
the POWER of PARTNERSHIPS
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Effective working with the voluntary, community and social enterprise sector to achieve local health goals
SOCIAL ENTERPRISE UK
IVAR
Institute for Voluntary Action Research
NHS
Commissioning Board

This guide has been produced by Social Enterprise UK in association with the Institute for Voluntary Action Research. Our organisations were funded by the Department of Health to bring together partner organisations in four locations in England to develop better approaches to local health needs, through partnerships between the new health structures and organisations from the voluntary, community and social enterprise (VCSE) sectors. Throughout 2012, we worked in local communities to identify how new structures like clinical commissioning groups can be used as a catalyst to develop new approaches and new methods, employing all of the resources and facilities available to the local communities. This guide is one of the results. It and a range of other materials are free to anyone working in healthcare. Our aim is to help them think differently, more creatively and more practically than ever before, about the opportunities they have to meet changing health needs in difficult economic times.

Contents

Introduction

Improving health outcomes with increasingly limited resources is the main challenge facing the NHS today. The changing health needs of local populations must be met, so we must find new approaches and solutions. In every local 'health economy' there are a range of potential providers – including NHS organisations, charities, private providers, voluntary and community groups, social enterprises, local institutions like universities, libraries and pharmacies, and other local agents who may not even have been considered. They and the resources at their disposal can add up to a rich mix of skill, knowledge and ability that, together, offer huge opportunities for meeting local need. Partnerships between providers can offer new ideas and different strengths to meet common goals.

This guide is full of fantastic examples of voluntary, community and social enterprise (VCSE)/public sector partnerships that save public money, while improving health outcomes. It draws on extensive research and solid experience of effective partnership working.

Social Enterprise UK and the Institute for Voluntary Action Research developed this guide, with support from the Department of Health, to provide ideas, inspiration and evidence to support productive partnerships across health and social care.

Designed to support newly-emerging clinical commissioning groups and health and wellbeing boards, it can be used as a stand-alone resource. However, the complex nature of partnership working and the need for real connections between people means that the principles covered in this guide and their implementation may be best explored with the support of independent facilitation.

Find out more about partnership working and how Social Enterprise UK can help.
Contact charlie.wigglesworth@socialenterprise.org.uk

Why we need better partnerships

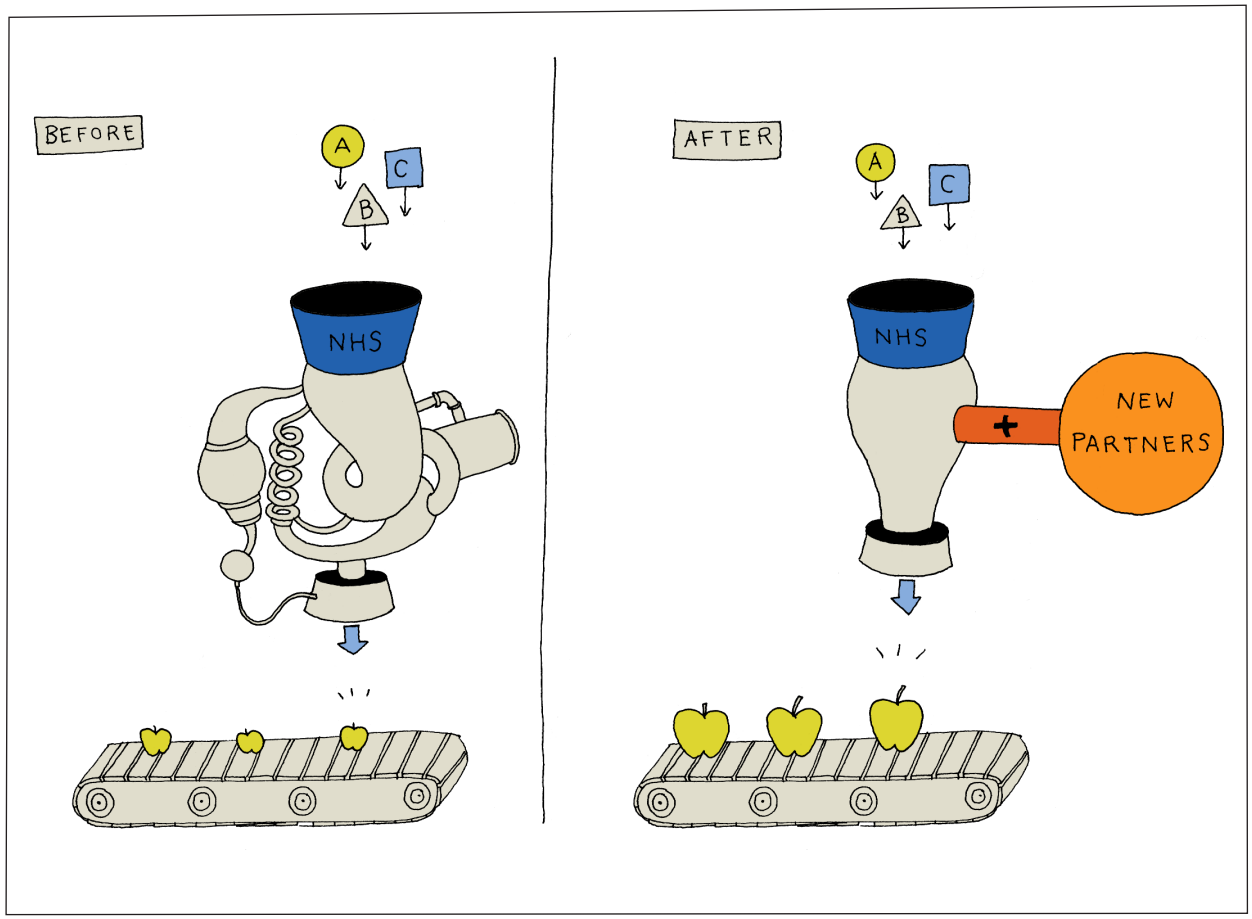
There has never been a greater need for partnership working in the NHS. The challenges of limited resources and increasing demand for services make it clear that we need to get better outcomes from the same resources. This means asking one question of all our activities – how do we create greater value?

