

Achieving parity of esteem? The role of the voluntary, community, faith and social enterprise (VCFSE) sector within integrated care systems – a case study of Lancashire and South Cumbria VCFSE Alliance

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INTRODUCTION – THE VCFSE SECTOR AND INTEGRATED CARE

Integrated care systems (ICSs) have been introduced in England to support place-based partnerships across a range of services, organisations and groups involved in health and care.¹ The NHS Long Term Plan stipulates that these partnership structures should bring together local stakeholders 'to redesign care and improve population health, creating shared leadership and action'(p.29).² This is likely to involve new or strengthened relationships between the NHS, local authorities and the public, as well as the voluntary, community, faith and social enterprise (VCFSE) sector. The evidence base for integrated care is developing, with a major international review identifying improvements in perceived quality of care, patient satisfaction and access to care.³

There is a growing recognition of the role of the VCFSE sector within ICS arrangements, evidenced, for example, by the inclusion of collaborative working with VCFSE organisations as a marker for considering ICSs as 'mature' or 'thriving'(p.9).⁴ As part of the Covid-19 response, the VCFSE sector is recognised to have made a key contribution in responding to the early and continuing effects of the pandemic within local systems, explained by its ability to respond flexibly and rapidly to community needs.⁵ More generally, VCFSE organisations are suggested to play an essential role in improving population health outcomes and addressing health inequalities for a variety of reasons: this includes the sector's knowledge and expertise as longstanding providers of services, their reach across communities – engaging groups with poor health outcomes or those reluctant to access services,⁶ or by responding more holistically to residents' needs.⁷

National implementation support to build capacity for integrated VCFSE models now includes a national VCFSE Alliance,⁸ a VCFSE leadership programme delivered in several ICSs across the country,⁹ with guidance for health and care systems also available.⁶ Locally, Lancashire and South Cumbria ICS has been actively involved in the forementioned 'test, learn and review' initiative exploring how leadership between statutory organisations and the VCFSE sector can improve health and wellbeing at a neighbourhood level.⁹ The research reported in this article – funded through the Applied Research Collaboration North West Coast (ARC NWC) – complements this existing activity and is concerned with building the evidence base for integrated approaches involving the VCFSE sector.

In this article, we report on findings from an initial phase of research aiming to understand the early impacts of an Alliance established to support engagement with the VCFSE sector across Lancashire and South Cumbria's ICS (see Box 1). The ICS is the health and care system across Lancashire and South Cumbria, serving a population of 1.8 million in the region; a third of whom live in some of the most deprived areas in England. Across the ICS geography there are five place-based partnerships (Central Lancashire, Fylde Coast,

Morecambe Bay, Pennine Lancashire and West Lancashire) formerly known as integrated care partnerships (ICPs). The ICS strategy places emphasis on greater collaboration to address the region's health needs across sectors including NHS, local authority, voluntary, community, faith and social enterprise and academic organisations.¹⁰ Figure 1 summarises the structure for VCFSE engagement with the ICS developed by the authors during fieldwork conducted for this study.

Box 1: Lancashire and South Cumbria VCFSE Alliance

Between 2018 and 2020, representatives of the VCFSE sector, working with colleagues from local government, the NHS, and the ICS, developed a system for VCFSE engagement in the region. The structure placed representatives of VCFSE leadership and/or engagement groups from five integrated care partnerships (ICP) as well as other VCFSE representatives, in a formal ICS level Alliance. Through an independent (and ICS funded) chair, the group also has a direct relationship with the ICS board. In addition, members of the Alliance serve as VCFSE representatives on each ICP (now place-based partnership) board.

Source: <https://www.healthierlsc.co.uk/VCFSE>

METHODS

The research involved a short term study (October 2020 – February 2021) to investigate the early implementation and impacts of Lancashire and South Cumbria's VCFSE Alliance. Fifteen semi-structured interviews were conducted via Microsoft Teams. Participants to this research included: strategic level representatives from the VCFSE sector who were also members of the VCFSE Alliance (n=7); integrated care partnership (ICP) programme directors (n=3); strategic representatives from organisations with statutory funding who worked closely with both statutory organisations and the VCFSE sector (n=2); and a manager from a statutory organisation who worked closely with the VCFSE sector (n=1). Two interviews were also conducted with leaders of VCFSE organisations responding to Covid-19 'on-the-ground'. Although our initial plans for this research included interviews with strategic level representatives from statutory organisations, in light of the pandemic, initial unsuccessful attempts to recruit these participants, and the time scale for the completion of fieldwork, it was decided that their inclusion in this study was out of scope. Data collected through this research has undergone thematic analysis (the drawing out of key themes)¹¹ through which a number of findings have emerged and will be discussed in the following section.

