Improving the health and wellbeing of people living in Norfolk and Waveney

Summary of feedback from VCSE sector engagement events - October 2019

- Norwich, King's Centre, 15 October 2019
- Great Yarmouth, King's Centre, 16 October 2019
- Lowestoft, Kirkley Centre, 28 October 2019
- King's Lynn, Town Hall, 31 October 2019

Summary

To develop and build new ways of working between the Voluntary and Community Sector, Health and Social care, the following organisations and representatives have formed a Steering Group to guide this work:

- Community Action Norfolk
- Community Action Suffolk
- Voluntary Norfolk (including Momentum Norfolk)
- Norfolk County Council
- NHS Clinical Commissioning Groups in Norfolk and Waveney

Together, we ran a series of events across Norfolk and Waveney to work with voluntary and community sector partners and get their input on the priorities within our five year strategic plan for health and care services locally. The events were also aimed at discussing a future model of working between the voluntary sector and health and social care statutory partners to support the delivery of the plan.

Over 100 representatives from VCSE organisations of all sizes across Norfolk and Waveney attended the events. This document summarises the themes from the discussions, and what we will do next. You told us:

- **The voluntary and community sector needs to be treated as an 'equal partner' by statutory health and care organisations**

- **We need to change the culture of working together, to enable more collaboration and integration and remove logistical barriers that exist (like data sharing and training)**

- **Norfolk and Waveney's five-year plan needs further focus on prevention (and the role of the voluntary sector in this)**

- **The voluntary and community sector workforce needs to be recognised as a key part of health and social care**

- **Health and social care funding for the voluntary sector needs to evolve – current commissioning is rigid and inflexible**

- **We should continue to develop an 'Assembly' - to improve working between sectors, but this must complement and work with local arrangements that already work well, and it must have independence and authority**

- **Developing an assembly that covers the whole of Norfolk and Waveney must enable a balance between voluntary and community groups of different sizes and enable effective locality engagement**

- **A Memorandum of Understanding must be jointly owned and collaboratively developed to be meaningful**

Part one: Developing a five year plan for health and care in Norfolk and Waveney

In January 2019, the NHS published its Long Term Plan setting-out how it will make services fit for the future. Every health and care partnership in the country is now developing five year plans covering the period to 2023/24, setting-out how they will deliver the ambitions of the NHS Long Term Plan and their local priorities.

At each event, we asked attendees:

- We've shared a summary of our five year plan outlining the big changes we want to make and the actions we're proposing to take. What do you think of it? What would you like to see in the plan? What are your priorities?
- We're proposing to set three overarching goals for our partnership around tackling health inequalities, integrating care and supporting our health and care workforce. What do you think of these goals?

Here is a summary of the main themes from the discussion:

Overarching comments about the plan and the partnership's goals

There was broad support for the partnership's goals. Attendees felt they "chime" and "make sense" in the context of local health and care organisations trying to work more closely together. A culture shift will be required from all sectors to achieve the goals.

Achieving the goal around health inequalities will be particularly challenging in our large, rural geography. Transport to and from health services, as well as to healthy activities, can be difficult.

Prevention is important, but this isn't really captured in the goals.

A few attendees questioned whether the partnership has the resources to deliver the plan. And there was some concern about the potential impact on the VCSE sector and additional strain being placed on VCSE organisations.

Many attendees shared the view that competition doesn't work and support the move towards greater collaboration between health, care and the VCSE sector.

There were some concerns that we have been having the same discussions about integration for years, but that we have not made enough progress. Why will things be different this time?

There was a suggestion that the plan needs to be focused on a set of outcomes that we can all sign-up to achieving by working together. By defining the outcomes we want to achieve, this would dictate what we do and how we do it. What do we mean by collaboration and integration? How will we know if we've succeeded or failed? The summary of the plan doesn't say how the goals will be measured.

Funding and commissioning processes

The way that health and councils commission services from the VCSE sector creates competition. Too much money is spent on commissioning. Too often the money goes to bigger VCSE organisations that can afford to employ people to write bids.

The NHS and councils should want to give VCSE organisations some stability – competition is divisive and short-term contracts affect service users. So that VCSE organisations can focus on helping people, rather than fund raising, there should be longer-term projects and funding. Continual improvement is helped by continuity, together with the flexibility to innovate. Staff turnover caused by the short-term commissioning cycle is a real barrier to good implementation.

Social value and social return on investment should be included in the procurement model.

