

MEMORANDUM OF UNDERSTANDING

between

The Greater Manchester Health and Social Care Partnership

and

The Voluntary, Community and Social Enterprise Sector in Greater Manchester

1. Introduction

- 1.1 In the context of Health and Social Care Devolution in Greater Manchester, this Memorandum of Understanding is intended to provide a framework to support engagement across Greater Manchester's devolution agenda in relation to health, social care and wellbeing between the statutory sector and the voluntary, community and social enterprise (VCSE) sector.
- 1.2 In signing this MOU, each party undertakes to build on the strength of our existing relationships, and the opportunity presented by devolution, and to work within a set of principles.

2. Parties to this Agreement

- 2.1 The Memorandum of Understanding (MoU) is between the Greater Manchester Health and Social Care Partnership and the Voluntary, Community and Social Enterprise Sector in Greater Manchester. It has been brokered by and is signed by the GM VCSE Reference Group on behalf of the VCSE sector in Greater Manchester.
- 2.2 See Appendix A for further information on the parties.

3. Commencement Date and Term

- 3.1 The parties will work collaboratively for an initial period of five years commencing on 1 January 2017 and work across a range of activities to support both parties' shared objectives.
- 3.2 This collaborative partnership will be reviewed annually to confirm continuation and update shared objectives.

4. Scope of the Agreement

- 4.1 This agreement is based on a number of shared ambitions to which the parties commit as the outcomes of the partnership:
 - 4.1.1 A step change in the understanding and involvement of people and communities in the transformation of health and social care.
 - 4.1.2 Better services and greater support for the public.
 - 4.1.3 The development of Local Care Organisations with highly bespoke local place-based characteristics
 - 4.1.4 Increased mutual learning and continuous professional development
 - 4.1.5 Increased leverage of the talent, capacity and social value of VCSE organisations above and beyond whatever is commissioned from it
 - 4.1.6 Effective development of VCSE activity.
- 4.2 These ambitions, which define the outcomes of this agreement, are expanded upon with actions and commitments in Appendix B.

5. Background: Current Opportunity

- 5.1 The Greater Manchester Health and Social Care Strategy Taking Charge is a public service reform strategy around health social care and wellbeing based on rebalancing the existing health and social care system towards prevention, community resilience and self-help. It is plain that successful implementation of *Taking Charge* will require leveraging of voluntary action on a grand scale: if we define voluntary action as “*people looking after themselves and each other, by organising into groups with a common purpose*”. Ensuring the involvement of our existing voluntary, community and social enterprise (VCSE) sector and fostering targeted development of new and additional voluntary action, enterprise and volunteering is therefore a crucial enabler of the ambitions of *Taking Charge*.
- 5.2 This MoU represents an opportunity for the parties to implement new ways to work together to plan, design and deliver all aspects of *Taking Charge* and thereby increase the health and wellbeing of the people who live, work and study in Greater Manchester. There is widespread acknowledgement that the VCSE sector is already a major contributor to the current system, delivering across all five key areas for transformational change described in the strategy and bringing considerable resources and knowledge to Greater Manchester.
- 5.3 Within the VCSE sector there is an existing body of knowledge offering indications about how it is in practice possible to reduce the need for formal services whilst increasing the wellbeing of residents and the resourcefulness of communities, thus enabling people to Start Well, Live Well and Age Well. Some of this is recorded in formal evaluations and research reports.
- 5.4 The VCSE sector is well-connected and organised and eager to become more involved. It has repeatedly evidenced its ability to work strategically at pace and scale and deliver to a high quality. Very recently this was done in the context of health and social care, when more than a hundred organisations across GM collaborated at short notice to deliver the VCSE/Healthwatch contribution to the *Taking Charge Together* consultation¹. The knowledge and experience of people from VCSE organisations has been repeatedly demonstrated over the last year in meetings with statutory sector professionals and involvement in some locality planning and cross-cutting themes.
- 5.5 There is potential to increase and expand the VCSE sector’s contribution and connect it to that of the public sector. It is also agreed that the public and VCSE sectors need to find new ways to collaborate, learn from each other and work at scale across Greater Manchester and within every locality.
- 5.6 This thinking is not unique to Greater Manchester but applies across the health and social care system in England. It has been clearly explored and expressed in the *Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector (Dept. of Health, NHS England & Public Health England, May 2016)*². See Appendix E for a summary. This MoU is a shared recognition of the opportunity for Greater Manchester to pioneer the implementation of the recommendations of the Review in pursuit of the ambitions of *Taking Charge*.

¹ It should be noted that this work had a very limited budget, considerable time constraints and a fixed model of consultation. It was taken on by the VCSE sector as a means to demonstrate both our willingness and capability to deliver in such exercises. Our ambition is future projects to be co-designed between public and VCSE partners.

² <https://vcsereview.org.uk/>

6. Realising the VCSE sector's contribution to the five transformation programmes

Effective co-production and joint leadership with the VCSE sector will enable the achievement of Taking Charge outcomes across all five transformation areas:

- 6.1 **Contribution to Transformation Programme One:** The most difficult and most crucial outcome in *Taking Charge* is to achieve a shift in focus from services to prevention and enable people to look after themselves and each other in the community. This is because success is not within the control of the statutory sector. It depends on “*a new deal with the public*”. VCSE groups reach huge numbers of residents, and can help to mobilise communities, change behaviours and find the “missing thousands”. The VCSE sector is already at the forefront of providing the community activities and resources that allow people to stay well and live independently. VCSE organisations support, for example, parks and environments, community centres, libraries and theatres, allotments, playgroups, sports groups, choirs, festivals and much more. Social movements also lie within the broader spectrum of voluntary action, and many are active in Greater Manchester. Much of all this is at present invisible to the statutory sector and would not identify itself as anything to do with “health and social care”. In addition, it will be necessary to undertake targeted work in some communities to develop new VCSE activity and organisations, learning from replicable practice elsewhere; this will be most effectively done by the statutory and VCSE sector working together.
- 6.2 **Contribution to Transformation Programme Two:** Integrated care and support and consistent, efficient, co-ordinated services within the community will benefit from the involvement of VCSE providers to assist with co-design, co-delivery, and provision of services and support to allow people to manage conditions at home and in the community, and achieve rehabilitation and reablement. VCSE organisations are already providing community based services at considerable scale, to communities of locality, identity and experience:- 41% (of around 15,000) work in a specific neighbourhood; 23% work with older people, 14% with disabled people, 11% BME people, 11% with families, 11% with people with mental health problems. There are also substantial numbers working with, for example, unemployed people, people involved in the criminal justice system, people who are homeless, refugees, carers, looked after children and people with drug and alcohol dependency (*Greater Manchester State of the Voluntary Sector 2013, Sheffield Hallam University*). VCSE organisations also run peer support networks, volunteering and time-sharing services, community transport, homecare services and similar, and provide information, advice and signposting.
- 6.3 **Contribution to Transformation Programme Three:** Relevant organisations from the VCSE sector should be embedded into Whole Care Pathways. Some VCSE organisations provide specialist services on which patients already rely. Others will be particularly important to enabling smooth transition into and out of clinical care and providing early warning and recovery support within the community. There is already activity within the VCSE sector in areas like community transport, language interpretation, peer buddying, meet and greet, arts and culture, advice and through the gates support. Following the standardisation of acute and specialist services, VCSE organisations can also help with ensuring disadvantaged groups, people with needs for reasonable adjustments and people with experience of discrimination are able to benefit equally from the new system, and can help the statutory sector avoid any unintended and undesirable consequences of system change.

- 6.4 **Contribution to Transformation Programme Four:** Whilst this programme is largely about the rationalisation of existing statutory sector back office the VCSE sector is again well placed to assist the statutory sector to avoid any unintended and undesirable consequences. Some organisations may be able to participate in some of the proposed central services, and/or care co-ordination system, thus reducing overheads and enabling more resource to go to the frontline. Data already collected by VCSE organisations can help inform decision-making, and they are well-placed to collect additional data.
- 6.5 **Contribution to Transformation Programme Five:** Full involvement of the VCSE sector as described in the *Joint Review* is itself within the spirit of Programme Five and if implemented would represent real innovation. In addition there are VCSE organisations with interest and expertise in areas like technology, research and new delivery models. There is an existing VCSE estate, and some organisations can offer premises and venues within communities or can consider taking on public buildings through asset transfer. There is also a substantial workforce of paid staff, volunteers and informal carers which can be developed alongside that of the statutory sector, enabling mutual support and learning . VCSE organisations are in a very strong position to advise statutory organisations on improving commissioning and contracting, and on implementing social value and social innovation.
- 6.6 **Cross-cutting themes:** There are a number of emerging and current elements of the work which the VCSE sector either is or needs to be directly involved in, including the official cross-cutting programmes of mental health, cancer, dementia, diabetes and learning disabilities. VCSE organisations have strengths in thinking about the aspects of health and social care which can't best be delivered with a locality focus: communities of identity (e.g. LGBT, ethnicity etc.); communities of experience (e.g. ex-offenders, mental health service users etc.) who may not see the locality as their community at all. VCSE organisations are also important in adult social care, children's care, health innovation, social movements, carers, work and health and other emerging important areas. The VCSE sector would like the Health and Social Care Partnership to consider additional cross-cutting themes such as food, welfare benefits and access and inclusion.

7. What the VCSE sector brings

- 7.1 The ability to engage in this MoU is possible only because we are building on a large, well-networked VCSE sector with strong, collaborative leadership which is able to convene and act around general or specific strategic objectives and a variety of geographic footprints. Key enabling structures include
- **VCSE Reference Group:** A forum of people which has come together to reflect a range of constituent networks including local infrastructure, equalities organisations, Healthwatch, faith, social enterprise and provider organisations, to act as “catalysts and connectors”, influencers and advocates for the VCSE.
 - **GMCVO:** Established VCSE support and development organisation operating on the Greater Manchester footprint, offering collaborative leadership, experience of acting as a “lead body” and extremely well connected into localities and across all sectors.
 - **Local Infrastructure:** civic institutions which provide VCSE sector support and development at local level with a borough identity. These organisations deliver place-shaping roles including nurturing local group development (those micro organisations operating at neighbourhood level which comprise some 85% of our sector), hosting

Volunteer Centres, and engaging with borough partners such as Local Authorities, CCGs and NHS Trusts. (There is no longer a local infrastructure organisation in every GM borough but some of the existing organisations have established a joint venture called “10GM” with the aim of ensuring support is available in all 10 boroughs.)

- **Equalities Advisory Board:** Originally established to support Healthier Together, and able to offer scrutiny of strategies and plans to ensure inclusivity and avoid unintentionally disadvantaging or discriminating against people with protected characteristics.
- **Established communications channels:** The sector has established communications channels to reach and engage with around 15,000 Greater Manchester based VCSE organisations. These are facilitated by our infrastructure bodies such as GMCVO, local infrastructure and collaborative structures such as the GM VCSE Reference Group and key Equalities Organisations.
- **Established forums and networks:** In addition there are some strong networks including BME, Social Enterprise and Healthwatch, and a growing number of VCSE formal collaborative partnerships such as Age UK, Mind and Richmond Group.
- **Established lines of accountability:** By building on the membership criteria of the infrastructure organisations, it is possible to identify those organisations which are genuinely “voluntary, community or social enterprise” and which are active within Greater Manchester. These are the organisations which will be invited to participate in the “Assembly” and associated meetings and activities.

