# Engaging the Voluntary Sector to Address Health Inequalities


A Report from Overview and Scrutiny, **11th April 2007**

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**Reports that have been submitted to the Health Overview and Scrutiny Committee can be downloaded from www.birmingham.gov.uk/scrutiny.**

# Preface

# Summary

## 1.1 Summary

1.1.1 The Health Overview and Scrutiny Committee found that there is a substantial national movement to change the relationship between the Statutory and Voluntary Sectors. This is evidenced through a number of reports that support utilising the sector in a more imaginative way.

1.1.2 The NHS itself has recognised the importance of increasing the range of services it supplies and ensuring that those groups of people that have the poorest health have better access to services. In order to achieve this it is accepted that services need to be delivered in a more flexible and locally responsive manner.

1.1.3 The evidence heard by the Committee indicated that the Primary Care Trusts have a commitment to change the way they commission services as well as ensuring those services reflect the health needs of the populations they serve. This can be demonstrated by the move to tendering for services and not merely funding organisations purely based on their historical relationship.

1.1.4 The Voluntary and Community Sector also needs to recognise the changing environment and adapt to provide greater evidence of need for its services. This can be done through embracing tendering processes and delivering discernable outcomes that are aligned to identified health needs.

1.1.5 A much greater spirit of partnership is needed throughout the city in terms of planning services and day to day management. The Committee heard evidence that a lack of communication between commissioning and service delivery was the norm rather than the exception.

1.1.6 The b.5( th9l54 -5.4(3.(ed)1.)-4.8(59 5as(h)-0.2ee ind459 Tc)2nean )-5.53 -36 TD0.ded(ther)-6.24a

Birmingham City Council Adults & Communities Department (previously the Social Care and Health Department).

1.2.2 Evidence was requested from participants in order to demonstrate how services are commissioned, how service level agreements are managed and how strategic planning is developed. Evidence was requested in written form as well as further meetings in front of the full Committee and visits to

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|---|---|---|---|
| R5 | Progress towards achievement of these recommendations should be reported to the Health Overview and Scrutiny Committee on a yearly basis. The first report should be made in April 2008. | Chief Executives of PCTs | April 2008 |

# 2 Introduction

## 2.1 Background

2.1.1 In 2004, the Government's White Paper "Choosing Health" set out a plan for helping people to make healthy decisions about their lifestyles and promoting health and wellbeing. Through the process of promoting health and wellbeing it waR TD97[BaD09 Tc(2.1.1 )Tj2Tj/2T14 1 Tf2.2459 0 TD

Organisations are being commissioned to provide services that address the most important needs of the population. Appropriate monitoring systems would also ensure that the work commissioned from the Voluntary Sector will address those disparities of service that exist within the city.

2.1.8 Before examining the evidence provided to the Committee it is important to look at how the current national situation developed. The relationship between the Voluntary and Community Sector and the state has been fundamentally entwined with the birth of the welfare state itself and it is important to recognise their comparative development.

## 2.2 Voluntary Action

2.2.1 In 1948 Lord Beveridge wrote "Voluntary Action", which set out an idea of the relationship between Voluntary and Private Sector Organisations and how these should relate to the state. Voluntary Action set out eight points that the state should adopt in order to make this relationship work[1]:-

- Co-operation of Public Authorities and Voluntary Agencies
- A Friendly Societies Act
- A Royal Commission on Charitable Trusts
- Re-Examination of Taxation of Voluntary Agencies
- An Enquiry as to the Physically Handicapped
- A Minister-Guardian of Voluntary Action
- Specialised Staff Training
- Continuance and Extension of Public Grants to Voluntary Agencies

2.2.2 It is interesting to note that over half a century later many of these issues are still as relevant to the relationship between the state and voluntary sectors as they were at the conclusion of the Second World War. For example, it was only in 2006 that the Office of the Third Sector was created, thus establishing a Minister of State within the Cabinet Office.

2.2.3 The first and last points, set out by Beveridge reach to the heart of the intentions of the "Choosing Health" White Paper. They also demonstrate a theme that has run through social policy for decades.