Ethical approval was gained from Lancaster University's Faculty of Health and Medicine's Ethics Committee in October 2020 (FHMREC20006). Direct quotations from participants are included to illustrate key themes in the findings. However, to protect anonymity as far as feasible (due the relatively

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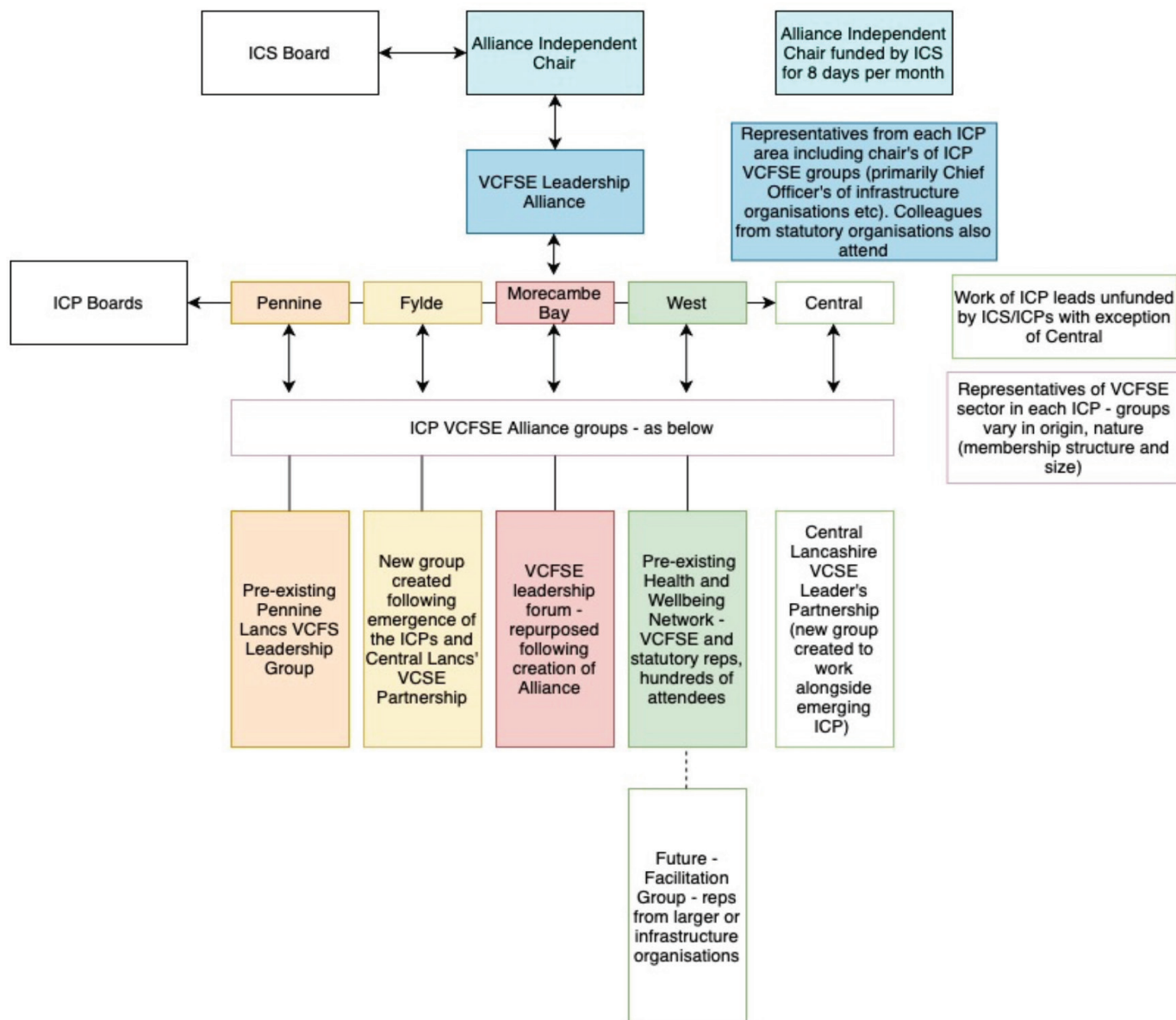