- 7.2 Within the VCSE sector, there are high levels of commitment to delivering the vision of the GM/c Strategy “By 2020, the city region will have pioneered a new model for sustainable economic growth based around a more connected, talented and greener city region, where all our residents are able to contribute to and benefit from sustained prosperity and a good quality of life” (70%) and support for GM/c devolution “I am in favour of more devolution to Greater Manchester” (93%). However 86% also believe devolution is “necessary but not sufficient if we want to address the problems of poverty, inequality and unemployment and create a city region in which everyone can enjoy a good quality of life and 94% think the VCSE sector could make a much bigger contribution (*GMCVO Devolution Survey Nov 2014*) .
- 7.3 The existing VCSE sector is already delivering at scale. Much activity is hidden from the statutory sector and is not resourced with public money. For example over 5,000 organisations are working on community development; over 5,000 in health and wellbeing. Volunteers within the VCSE sector are contributing 1.1 million hours every week, worth £656.3m pa (New Economy methodology based on median NW wage), and 76% of organisations receive or generate income from sources other than public funds (*Greater Manchester State of the Voluntary Sector 2013, Sheffield Hallam University*)
- 7.4 The VCSE sector is already working across every aspect of Greater Manchester devolution including skills, employment and enterprise; housing and transport; environment and carbon reduction; poverty reduction; inclusive economic growth and inclusive governance. Many VCSE leaders have an overview of devolution and understand how health and social care and other agendas (such as work and skills, housing and transport or the justice system) are inter-connected. In addition many of them are already active in community development, social movements, social innovation and poverty action. Many of them are also firefighting the symptoms of a situation which is increasingly creating unequal outcomes - addressing homelessness, addiction, hunger, poverty and abuse – 90% of organisations report experiencing increasing demand and/or identifying unmet needs. There is still enormous

goodwill and willingness within the VCSE sector to deploy and align its own time, knowledge and resources and to work in partnership with other sectors towards shared goals.

- 7.5 Events which bring VCSE and statutory sector colleagues together, like the various “Assemblies” already held, repeatedly demonstrate the level of on-the-ground intelligence and knowledge within the VCSE sector, hint at the range of work already being done by VCSE organisations, and evidence the interest they have in getting more involved in health and social care devolution.

8. Joint Commitments

Our joint commitments to enable these outcomes to be achieved are to:

- 8.1 Development and maintenance of a GM VCSE Assembly which can be convened on generic and specific issues and interact with statutory sector leaders through events, round tables, meetings, forums etc.
- 8.2 Enabling dialogue between statutory and VCSE sector through surveys, social media and other methods as appropriate; publishing early drafts for comment, enabling discussion with focus groups and/or VCSE Reference Group and through Assembly events
- 8.3 Facilitating and providing good, consistent, up to date information and communication with the VCSE sector making use of and building on established sectoral channels of communication and existing relationships.
- 8.4 Supporting members of the GM VCSE Reference Group along with other appropriate VCSE leaders chosen by their peers to represent them at a wide range of strategic boards and working parties.
- 8.5 Reviewing and sharing good practice within statutory and VCSE sectors in GM and in each locality, supporting a more consistent and effective approach to engaging VCSE organisations and operating according to the principles set out in this Memorandum of Understanding.
- 8.6 Enabling VCSE policy experts when necessary to spend time on contributing and responding to the detail of strategy and policy documents; commissioning models; impact assessment; social value methodologies etc.
- 8.7 Supporting the VCSE Reference Group to act as “first point of call” for engagement with the VCSE sector to facilitate the work outlined above; the group can also offer a sounding board or informal policy discussion to key statutory sector people.
- 8.8 Supporting and extending the remit of the VCSE Healthier Together Equalities Group from Programme Three to all programmes of work, cross-cutting themes and enablers.

9. Key Risks

Failure to implement the vision enshrined in this MoU brings a number of significant risks including:

- 9.1.1 Reduced ability to establish a new deal the public
- 9.1.2 Outdated transactional relationships across the sectors
- 9.1.3 Missing key enablers that connect and mobilise communities

9.1.4 Misunderstanding the real demand and supply issues across the system

9.2 Further analysis of these risks can be found in Appendix C

10. Working Relationship

The following key principles will be adopted by both parties in realising the ambitions of this MoU:

- 10.1 Both parties recognise that this is an evolving situation, and priorities and details of specific activity will change over time; this Memorandum will be reviewed and amended periodically by mutual agreement.
- 10.2 To seek to embed the recommendations of the Joint Review of Partnerships and Investment in Voluntary, Community and Social Enterprise Organisations in the Health and Care Sector (2015). Again, each party agrees to take a pragmatic approach.
- 10.3 To respect the principles of the Compact as a framework for effective collaboration between VCSE and statutory sectors but, acknowledging practical difficulties out of the control of the parties, will not be constrained by them. Each party agrees to take a pragmatic approach.
- 10.4 To achieve the outcomes outlined above through increased collaboration, enabling the systematic and comprehensive inclusion and involvement of the VCSE sector exploring a variety of mechanisms to facilitate this including VCSE sector secondment(s) into statutory sector teams, and from the statutory sector into key VCSE organisations to improve communications and avoid missing opportunities to increase effectiveness through collaboration.
- 10.5 To encourage statutory sector representatives to attend VCSE sector events and standing meetings as regular members or guests; to participate in governance structures; to undertake visits and temporary placements including across localities or themes. This will assist with building mutual understanding.
- 10.6 Where specifications are developed for consultancies to be undertaken, due consideration will be given to using VCSE organisations or partnerships as providers (e.g. see recent Taking Charge consultation).
- 10.7 That assumptions will not be made about the value of the assets, spaces and workforce of the respective sectors and investments will be made based on relevance and merit.
- 10.8 That there will be a need for some investment to support this Memorandum.
- 10.9 That the above principles of collaborative working should be applied equally to the relationship between the statutory and VCSE sectors within localities.

11. Wider Opportunities

Outside of the formal MoU there will be other opportunities where the parties will explore how best to collaborate, operating according to the same principles.

- 11.1 VCSE leaders tend to work holistically across different elements of public service delivery and reform, economy and enterprise, focused on the needs of their members or service users. They are useful connectors to other enablers of health, social care and wellbeing, such as transport, planning, housing, education and economic inclusion locally, regionally and nationally. For example:

- 11.1.1 The VCSE sector convenes several important GM forums including the GM Poverty Action Group, GM Social Value Network and Volunteering GM.
- 11.1.2 GMCVO is leading on the delivery of Ambition for Ageing (age friendly neighbourhoods) and is a partner in Jam and Justice (inclusive governance within devolution).
- 11.1.3 Organisations such as LGBT Foundation and Breakthrough UK have nationally recognised expertise in equalities agendas with a history of working with Government Departments in a range of roles from informal advisers to Strategic Partners.