While savings may be found from efficiencies, cutting costs and adopting new technologies, ultimately the scale of the challenge calls for us to think differently about the resources at our disposal and how to deploy these in a more effective way.

New health structures currently being put in place provide the opportunity for such change. They offer a platform from which to rethink who, how, what and where services are provided, capitalising on the strengths of different partners and organisations.

We can use changes to the health system as an opportunity to look at the full value of our health economies and assess how we make the most of every contribution to them. This means thinking through what the NHS is very good at, and where other organisations may be able to provide better, more cost-effective interventions.

This isn't just theory. The organisations in this guide have put it into practice – creating greater value for patients and the public.



Value in the voluntary, community and social enterprise sector

As an example, let's begin with the need to boost early diagnosis of gastric intestinal cancer among men in the most deprived wards in England. We know from data on health inequalities that the standard NHS model has failed to reach men at high risk of cancer in deprived wards and that mortality from gastric intestinal cancer among men in these wards is 11% higher than the national average[1]. We also know that late diagnosis of cancer costs significantly more in terms of personal distress, health outcomes and financially. Traditional approaches have repeatedly failed.

In Salford, a social enterprise called Unlimited Potential has taken a new approach. Using their strong community connections, they found out how and where to best engage with men on this subject in a friendly and approachable way. They were able to build up a rapport and empathise with at-risk men, and gain an understanding of what might trigger them to seek a health check up. Seeing the target group as part of the solution, rather than as passive recipients, they trained lay experts as peer educators, including people from the at-risk group. They recognised that they needed to reach people in the places where they already spend time – like pubs, 'greasy spoon' cafes and taxis – and that they needed to take the fear out of the messages they used. The solution they co-designed is creative, innovative and highly effective. Read more about how this came about and the savings it generated in the case study on page 9.

In this example, the community organisation offers an effective and cost effective intervention that is more appropriate and acceptable to this patient group than the existing NHS solution. Rethinking and relocating services that clinicians currently provide in clinical settings into more appropriate and economical settings is just one way the NHS can begin to meet its challenges.

How do partnerships create more value?

The reason examples like the above work so well is because of a different value proposition in the voluntary, community and social enterprise (VCSE) sector that complements the aims and values of the NHS.

Why these organisations are established; how they engage with their communities; how they are funded and how they view their profits or surpluses, sets them apart from other sectors in terms of both their operational model and overall philosophy.

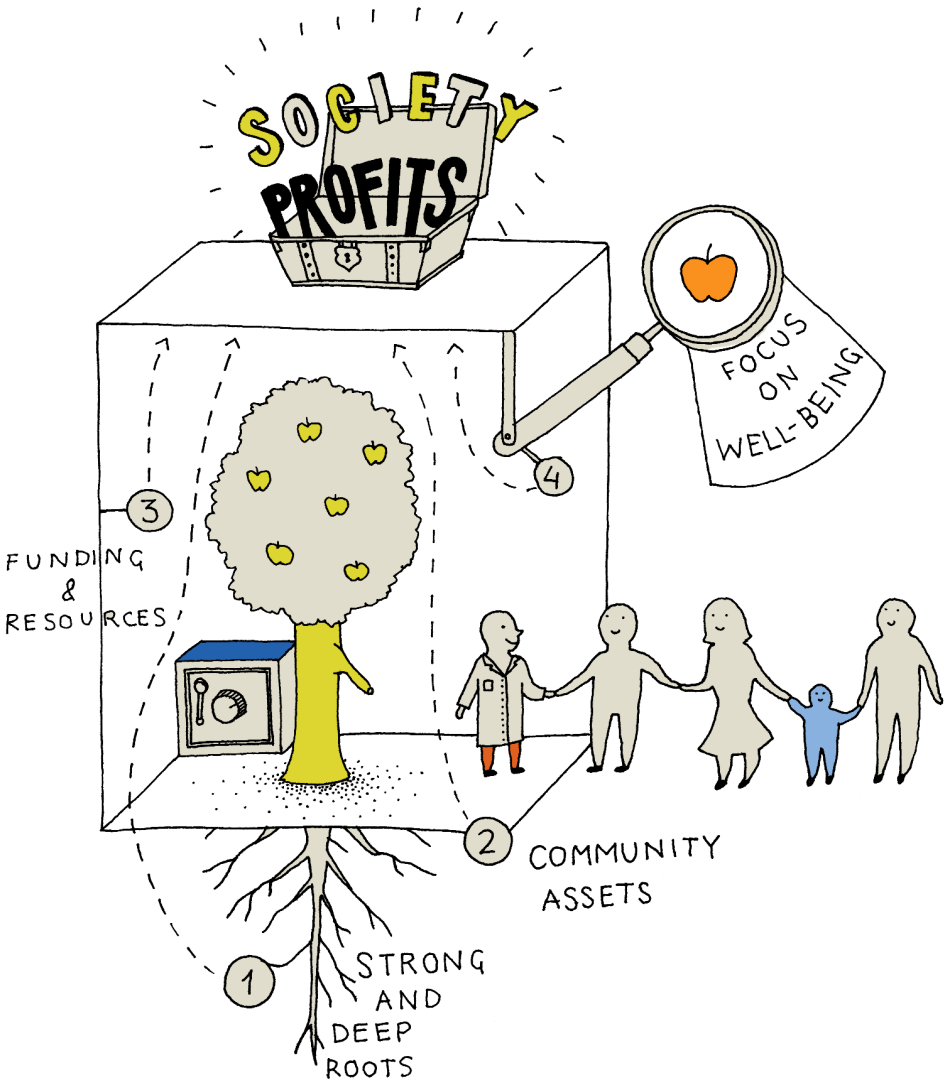
1 National Cancer Intelligence Network (2008) *Cancer incidence by deprivation* England, 1995-2004.