The independence of the VCSE sector is difficult to maintain for organisations receiving funding from statutory organisations, but the funding is also essential to their survival.

It's important to remove the assumption that volunteers are the low-cost option to funding statutory services. Value the outcomes delivered by VCSE organisations, rather than focus on savings to system.

It's important that the views of frontline staff and volunteers are used to inform commissioning decisions.

The NHS, NCC and SCC need to be better at talking about changes to services and savings they are proposing.

Effective working between the sectors

First and foremost, it is important that the VCSE sector is viewed as an equal partner by the statutory sector. Many attendees at the events said they feel this isn't the case now.

We need to build relationships and trust between statutory and VCSE providers. It was suggested that together we should agree and follow the same processes, for example about how to raise and act on safeguarding concerns, so that everyone is pulling in the same direction. This would support operational relationships between practitioners across sectors and ensure that our ways of working are collectively understood and shared.

We need a shift in cultures in terms of how VCSE organisations work together, and how the VCSE sector works with its statutory partners.

People set-up VCSE organisations because they are passionate about a cause or an issue. We don't want to stifle that – they are the heart of communities.

Some specific examples were given of where there is a lack of integration or gaps in services – these included:

- There should be no wrong door for people who need occupational therapy – at the moment there are teams in social care, health and in hospitals – these teams should be integrated.
- There's an issue with end of life care in Great Yarmouth and Waveney. Marie Curie provide initial care to some people, but the organisation is not on the CHC fast track system and as a result when people go through the CHC process they have to change carers and their care package. This is disruptive for people. There isn't the same problem in Suffolk.
- More could be done to plan for the longer-term support for people who've had a stroke when they are discharged from hospital.
- Broadly speaking, it would be worth investing more in supporting people with long-term health conditions so that fewer people's health deteriorates to the point they need urgent care.
- The NNAB feel that they had good relationships developed with hospital teams, but that there is a lack of coordination and knowledge about the support they can provide at primary care level within GP practices and in health business like opticians.
- There should investment in specialised support, advice, and a directory for VCSE organisations, about how to refer into statutory services.

Data / information sharing and referrals

Many attendees said that information sharing is poor with the public sector, particularly with health organisations. It was felt that the VCSE sector sometimes take referrals from health and care partners with very little contextual information or supporting data. This doesn't help the individual and can put VCSE staff at risk if they don't know enough about the person they are going to be supporting.

There was a question about why data sharing is poor and whether public sector colleagues are worried that VCSE organisations wouldn't take referrals if they knew more about the needs of the individuals being referred to them.

At the same time, a few attendees said that when smaller community groups and organisations refer clients into statutory services that they don't often know what the outcome is. As a result, the VCSE organisations don't know if they've done the right thing and therefore whether they should do the same thing when they are next faced with a similar situation.

In West Norfolk, colleagues said they felt the Police has got much better at sharing information. This has been achieved by building trust and relationships – it was felt the Police know and recognise that VCSE organisations can help people.

Some VCSE colleagues said they feel they have to 'fight' to make connections with statutory colleagues, and that this is because VCSE colleagues are not always considered to be part of the bigger team.

It was suggested we should use and share the systems and information we already have, and apply common sense about when to share information. We should integrate VCSE partners into health and care data system developments, like the digital care record. And we should build on what works well, for example the Suffolk Information Partnership.

People should only have to tell their story once. It was suggested that sometimes the reason people have to repeat themselves is because their care is being funded by different organisations. Whilst the multiple assessments might help the statutory organisations involved decide who pays for what, it is not good for the individual. It can be really traumatic for people to have to tell their story over and again. And, by the time someone has told their story 20 times, they start to dilute it and miss bits out, which makes it harder to help them and puts the person at risk.

It was felt that online and multi channelled approaches are a sensible way forward, however there is much support required at a local level where access, IT literacy, confidence, capacity and cost are key blocks to engagement. As well as the challenges for professionals, it was noted that it's important to remember there are patients and service users who can't access services digitally because they don't have the means to. It was suggested we should expand existing digital inclusion projects, like the one run by Norwich City Council.

Workforce, staff and volunteer development

We need to more effectively articulate how and why the VCSE sector is part of the health and care workforce – expanding beyond the health / NHS concept of workforce. We need to focus on transformational ways of working as a combined workforce.

For some, the word 'staff' is exclusionary and 'professionals' is more inclusive – VCSE colleagues are professionals too. "You shouldn't have to show your CV to get respect."

