HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Mark Tuckett and Brain Hughes
Date:	31st March 2022
Subject:	Strengthening of statutory bodies strategic relationship with the Voluntary Sector in Sheffield
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Summary:

This paper provides an update to the Health and Wellbeing Board on the development of the strategic relationship between statutory bodies the and the Voluntary Sector in Sheffield

Since the discussion paper on this issue was brought to the HWBB in February 2021 Statements of intent have been agreed by both the HWBB and the Sheffield Health and Care Partnership (Appendix 1)

A set of actions to ensure intent becomes reality has been developed and is being taken forward by a working group. The group is made up of a broad range of VCS organisations as well as health and care commissioners and aims to bring together the various conversations and plans that were being developed in the city on this issue.

Questions for the Health and Wellbeing Board:

Health and Well-Being Board are asked to consider whether this provides sufficient assurance on progress against the Voluntary Sector Statement of Intent.

Recommendations for the Health and Wellbeing Board:

We need to be sure this action plan is a vehicle for change, rather than a process we move through. In particular this requires bold action to tackle the areas of concern outlined.

HWB Board are asked to debate the points outlined and:

- Note the areas of progress
- Outline any further points they wish the HCP to consider to secure a more strategic and equitable relationship with the voluntary sector in the city

Background Papers:

Statement of Intent and illustrative plan approved by Sheffield Health and Care Partnership Board June 2021 (Appendix 1)

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

The work has the potential to support delivery of all 9 of the strategy ambitions

Who has contributed to this paper?

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Development of statutory bodies strategic relationship with the voluntary sector in Sheffield

1.0 SUMMARY

1.1 This paper provides an update to the Health and Wellbeing Board on the development of the strategic relationship between statutory bodies the and the Voluntary Sector in Sheffield

1.2 Since the discussion paper on this issue was brought to the HWBB in February 2021 Statements of intent have been agreed by both the HWBB and the Sheffield Health and Care Partnership (Appendix 1)

1.3 A set of actions to ensure intent becomes reality has also been developed and is being taken forward by a working group. The group is made up of a broad range of VCS organisations as well as health and care commissioners and aims to bring together the various conversations and plans that were being developed in the city on this issue.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 By working more closely with the VCS and having VCS organisations integral to health and care planning and provision we will be better able to reach and build connections with parts of our city which our statutory partners are less good at reaching. We know our VCS organisations are often very firmly rooted in their communities – both of geography and identify – and so have a trust and engagement with people that other providers could hugely benefit from.

2.2 It provides opportunity for decision makers to come together with people advocating for and providing support to those experiencing inequalities or experiencing inequalities themselves to work towards solutions and give people more opportunity to achieve good health outcomes

3.0 MAIN BODY OF THE REPORT

3.1 A discussion paper was considered by the Health and Wellbeing Board (HWBB) in February 2021. This paper explored ways in which the Health and Wellbeing Board and the voluntary sector in Sheffield, can develop their relationship to be more open, strategic, mutually supportive and sustainably funded as we begin to move towards recovery.

3.2 There was recognition at that time that discussions about the development of the relationship with the sector were taking place in different forums (e.g. Joint Commissioning, HCP and the HWBB) and that these needed to

be brought together. Recognising that this work is not just about commissioning, but about relationships and doing things in a different way.

3.3 This paper aims to provide an update to the HWBB Board on the progression of those conversations and the actions underway to develop the relationship with the VCS

3.4 In March 2021 the HWBB agreed its Statement of Intent for its relationship with the Voluntary and Community Sector.

3.5 In support of this, in June 2021 the Sheffield Health and Care Partnership agreed its Statement of Intent outlining its commitment to working differently with the VCS and providing an illustrative action plan (see Appendix 1)

3.6 The ten-year vision for Health and Care in the city was approved by the HCP partners at the end of 2021. There is a clear role for the Voluntary and Community Sector (VCS) within all three pillars of the vision:

On *inequalities*, the different models and modes of delivery are an invaluable asset in reaching and building connections with parts of our city and communities which our statutory partners are less good at reaching

On *integration*, the opportunities for fully realising the potential of holistic health, care and wellbeing stretches beyond connecting primary with secondary care, or health with social care, to also integrating voluntary services with statutory provision, as full partners

And on *people*, those both working in and volunteering for VCS organisations should be recognised as and identify with 'Team Sheffield'.

3.7 Voluntary Sector leaders are now key members of the Sheffield Outcomes Framework Board, enabling the establishment of service user and VCS experiences feedback into the outcomes framework dashboard. A proposal is being taken to the Outcomes Framework Board to ensure the dashboard is regularly shared with the HWBB.