Strong and deep roots

Many social enterprises and voluntary organisations have grown out of the communities they serve, in response to a need, and under the direction of people who are passionate about their cause. They have a fundamentally different reason for being from private and public sector organisations. A private business is set up with a profit motivation, while the public sector delivers a range of services that are determined and directed by a statutory duty. In even the most commercial of social enterprises, the social mission comes first – as a famous US social enterprise says: "We don't employ people to bake brownies, we bake brownies to employ people." Social enterprises often thrive in the UK's most deprived communities, and they are known to be very sustainable.

Community assets

Instead of seeing people as customers, patients, beneficiaries or recipients of services, VCSEs see them as net contributors to the health economy. They tap into the skills and strengths of the people in their communities, be it for designing interventions, training their peers, fundraising or acting as advocates or community researchers. For example, a charity like Asthma UK works on behalf of people with asthma, providing campaigning and support. But the people they support are also critical to their income, raising thousands on their behalf. The same goes for time banking, volunteering and peer-health supporters and educators. These relationships aren't contractual, these people are in no way obliged to do it, and it represents a very different form of economic exchange.



Funding and resources

The VCSE sector has a wide pool of funding and resources available to it and is familiar with the need to do more with less. This is a sector where people are willing to give their time, their funds, their expertise and their resources in abundance. You'd probably be unwilling to run the London Marathon in aid of Microsoft or volunteer for a call centre selling car insurance. Yet thousands of people every year raise a sweat in aid of cancer research and volunteer as call centre operators for Childline.

This is a sector that contributes millions to our health economies each year through its own fundraising, through sources such as trusts and foundations and through its own trading activities.

Focus on wellbeing

It is well evidenced that formal health care systems make only a fraction of the contribution to our overall wellbeing. Our social and economic experiences, social networks, employment and housing are major contributing factors. Improved wellbeing reduces the prevalence of mental illness, can improve physical health and increase employability, productivity and earnings. In fact, the effect of having strong social networks and a sense of belonging is comparable with quitting smoking as a risk factor for mortality[2].

Wellbeing and wider contributing factors are areas where the VCSE sector excels. It provides employment opportunities for people disadvantaged in the labour market, develops green spaces and social housing, offers parenting classes and lunch clubs, and supports wider social networks.

2 Holt-Lundstad et al 2010

Society profits

When it comes to profit, VCSEs are fundamentally non-profit distributing and there's no central treasury that will claw back any underspend. This means that any profit or surplus they generate is reinvested in the service, remaining within the health economy to continue to create greater value.

All of this adds up to an attractive value proposition for the NHS. At a time when it is critical that we support people to help themselves, reduce demand on services and find the most appropriate solutions, it is critical that we look to a sector that has been taking this approach for well over a century. It is also essential in meeting the requirements of the Social Value Act that came into force in January 2013 (see below).

Meeting statutory requirements

Partnership working can also support the new health structures to meet their statutory requirements. For example, for Clinical Commissioning Group (CCG) authorisation it can support better governance (domain 6), reduced health inequalities (domain 4) and more specifically it can help CCGs demonstrate domain 2: Providing direct examples of meaningful engagement with patients, carers and their communities.

Under the Public Service (Social Value) Act, public bodies including the NHS will be required to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the area. Recent research shows that there is a real appetite amongst public bodies for delivering increased social value, with 75% of survey respondents already engaging with suppliers to increase social value. VCSE partnerships are the obvious way to do this. For more details download our Social Value guide: www.socialenterprise.org.uk

CASE STUDY:

Unlimited Potential in Salford

Unlimited Potential aims to help people fulfil their full potential through supporting them to lead healthier and happier lives. They take a social innovation approach to solving tough health and social problems and try to develop radical, alternative ways to address the issue and find new solutions from a lay person's perspective.

Vital stats

Location: Salford

Structure: Social enterprise; formed in 2002 and converted from a limited company to an industrial and provident society (IPS) in 2009.

Clients: approximately 6,500 per year

Employees: 33 people whole-time equivalent

Costs of delivery: approximately £1.3 million per year

Source of funding: contracts with NHS and local authority

The problem

Big health and social problems such as cancer or alcohol abuse can seem overwhelming and intractable to the multiple agencies dealing with the consequences. Where behaviour change and prevention are concerned, potential patients are often not adequately engaged with the health system. This can mean that traditional models of healthcare delivery fail to make an impact. New approaches without a solid evidence base are unlikely to be funded and therefore the kind of experiementation and risk taking needed for innovation is stifled.

The solution

Start with a problem, a small amount of money and run the idea on a small scale, then evaluate it working with experts from universities and think tanks and establish an evidence base. If the idea doesn't work the project ends there. If it does work turn it into a contract and carry on running it. Any surplus made can be reinvested in new innovations.

The Healthy Communities Collaborative

In deprived parts of Salford the number of people going to see a GP with cancer symptoms was very low. Traditional approaches had not had much impact. We worked with people living in those neighbourhoods and asked them how they would engage people like them. With a mix of lay experts and academics we co-created a series of games with messages about the symptoms of cancer and evidence around behavior-change built into the game. The games could be played wherever people were – market, pub, shopping centre. They reached people who would never come to a health event. In 2011, cancer referrals increased for upper gastro-intestinal by 43% (compared to the Salford average of 12%), for lung by 40% (compared to 33%) and for bowel by 27% (compared to 10%). The HCC is saving the NHS 8-10 times the amount it costs to run the programme.

Is a VCSE partnership for you?

Benchmark	YES – action is needed	YES – but action is at hand	NO – but needs improving	NO – working well	Action needed	By whom?
Are people in your area with social/medical problems being treated with clinical solutions in clinical settings when they could be effectively supported elsewhere?						
Are there specific groups of people that you are failing to reach?						
Are people presenting at hospital when an acute intervention is unnecessary or could have been prevented?						
Are you effectively addressing the wider determinants of health that can be enormously effective in reducing demand in your local area?						
Are you failing to get the most out of your community and to see them as assets with much to contribute?						

If you answered yes to any of these questions, a partnership with the VCSE sector could help you to create greater value.