Figure 1: Lancashire and South Cumbria ICS – structure for VCFSE engagement

small number of participants and potentially identifiable nature of their roles), names of participants and information about local VCFSE organisations are not detailed in the findings presented below. As the fieldwork was undertaken prior to the transition to place-based partnerships, the original terminology (ICPs) is also used in the findings.

FINDINGS

Developing relationships within the VCFSE sector

Leadership groups for the VCFSE sector and working relationships between VCFSE organisations pre-dated the creation of the Alliance in the region. Nevertheless, the Alliance's establishment was found to have contributed to the development of positive relationships between members of the VCFSE Alliance leadership group, and relationships between VCFSE organisations at the ICP level. In some areas, the creation of the VCFSE leadership group at ICP level

prompted a marked and positive shift in relationships between VCFSE organisations, including joint working between these organisations. Instances were given of increased collaboration on bids or tenders, better understanding of different stakeholders' roles and increased instances of informal communication occurring outside of formal meeting structures as the following quote illustrates:

"I think, another thing that's come out of it is really good is WhatsApp groups...I've been in a meeting at an ICP board once and sort of texted somebody and said like "I've just been asked this I've got no idea what to answer"...and they were like "say this". That was really positive because...I was able to demonstrate not only the value of that person's insight, but the value of the partnership in the first place because I could text the person and say "hey help me out" and they did."
(Local VCFSE organisation/VCFSE Alliance member)

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Improved relationships within the VCFSE sector were also discussed as an outcome of the Covid-19 pandemic. Whilst this research did not capture a lot of ‘on the ground’ experiences in relation to the pandemic response (a consequence of the sample size and research timeframe), findings suggest that in some cases at least, the onset of the pandemic facilitated more productive relationships; relationships that, if carried forward, could enable the sector to play a greater role in terms of service delivery in the future (for instance by facilitating joint bids). In this regard, participants discussed the pandemic as creating impetus to shift relationships between VCFSE organisations in the longer term as a consequence of revealing the benefits of working together.

“I think when we [are] all trying to fight for the same pot of money and I’ve always found that people become a bit more secretive ... but it might teach us, this pandemic might also teach us that we don’t have to be, we can share ... I have approached other organisations to say “look are you interested, I’ve seen this funding would you like to go into partnership?”...I hope this pandemic has brought organisations together.”
(VCFSE organisation involved in Covid-19 response)

The extent to which these positive developments occurred was variable across localities. In particular, the relationship between VCFSE organisations was different in each ICP area, owing to varying histories, and affected by (amongst other factors): the absence, presence, and strength of local infrastructure organisations; the absence or presence of VCFSE leaders with a particular commitment to developing relationships across the sector (and the capacity to do this); and by the size and scale of the VCFSE organisations working in the area.

Relationships between ICP programme directors and the VCFSE Alliance

The creation of the VCFSE Alliance not only affected relationships within the VCFSE sector, but also created entirely new relationships, a notable example of which were those with the ICP programme directors; individuals responsible for designing and delivering the structures of the ICPs across Lancashire and South Cumbria, and for establishing partnership working. Interviews showed that ICP programme directors were essential in ensuring the representation of the VCFSE sector at the ICP level. Programme directors were notably enthusiastic about the VCFSE sector, an enthusiasm that was apparent throughout the interviews. For example, one aspect of support described was ensuring VCFSE representatives had opportunities to contribute to board meetings (for instance by placing items on the agenda), and to direct and inform broader ICP development.