3.8 Development of the Joint Commissioning Intentions has also ensured that the VCS were part of the consultation process. This engagement is planned to expand for future years. Good commissioning practice and also the role of VCS intelligence and data to City decision making are key to providing appropriate health and care for our population

3.9 A working group has been established to take forward and further develop the illustrative action plan outlined in the Statement of Intent. We need to be sure the action plan being developed by the working group to be a vehicle for change, rather than a process we move through. In particular

this requires bold action to tackle the areas of concern outlined. This group continues to develop and its membership includes a wide range of VCS organisations as well as commissioners from health and social care. The work of the group is focussed on five key areas:

- **Coordination and leadership**: investing in how a diverse VCS is connected, coordinated and led
- **Delivery**: recognise the 'otherness' and reach that the VCS brings to delivery and see VCS organisations as essential partners for delivery
- **Financial security**: support and enable longer term resilience and security for VCS organisations. This has been identified by the group as the most pressing area of work to focus on.
- **Voice**: listen, respect and respond to VCS organisations, both established and new and different voices
- **Shared learning and experience**: value, support, develop and connect people working across our health and care system, building on and sharing good practice about existing good connections and partnership between our statutory services and VCS.

3.10 There are already examples in the city where the VCS are taking a leading role bringing investment into the city and leading change in health and care provision. For example, the investment (secured through a bid led by Voluntary Action Sheffield) by the Kings Fund Healthy Communities Together Fund to support a piece work to improve connections between communities and the health system particularly where health inequalities are highest, to improve the prevention and management of diabetes.

4.0 WHAT NEEDS TO HAPPEN TO MAKE A DIFFERENCE IN THIS AREA?

4.1 This paper provides an update on the early work to develop the relationship with the VCS. Board will need to continue to engage with the development of this and consider its role in challenging other bodies to do the same.

5.0 QUESTIONS FOR THE BOARD

5.1 Health and Well-Being Board are asked to consider whether this provides sufficient assurance on progress against the Voluntary Sector Statement of Intent.

6.0 RECOMMENDATIONS

6.1 HWB Board are asked to note and debate the points outlined below:

- Note the embedding of the VCS in strategic conversations across health and care.
- Note the establishment of a working group and its key areas of focus.
- Note the proposal that the Sheffield Outcomes Framework be brought to HWBB on a regular basis.
- Outline any further points they wish the HCP to consider relating to how they are developing a more strategic relationship with the voluntary sector in the city

Appendix 1 – Statement of Intent and illustrative plan approved by Sheffield Health and Care Partnership Board June 2021

Statutory Bodies – VCS relationship

Since the inception of the Sheffield Health and Care Partnership (SHCP), we have been in full agreement about the importance of the Voluntary and Community Sector (VCS) and the critical role it plays within our health and care system. This relationship has developed over time, with Voluntary Action Sheffield (VAS) joining the SHCP as a full member in Summer 2018 and the following year, funding of £50,000 per annum agreed for a 3-year period to support the integration within the city's health and care infrastructure and the broader development of the VCS.

Pre-covid, our conversations had already turned to the next steps in strengthening this relationship and how to ensure the sustainability of critical VCS services. The events of the past 12 months have showcased the flexibility and added value, with which the VCS enhances our statutory service provision. As a result though, our VCS finds itself under significantly increased pressure, and there are real concerns about the short to medium term sustainability of critical services which we have come to rely on as a city. One example of this is the increase in activity at Manor and Castle Development Trust: they would typically be supporting 440 people at any one time, whereas by February 2021 they were supporting 1170 people, with the same resources and no additional capacity, leaving their staff and services at breaking point.

As stated in our draft 10-year vision:

The VCS in Sheffield is already a key part of our health and care system, whether through commissioned services or through the support provided to individuals and communities using charitable funding. *Given this key role we need to support its long-term future. Although a number of VCS organisations in Sheffield have been in existence for longer than some of our statutory partners, sustainability and funding remain common challenges. Funding processes have been known to stifle progress and effective ways of working, whilst our VCS representatives have described the tension between our strategic and planning intentions to work with the sector in a supportive and strategic way, and how services are procured and contracts are established. This is reflected in a wider concern about the extent to which the appetite for a strategic relationship with the VCS is embedded in the culture across and throughout our organisations.*
The VCS can be recognised as disruptors, challenging the status quo and thinking differently about the delivery of better outcomes with and within communities. Simply sub-contracting elements of service delivery risks understating thus undermining the benefits which can be achieved, and perpetuates an assumption that VCS services are simply cheaper alternatives to statutory providers. If we are serious about working with communities, community reference groups will need to share the same status as clinical reference groups as service plans are developed; with a shared focus on the social determinants of health alongside medical models of healthcare.