Getting to know your VCSE sector

In a partnership, you want to be sure about who you're working with. So it's reassuring that the voluntary, community and social enterprise sector in the UK is one of the largest, most vibrant and most mature in the world. It's made up of 171,000 VCSE organisations with a combined income of more than £170 billion a year.

Its strength is in its diversity. The sector includes:

- national and regional charities such as Diabetes UK and Macmillan Cancer Support
- local charities focused on a geographical area, including local branches of federated charities such as Age UK and Mind or locally-based charities such as Hackney youth counselling service Off Centre
- local community organisations, such as carers' networks or lesbian, gay, bi, transexual (LGBT) support groups
- local and national support and development organisations eg. local community and voluntary service organisations or national bodies like Social Enterprise UK
- social enterprises – businesses with social missions who reinvest their profits and surpluses in the social cause, eg. Central Surrey Health, Patient Opinion and Turning Point.

It provides a vast range of services, including:

- representation, voice and advocacy
- designing, delivering and supporting services
- informing and shaping policy and strategy.

The sector makes a vast contribution to the health economy. VCSEs in health-related services have a combined turnover of £8.3 billion yet only 41% of this comes from the statutory sector. The remainder is earned or voluntary income, meaning these organisations contribute £4.8 billion to the UK's health economy[3].

If you are diagnosed with diabetes, your first port of call is likely to be Diabetes UK and the information and support they provide at little cost to the taxpayer. It is important that the scale of this is fully understood. If the NHS had to pick up the bill for filling this gap the cost would be destabilising.

And that's just income. When five NHS trusts piloted the Volunteer Investment and Value Audit (VIVA) they calculated that the economic value of volunteering averaged £250,000 a year for the primary care trust and £500,000 for a mental health trust (based on applying a nominal median hourly wage to the sum of hours of volunteer work in each trust). This is without calculating the wider benefit the hours of volunteers provide[4].

Putting these figures together is powerful. In St Helens in the North West, a pilot area for this programme, of the combined turnover and contribution of the VCSE sector to the local health economy, the statutory sector funds only 25%. Understanding this was a critical part in the local CCG fully recognising the value of the VCSE.

3 Clark et al 2010

4 Simon Teasdale (2008) *In Good Health – Assessing the Impact of Volunteering in the NHS*

VCSE facts

VCSEs have given birth to some critically important innovations in health and care.

- The first HIV-focused public health campaign in Europe, which saved thousands of lives and transformed our approach to sexual health, was largely the work of the Terrence Higgins Trust.
- Individual budgets in social care were introduced and pioneered by a small local charity called In Control, founded by local families with disabled relatives in Wigan.
- The way in which end of life care is managed was transformed by the Marie Curie Delivering Choice Programme.
- The living wage campaign was introduced by a community group in east London.
- A strategy that dramatically increased screening among men as part of the National Chlamydia Screening Programme was the work of Men's Health Forum.
- The first time bank in the UK was established by a community group in Stonehouse Gloucestershire – there are now more than 250 time banks active across the UK.
- The 'we need to talk' campaign led by a coalition of mental health charities dramatically increased access to psychological therapies including the IAPT programme.
- Savings to the NHS of £1,359,453 and 132 quality adjusted life years (QALYs) were delivered over four years as part of Green Gyms – a programme to improve physical and mental health through environmental volunteering.
- Hearing screening for newborn babies was introduced following a campaign by what was then RNID (now Action on Hearing Loss) and the National Deaf Children's Society.

CASE STUDY:

Better quality of life for people with muscular dystrophy

The NeuroMuscular Centre (NMC) is the only centre in the UK and Europe supporting young people and adults with muscular dystrophy. It provides physiotherapy, respite breaks for carers, holidays for disabled children, careers advocacy, vocational training and employment opportunities for 660 service users at a cost of £750,000 a year.

Vital stats

Location: Winsford, Cheshire

Structure: Charity and social enterprise, formed in 1990

Service users: 660 and growing

Employees: 40

Costs of delivery: Average £1,500 to £2,000 to support one person a year.

Sources of funding: 28% from the PCT, local authority and government contracts; 12% from the design and print social enterprise; 28% from the charity and 30% from fundraising activities

The problem

In the UK there is no specific health provision for adults with muscular dystrophy (MD). They're not entitled to physiotherapy on the NHS even though this is proven to keep them mobile and active for longer. Young people with MD find the transition to adulthood particularly challenging and carers are often family members who need breaks and contact with other people in similar circumstances.

The solution

The services the NMC provides keep about 60 per cent of service users in work for longer, amounting to benefits of more than six times the investment in the service through savings on employment support and revenue from tax and NI contributions.

Physiotherapy helps to keep people mobile for longer. Mental health and peer support improve general wellbeing, hopes and aspirations. A graphic design and print social enterprise provides supported employment opportunities, with commercial graphic design work cross-subsidising the service and enabling more people to experience work.

Social accounting and audit allows the NMC to measure the impact of its work. Among service users:

- 100% stay out of hospital
- 80% see the NMC as their primary health care support (rather than the GP or district nurse)
- 94% say the service inspires them to achieve more in life
- 96% walk for longer and are prevented from having falls
- 90% of carers say they feel more in control.

The local authority funds breaks for carers and, in collaboration with the council, the NMC has also developed inspiring short breaks for young people with MD.

"It's user led, not a bunch of professionals that do things for people. A sort of community – like a family," says chief executive Matthew Lanham.

"It's got to work and no one else is going to do it so we'll have to do it together."

How to commission for greater value

Once they become aware of the VCSE sector and the potential it has to transform healthcare outcomes, many GPs, clinical professionals, and other commissioners across health and social care can still find it difficult to commission the sector.

Cultural differences, different organisational structures and differing expectations can form barriers to successfully working with VCSEs. The following steps are designed to help you find the right organisations, commission and measure the right things and understand the funding options available for your VCSE partnerships. Finally, it is important to look at what your area needs and then commission, de-commission or commission differently to make the most of available resources to deliver the best outcomes.

