Voluntary Sector Health and Wellbeing Board Update January 2019

Building Health Partnerships
The stakeholder event took place at the end of November and was well attended. The work has become more focused on delayed transfers of care for patients with low level dementia through an action research project.

Volunteer Opportunities
The Volunteer Buddies and Poolside Helpers volunteer opportunities are now available. To find out more contact volunteercentre@nottinghamcvs.co.uk.

VCS Networks
The January Vulnerable Adults Providers Network meeting will have a focus on the EU Settlement Scheme, the NCC Autism Strategy and an update from on the ICS Community Centred Approaches. The VCSE position statement on social prescribing has been finalised (see attachment).

The January Children and Young People's Provider Network meeting had a focus on addressing weapon enabled violence. We had presentations from the Ending Youth Violence Team, Youth Offending Team and City Council. We discussed the public health approach to addressing knife crime.

There was a meeting of the Food Poverty Network in December. This group are keen to continue to meet but the network will need to access some resources to do so.

EU Settlement Scheme
The EU Settlement Scheme is likely to have a detrimental impact on the health and wellbeing of some of the EU Citizen population in Nottingham. The Nottingham Law Centre is leading a city and county wide bid to apply for funding from the Home Office. There is a need for a joined up Nottingham approach to support for EU Citizens who are registering for the scheme whether this funding bid is successful or not. There are some concerns about the wider impact of this scheme on individual's wellbeing and financial circumstances as well as the consequences for those who do not register within the allotted time period, for example, there is a risk in relation to access to healthcare. For more information on the scheme click here. To find out about the Nottingham Law Centre support project proposal contact them directly.

ICS-Voluntary and Community Sector Engagement
NCVS continues to attend ICS meetings and is involved in the formation of the new ICS Partnership Forum which will replace the ICS Advisory Board. Wider discussions about how the voluntary sector engages with each level of the ICS (PCN, ICP and ICS) are underway. This follows on from the think piece written by Jane Todd, NCVS CEO (see attached). We are fortunate to be currently working with Angela Probert who is reviewing the ICS-VCS relationship and engagement. The outcome of this work will be available in February.

State of the Sector Update
NCVS is continuing to explore options to develop an academically robust measure and report about Nottingham's voluntary sector. We are currently interviewing for a University of Nottingham student placement to support this work. We are keen to work with partners and to have input from health and social care alongside the in-depth consultation with the voluntary sector.

For more information about networks and the state of the sector project please contact ncvs@nottinghamcvs.co.uk.

Exploring a Way Forward for Integrated Care System (ICS) Engagement for Nottingham

"If you always do what you've always done, you'll always get what you've always got …"

Introduction

The Nottingham & Nottinghamshire Integrated Care System (ICS), as it is now known, is a partnership of NHS and other health organisations, formerly known as the Sustainability and Transformation Partnership (STP). STPs were introduced by the Government in 2016 in every area of the country to look at how local organisations can work together to improve care, health and wellbeing.

Partnership working across sectors can be a challenge. This is widely accepted and Nottinghamshire is no exception. For Health and the voluntary and community sector (VCS) these challenges are compounded by historical relationships, austerity driving budget cuts and the national NHS England direction on targets and STPs.

We also can't escape from or underestimate the influencing factors of limited resources and the cost saving targets placed upon ICS staff in Nottinghamshire. Large scale change is difficult for any organisation and we recognise the significant challenge of moving from what was 'health' to the vision for the ICS. For us to build a strong working relationship and partnership going forward, we first need to recognise and accept the challenges of the past and present.

The voluntary sector is diverse and can be difficult to navigate and work with as a collective. NCVS is well placed and well established to act as a conduit for the ICS-VCS partnership.

The diagram attached on page 3 demonstrates the core challenge of partnership working between health services and the VCS. By their nature they are inherently different in their ethos and culture. Both have much to offer and at the core of both sectors is a commitment to improve the lives of the people of Nottinghamshire. This shared aim is the building block we can use to develop a genuine, meaningful and functional working relationship which recognises the differences in approach which should strengthen each other.

The VCS would like to be a key partner with health: recognised for its value and knowledge, with a voice in the strategic decisions that impact on our local communities.

Where we are now

Taking stock of where we are in December 2018, the wider ICS Partnership faces similar challenges and, as a result, is fractured. With Nottingham City Council pausing their ICS membership on 20 November 2018 – citing a lack of democratic oversight and meaningful engagement of those impacted by the change – now, more than ever, it is crucial the wider ICS addresses its partnership approach. Central to this for NCVS is a healthy ICS-VCS-patient experience relationship.