Other attendees said that not all volunteers and carers identify as health and care 'professionals', so the goal to make Norfolk and Waveney the best place for health and care professionals to work wouldn't have any resonance with them.

In addition, it was suggested that using the word 'professional' puts some people off from considering careers in health and care, because they don't consider that they could become a 'professional'.

It was seen as good that the plan mentions increasing the number of volunteering opportunities in health and care. Attendees said we need to make sure that we are not just creating new opportunities for the same pool of volunteers – we need to increase the total number of volunteers too. In addition, it was said that volunteer recruitment between organisations shouldn't be a competition; the sector should be more collaborative.

It was suggested that we need to recruit different types of volunteers, for example people with LD and other disabilities, and people with lived experience of mental health conditions. Volunteering is a way to help people like these with their health

and wellbeing. To support this, we would need to change how we advertise volunteering opportunities and make it easier for people to apply, with fewer forms to fill in. It was noted that debt and poverty will affect the ability of people to volunteer.

There was broad support for the idea of a volunteer passport making volunteering more flexible. It is good for individuals and organisations, and it streamlines the process of volunteering for different organisations.

The principle of 'growing our own' workforce was welcomed, particularly encouraging younger people to start careers and take-up volunteering opportunities in health and care. This would require closer working with colleges. It was also noted that young people can need money to get into employment, for example to pay for training or to pay for transport to get to their job for the first month before they get their first pay packet.

There was support for shared training opportunities to help break down barriers between sectors, as well as to have placements or shadowing opportunities, for example student nurses could have placements in VCSE organisations as part of their learning experience and so that staff gain a wider perspective.

It was suggested that safeguarding and other training should be mandatory, and infrastructure organisations (like Voluntary Norfolk) should be providing affordable training.

A few attendees commented that people would be more interested in coming to work here if we had a reputation for being an innovate health and care system.

Prevention and health improvement

The recognition of the importance of prevention in the five year plan was broadly welcomed. Attendees said it should be more prominent and must be backed-up with more detail about how we are collectively going to invest more in prevention, increase our prevention activity and ensure the effectiveness of that activity.

As one attendee put it: "Do we want to build a fence at the top of the cliff to prevent people falling or to provide an ambulance at the bottom to treat the injuries resulting from falls?"

It was suggested that we should explore how we could more effectively commission what we spend within the NHS budget on low level prevention activities – this is where the VCSE sector comes into its own. For example, it was proposed the NHS could commit to ring fencing 1% of its budget for low level prevention activities.

Attendees said it's important to recognise the wider definition of the network that exists around an individual, above and beyond their health needs. A person may interact more with non-health / social care service professionals despite their needs.

Some specific examples were given of how we could improve our approach to prevention – these included:

- More direct involvement of advice charities would enable people to improve their circumstances and health.

- We should invest in community development as a way to encourage people to take more responsibility for their own health.
- There are no good neighbour schemes in West Norfolk. Changing this would be a positive move – they are a good example of prevention.
- The impact on people if their hearing aids do not work is huge, for example people are more likely to get dementia. There is a real prevention opportunity here.
- Health coaching is a good idea and helps with the prevention agenda. This support does need to have a wider remit than just clinical issues and address the wider determinants of health too. How can we ensure that statutory services and the VCSE sector are working together on this?
- The current criteria for many health and care services are not known or the information is unclear - this prevents early intervention. How can we change this?
- We need to enable people with experience of health conditions and care to run and manage their own support groups, working with local VCSE organisations and assets to develop and maintain them.

Wider determinants of health

Attendees said that there is a risk of 'medicalising' all needs by commissioning rigidly through health / care processes. GP's and primary care staff do not always have the knowledge or time to research, access or refer to wider community based services. Staff under pressure tend to refer or signpost only to services they already know.

It was felt that the social prescribing model currently in place acts as a bridge between different sectors and could be developed to further support grass roots links and referrals. Resolving the issues with the social prescribing model is important.

To tackle the wider determinants of health, it was said we need to involve the Local Enterprise Partnership and business – employment is really important to people's health and wellbeing. We need to be attracting businesses and investing in our roads and infrastructure.

Focus is needed on community resiliency and associated assets in each area – look at commonalities that support communities and existing community assets.

Part two: Developing a Voluntary Sector Health and Social Care Assembly

The role of the VCSE within the emerging Integrated Commissioning System (ICS) is key. In partnership, the VCSE sector and local health and care organisations could:

- Do more to improve the health and wellbeing of local people
- Start to address some of the challenges facing VCSE organisations
- Build the resilience of the VCSE sector and help to make work more rewarding for staff and volunteers

During the second part of the events we discussed the development of a Voluntary Sector Health and Social Care 'Assembly' to enable VCSE groups and statutory services to work together more effectively to improve health and care outcomes.