12. Signatories

Signed on behalf of the GM Health and Social Care Partnership

Signed Date

Signed on behalf of the GM VCSE Reference Group

Signed Date

Appendix A: About the Parties

- A.1 The **GM Health and Social Care Partnership** is the body made up of the 37 NHS organisations and councils in the city region, which is overseeing devolution and taking charge of the £6bn health and social care budget. Governed by the Health and Social Care Partnership Board, which meets in public each month, the Partnership comprises the 37 local authority and NHS organisations in Greater Manchester, plus representatives from primary care, NHS England, the community and voluntary sectors, Healthwatch, Greater Manchester Police and the Greater Manchester Fire and Rescue Service.

The Greater Manchester Health and Social Care Partnership Team is the group of people who came together on April 1 2016, from the former health and social care devolution team and the former NHS England Greater Manchester team. The purpose of the team is to ensure Greater Manchester delivers on its vision and strategic objectives.

<http://www.gmhsc.org.uk/>

- A.2 The **GM VCSE Reference Group** works to support VCSE sector engagement across Greater Manchester's devolution agenda. It originated as a formal part of the health and social care devolution architecture and works closely with GMCVO <http://gmcvo.org.uk>, the city-region level VCSE support and development organisation, which is a member of the Reference Group.

The Reference Group is not a representative structure but individuals are nominated by their own networks and are held accountable to their network and/or the Reference Group by a signed protocol agreement. Members of the Reference Group are expected to be 'catalysts and connectors' on behalf of the sector.

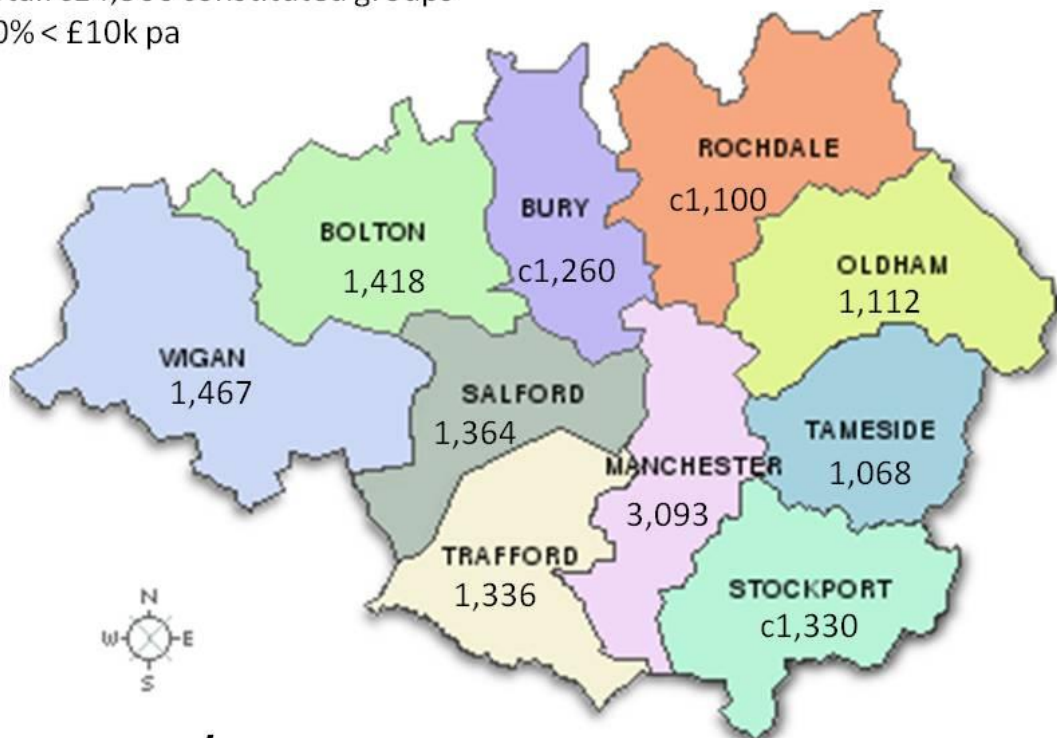
The secretariat for the Reference Group is provided by Voluntary Sector North West and a full list of current membership can be found on their website.

<https://www.vsnw.org.uk/gm-vcse-devolution-reference-group>

(2013)

Total: c14,500 constituted groups

80% < £10k pa



GM/c VOLUNTARY SECTOR

Appendix B: Outcomes and Actions

These notes expand upon the ambitions set out in section 4 and define actions and commitments which will be used to realise these outcomes.

B.1 **A step change in the understanding and involvement of people and communities.**

The role of the VCSE sector is critical for the economic success of devolution in Greater Manchester but also for the equally important cultural and social devolution that will help build a truly equal region. The VCSE sector is well placed to take a lead on the engagement and recruitment of residents to making the desired “new deal”, and to advocate on behalf of those residents least likely to be heard, and those facing particularly challenging barriers to social and economic inclusion. Fieldwork for *Taking Charge Together* involved 15 VCSE partnerships (10 locality, 5 thematic) conducting 138 group conversations with 1,837 participants, enabling 1,746 responses to the standard online survey (contributing 29.9% of the total). VCSE groups are on the ground in communities, offering very wide reach into the population which complements that of statutory institutions, elected members and businesses. The VCSE has a crucial role in acting as a challenge and a conscience to the statutory sector on behalf of people and communities

Actions & Commitments:

- B.1.1 For the statutory sector in all localities to progress asset based approaches that recognise and build on the strengths and ambitions of individuals, families and our communities rather than focussing on the deficits
- B.1.2 Development and maintenance of a GM VCSE Assembly which can be convened on generic and specific issues and interact with statutory sector leaders through events, round tables, meetings, forums etc.
- B.1.3 Enabling dialogue between statutory and VCSE sector through surveys, social media and other methods as appropriate; publishing early drafts for comment, enabling discussion with the GM VCSE Reference Group and through a variety of meetings and events with Assembly members
- B.1.4 Facilitating and providing good, consistent, up to date information and communication with the VCSE sector making use of and building on established sectoral channels of communication and existing relationships.
- B.1.5 Supporting and extending the remit of the VCSE Healthier Together Equalities Group from Programme Three to all programmes of work, cross-cutting themes and enablers.