1. Find the right organisations

THE CHALLENGE:

Part of the challenge of engaging effectively with the VCSE sector is the diversity of the sector and of the roles it fills. This means that there is not a one-size-fits-all approach to effective commissioning.

Using market mechanisms alone can often result in the VCSE missing out. The specification, size and the clauses within contract tenders are often designed for a very different entity and unintentionally exclude VCSE organisations, particularly small local and more specialist organisations. While many VCSE organisations are very much able to compete in the market, a traditional market approach can result in your organisation missing out on the full breadth of organisations and solutions on offer.

Relying on the market alone can also fail to take account of the wider resources that VCSE organisations contribute to local health economies.

1. Find the right organisations

THE SOLUTION:

Taking time to get to know your local VCSEs is essential. Combining formal mechanisms such as a sub-group of the health and wellbeing board (HWB) with regular partnership meetings can provide the VCSE sector with the chance to showcase what it can do to meet existing priorities and help build understanding of where VCSEs can truly add value. If you are unsure of how best to include them effectively in your commissioning processes, keep asking the question directly. It's a common question and one that is always welcome.

Involving all partners in designing the processes to commission these organisations effectively and mapping the commissioning priorities of the CCG and HWB against the offer of the VCSE sector will help to work out where collaboration will be most effective and how partnerships can help to save money elsewhere.

When you are looking to commission services, take account of your potential suppliers when designing contracts. Look at contract size and length and ensure pre-qualification requirements are proportionate and fair – this will give you the greatest chance to effectively commission the VCSE. There is much flexibility within procurement rules – further details on what you can and can't do can be found here www.socialenterprise.org.uk/advice-support/resources/working-with-the-public-sector-busting-the-myths

2. Commission and measure the right thing

THE CHALLENGE:

The structures surrounding health service commissioning primarily support the flow of money for specified interventions, such as admissions, procedures and visits, or provide for large block contracts for pre-specified services.

Much of the value the VCSE sector offers is far more outcomes-focused and while this fits with the direction the new health structures are taking, the systems and processes for commissioning for outcomes are not yet fully developed or widely adopted.

The right approach may be to measure avoiding re-admissions or accidental falls, reduced use of anti-depressants, or community resilience and general wellbeing through social networks. However, there is powerful evidence and data available that is not being used. See the Resources section on page 29. With pressures of quality, innovation, productivity and prevention (QIPP) dominating decision making in CCGs, and councils experiencing significant cuts, proving that outcomes-based methodologies create greater value is of utmost importance.

2. Commission and measure the right thing

THE SOLUTION:

Start by looking at what already exists in the field of impact measurement – much has been produced on the economic case. There is particularly good data in areas such as the benefits of befriending and parenting programmes and many other low-level mental health interventions[5] (see the Resource section).

Alongside what already exists, building capacity to measure the impact of these forms of interventions, so that you can track the benefit, is a critical step. Often it is best to start simply and to tackle one problem at a time, building up the evidence for investment through demonstrated savings. In North East Lincolnshire, for example, the PCT noticed that the levels of accidental breaks among the elderly increased after a frost or snowfall that lasted for more than two consecutive days. This was because most elderly people had sufficient supplies to last two days, but on day three they ran out of essentials such as milk and bread and were forced to make a trip to the local shops – with the conditions causing slips and falls that resulted in more accidental breaks.

The local social enterprise that delivered meals on wheels discussed the issue with their commissioners and set up an additional emergency service providing milk, bread and some other essentials in times of adverse conditions. They were able to track how this affected the number of falls and redirect some of the funds that were saved to ensure this emergency service was a permanent solution.

5 http://www2.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf

3. Find funding for your partnership project

THE CHALLENGE:

Part of the challenge when commissioning early intervention and preventative solutions is the ability to reallocate limited resources.

Programmes such as time banking can be cost effective interventions that can be so effectively managed that they can save considerable funding in the longer term. However, the start-up cost still needs to be funded alongside business as usual before the intervention begins to take the pressure off and replace existing services.

Similarly, proven public health interventions that can reduce the need for hospital visits in the future may take time before the reduced demand is felt in acute services. Funding this time lag is a big challenge for commissioners.

3. Find funding for your partnership project

THE SOLUTION:

Social finance can be an appropriate form of funding to bridge the gap between the start of an intervention and a time when results can be seen and costs saved.

In the health and social care space it can support proven interventions to grow, or invest in interventions where the business case is yet to be made.

Social impact bonds (SIBs) are an example of a financial instrument channelling external finance into early intervention or preventative initiatives. These work by establishing a contract between a financial institution and the commissioner, who commits to pay for improved outcomes delivered over a fixed period.