## 2.3 The Deakin Report

2.3.1 In 1996, "Meeting the challenge of change: Voluntary action into the 21st century" sought to provide a clear and coherent vision of the Voluntary Sector and how it could be used to provide services over the coming ten years. The report, containing 61 recommendations, was seen as a key component in the drive to reform public services and would shape the legal framework that organisations find themselves in today.

[1] Voluntary Action: Meeting the challenges of the 21st Century - Campbell Robb

2.3.2

on a drug rehabilitation programme or ex-offenders working with young criminals.

- Particular ways of involving people in service delivery, whether as users or self-

yse

# 3 Local Situation and Context

## 3.1 The Primary Care Trusts and Commissioning

3.1.1 The Committee met with representatives of each of the Primary Care Trusts in Birmingham, so that they could outline their approach to commissioning services from the Voluntary Sector. The main theme outlined by the Trusts is that services commissioned from the Voluntary Sector affect health in a wider sense. For example, funding local sporting clubs has an impact on wider health but does not approach specific health targets. This fits in with priorities set out in the "Choosing Health" White Paper but these do tend to concentrate on preventative issues.

3.1.2 There is also substantial service provision in the city by national organisations, such as Age Concern and Marie Curie Cancer Research. In many cases such organisations were preferred by the PCTs as service providers because of their specialist knowledge in a particular field. This is evidenced by the fact that substantially more investment is given to these organisations than smaller Voluntary Organisations.

3.1.3 The meetings with the Primary Care Trusts set out certain issues that appeared consistent across the city. For example, in a number of cases services were being commissioned because of an historical relationship between the Trusts and the Voluntary Sector organisation rather than a demonstrable need for the service provision or demonstrable outcomes.

3.1.4 It was explained to the Committee that funding often appeared "stop-start" because of uncertainty in commissioning budgets. This, coupled with a lack of clear exit strategies, created an uncertain environment for Voluntary Sector organisations.

3.1.5 A theme presented by each of the Trusts was that as a result of the "Choosing Health" White Paper, each is looking to change the way its commissioning function is administered. The Committee was concerned to hear that there did not appear was limited evidence that the Trusts have attempted to discuss between them how this is done in order to create a consistent experience across the city.

3.1.6 The Committee asked the PCTs if there was evidence of duplicate funding across the city and whether there was a systematic assessment of value for money. The PCTs stated there was a need for auditing to be carried out in order to ascertain which organisations were being commissioned to provide certain services and whether duplication between Health Bodies and the Local Authority existed. The Committee was reassured that through its Third Sector Framework, Birmingham City Council was developing a database of service provision which will identify cases of duplicate funding.

3.1.7 In cases where Voluntary Organisations are registered charities there is a requirement that The Charities Commission audits accounts. This process should identify cases of duplicate funding.

3.1.8 The Committee raised the issue that in many cases Voluntary Sector Organisations do not take up funding allocated under Neighbourhood Renewal Fund (NRF). It was explained that the process for securing funding was often complicated for smaller organisations. The cycle of funding does not aid organisations where they are required to make an application in April but are not notified about success until September. This leaves organisations with extremely short periods of time to spend the money which is awarded. This poses particular challenges where there is a requirement to recruit staff.

3.1.9

3.3.3 In the spring of 2004 Eastern Birmingham PCT formulated its own PCT-wide Voluntary Sector Compact. This document set out the Trust's commitment to how it would work with the Voluntary Sector. It committed the Trust to developing a strategic approach to funding the sector as well maintaining a transparent approach.

3.3.4 Specific measures taken by the PCT to promote more open working are regular reviews of investment, development of service strategies to set an investment framework and moving from a concept whereby bids are requested to a process of tendering.

3.3.5 The Committee was interested to note that at present there is not a formal process of explaining to organisations which are unsuccessful in a tendering process just why their tender has failed. The PCT representative acknowledged that such a process would be useful to organisations for future tendering.