B.2 **Better services and greater support for the public**

The VCSE sector can devise, develop and deliver solutions to some of the most challenging problems faced by Greater Manchester, breaking down barriers and building community confidence and cohesion, and ensure we move from crisis resolution to anticipation and prevention. Engaging and connecting relevant VCSE sectors in co-design and co-production of strategies, action plans and services, at GM and locality level health and social care / public service reform, will enable them to offer intelligence and ideas, identify common ground and mobilise their existing capacity. By involving the VCSE sector and the communities it engages from an early stage it will be possible to achieve a sense of shared ownership and responsibility, to draw on the knowledge and experience of VCSE organisations in community consultation, co-design and co-delivery, and to enable fresh thinking through pooling the strengths of people from the statutory and VCSE sectors and those of intended beneficiaries.

Actions and Commitments

B.2.1 Supporting VCSE leaders chosen by their peers to represent them at on Greater Manchester strategic, thematic and enabler boards and executive bodies

B.2.2 Describing and securing the application of equivalent commitments in all localities, sharing knowledge and learning where this is already happening and testing this development through relevant Transformation Fund proposals.

B.2.3 To sponsor and launch a design process across all ten localities to generate proposals to build the evidence base to enhance prevention, community resilience and self-help, and scale the application of approaches which are already proven

B.2.4 To identify and progress one or more specific 'tracer projects' which would identify, explore and make recommendations as to the commissioning and delivery of services for specific communities of identity or experience where consideration within and beyond individual localities is necessary.

B.3 Developing Local Care Organisations with highly bespoke local place-based characteristics.

The VCSE sector's expertise is its understanding of our communities (of place, identity and interest). We can help drive people-powered change, harnessing social action and bridging the gap that can exist between public services and the people they serve. The consistent involvement of VCSE organisations in developing locality plans and shaping Local Care Organisations will improve their responsiveness and help to achieve local ownership. The level and quality of VCSE sector involvement to date in the development of locality plans has been extremely inconsistent across localities. It should be possible to assist locality working by making use of the existing points of contact and communications into the VCSE sector and enabling those organisations best placed to be involved to organise themselves and connect with statutory sector colleagues. Note that not all of these may be based in a locality or known to the local statutory sector especially if there is no pre-existing relationship. This will improve the consistency and quality of the VCSE offer.

Actions & Commitments:

B.3.1 Describing and securing the application of equivalent commitments in all localities, sharing knowledge and learning where this is already happening and testing this development through relevant Transformation Fund proposals.

B.4 Increased mutual learning and continuous professional development

By developing relationships between the VCSE and statutory sector workforces we will learn from each other, benefiting from our complementary strengths and different cultures.

Actions & Commitments

B.4.1 Develop understanding of the VCSE within the statutory sector workforce through Workforce Development initiatives, and encourage close working relationships

B.4.2 Reviewing and sharing good practice within statutory and VCSE sectors in GM and in each locality, supporting a more consistent and effective approach to engaging VCSE organisations and operating according to the principles set out in this Memorandum of Understanding. Enabling VCSE policy experts to spend time on contributing and responding to the detail of strategy and policy documents; commissioning models; impact assessment; social value methodologies etc

B.4.3 Supporting the VCSE Reference Group to act as “first point of call” for engagement with the VCSE sector and collaborate with GMCVO to facilitate the work outlined above; the group can also offer a sounding board or informal policy discussion to key statutory sector people.

B.4.4 Involving the VCSE in the development of innovation through direct involvement in the structure and work of Health Innovation Manchester

B.5 Leverage of the talent, capacity and social value of VCSE organisations above and beyond whatever is commissioned from it

A key message of the VCSE Reference Group is “We are many”. The army of staff, volunteers and supporters across the sector are a catalyst for change and a connector of people. The appropriate inclusion of VCSE organisations in delivery of agreed shared outcomes could enable considerable added value. Overall, local government and the statutory health sector contribute 38% of GM VCSE funds, mainly to medium-sized organisations, whilst 76% of VCSE organisations bring in funds from non-public sources (donations, independent funders, subscriptions and charging). VCSE organisations bring added economic and social value through the deployment of volunteers; the sector hosts the majority of Greater Manchester formal volunteers, giving 1.1m hours every week.³ It also has particular strengths in peer support, and in working with communities of identity and communities of experience. Where VCSE organisations are included in delivering shared outcomes, it may be possible to align funding and resources, creating efficiencies and added value.

Actions & Commitments

B.5.1 Consider social value and added value as essential aspects of all commissioning, and work with the GM Social Value Network to establish appropriate measures

B.5.2 Invest in volunteering brokerage and management within the VCSE, enabling more volunteers to be taken on by VCSE organisations.

B.5.3 Review learning from the use of grants programmes and consider where statutory funding at GM and local level can provide opportunities for leverage for other resources.

B.5.4 Consider how the health and social care partnership and VCSE sector can collaborate leveraging additional social value from local businesses (e.g. as employers which support a healthy workforce, through philanthropy and social responsibility)

B.6 Effective development of VCSE activity

The existing VCSE sector, strong and diverse though it is, varies in number and capacity across different neighbourhoods, often inversely correlated with deprivation (for example, the BME sector is less well developed and resourced). Also, a sector which developed in the context of a more reactive health and social care system will now need to extend and considerably increase activities based on prevention and early intervention. Collaboration between the statutory sector and VCSE leadership will enable more effective and relevant deployment of investment and support for new voluntary action, volunteering and enterprise, building on pooled knowledge and learning from replicable practice elsewhere.

Actions & Commitments

³ Figures used are from the *State of the Sector* research published in 2013 conducted by a partnership comprising 7 GM local infrastructure organisations and GMCVO in collaboration with Sheffield Hallam University.

- B.6.1 To consider the findings of the *Greater Manchester State of the Voluntary Sector* report (and local borough reports where available) due for publication in 2017 in the light of existing knowledge of activity, capacity, demand and investment.
- B.6.2 Work with GM VCSE Reference Group (membership of which includes GMCVO and representatives of local infrastructure organisations) and VCSE leaders to understand where and how community development activities and targeted investment could encourage additional resident-led voluntary and community action.