“And I think, again what I’ve tried to do in my role is to help [the VCFSE reps] shape some of the agendas and if they want to bring things to the agenda they need to just say ... and I think we need to help the third sector with that, to feel that they are equal partners and it’s in actions rather than words as well.”
(ICP Programme Director-2)

Programme directors described themselves as committed to ensuring ongoing inclusion in this way and addressing inequities in representation of the VCFSE sector on boards.

Relationships between VCFSE sector and statutory partners

The research found less evidence of joint working occurring between statutory organisations and the VCFSE sector as a result of the Alliance at the time of the research. Where examples were cited, these were typically in relation to the recent pandemic response in the community. Joint working tended to occur where there was already on-going individual, contractual and existing relationships between the statutory and VCFSE sectors within local areas. For example, one member of the VCFSE Alliance interviewed described how their VCFSE organisation had been ‘immediately contacted by the health commissioners ... and the local authority’ as part of the response planning, leading to the organisation being ‘immediately included as a partner within that local planning work.’ One factor potentially influencing this finding is that the Alliance is relatively new and partnership working was at an early stage of development when interviews occurred. VCFSE interviewees also highlighted a number of challenges for consideration (discussed next) that, if addressed, could enable the sector to play a more significant role in the design and delivery of health and care.

Funding, capacity and influence

Firstly, whilst it was acknowledged by Alliance members and by ICP Programme Directors that the funding of the independent chair was an important step forward in terms of building and developing relationships between the VCFSE sector and statutory partners, the absence of similar funding for other VCFSE representatives at the time of this research (with one exception) was described as a key issue for parity of esteem, through which meaningful partnership working could emerge. This lack of funding also had practical implications, for example, limiting the time that representatives were able to spend preparing for board meetings.

“We’re in a bit of a difficult situation because I think that at the moment the ICS is demanding a lot of [VCFSE] leads time, and yet, it’s not coming up with any sort of costing structure to do it. ... I have to justify my time, quite rightly, because we’re spending public money.”
(Local VCFSE organisation/VCFSE Alliance representative)

Inequitable financial positions were also suggested to affect how the VCFSE sector could engage at ICP board level. In this respect, participants felt that Alliance representatives were not always viewed as equal partners on the ICS and ICP boards because they did not contribute to respective budgets. Related to this, it was suggested that VCFSE organisations needed to prove their relevance in a way that other partners or professional members (e.g. clinical staff) did not.

“I think there’s something for me about the sector being seen as a professional partner, so in the same way we have very very strong partners around that table, you know an acute hospital...you compare that to the VCFSE sector where you might have somebody who’s involved in a small group, yeah it’s, you’re always going to have disparities I suppose.”
(ICP Programme Director-1)

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Next, the importance of capacity, in terms of knowledge and expertise, for building and developing relationships between the VCFSE sector and statutory organisations through participation at the ICS and ICP boards was alluded to by both programme directors and Alliance members. Two main issues were widely discussed by participants: the need for VCFSE representatives on the boards to be comfortable discussing a range of different things (e.g. finances) that they may have varying prior experience of; and the prominent health focus of the boards which could limit the opportunities representatives had to demonstrate and utilise their own expertise across a range of issues related to health and wellbeing.

"[Sitting on the ICP board] it's daunting I've got to be honest, it's a lot to take on, it's a lot of reading, and it's a lot to understand, especially the clinical side of things."

(Local VCFSE organisation/VCFSE Alliance representative)

"I think if VCFSE representatives are coming to ICP boards and are finding it difficult to engage because the agenda is too health focused then the [ICS] partnership has got something wrong rather than the [VCFSE] sector."

(ICP Programme Director-1)

A final way in which capacity and funding were reflected upon was in relation to the long-term sustainability of the VCFSE sector and the role of commissioning. This issue was by far the most significant concern among stakeholders interviewed. In particular, VCFSE representatives interviewed were concerned that without investment, the long-term sustainability of the sector could not be guaranteed, and moreover, that the potential for preventative interventions offered by the sector, and in turn improvements in population health, could not be realised. This wider funding environment for the VCFSE sector was suggested to have implications for its long-term stability, both reducing the ability of VCFSE Alliance members to contribute to boards (because as leaders of infrastructure organisations they have a primary responsibility to help sustain their membership and their own organisations), and in some cases encouraging competition rather than collegiality and co-operation between organisations.