3.3.6 The Trust has created a district structure which follows the Birmingham City Council district health theme panels. They have also made a commitment to agree future take up of services in advance, in order to facilitate strategic planning as well as including Voluntary Sector Organisations in service planning.

3.3.7 The Trust believes that through implementing the above they will be in a better position to address health inequalities and demonstrate compliance with performance management frameworks such as the Healthcare Commission's Annual Healthcheck.

3.3.8 A practical example of how these commitments are working in the Eastern Birmingham PCT can be seen in the strategic decision to implement Homestart services across the PCT area. Homestart provides friendship, support and advice to parents of young children. This is done through recruiting and training volunteers to go and meet parents in their own homes. The decision to implement the service across the PCT area was set out in the strategic objectives of the PCT.

3.3.9

services supplied to the Committee showed how Voluntary Sector Organisations can be used to provide such services to hard to reach groups.

3.4.3 Another example of the work commissioned by South Birmingham PCT is through WorkDirections. This is a project to develop adult literacy and increase access to employment. The PCT recognises that unemployment and low literacy levels undermine health and increase health inequalities. This is an example of how a project can have an indirectly beneficial effect on the health of residents.

3.4.4 The PCT stated that in relation to capacity building of smaller organisations, it does attempt to provide assistance with tendering processes. The PCT has also worked closely with Heart of Birmingham PCT to create coherence with their commissioning process - though this has tended to concentrate on services which are commissioned across the city.

3.4.5 The Trust has recognised that the problems created by short funding cycles and is attempting to move to a model where contracts are awarded on a 2-3 year basis. It was acknowledged that considerably more work needs to be done in this area.

## 3.5 Birmingham Voluntary Services Council

3.5.1 Birmingham Voluntary Services Council is one of the largest Voluntary Sector support organisations

3.6.2 This outlined how Social Care intended to create a new environment for Third Sector Commissioning by creating a citywide framework which would set out minimum standards for commissioning. Through implementing the framework it was intended to create key goals for both Birmingham City Council and the Voluntary Sector.

3.6.3 The perceived benefits for the City Council are increased value for money and greater financial control, whilst also focussing on measuring outcomes of service provision. In return, this approach would offer service providers increased clarity of the services they were expected to supply and a move to longer term funding cycles.

3.6.4 The main principles of the Framework, as set out to the Committee, are matching service provision to the Council Plan and Community Strategy priorities, enforcing the principles of the Birmingham Voluntary Sector Compact and addressing weaknesses that had been identified by previous audit processes.

3.6.5 Examples of weaknesses which had been identified are:-

- No corporate strategy for third sector/not-for-profit funding
- No clear link to corporate priorities
- Risk of duplicate funding; procedures not applied consistently
- Historic funding relationships

3.6.6 The implementation of the Framework seeks to provide clear solutions to the above weaknesses in preparation for the forthcoming Comprehensive Performance Assessment. This was of particular interest to the Committee as it demonstrated a spirit of partnership between the City Council and the Voluntary Sector which clearly met the aims of the 'Choosing Health' White Paper.