Appendix C: Key Risks

These notes expand on the key risks to achieving the ambitions of this MoU:

C.1 **Reduced ability to establish a new deal the public:**

Failure to implement the vision enshrined in this MoU brings a number of significant risks, not only to securing the systematic and comprehensive commitment and involvement of the VCSE sector itself but de facto to the successful delivery of *Taking Charge* itself, which depends upon making “*a new deal with the public*”. There is a window of opportunity within which to act to renew and strengthen the relationship. It is recognised that this will require adjustments on both sides and is not without challenges (see below). In the same way as the statutory sector is having to find new ways of collaborating and operating in new formal and informal partnerships, so does the VCSE need to find ways of re-organising and collaborating in order to take advantage of the opportunities of devolution and mitigate the pressures we are facing.

C.2 **Outdated transactional relationships across the sectors:**

Whilst many VCSE colleagues are still generally very committed to being involved in *Taking Charge*, there is a high level of unhappiness with the poor involvement of the VCSE sector in the development of key strategic and implementation plans to date, especially locality plans and population health and so a real risk of the disengagement of those who should be involved. Should this occur, the VCSE voices heard will be limited in diversity, knowledge and connectivity. If the relationship with the sector is allowed to become a purely transactional one seeing only the large scale providers, the leveraging of the wealth of the contribution of the VCSE sector will fail.

C.3 **Missing key enablers that connect and mobilise communities:**

Alongside the above, there is a risk to key enablers in the VCSE sector: the internal communications systems, networks, collective knowledge and reach, including to those of GM and local support institutions. These will be required for the future and action should be taken to maintain and develop them. The current communications networks within the Greater Manchester VCSE are the key sector infrastructure which makes it possible for organisations of all sizes and types to be assembled on any geography and any topic desired. This is not something available in all parts of the country and has been developed through years of investment and effort which is costly to lose and rebuild. Reach into the full diversity of the sector has been weakened in some localities over recent years through lack of investment in both financial terms and maintaining relationships. This is a false economy in the long term as it causes local organisations to become more isolated, and it reduces the leverage available to the system – without this infrastructure as catalyst and connector, it is difficult for public sector partners even to know all the organisations or resources that are out there or how to contact them (still less to ensure that they are supported and developed).

C.4 **Misunderstanding the real demand and supply issues across the system:** Many VCSE organisations are under strain due to reducing resources and/or rising demand and many are already fragile. There is reduced capability to make funding applications, evaluate work, assess impact and publicise successful work; this translates into a reduction in the non-public funding and volunteering on which VCSE provision depends and has a direct impact on some of our most vulnerable and marginalised residents. It is also likely that some current VCSE activities and services are more successful and cost-effective than statutory organisations at achieving the desired outcomes of the Health and Social Care Partnership, but unless they

are given equal consideration they will be overlooked. Meanwhile the statutory sector faces its own financial challenges, which have already affected the provision of services to the public. Co-production between the statutory and VCSE sectors would enable the most effective preventative work, services and provision from each sector to be drawn into a new more efficient system.

C.5 Inherent in these risks are a number of key challenges which need to be addressed in building collaboration between the public sector and the VCSE sector. Some discussion of these has taken place in the development of this MoU which is captured below.

- The culture, mode of operation and business models within the VCSE and statutory sectors are different in a number of significant respects. Whilst this difference is valuable, it will need to be understood and accommodated in order to realise the benefits of real collaboration.
- The strengths and perceived weaknesses of the Greater Manchester VCSE sector are related. For example, the existence of numerous small organisations doing similar things is related to being closely embedded within a specific community, involving people from that community in governance, volunteering, design and evaluation. These small organisations tend to be asset-rich, flexible and responsive, and to enjoy the trust of their members / service users; their “back office” functions tend to be externally sourced or funded by third parties, and so they may not easily cope with formal processes, evidence their impact through quantitative data or access “supplier lists”. To some extent the VCSE sector has evolved mechanisms for overcoming these barriers and mobilising the smaller organisations (e.g. local infrastructure organisations, consortiums, lead bodies, networks); however these mechanisms are not consistently well-developed in all boroughs.
- Traditional tendering and contracting for specified services are accessible only to a minority of VCSE organisations, and even this minority may be disadvantaged by scale and complex process; much potential added value is probably being lost. The shift in emphasis to prevention and early intervention could enable more VCSE organisations to get involved, and suggests there will be a need for more flexible and imaginative commissioning through a wider variety of methodologies (e.g. grants schemes of the kinds run in Rochdale, Salford and Manchester on behalf of CCGs); this will challenge commissioners and procurement departments. Developing this kind of diverse, outcomes-based, social value-led commissioning is a mutual responsibility to which statutory and VCSE sector leaders will each bring important expertise.
- VCSE organisations tend to be most effective in making long term commitments to individuals and/or communities, delivering outcomes agreed with the individual through a variety of inputs, projects, services etc. depending on resources, opportunities and need. This has an effect on VCSE sector attitudes to adapting the intervention to the person, data collection and confidentiality and the distinction (or not) between provider and beneficiary, and can make it difficult for VCSE organisations to comply with statutory systems designed for fixed and bounded services.
- The VCSE sector in Greater Manchester is not homogenous. The size and composition of the sector varies across localities, due to history, leadership, previous investment etc. VCSE organisations come in all sizes and have a diversity of business models and legal forms. Different approaches may be needed in order to involve as many relevant organisations as possible and play to the various strengths of large charities, social enterprises, faith-based groups, campaigning and advocacy organisations, community

groups, co-operatives and community hubs, to name but a few. The VCSE sector is also evolving, and new organisations are constantly emerging. Whilst statutory sector policy and public money are not the only factors in shaping this changing sector, they are important, and consideration will need to be given to the impact of policy and spending on the future shape and nature of the VCSE sector, and where possible, decisions will be informed by an assessment of this impact.