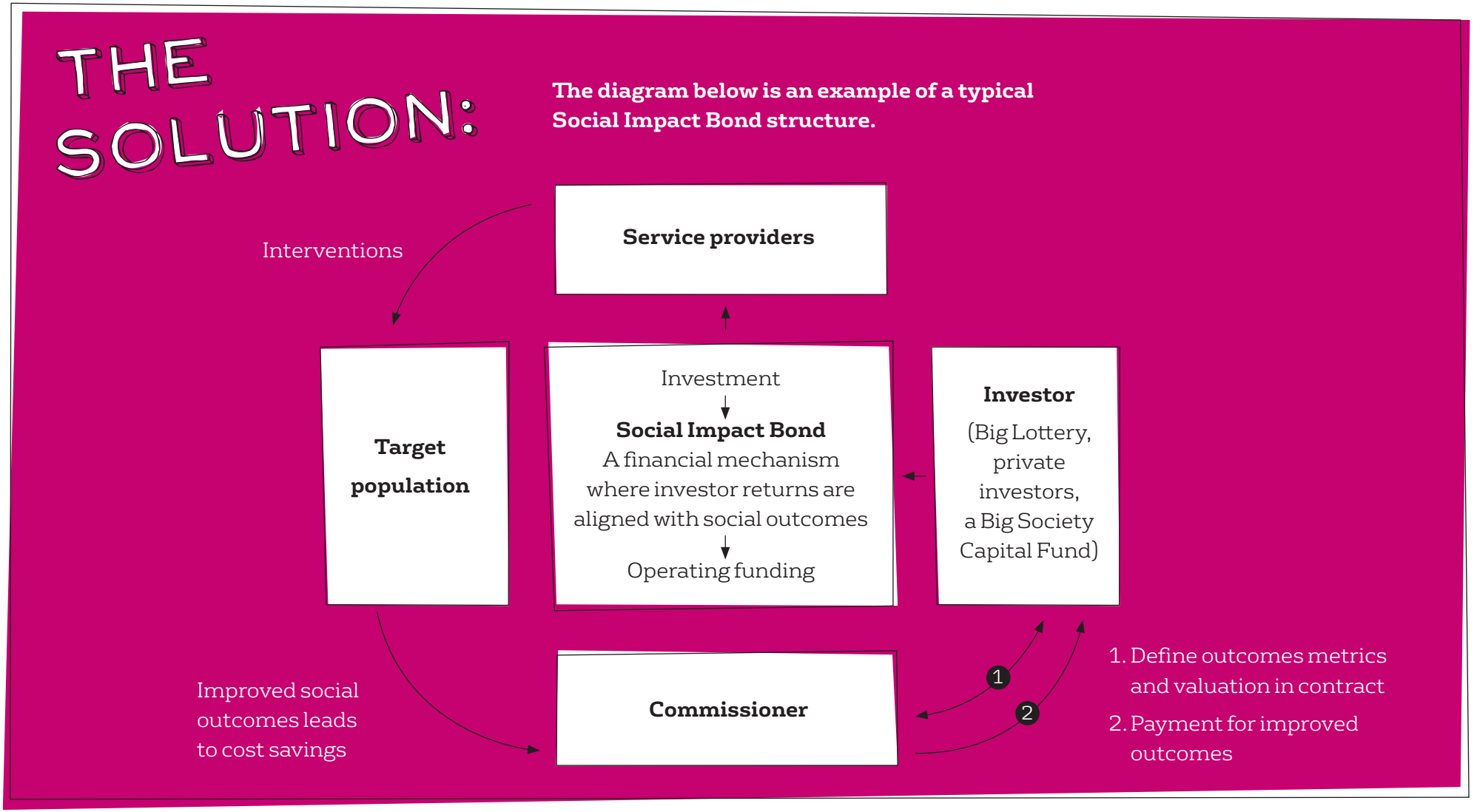
Through a Social Impact Bond, social investment is used to pay for interventions, which are delivered by service providers with a proven track record. Financial returns to investors are made by the public sector on the basis of improved social outcomes and net savings. If outcomes do not improve, then investors do not recover their investment.

These contracts could be used to redirect resources from expensive hospital care to community-based interventions for people with long-term conditions. Worcestershire Council has conducted a feasibility study to construct a social impact bond to reduce emergency hospital admissions for the elderly with diabetes (See www.socialfinance.org.uk/sites/default/files/social_impact_presentation_trish_haines.pdf). There is now a centre of excellence for social impact bonds in the Cabinet Office.

3. Find funding for your partnership project

THE SOLUTION:

The diagram below is an example of a typical Social Impact Bond structure.



CASE STUDY:

Changing Lives in Cornwall

Changing Lives is a new approach to meeting the community's health needs that joins up a range of existing services for older people to prevent hospital admissions, reduce falls, increase independence, treat dementia and generally promote healthy and active lifestyles.

Volunteer Cornwall and Age UK Cornwall pioneered the approach with support from statutory and voluntary partners. The successes below demonstrate the positive impact of community-based activity in reducing health inequalities, tackling social exclusion and enhancing health and wellbeing.

Vital stats

Location: Cornwall, 4 volunteer centres, Truro Wellbeing Centre

Structure: established by local volunteers in 1978

Service users: 6,098

Employees: 43, about 40 full-time-equivalent

Costs of delivery: £2.2 million last year

Source of funding: National and regional contracts, some services pay for themselves through small contributions from service users.

The problem

People often have complicated health concerns, exacerbated by challenging personal circumstances. Social isolation and a lack of support for people to retain their independence into old age can lead to an over-reliance on or inappropriate use of acute and primary care.

The solution

Volunteering and time banking provides opportunities for individuals to gain skills and connect with their communities. Changing Lives harnesses the power of volunteers to provide much-needed services and practical support, join up existing services and improve health and wellbeing.

Successes include:

Improving hospital discharge/preventing hospital admissions (Get Well, Stay Well) – of the 7 individuals supported through the pilot project who were considered to be at high risk of hospital admission, none returned to hospital within a three month period.

Preventing falls (Steady On) – of the ten people identified as 'at risk of falling' by their GPs who pay £3 each to attend a balance class with a trained postural stability instructor, only one (out of how many?) has reported having a fall since attending the class and using the techniques she learned she was able to get back on her feet and continue with her day.

Memory support (GP practice based worker) – in the first six months the project supported two people to remain at home, saving £30,000 in residential care fees.

Maintenance Cognitive Stimulation Therapy – of the participants in the current 210 groups, 73% have scored the same or increased their scores in their mini-mental state examination and Quality of Life assessments.

Assisting patients to travel to health appointments – over 200,000 journeys a year with more than 500 volunteer drivers provide a vital link to transport for people in more remote locations, reducing the sense of isolation and increasing independence.

4. Stop doing what you're currently doing

THE CHALLENGE:

Commissioning VCSEs can mean using resources very differently. For example, you could be using a social club rather than a GP surgery to deal with 'socio-clinical' problems, commissioning a service-user organisation to increase treatment compliance, or mobilising relatives or peers rather than social workers or community nurses to relieve loneliness, foster self-confidence or deliver public health messages.