## 3.7 The Birmingham Compact

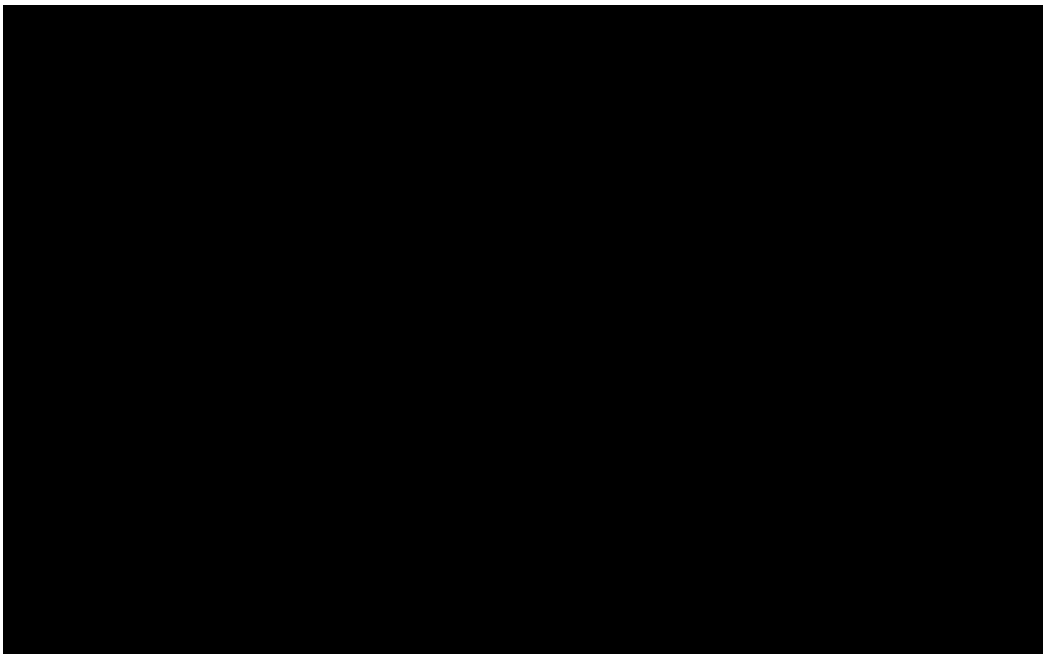
3.7.1 The Birmingham Voluntary Sector Compact is an agreement between the statutory and voluntary sectors that resulted from work carried out by the Birmingham Voluntary and Community Sector Commission. Although not specific to health provision in the city, it sets out a moral commitment by its signatories.

3.7.2 The Birmingham Voluntary and Community Sector Commission was set up by both BVSC and Birmingham City Council in 2000 to begin the process of exploring exactly how a Voluntary Sector Compact would work in Birmingham. In the light of key national policies it was necessary that bodies that commission services from the Voluntary Sector and the Sector itself look at how they interact.

3.7.3 The Commission set out to explore how the changing demographics of the city and changes in social policy would affect how services are provided and whether there was a common agenda that could form the basis of the Compact document.

3.7.4 Evidence was sought by the Commission through a series of area meetings across the city, visits to Voluntary and Community groups and questionnaires[8]. The Commission made its report in 2002 and recommended that the Birmingham Strategic Partnership should establish key thematic working groups to deal with specific areas. The five areas identified by the Commission were:-

- Governance
- Partnership
- Diversity and BME Issues
- Funding
- Commissioning



3.7.5 The conclusions of each of the working groups were then brought together to form the Birmingham Voluntary Sector Compact. The Birmingham Strategic Partnership Board endorsed the Compact in July 2005 with signatories such as BVSC, Eastern Birmingham PCT and Birmingham City Council endorsing the document in October 2005. Although the other PCTs did not specifically sign up to the compact they were signed up through their membership of the Birmingham Strategic Partnership.

[8] Making the Relationship Work: Creating a Compact. BCVSC

3.7.6 The Compact sets out a framework of principles and values that, although not legally binding, do set out what Voluntary Sector organisations can expect when being commissioned to provide services.

3.7.7 There are certain key commitments within the document that affect the relationship between the Voluntary and Statutory sector - for example, the commitment to consult with the sector on policy development. This commitment also recognises that the sector is not cohesive, thus consultation can be a lengthy and complicated process.

3.7.8 The Compact commits the signatories to strengthening the recruitment to governing boards, to supporting capacity building across the sector and to developing a "Think Tank" to undertake a policy development role.

3.7.9 With regard to the issue of diversity and the BME community, the Compact recognises that there is not a specific BME Voluntary Sector with shared aims and objectives. This recognition is useful in order to begin categorising organisations in terms of their purpose rather than the community they are perceived to serve. The Compact also recommends that the needs of BME communities should be met through mainstream provision rather than separate projects.