The role of NCVS is to reflect the views and diversity of the VCS, which we actively seek through a variety of methods. This includes traditional communications, communities of practice and social media platforms. For example, the Vulnerable Adults' Providers Network (VAPN), which involves over 300 VCS members, directed NCVS to develop a position statement on social prescribing to capture their concerns and ambitions.

Going forward

We hear that ICS colleagues are thinking of setting up a new partnership forum as part of its consultation and engagement mechanism. NCVS is supportive of developing a new approach to working together in the form of a partnership forum, where the central aim is to build trust and mutual understanding, leading to action on the ground.

To help get this working, we have attempted to characterise health services and the Voluntary and Community Sector. Attached is our diagram which demonstrates the current position. This exercise has shown us that health is largely formal in its approach, while the VCS is largely informal. However, our aims and values are similar.

If only we could grow the trust, respect and understanding, it would be such a win-win for patients and communities. This is an opportunity to re-think our future partnerships. Otherwise there's a danger that, "if you always do what you've always done, you'll always get what you've always got …"

NCVS would like to consult with the VCS and local patients on what an effective partnership forum might look like, how it can be achieved, and who would be involved in achieving a systemised and practical way forward.

What would you want a partnership forum to do? Who should be there? What principles would it follow?

Please share this paper with your networks and respond by **Monday 14 January 2019** to janet@nottinghamcvs.co.uk.

Jane Todd
Chief Executive
Nottingham Community and Voluntary Service (NCVS)

December 2018

Health Service Characterised By:	Partnership Forum including patient voice	Voluntary Sector Characterised By:
Top Down	What?	Bottom Up
National System		Local System
Corporate / Managerial		Emotional Labour Force who are emotionally involved This is valued by beneficiaries but not the health system Hard to measure emotional labour
Professional Relationships	Why?	
Formal		Informal
Clinical Relationships with Individuals		P.I.E.
Funded		Largely Unfunded
Assessment of Need Based on a Professionalised Interpretation of Statistics	How?	Assessment of Need Based on Intuition and Knowledge of Local Communities
Distant from Local Communities of Interest or Geography		Close to their Communities and Support Base
Powerful – High Status	Who?	Lack Power – Low Status
Service Change Takes an Age		Responsive, Quick, Pop Up Care
Presenting issue		Whole person

Nottingham Community and Voluntary Service

A suggested framework for any Partnership Forum

1. Aim to build trust and understanding and action through system change.
2. Recognise this is hard going.
3. View positions through a number of lenses – not just from ICS down (assuming that is the dominant position).
4. Recognise partners' power is unequal.
5. Recognise some impacts are harder to measure but no less real.
6. Recognise pop up, responsive care.

Vulnerable Adult Providers Network (VAPN) – Social Prescribing - Position Paper for local Health and Social Care Commissioners

Background

This paper is a response on behalf of the local Voluntary Community and Social Enterprise (VCSE) sector in Nottingham, coordinated by leading members of the Vulnerable Adults' Providers Network (VAPN) to emerging proposals for the development of Social Prescribing/Community Connectivity/Community Centred Approaches across the Greater Nottingham area. It summarises the VCSE position following consultation with VAPN Members and the wider VCSE in Nottingham between September and November 2018. This incorporates the emerging information from the Integrated Care System (ICS) Prevention, Person and Community Centred Approaches work stream and recent NHS England guidance on a common outcomes framework for social prescribing.

Commitment and Opportunity

It is important to set out from the beginning that VAPN members are fully committed to working with the ICS/other Commissioners to develop best practice Social Prescribing/Community Connection Services/Systems that meet the needs of all stakeholders – primarily vulnerable people with long-term health conditions and including Commissioners, health professionals and local VCSE organisations. Working together we have an opportunity to develop fully integrated service delivery models that will:

- Deliver on the emerging Personalised Care Programme approach, local ICS priorities and the NHSE Social Prescribing Outcomes Framework.
- Reduce the need for primary and secondary health care interventions by people with long-term health conditions and other chronic issues e.g. loneliness.
- Enable improvements in the overall health and well-being of patients and in their ability to self-manage their conditions by linking them into positive and supportive activities in the community.
- Be workable, effective and cost-effective.
- Help sustain vital VCSE services.

The role of the VCSE

We firmly believe that it is vital that the VCSE is centrally involved in the design, planning, implementation, delivery and evaluation of any systems. We have:

- The expertise to understand the 'beyond medicine' needs of patients.
- The ability to match them with suitable opportunities in their local community.
- The ability to enable them to fully benefit from and sustain those opportunities.
- A presence and reach in all local communities.
- The ability to help monitor and track progress and report on outcomes and impact.
- A strong track-record of successful delivery in partnership with health and social care providers.
- An understanding of and commitment to delivering on local ICS priorities.
- Existing networks through which to mobilise and engage the sector and to share best practice and knowledge.