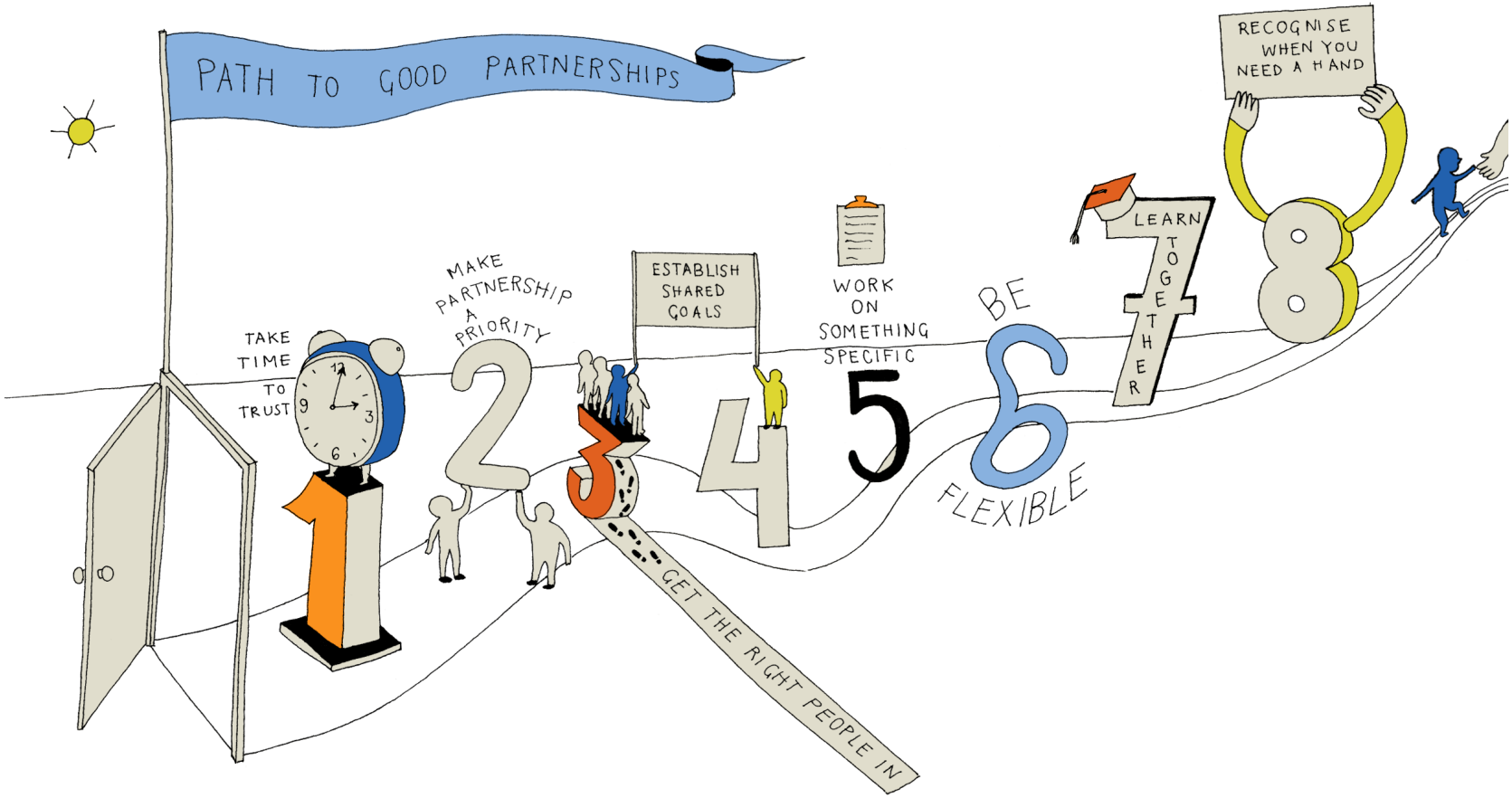
Eventually this may mean reallocating resources and de-commissioning existing services where appropriate. This is a particularly difficult challenge in the NHS, which has a poor track record in introducing and managing change that involves win/lose trade-offs.

4. Stop doing what you're currently doing

THE SOLUTION:

De-commissioning a service or just part of a service in order to introduce a more effective one is an essential part of improving health outcomes and value for money. Unlike cutting services to save money, this approach continues to deliver an intervention, but may do so through a different provider or in a different way. The need to de-commission can arise for a number of reasons, including addressing poor performance, responding to better evidence or changes in user needs, coping with reduced funding or deciding to join up budgets and re-design services. The National Audit Office has identified nine principles of good de-commisisoning. See www.nao.org.uk/sectors/civil_society/decommissioning_csos/before_you_start/principles.aspx

The path to good partnerships



This guide is based on a health commissioning improvement programme that worked in four areas to support more effective and productive partnerships between the VCSE sector and the new health structures. Through examining what makes a good partnership, and working towards this, the programme identified the following eight steps to get you started with successful VCSE partnerships.

1. Take time to trust

There is no shortcut to investing in face-to-face relationships. Just like it does in our personal and social lives, building trust and understanding in a professional setting takes time. Each partner needs to understand what the other has to offer and what their combined resources can achieve in terms of improving health outcomes. No directory of organisations, website or pamphlet can ever replace the value of conversations and it is only through these conversations that this shared understanding can be reached.

"We recognise the need for a changing culture but there is less recognition of the time it takes to do things like build consortia, develop trust, form the relationships needed to commission differently."

2. Make partnership a priority

Partnerships can be-time consuming but the return on investment can be huge. Investing in building relationships without tangible outputs attached to them can be seen as a luxury that is all too often trumped by other priorities. Understanding the mutual benefits of a partnership and aligning the goals of the partnership with partner organiations' strategic objectives will help to ensure that it is given the priority it deserves.

"Not until I sat here did it even cross my mind that the VCSE could help with this." – *Clinical Commissioning Group strategic director, referring to the problem of rising urgent care admissions in the local hospital.*

3. Get the right people in the room

Consistent representation at the appropriate strategic level is critical. A lack of continuity in who attends meetings makes it impossible to maintain a shared vision and to sustain progress. Equally, in order to maintain momentum, the individuals in the partnership need to be invested with the power to make decisions and the same level of representation is needed from all partners.