3.7.10 The issue of funding cycles is addressed by the Compact encouraging partners to move to a medium-term model of three-year contracts. In addition, the contracts agreed with the sector should provide for a full-cost recovery model that is suitable for the particular circumstances in Birmingham.

3.7.11 There is also a requirement for signatories to create a single funding gateway together with a transparent commissioning process. This would ensure a commonality of experience for organisations that are commissioned to provide services as well as an understanding of how the process works.

# 4 The Voluntary and Community Sector

## 4.1 Methodology

4.1.1 In order to assess the current situation within the Voluntary and Community Sector in Birmingham the Committee heard evidence from a number of organisations which receive funding from the Primary Care Trusts. The Committee considered it was beneficial to hear evidence from organisations across a range of disciplines in order to gauge a variety of experiences.

4.1.2 Organisations that presented evidence to the Committee included:-

- MIND Birmingham
- BITA Pathways
- Servol Community Trust
- NimHE
- The Stroke Association
- The Alzheimer's Society
- Birmingham Mencap
- Age Concern
- Birmingham Drugline

4.1.3 The Committee received evidence through presentations and Committee meetings and a number of visits by officers. This provided an opportunity to gain a broad view of service provision and equate this with the reality of organisations' day-to-day situations.

4.1.4

allocation of funding. A concern that was frequently raised with the Committee was that the PCTs made little effort to communicate when tenders were being invited.

4.2.2

addressing health inequalities, as the information contained within service level agreements does not appear to relate to health outcomes.

## 4.5 Needs Assessment and Strategic Planning

4.5.1 The commitment by the PCTs to include Voluntary Sector organisations in strategic planning does appear to be having some success. An example provided by Birmingham Drugline was the Adult Drug Treatment Plan 2006/07. The organisation was invited by the Drug Treatment Team to assess need and future service provision and these views were incorporated in the subsequent plan.

4.5.2 Age Concern illustrated to the Committee that as a matter of course the organisation carries out a service deficiency analysis in order to assess the need for service development. Age Concern break down their service delivery by ward and PCT area and on a regular basis identify services that are requested by their clients but are not currently available. At present this information is sent to any organisations that commission services from Age Concern. The PCTs do not have a systematic approach to using this information in the development of their Local Delivery Plans.

4.5.3 The Stroke Association is currently involved in Eastern Birmingham PCTs strategy group. At present this is the only part of the city that has begun to involve them in strategic development.

4.5.4 The Committee was disappointed that there appeared to be no demonstrable link between services that were commissioned and identified health inequalities.

## 4.6 Full Cost Recovery

4.6.1

provide services is that they often do not know

# 6 Appendix 1

Proposed Scrutiny Review:

# Engaging the Voluntary Sector to Address Health Inequalities

**Review Outline**

| | |
|---|---|
| Subject of review | How do NHS bodies engage with the Voluntary Sector in order to address Health Inequalities. With reference to the commissioning process used by PCTs and Acute Trusts, monitoring of contracts and how such projects are mainstreamed. |
| Overview and Scrutiny Committee | Health Overview and Scrutiny Committee |

**Reasons for Conducting the Review**

| | |
|---|---|
| Reasons for conducting this review | The Government's White paper "Choosing Health" places the Voluntary Sector at the heart of the NHS' plans to address Health Inequalities.<br>The Committee wishes to establish if there is a systematic approach to engaging, commissioning and evaluating the Voluntary Sector's role in addressing Health Inequalities. |
| Key question that the review is seeking to answer | What Commissioning structures are in place to commission services from |

| | |
|---|---|
| | successful projects are mainstreamed into PCT budgets? |
| Objectives of review / Areas for investigation | To examine the current status of the Birmingham Voluntary Sector Compact.<br>To identify good practice in commissioning.<br>To identify areas where monitoring processes address health inequalities.<br>To identify how projects are evaluated and mainstreamed.<br>To look at particular health inequalities within BME communities such as healthy lifestyles and smoking cessation to ascertain the extent of engagement with the Voluntary Sector. |
| Outcomes expected from conducting this work | Encourage a consistent policy on commissioning and monitoring.<br>Clarify the status of the Birmingham Voluntary Sector Compact as a framework for effective engagement.<br>Clarify PCTs commitment to the Voluntary Sector through Local Deliver Plans(LDPs).<br>Disseminate good practice to all bodies involved. |