- It is accepted that no single voice or group can represent the views of the whole VCSE sector; there is however in existence clear leadership and a range of organisations, partnership and networks each of which can give a partial view. The diversity and specificity of voices is valuable, and it is important to ensure they can be heard. Where there is consultation or involvement of VCSE organisations, it will be important to take care that any “representatives” are accountable back to other stakeholders, conflicts of interest are declared and dealt with, and valid participants are not excluded. The GM VCSE Reference Group was established to model this approach, bringing together leaders who have both the capability and capacity to act as catalysts and connectors and are able to operate at pace within the developing *Taking Charge* agenda.

Appendix D: Funding, Governance and Accountability

Although VCSE leaders are already giving some time to health and social care devolution planning and design, they have limited capacity to work at risk because they operate as charities and social enterprises (i.e. funding is either tied to the delivery of specific work, or earned through trading) and this capacity is not adequate to the task. There is a need to provide a modest amount of funding annually at both GM and locality levels to enable full involvement and the delivery of the activities and outcomes outlined in the MoU.

D.1 Deliverables

- D.1.1 Ongoing support for the GM VCSE Reference Group) to act as “first point of call” for engagement with the VCSE sector, to facilitate the work outlined in the MoU; the group can also offer a sounding board or informal policy discussion to key statutory sector people.
- D.1.2 Development and maintenance of a health and social care focus in the GM VCSE Assembly. The Assembly which can be convened on generic and specific issues and interact with statutory sector leaders through events, round tables, meetings, forums etc.
- D.1.3 Enabling dialogue between statutory and VCSE sector through surveys, social media and other methods as appropriate; publishing early drafts for comment, enabling discussion with focus groups and/or VCSE Reference Group and through Assembly events
- D.1.4 Facilitating and providing good, consistent, up to date information and communication with the VCSE sector making use of and building on established sectoral channels of communication and existing relationships.
- D.1.5 Supporting GM VCSE Reference Group members and other VCSE leaders chosen by their peers to represent them at a wide range of strategic boards and working parties.
- D.1.6 Enabling VCSE subject experts when necessary to spend time on contributing and responding to the detail of strategy and policy documents; commissioning models; impact assessment; social value methodologies, service models, etc.
- D.1.7 Reviewing and sharing good practice within statutory and VCSE sectors in GM and in each locality, supporting a more consistent and effective approach to engaging VCSE organisations and operating according to the principles set out in this Memorandum of Understanding.
- D.1.8 Enabling the participation of VCSE representatives in the Healthier Together Equalities Group from Programme Three, allowing the group to develop its remit to address all programmes of work, cross-cutting themes and enablers.
- D.1.9 Supporting localities by bringing people together across boundaries to share experiences and knowledge; identifying, highlighting and sharing good practice; connecting locality-based VCSE organisations with the cross-cutting themes and other GM-level activities.

D.2 Exclusions

- D.2.1 Funding for enabling VCSE participation in Locality Plans at borough level. It is acknowledged that similar provision must be made by each locality.
- D.2.2 The cost of additional consultancy projects (e.g. like the Taking Charge Together consultation).

D.3 Governance and Accountability

- D.3.1 As the MOU is signed off and implemented arrangements will inevitably strengthen and develop further.
- D.3.2 The Parties to the MoU (see Appendix A) will convene a small working group to confer on the design and delivery of a programme of activity to achieve the outcomes and actions described in Appendix B.
- D.3.3 The GMVCSE Reference Group has asked GMCVO to act as Accountable body for this funding, undertaking the necessary administration of the funds as required. It is agreed that GMCVO's leadership role in the GM VCSE sector makes them eminently suitable for this task.
- D.3.4 The GMVCSE Reference Group has asked Voluntary Sector North West to act as its secretariat, building on the work carried out so far and the strong collaborative relationship. The Equalities Advisory Board will nominate its own secretariat. GMCVO will subcontract to Voluntary Sector North West and (another) the secretariats for the VCSE Reference Group and the Equalities Advisory Board.
- D.3.5 Membership of the GM VCSE Assembly is voluntary and is open to all GM VCSE organisations (see MoU 7.1)
- D.3.6 The following operating principles will apply to the appointment of VCSE representatives:
- i. Organisations with established representative functions and an existing mandate as neutral VCSE advocates will continue to exercise this function (GMCVO, local infrastructure organisations, established VCSE networks).
 - ii. Other VCSE representatives should be chosen by their peers i.e. the stakeholder group drawn from the Assembly with a legitimate interest in the business of the board or working party.
 - iii. All such representatives with GM level positions will be supported by the GM VCSE Reference Group (which includes GMCVO) and will be expected and enabled to communicate with their networks and stakeholders.
 - iv. The default assumption will be a minimum of 2 VCSE representatives.
 - v. A range of mechanisms such as deputies and rotation will be used. This will ensure capacity is managed collectively and that there is a plurality of voices, modelling collaborative leadership.
- D.3.7 The following operating principles will apply to the commissioning of specific pieces of work:
- i. The VCSE Reference Group will be responsible for identifying the need for a piece of work and draft the brief. Commissioning will be carried out through a transparent process by a panel including representatives of the Accountable body, the Greater Manchester Health & Social Care Partnership and the VCSE Reference Group. A protocol will be drawn up for this by the Parties.
 - ii. Reference Group members may be the most relevant subject expert to undertake additional work and should not be debarred from carrying out this role because of their membership. Management of such a situation will be included in the protocol to be developed.

D.4 Funding

	<u>£ pa</u>
Meetings costs for Assembly including events, round tables, working groups etc	21,000
VCSE Reference Group meetings	3,000
Expenses for Representatives, Reference Group, Equalities Advisory Board	22,000
GMCVO administration and communications	70,000
Secretariat for VCSE Reference Group (VSNW)	15,000
Secretariat for Equalities Group (provider TBC)	15,000
Commissioned work by VCSE subject experts	60,000
Training and meetings for VCSE representatives on boards and execs	7,500
Contingency	10,000
<u>TOTAL PA</u>	<u>223,500</u>

NOTE: This is a rapidly evolving situation and there may be a need to adjust the proportions of funding between identified areas of work to ensure responsiveness. The sums suggested are a fair reflection of the volume of work felt to be necessary to enable the VCSE Reference Group to drive the implementation of the MoU

Appendix E: VCSE Review⁴

In November 2014, the Department of Health, Public Health England, and NHS England initiated a review of the role of the VCSE sector in improving health, wellbeing and care outcomes. The review included a comprehensive consultation process which ran from August to November 2015.