CONCLUSIONS

Through this research we explored the role of the VCFSE sector within Lancashire and South Cumbria ICS, and attended to the ways in which relationships within the VCFSE sector, and between the sector, the ICS, and statutory organisations, affected and informed the role that the sector was able to take in decision making. We have highlighted the positive impact that the creation of the VCFSE Alliance has had in terms of facilitating productive relationships. More generally, we have noted the barriers faced by the sector including capacity and funding issues, the extent of influence in strategic decision making structures and the ways in which the competitive funding environment may in some cases discourage organisations from working together. Nevertheless, whilst these factors were suggested to be limiting the role of the VCFSE sector, they were not discussed as insurmountable or unique to the region. A limitation to the study was the lesser engagement with statutory organisations due to the timing of the research.

Moreover it is recognised that in the period since this research was undertaken, there will have been new developments in relationships and in the activities of the Alliance that are not reflected in our findings.

Existing UK and international evidence on integrated approaches to health and care shows that this can contribute to improvements for local populations and services.³ However, gaps have also been noted in the extent that integrated care decision making prioritises clinical or individual-level approaches to prevention rather than interventions focused on social determinants.¹² Much of the evidence specifically related to local models involving the VCFSE sector is also located in descriptive case studies with relatively few evaluations conducted.¹³ There is also variation in how local areas and organisations collate data on impact and in some cases, a lack of available data, presenting additional challenges in evidencing the impact of the VCFSE's contribution.¹⁴

Looking ahead, we propose the following ways in which future research activity can support this agenda. Firstly, our project stakeholders have highlighted the need for future evaluations of models of integrated health and care involving partnership with the VCFSE sector including evidence on the cost and value of integrated approaches. To support planning for future evaluation, ARC NWC researchers in collaboration with VCFSE and statutory partners and ARC NWC public advisers are developing a logic model providing a visual representation of the relationships between the activities and the intended outcomes of designing and delivering integrated health and care in partnership with the VCFSE sector. The logic model remains under development but will be freely available in early 2022 from the following ARC NWC webpage: (<https://arc-nwc.nihr.ac.uk/equitable-place-based-health-and-care/>). Secondly and related to this, a recent report has drawn attention to barriers in the use of VCFSE data within service planning, providing useful learning to support more effective sharing of data between sectors at the local level.¹⁴ Finally, as plans for place-based partnerships develop and are implemented over time, these could also be supported by performance/outcomes frameworks that help to understand the specific contribution and roles of different sectors (e.g. health, local authorities, VCFSE) in achieving improvements in health and social outcomes for local populations. This could include the use of contribution analysis (a theory based approach to planning, performance management and evaluation), which can practically support accountability for partnership working where is necessary to articulate the contribution of a range of sectors and/or organisations to shared outcomes delivered collaboratively.¹⁵

Finally, achieving genuine and long lasting partnerships between sectors is unlikely to be obtained without addressing structural and organisational factors. This requires attention to commissioning and funding arrangements that encourage collaboration rather than competition,⁸ capacity, trust and strategic leadership across the system,¹⁶ as well as a shift in the focus of ICSs to social determinants of health and population health more broadly.¹²

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Hello! My name is Emma, and I am an Advanced Clinical Practitioner (ACP) in General Practice at Lancaster Medical Practice. I have been nursing for over 6 years now, and just recently qualified as an Advanced Clinical Practitioner. I have recently joined the editorial board of the MBMJ following peer reviewing other journal articles and having work published, I am relishing the opportunities it provides in research and evidence based practice. I feel honoured to be asked to provide my profile here.

I am thoroughly enjoying my career so far and feel privileged to have been given so many opportunities to further my knowledge and skills, which have brought me to where I am today. I would encourage everyone to take all the opportunities put towards them and enjoy every minute.

General Practice provides the fortunate position to be able to look after individuals in their homes and local community across the lifespan, encountering a range of conditions. I have a specialist interest in respiratory conditions and have been lucky to be involved in the Morecambe Bay Respiratory Network, which has provided great opportunities for networking and working more closely with colleagues across primary, secondary and community services.