**Project Plan and Resourcing**

**Overarching review question/s or aim of investigation**

| |
|---|
| What is the basis for commissioning services off of the voluntary sector?<br>What account is taken of how commissioned services address health inequalities?<br>How are services commissioned from the voluntary sector monitored?<br>Do voluntary sector organisations have sufficient capacity to meet monitoring requirements?<br>How are services delivered by the voluntary sector mainstreamed once proven to be effective? |

**Detailed areas for Inquiry/Investigation**

| Meeting date / timescale | Area | Methodology | Responsibility / witnesses |
|---|---|---|---|
| End of September | PCT and acute Sector Commissioning strategies. | Write to each Trust and request :-<br><br>copy of their commissioning strategy for the Voluntary Sector<br><br>structure of commissioning department and lines of responsibility<br><br>details on services commissioned over the previous 12 months (i.e. number of services and monetary value)<br><br>copies of equity audits for each PCT<br><br>details of standard service level agreements<br><br>details on how services are monitored<br><br>details on projects that have mainstreamed in the last 12 months | Darren Wright |

| Meeting date / timescale | Area | Methodology | Responsibility / witnesses |
|---|---|---|---|
| End of September | PCT and acute Sector Commissioning strategies. | Invite representatives of commissioning and monitoring from PCTs to present details on existing policies to the Committee | Darren Wright |
| End of September | Voluntary Sector experience | Survey Voluntary organisations on experience of commissioning and monitoring | Darren Wright |
| October | Voluntary Sector | Invite selected voluntary sector organisations to attend Committee and present their experiences of being commissioned and monitored | Darren Wright |

**Officer and External Involvement**

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|---|---|
| Link Officer | Dr Jacky Chambers |
| Lead Review Officer | Darren Wright |

**Council Departments Expected to Contribute**

| Contact / Department | Objective | Contribution Expected |
|---|---|---|
| Social Care and Health | To compare and contrast commissioning and evaluation systems with those of Health Bodies | Written and attendance at Committee |

**External Organisations Expected to Contribute**

| Contact /Organisation | Objective | Contribution Expected |
|---|---|---|
| PCTs and Acute Trusts | To highlight good practice in Health Bodies. | Written and attendance at Committee |

# 7 Appendix 2

| Meeting Date | Organisation | Representative |
|---|---|---|
| 22/07/05 | Birmingham & Black Country Strategic Health Authority | Yvonne Thomas |
| 05/10/05 | BVSC | Brian Carr |
| 05/10/05 | Eastern Birmingham PCT | Tony Ruffell |
| 05/10/05 | Eastern Birmingham PCT | John Grayland |
| 07/11/05 | Heart of Birmingham PCT | Anna Frankel |
| 07/11/05 | South Birmingham PCT | Dr Chris Spencer- Jones |
| 07/11/05 | Eastern Birmingham PCT | Tony Ruffell |
| 07/11/05 | Eastern Birmingham PCT | John Grayland |
| 28/11/05 | Birmingham & Black Country Strategic Health Authority | Rita Symons |
| 28/11/05 | Birmingham City Council Corporate Third sector project | Pauline Roche |
| 19/12/05 | MIND Birmingham | Helen Wadley |
| 19/12/05 | NimHE | Paul Dodd |
| 19/12/05 | BITA Pathways | Erica Barnett |
| 19/12/05 | Servol Community Trust | Sharon Annakie |
| 05/07/06 | The Stroke Association | Chris Bennett |
| 14/07/06 | Birmingham Mencap | Dave Rogers |
| 10/07/06 | The Alzheimer's Society | Robin Felton |
| 14/07/06 | Age Concern | Elaine Jones |
| 10/08/06 | Birmingham Drug Line | Sophie Painter |