There is a clear role for the VCS within all three pillars of our draft vision:

- On *inequalities*, the different models and modes of delivery are an invaluable asset in reaching and building connections with parts of our city and communities which our statutory partners are less good at reaching

- On *integration*, the opportunities for fully realising the potential of holistic health, care and wellbeing stretches beyond connecting primary with secondary care, or health with social care, to also integrating voluntary services with statutory provision, as full partners

- And on *people*, those both working in and volunteering for VCS organisations should be recognised as and identify with 'Team Sheffield'.

We have a good story to tell in Sheffield, which is starting to be recognised beyond our own city (the University of Birmingham is currently undertaking some research based on the positive stories they have heard about the role our VCS organisations have played as part of Sheffield's COVID response). We need to build on this.
The table below has been developed through collaboration between the CCG, Sheffield City Council, VAS and the SHCP core team. It outlines their initial views on what we must, should and could do to maximise the full benefit of a strong and integrated VCS for our Sheffield citizens, thus strengthening our strategic relationship and recognising the value of the 'otherness' which the VCS brings. Five key areas are covered:

- **Coordination and leadership**: investing in how a diverse VCS is connected, coordinated and led

- **Delivery**: recognise the 'otherness' and reach that the VCS brings to delivery and see VCS organisations as essential partners for delivery

- **Financial security**: support and enable longer term resilience and security for VCS organisations

- **Voice**: listen, respect and respond to VCS organisations, both established and new and different voices

- **Shared learning and experience**: value, support, develop and connect people working across our health and care system, building on and sharing good practice about existing good connections and partnership between our statutory services and VCS.

The table below is included in this paper for illustrative purposes, to share with SHCP Board the range of thinking and options currently under consideration. It is fully expected that these will be adapted to reflect wider and evolving views, including those of SHCP members beyond the CCG, City Council and VAS. As firmer proposals are developed, we will take them to EDG and, where appropriate, to Board. We have identified a number of actions, which we believe should be implemented within the next 12 months – these are listed below and are presented for SHCP Board approval.

This paper also reflects, and brings together, similar conversations currently taking place at both the Health and Wellbeing Board and the Joint Commissioning Committee. The actions proposed below contribute directly to the Health and Wellbeing Board's recently endorsed 'Statement of Intent for VCS Relationship'.

<u>In the next 12 months we will, as a minimum:</u>

Coordination and leadership

- Embed VCS leadership in our future place partnership model of working
- Agree what our shared investment in VCS leadership (through VAS and other coordination and leadership organisations) and aligned expectations for this money, so that it can have greater impact

Delivery

- Implement the diabetes project, led by the VCS and with all partners playing a full role
- Working with Primary Care Networks and community care teams, develop an employment model for care coordination posts, which fully integrates VCS organisations
- In line with our ambitions around prevention and community-based care and support, assess the level of risk currently being held (and contained) within the VCS to agree actions which will either:
    i. minimise escalation to statutory services,
    ii. enable individuals'/families' continued support in community-based settings or
    iii. support a managed transition to clinically-led care
- Reframe the way we work with the VCS: shift away from a transactional relationship based around funding distribution, to one which delivers better services in partnership with our communities

Financial security

- VAS, SCC and the CCG to identify specific ways through which longer term financial security could be achieved and implement those changes

Voice

- Recognise Sheffield Healthwatch as our experts and independent champion for voice and influence (in our governance, in our discussions, and through specific improvement work)

Shared learning and experience

- The implementation of our reciprocal mentoring programme at EDG
- Expansion of system leadership development, including across voluntary sector providers

	We must…	*We should…*	*We could…*
Coordination and leadership	1. Invest in additional capacity within VAS and the wider VCS to coordinate VCS and specific community of interest connections, with decision-making at a city and locality level to support more effective "place based" arrangements 2. Tackle inequality in leadership, including investment in BAME leadership to bring more voices to influence. 3. Coordinate the various conversations and funding streams into VAS and the wider VCS and focus on outcomes.	1. Invest in other organisations doing this leadership 2. Support the VCS to coordinate network activities – map out current infrastructure funding and put on a recurrent basis (at least 3 year contracting arrangements) where possible.	
Delivery	4. Make continued investment to support wellbeing across the city, e.g. a small grants pot to enhance services and support from the statutory sector, or to wrap around individuals and communities in a way the statutory services do not and targeted to address inequalities, with an expectation that e.g. 50% of the fund is invested through BAME/community led groups to generate a levelling up effect. 5. Understand the collective cash input into the sector through grants and commissioned services to understand gaps and/or duplication 6. Capture the outcomes achieved through the work with the sector	3. Invest in capacity within organisations to allow the VCS to shape local partnerships 4. Have an expectation that each SHCP partner invests 1% of its turnover in the VCS in Sheffield 5. Consider further investment in managing the impact of COVID-19 to ensure longer term infrastructure funding commitment. 6. Develop more capacity within Social Prescribing organisations to support hospital rehabilitation and recovery services.	1. Develop capacity within VAS to have a greater role in connecting commissioning to VCS delivery in identified areas e.g. Autism or COVID recovery. 2. Each (non-VCS) SHCP member to identify a tricky problem on which it will work with VCS partners to find and invest in alternative practices and solutions. During 2021/22, we will implement changes in light of the recommendations that arise from this work