The Vision

The VCSE sector has a consistent track record of working in a way that is holistic, long term, relational and locally-rooted. At its best, the VCSE does not just deliver to individuals, it draws upon whole communities; for volunteering and social action which addresses service-resistant problems like loneliness and stigma, and for the expertise of lived experience in designing more effective, sustainable services and systems. This is the way to address the social determinants of health, build resilience and promote self-care and independence.

The 'Joint review of partnership and investment in VCSE in the health and care sector' report sets out a series of recommendations to enable the sector to work in the best way it can to support people and communities and to deliver the Vision set out in the report. These are summarised below.

Summary of Recommendations

Health and care services are co-produced, focussed on wellbeing, and value individuals' and communities' capacities

1. DH, NHSE and PHE should explore opportunities to further embed the 5 Year Forward View and Care Act goal of **promoting wellbeing** (including identifying, measuring and commissioning for key wellbeing outcomes for all)
2. **Greater co-production** with people who use services and their families at every level of the health and care system (including requiring local health and care systems to draw on on the 'six principles' ([link](#)), Engaging and Empowering Communities MOU ([link](#)) and TLAP definition of co-production ([link](#)))
3. NHSE should issue revised 'Transforming Participation in Health and Care' guidance on working with VCSE sector to help **ensure CCG's meet their Health and Social Care Act duty to involve**.
4. Health and Wellbeing Boards should engage effectively with local VCSE organisations and all groups experiencing health inequalities to ensure that **JSNA's include a comprehensive assessment of assets** as well as needs.

Commitment to the Compact

5. The government, led by cabinet office, should demonstrate its support for the **Compact principles as a framework for effective collaboration between VCSE and statutory sectors**

VCSE organisations are involved in strategic processes

6. Any future transformation programmes (eg Integrated Personal Commissioning) should only be approved if proposals are included for **involving the full range of local VCSE sector organisations**

⁴ Summary taken from Regional Voices briefing <http://www.regionalvoices.org/node/338>

7. **Health and Wellbeing Boards should work closely with local VCSE organisations** to ensure that strategies are co-designed with local citizens (particularly those groups which may be under-represented or overlooked).

Social value becomes a fundamental part of health and care commissioning, service provision and regulation

8. **Social value should be better embedded in the commissioning approaches** of local authorities and NHS commissioners (including Cabinet Office working closely with NHSE to ensure training and support are available to commissioners and procurement teams and with NHS SDU to explore ways to identify and incentivise social value creation and fill gaps in the social value evidence base)
9. **CQC should include the value of personalisation, social action and volunteering** in its Key Lines of Enquiry and ratings characteristics

Social prescribing is given greater support

10. NHSE (working with DH, NICE and other key partners) should **publish good practice guidance on social prescribing** (including advice on different models and **recognition that prescriptions should be appropriately and sustainably funded**)

The skills of those involved in health and care commissioning are improved

11. Government should consider how they can support and encourage **health and care commissioning bodies to access skills development training for their workforce** (particularly on co-commissioning)
12. Cabinet Office and DH should consider providing support to **build the capacity of VCSE organisations to compete for and win health and care contracts**

Long term funding as standard

13. (Funders) should move away from short-term pilot funding to **provide core and long term funding** with capacity building support (particularly to smaller and/or specialist VCSE organisations)

Health and care bodies fund on simplest-by-default basis

14. Health and care **commissioners should by default use the simplest possible funding mechanism** (including, but not limited to, grants, 'fee for service' contracts, 'payment by results' contracts, social impact bonds, social prescribing models, personal budgets and personal health budgets)

Greater transparency

15. Government should make **full details of contracts available** through the Contracts Finder website (including awards, amendments, termination and financial flows to subcontractors)
16. DH should consider commissioning **NICE to develop an indicator of VCSE engagement** for NHS and other public health and social care commissioners

Volunteering is valued, improved and promoted

17. All NHS settings should develop **more high-quality, inclusive opportunities for volunteering** (particularly for young people and those from disadvantaged communities)

Dormant funds are used for good

18. NHS Charities, with support from the relevant sector bodies, should **develop links with their local Community Foundations and the wider VCSE sector** to achieve broader health outcomes and share learning and good practice

Evidence underpins health and care

19. **Service objectives should be developed in partnership with funded organisations and service users.** Standard tools to support credible outcomes measurement should be adopted. Providers should be supported to effectively undertake evaluations, measurement of social value and cost-benefit analysis of savings.
20. Government should consider funding the 'What Works Centre for Wellbeing to **set up a wellbeing data lab service**
21. NHS commissioners, local authorities and independent funders should **publish evaluation methodology and results for all grants and funded projects**
22. NIHR should use existing research to **identify and develop tools to measure preventative outcomes** (using suitable proxies and regard for what works for different communities)
23. VCSE organisations should **engage effectively with the evidence base.** Strategic Partners and national infrastructure bodies should promote this.

A sustainable and responsive infrastructure

24. Government, local infrastructure and independent funders should **consider the recommendations set out in Change for Good** and subsequent work from the Independent Commission on the Future of Local Infrastructure
25. NHS commissioners and local authorities should consider providing **funding for suitable infrastructure** to better connect personal budget and personal health budget holders with a range of providers and facilitate development of a more diverse range of services

A greater focus on equality and health inequalities

26. NHS commissioners and local authorities should work with the VCSE sector to **enable all groups in society to have a say in how services can achieve better health and care outcomes** (especially those experiencing health inequalities)

Market diversity

27. Government should consider extending the '**market diversity duty**' to include NHS commissioners

A streamlined Voluntary Sector Investment Programme

28. Central **grant funds IESD and HSCVF should be unified with the strategic partner programme into one health and wellbeing programme.** Project funding should be used to demonstrate effective models for supporting local infrastructure to tackle health inequalities and better embed VCSE groups with expertise in this area into local health and care systems. **Demonstration projects should work closely with the Health and Care strategic partnership programme** to support government to disseminate learning, develop policy and identify new models for reducing health inequalities in line with the overall strategy set out in the Five Year Forward View.