However, to enable us to fully contribute our expertise and make our services available we need an equitable 'seat at the table'. We need acknowledgement of our integral role in delivering a successful social

prescribing services to patients and the importance of our expertise in shaping any extension or development of new or existing social prescribing systems. Whilst we understand issues of resource constraints and time pressures, we are aware of a number of models of best practice that could be used/considered/built-on, all of them fully involving and in some cases led by the VCSE. These include the pilot service currently delivered in Bassetlaw, led by BCVS, and the Rotherham Model – widely regarded as a best practice model nationally. Both these models work successfully as a result of the central role of leading local VCSE organisations that coordinate and act as a central hub for the service and employ experienced VCSE Link Workers to work with and support patients. These models also invest in the VCSE to ensure sustainable models of working are established.

Issues highlighted through the September – November VCSE consultation

Capacity

- The VCSE is already stretched and has experienced years of austerity which has led to many organisations closing or reaching breaking point. There are concerns about any increases in demand on services.
- Large organisations may be better placed to cope with increased demands and therefore receive funds but smaller organisations may be better placed to offer localised services in line with the ethos of social prescribing.
- There could be waiting periods for patients the organisations cannot manage where Link Workers continuing to refer. This could have a negative impact on the organisation's reputation.
- There are VCSE organisations who do not wish to be signposted or referred to. The proposed models suggest all of the VCSE is available for the purposes of social prescribing.

Funding

- Funding restrictions – existing funders often place restrictions on the categories of people who can access the service. This information isn't currently widely available for all organisations and projects. There could be referrals and signposting to organisations who cannot take on the patient which could in turn impact on the reputation of the organisation or the patient's motivation to seek an alternative.
- Sustainable funding – long term investment and capacity of the VCSE needs to be considered.
- Not free – volunteers and voluntary sector services have costs associated to them. This appears to be regularly overlooked and perpetuate stereotypes of the VCSE as a free rather than funded. Investment and resources are needed for any social prescribing models.
- Funding for completing additional tasks and paperwork is required.

Commissioning

- The commissioner and commissioning is not explicitly mentioned in the proposed models. What is their role?
- Future commissioning intentions – there is an opportunity to reshape commissioning to create a more fair market for smaller organisations.

Safeguarding

- There is a potential increased risk of safeguarding concerns and a need for accessible safeguarding training for VCSE organisations.
- Managing complex needs and specific service needs – this is an existing issue that many VCSE organisations face. They are already supporting patients with more needs than anticipated and

are largely left to it by health and social care who have closed their cases citing the VCSE organisation as the suitable outcome.

Information and data

- The ICS will need to be willing to share data to gain the full patient story to support meaningful social prescribing referrals. There is a need to see VCSE staff and volunteers as part of the wider workforce.
- LiON and Notts Help Yourself – these are limited resources e.g. it does not show the funder of organisations and any restrictions unless an organisation has volunteered this information. Organisations often do not prioritise keeping their entry and keywords up to date.

Infrastructure

- Infrastructure is needed for VCSE – suggestions were made for a single point of access, managing referrals, marketing, project coordination and strategic level voice needed

Social prescribing is already being delivered – social prescribing is not new. VCSE organisations have experience is delivering social prescribing and have evidence and experience to offer in how place based models are formed and developed. Develop it with the VCSE rather than impose models.

Observations on current proposals

The statement has been delayed until after the ICS Community Centred Approaches governance had been defined.

We recognise the fluid nature of the developments of the ICS and the challenges this poses to ICS staff. However, we are concerned that there has been significant change and confusion in the past 6 months which has led to decisions being taken in the absence of full consultation with the VCSE and patient voice. Whilst recognising the time constraints placed on the ICS staff to move this and similar projects forward, this has been done without considering the VCSE as a strategic partner and without democratic oversight.

The concerns laid out in this document have been raised on numerous occasions. Rather than being acknowledged and addressed they are noted as part of co-production with little evidence of being taken into consideration in the design of social prescribing models. To date there has been one co-production workshop held in September and the ongoing input of the My Life Choices group. Our concern is this process is being labelled as co-production when it is more reflective of gathering feedback from a select group. Co-production with the VCSE is not visible. With the time constraint of March 2019 for social prescribing to be in a working position, co-production, in its traditional sense is not possible. We would strongly recommend extending this time scale in order to undertake genuine co-production or to change the term being used in order to realign expectations.