Financial Security	7. Make a public commitment of support to the VCS 8. Not financially penalise VCS organisations in Sheffield as a result of Covid 9. Prioritise business continuity through financial arrangements, and commit to taking every opportunity to foster collaboration not competition 10. Make timely decisions and take timely action to reduce financial insecurity for organisations and their staff 11. Fully fund all contracted activity (a lot of VCS activity is currently cross-subsidised from charitable activity funds). 12. Work with voluntary and community based organisations with longer term, secure funding arrangements - in the immediate term, we will ask VAS, SCC and the CCG to identify specific ways through which this longer term security could be achieved. Annually renegotiated budgets and contracts will become the exception rather than the norm.	7. Join up commissioning so an administrative layer isn't added to the VCS burden 8. Recognise and understand the complexity of VCS funding – e.g. ZEST funding for weight management, swimming pool, adult education – each relies on the other and one decision impacts on the whole organisation, yet decisions are taken in isolation 9. Use joint commissioning to bring decisions together and make them work for the VCS 10. Change perceptions of value – people, assets, skills, continuity of service, wider support for and investment in communities to enable resilient support. It isn't just about the £ and saving or spending money 11. Refer to good examples of where this is done well to achieve excellence (e.g. Preston and Wigan) 12. Develop more VCS led interventions that support people with multiple, complex support needs that currently fall between services, resulting in inefficient demands being placed on statutory services.	3. Decide how to invest more in the VCS, without strings around outcomes and to enable a leadership role in community led approaches.
Voice	13. Bring people's voices and what matters to them to the heart of improving health and social care	13. Embed understanding of theory and experience the practice of engagement in CPD, training and career progression	4. Commit to testing ideas about service redesign to meet local population health priorities e.g. diabetes,

	14. Invest consistently in capacity of organisations to engage with need – small and flexible 15. Recognise Healthwatch's unique position as the independent champion 16. Create the expectation for all SHCP papers that they explicitly include a section on voice 17. Invest in the long term [5 year minimum] to build relationships, trust and confidence. 18. Involve in problem *setting* as well as problem *solving* 19. Understand voice's role *across* design, commissioning, management and evaluation of services ***and*** in wider discussion, outside specific services, in system changes and identifying what makes for well-being. 20. Be more consistent as a system in how we do it 21. Listen to people who are rarely heard and test for "blind spots". 22. Develop and support models which resource the co-ordination of voice, ***as well as*** resourcing organisations to participate. 23. Create/ continue the space for VCS organisations to engage with and be heard by our statutory partners (e.g. the SHCP BAME Communities Group)	14. Embed the role of the VCS in supporting communities to engage with and support devolved decision making in localities 15. Shift to a 'Radical Help' model to change the relationships from service provider and service user to collaborative relationship 16. Position civic society and communities at the heart of what we do – participants not consumers 17. Visibly base decisions in communities and need, not in commissioning silos e.g. bring together home care, employment, developing community assets; align different policies to achieve multiple and *connected* goals 18. Invite Healthwatch Sheffield to join our SHCP Board and fund it to do more. 19. Clarify and strengthen the connection between our *Improving Accountable Care Forum* at the Board and Executive Team. 20. Surface, hear, consider and resolve longstanding and emerging challenges that Healthwatch and other voice-based organisations and fora have identified as areas for improvement 21. Widen the membership of the SCC VCS Steering Group to develop this into a place-level meeting	dementia, young people's mental health 5. Use the Local Area Co-ordination Network (lacnetwork.org) in a defined area (PCN or community with an established organisation like Zest / SOAR etc.) or with a specific service e.g. a Doncaster peer support group has re-shaped their mental health crisis care service

	24. Focus on sharing intelligence between SHCP partners 25. Understand what the Community needs / and how it wants to be supported e.g. refugees		
Shared learning and experience	27. Adopt a strategic approach to our current system leadership provision (e.g. Leading Sheffield) to ensure impact is maximised across and within all organisations	22. Commit to activity to understand the VCS offer within organisations and drive that from a top level to embed activities 23. Establish peer mentoring 24. All senior leaders spend a day with a VCS organisation each year as part of their learning and development	6. Establish a "job exchange" scheme for staff working in our health and care system to experience working with and in VCS organisations; and vice versa