"It's been great getting to know people from across the [VCSE] sector. The level of depth of understanding of the issues, right round the table, is inspiring. The fact that we are all on the same page – VCSE, CCG, Council – we all 'get it' is heart-warming and hopeful."

4. Establish shared goals

All the evidence on partnership working points to the importance of shared goals. The Health Improvement Programme invests considerable time in establishing a shared vision and jointly identifying local learning and improvement objectives and building mutual understanding and communications between the VCSE and the CCG and council. These form a robust foundation from which to build and set the programme up for having sustained impact.

"This process is already helping us make progress in recognising that we are working as part of a whole system, and we have seen a significant improvement in recognition of how that overall system works."

5. Work on something specific

Start with a particular challenge that is manageable and specific. Particularly in light of the changes in the health sector and the ongoing battle of competing priorities, the goal of improving partnerships between the VCSE sector, CCGs and health and wellbeing boards can seem to be an overwhelming task. Starting with something specific, like tackling the problem of reducing fractures among the elderly or working collectively on a Joint Strategic Needs Assessment, can be an effective way to focus the partnership ensuring that this is used to build relationships and create the foundations for more effective collaborations in the future.

6. Be flexible

Try to stick to your aims and objectives but remember to be flexible! Something always goes wrong so be prepared to roll with the changes.

7. Learn together

Some of the changes you face are new to all sectors. Recognising that, on issues like the role of social finance in public services and commissioning and measuring social value, you will be learning together can be a great way of developing the partnership and helping to support the development of shared priorities in the new landscape. It also ensures new initiatives are designed effectively, taking account of all partners' perspectives and challenges and realising the opportunities.

8. Recognise when you need a hand

There have been many attempts to build partnerships between the VCSE and the statutory sector, many of which have failed. There remains a degree of misconception and lack of understanding of the VCSE sector on the part of commissioners and vice versa. Independent skilled facilitation can help to overcome these at an early stage, putting the owners of the partnership on a solid footing for sustaining it in the long term.

"The sessions have been astonishing. I have never seen commissioners, the VCSE and councillors coming into a room and talking as equals, it's been so wonderfully open."

Resources

Asset Based Approach
Foot J (2012) *What makes us healthy? The asset approach in practice: evidence, action, evaluation*
www.scdc.org.uk/media/resources/assets-alliance/What%20makes%20us%20healthy.pdf

Commissioning
www.socialenterprise.org.uk/advice-support/resources/working-with-the-public-sector-busting-the-myths

Decommissioning
National Audit Office web decommissioning toolkit
www.nao.org.uk/sectors/civil_society/decommission/home.aspx

NAVCA decommissioning resource webpage
www.navca.org.uk/localvs/lcp/briefings/decommissioning

Economic case for preventative services
Knapp M, McDaid D and Parsonage M (2011) *Mental health promotion and mental illness prevention: the economic case*
Department of Health
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123993.pdf

Friedli L and Parsonage M (2009) *Promoting mental health and preventing mental illness: the economic case for investment in Wales* Cardiff
www.publicmentalhealth.org/Documents/749/Promoting%20Mental%20Health%20Report%20%28English%29.pdf

Knapp M et al (2011) *Building community capacity: making an economic case*
www.pssru.ac.uk/pdf/dp2772.pdf

Carers UK (2012) *Growing the care market: turning a demographic challenge into an economic opportunity*
www.carersuk.org/professionals/resources/research-library/item/2570-future-care-growing-the-care-market-turning-the-demographic-challenge-into-an-economic-opportunity

Innovation
Hambleton R and Howard J, with Denters B, Klok P and Oude Vrielink M, (2012) *Innovation and Public leadership*, Joseph Rowntree Foundation
www.jrf.org.uk/sites/files/jrf/public-sector-innovation-full.pdf

Kings Fund (2011) *Transforming our health care system: 10 priorities for commissioners*
www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners

Measuring impact/ outcomes
www.thesroinetwork.org

www.scribd.com/doc/19678244/NEF-Measuring-Real-Value-Social-Return-on-Investment

New Economics Foundation (2012) *Measuring well being*
www.neweconomics.org/publications/measuring-well-being

The New Economics Foundation has a comprehensive toolkit *Proving and Improving: a quality and impact toolkit for social enterprise*
www.proveandimprove.org

Social Impact Bonds
Advice and information from the Government
www.gov.uk/social-impact-bonds

www.socialfinance.org.uk/work/sibs/health

The Social Value Act
SEUK guide to social value
www.socialenterprise.org.uk/uploads/files/2012/12/social_value_guide.pdf

Further information on social enterprise
www.socialenterprise.org.uk

Voluntary and Community Organisations
www.ncvo.org.uk

www.navca.org.uk/directory

www.regionalvoices.net/about

Further information on CCGs
www.commissioningboard.nhs.uk

More information on health and wellbeing boards
www.healthandcare.dh.gov.uk/category/public-health/hwb/

NHS Confederation has produced a series of tools to support boards
www.nhsconfed.org/Publications/Pages/lresources-health-wellbeing-boards.aspx

Operating principles for health and wellbeing boards
www.nhsconfed.org/Publications/reports/Pages/Operating-principles.aspx

Social Enterprise UK

We are the national membership body for social enterprise. We offer business support, do research, develop policy, campaign, build networks, share knowledge and understanding and raise awareness of social enterprise and what it can achieve. We also provide training and consultancy for clients of all kinds.

We have been working in health for more than a decade. We help organisations interested in social enterprise who work in health and social care, including those spinning out from the NHS, CCGs and voluntary and community organisations. We were among the architects of the Social Value Act and we are strategic partners of the Cabinet Office, Department for Communities and Local Government, the Department of Health and the Department for Education.

Social enterprise is a growing force for innovation in healthcare and we can support you to harness it.
To discuss your needs telephone 020 3589 4952 or email **charlie.wigglesworth@socialenterprise.org.uk**

Visit **www.socialenterprise.org.uk** to find out more.

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