Community Centred Approaches have an aim of reducing unnecessary dependence on services. Social prescribing is described as a short term intervention (approx. 12 weeks). Arguably, this raises questions about whether dependence will move to VCSE organisations along with the risk and associated costs. There is also a long term implication for the VCSE as the short term intervention increases long term usage of their services. Additionally, the cost saving for the ICS and in turn NHS from social prescribing as far as has been made clear is not available to invest in the VCSE.

Social prescribing will be built through strengthening place based community support. It is widely known there are disparities in the level of wealth and healthy life expectancy across Nottinghamshire. If these place based models build on what currently exists it could lead to a wider gap in health inequalities. We would recommend completing asset mapping in partnership with the VCSE to not only identify gaps in services but also where health inequalities and funding disparities exist alongside population data. This would build a robust asset map that is data driven incorporating both qualitative and quantitative data. Connected to this our concern that statutory services have inferred they could remove duplications in VCSE services and support.

The VCSE is referred to as provider and partner. This implies there is an agreement from the VCSE to provide services for social prescribing and that there is a defined relationship. However, the VCSE is currently largely not commissioned and most organisations do not have formal agreements in place to be considered in this way. Moving forwards the VCSE will expect to be funded and formally acknowledged as a provider and partner. We would be keen to see clarity around the relationship with the VCSE and the expectations of organisations.

'Workability'

There is still confusion about how social prescribing might be scaled across the ICS footprint. Even within the most recent proposals there seem to be unrelated and potentially competing developments underway or emerging throughout Greater Nottingham and beyond. For example, a VCSE organisation has recently received 3 years of funding to carry out social prescribing which does not appear to relate to any of the existing place based models suggested.

The current models still appear to present as medically driven/focused and do not fully acknowledge the central role of VCSE organisations in delivering social prescribing. They do not appear to take account of the contribution we can make to ensuring patients are matched with and sustain the most suitable and helpful opportunities and activities for them as individuals, nor do they seem to acknowledge the potential additional pressures on local VCSE organisations arising from the introduction of a new system.

The current models appear to assume that the VSCE can absorb additional demand without sustainable additional resource and infrastructure. As such, we believe the proposals in their current form are unworkable. In addition there are a number of concerns regarding the plans for link workers, the role of volunteers, patient activation measures, quality assurance and language. We believe all of these concerns can be addressed through the VCSE having a consistent strategic voice and meaningful collaborative working.

Risks

There is a risk that without the full involvement of the VCSE, through consultation and meaningful dialogue and full coproduction, any system will not work effectively. It is unlikely to deliver the best outcomes for patients and will potentially place unsustainable burdens on front-line VCSE organisations. Whilst we understand that there might need to be different systems in different areas, they should be consistent and fair and will need to meet the needs of the local population. At present it appears unlikely that this will be the case. In the worst case scenario some voluntary sector organisations might decide simply not to engage as a result of the lack of clarity of what is expected of them and the potential additional burdens placed upon them. This is something we are keen to avoid.

In summary

Our collective position in response to recent and proposed social prescribing developments can be summarised as a cautious 'Yes, but…'

In short, we believe there is a platform to build on and an opportunity to improve the proposals through dialogue and co-production. We are asking for (and believe we should be able to expect) a process of meaningful dialogue in order to:

- Clarify expectations of the VCSE.
- Ensure security of current VCSE funding (as a minimum).
- Explore the potential for additional resources/infrastructure for VCSE organisations who will be required to deliver activities and opportunities for patients, with an emphasis on enabling sustainable VCSE interventions.
- Co-produce an effective and workable system in the best interest of patients and all stakeholders.

The following quote from Dr. Marie Polley, Co-Chair of the Social Prescribing Network, during a recent episode of 'Inside Health' on BBC Radio 4 perfectly summarises our view:

> ***I think fast forward 10 years…I think that there will be universal access to social prescribing and that it will be embedded within the medical profession and I think it will be embedded in local authorities and social care. That will only work…if everybody realises that it's the voluntary community sector that are the real gem in all of this because they've been supporting people in the way that's very bespoke and appropriate for years and years and years and they've always been the poor relation at the table. So, if we don't invest in the voluntary sector there won't be social prescribing in 10 years' time and that's the message from the social prescribing network.***
>
> [Dr. Marie Polley, Senior Lecturer in Health Sciences at the University of Westminster and Co-Chair of the Social Prescribing Network.]

We have written and submitted this paper in good faith, in the hope that it will enable decision-makers to understand and accept our position and make a positive response towards the development and implementation of the best possible service/system.

Written on behalf of the Vulnerable Adults' Providers Network (VAPN) Nottingham
December 2018