that the sector grasps the opportunity to lead the way and set the agenda by taking a strategic and proactive approach.

If the government addresses the uncertainties, puts sufficient support in place in a timely manner, and makes provisions in the Bill to enable the sector to participate fully, then the aspirations set out in the White Paper could be achieved, and the government would make progress towards its vision of creating ‘the largest and most vibrant social enterprise sector in the world’ (Department of Health 2010a, p 36). However, there remain significant risks associated with the reforms, and it is important that they are addressed in any changes to the Bill now that the ‘listening exercise’ has concluded.

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# Recommendations

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In order to ensure that the voluntary and community sector can grasp this opportunity to fully participate in the new health and social care system, there are a number of recommendations that emerge from our analysis. They are presented according to the three groups we consider to be key to this debate:

- national policy-makers
- local bodies, including GP consortia and local authorities
- the voluntary and community sector.

## National policy-makers

It is clear that the new system aspires to involve and engage the sector, but in order to ensure that it operates as intended, we recommend that:

- requirements for GP consortia to involve and engage a wide range of local voluntary and community organisations are strengthened, and that these requirements are reflected in the consortia authorisation process
- roles and responsibilities around health inequalities are aligned, clarified and strengthened across the whole system so as to ensure that the sector is able to play a full part in tackling those inequalities. In particular, GP consortia need specific duties to become guardians of population health, and health and wellbeing boards need to be able to refer to the NHS Commissioning Board any consortia they regard as not taking sufficient account of local population needs and health inequalities
- sufficient funding is made available for the sector to survive the transition to the new arrangements
- new and innovative funding mechanisms are developed that recognise social value and the limited financial reserves (and therefore vulnerability) of many smaller organisations. This is vital to enable the sector to continue to innovate, and to enable new organisations to enter the market and compete on a level playing field
- training and toolkits are provided for commissioners on how best to work with the sector. These should build on best practice and the capacity already developed by the Department of Health and primary care trusts (PCTs)

- Monitor adopts a nuanced approach that promotes both competition and collaboration to enable the sector to develop partnerships with other providers – something that will be essential for the delivery of joined-up patient care.

## Local bodies, including GP consortia and local authorities

Certain activities can be undertaken at a local level to help ensure that the shared vision for health and social care is delivered. We recommend that:

- local statutory bodies, including GP consortia and health and wellbeing boards, engage with local voluntary and community organisations (whether statutory-funded or otherwise) and start to develop relationships, building on existing PCT relationships with organisations in the sector
- new sources of support are established to ensure that the sector develops the skills it requires to be able to compete. During the transition, it would be helpful for the sector to have support in place at local authority level to ensure that it is kept informed of, and up to date with, changes in the local area
- local statutory bodies map the full scope of provision offered by the sector and work collaboratively to ensure that the needs of all groups are addressed, particularly vulnerable and excluded groups, and where they are not, to commission services accordingly
- health and wellbeing boards ensure that knowledge within the sector about local populations and their needs is accessed and used appropriately during the Joint Strategic Needs Assessment process.

## The voluntary and community sector

The reforms present a significant opportunity for the sector, but it needs to address certain issues if it is to rise to the challenge. We recommend that:

- the sector demonstrates leadership and takes a strategic approach to the future. Organisations need to collaborate and streamline their communications to overcome internal fragmentation and to help commissioners understand the sector's diversity and value. An urgent internal debate is needed about how the sector can become more organised in order to benefit from economies of scale, and to bid for large contracts, while retaining its flexibility and core ethos

- the sector takes a strategic and proactive approach to building key partnerships and relationships. It should recognise the potential benefits of collaboration with organisations outside the sector as well as within it
- the sector urgently addresses the need to find better ways to measure and demonstrate its value, and engages in efforts to develop new funding mechanisms. It will be increasingly important for organisations to demonstrate value to each other if partnerships are to develop. It also needs to capitalise on the knowledge and data it has in order to engage with commissioners, as well as finding effective ways to present that information
- the sector develops transparent and robust governance structures to help demonstrate to commissioners that it is a viable and long-term partner
- the sector recognises the skills it will need in the new system (including marketing, measuring and demonstrating value, data analysis and, crucially, leadership), and that it actively strives to develop these skills.

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# Appendix 1 A note on definitions

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## What is the voluntary and community sector?

There is no consensus over a definition of the sector. We recognise the complexity of terminology, but for ease, have used the term ‘voluntary and community sector’ throughout this report to refer to organisations that:

- are self-governing, some being registered charities, some incorporated non-profit organisations and some outside both these classifications
- are of different sizes and have different structures
- work for the public benefit, beyond the membership of individual voluntary and community organisations
- are independent of both formal government structures and the profit sector
- have an important reliance on volunteers to carry out their work.

The sector is heterogeneous and diverse in the work that it undertakes, which does make it difficult to arrive at a single definition. However, the sector largely undertakes the following activities:

- delivering services
- advocating/lobbying on behalf of community causes
- facilitating international, community and economic development
- advancing religious faith and practice
- raising funds
- providing financial support to other voluntary and community organisations.

(adapted from Local Government Improvement and Development 2011)

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## Appendix 2 List of organisations represented at the expert seminar held in November 2010

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ACEVO  
Asthma UK  
Big Lottery Fund  
Cabinet Office  
Compact Voice  
Department of Health  
GP (Wandsworth)  
Hale Project  
Hartlepool CVS  
Hartlepool Mind  
Macmillan Cancer Support  
National Voice of Local Support and Development Organisations (NAVCA)  
NHS Lambeth  
NHS London  
NHS Westminster  
Northern Refugee Centre  
P3  
Positively UK  
Red Cross  
Sheffield PCT  
Southside Rehabilitation  
Third Sector Research Centre  
UK Public Health Association