We use the term 'assembly' to frame our discussions around creating a model – structures and a shared culture - underpinned by a Memorandum of Understanding. To this end, we have formed a cross-sector Steering Group, made up of representatives from VCSE infrastructure organisations across Norfolk and Waveney and statutory partners to develop and drive this ambition.

We recognise that creating an 'assembly' will take time, and needs to be built on the skills and experience of everyone involved. These engagement events are the first step in exploring what an 'assembly' needs to be and what it could look like.

At the events, we asked attendees:

- What do you think of our idea to set-up a Voluntary Sector Health and Social Care Assembly?
- What would a successful Assembly look like and how would it work? What would its role be and what powers would it have? How could we make sure it is broadly representative of the VCSE sector in Norfolk and Waveney?
- How do we achieve a more collaborative approach between statutory services and the VCSE sector? What might this look like in terms of funding models, decision making, development and how we care for people day-to-day? What impact would it have on the VCSE sector?
- What do you think of our idea to create a memorandum of understanding (MOU) setting-out how we as public sector and VCSE organisations will work together in future and the priority areas we want to tackle together?

The following is a summary of the main themes from the discussions across the four events, as well as priorities that emerged individually from each of the locations where the events took place:

Overarching comments about the development of an assembly and an MOU

Overall there was broad support from VCSE colleagues at the events for the proposal to develop an assembly and a Memorandum of Understanding. Attendees felt it sounded inclusive, that it could provide opportunities for learning and sharing, that it could help us understand each other better and help us develop a shared language across health, social care and the voluntary sector.

However, there was a clear feeling that an assembly must deliver meaningful change and some frustration of the lack of progress from previous engagement.

Priorities from Norwich, King's Centre, 15 October 2019

- For an 'assembly' to work, it needs a clear strategy to enable open conversations at an early stage between all partners
- Delivery of a model requires investment in infrastructure (for coordination, logistical delivery, communications, supporting digital access)
- Independence of the 'assembly' is crucial – and it needs to have power and responsibility
- Memorandum of Understanding needs to define relationships, but also contain logistical agreements around things like data sharing

Assembly following emerging health and care locality structure(s)

There were different discussions and feelings about what an assembly could look like and whether it might operate at 'system' level (across Norfolk and Waveney), at 'place' level (the current CCG areas) or both. There were lots of ideas, but no overall consensus.

Comments made about what an assembly could look like included:

- How would SLG (the VCSE Sector Leadership Group) fit with an assembly? Could SLG be the system level group / meeting? As an aside to this, a few attendees noted that they do not feel part of, or well connected with, SLG.
- Could there be an annual conference for colleagues from across Norfolk and Waveney? Maybe at the conference VCSE attendees could appoint representatives for a 'system' level group / meeting?
- It was suggested that the 'system' level group / meeting could be made-up of representatives from five locality groups – there are some existing forums which could form these locality groups.
- An assembly could just be the umbrella for a range of smaller sub-networks, organised by locality or around the PCNs – there doesn't need to be a 'system' level group.

- There was a lot of emphasis placed on the importance of having locality groups by the VCSE sector in West Norfolk. A few attendees at the King's Lynn event said that they fear the CCG merger could result in less focus on West Norfolk.
- Attendees had different views on whether or not thematic meetings are useful. Momentum's Voluntary Sector Forum about children and young people is well regarded.
- It was suggested at one of the events that the adult safeguarding board structure is a good model that could be replicated – they have locality groups, backed-up by a good website and a shared training offer. The flow of communications and decisions goes both ways – between the locality groups and the central board.
- It was felt by some attendees that there would need to be rigorous processes in place to elect VCSE representatives to positions on an assembly, such as chair.
- It's important to recognise that there are existing local networks, forums and relationships. Any assembly would need to relate to or link with the Local Delivery Groups, Primary Care Networks, existing CCG engagement panels, the early help hubs and council community development structures and projects.
- There was some support for any assembly to in part operate virtually.
- An assembly would need to span operational delivery and relationships, and be a space for professionals to talk strategically.
- There would need to be skilful setting of agendas in order to create a meaningful conversation. At one of the events it was suggested they could be structured as follows: start with individual 'bug fixing', such as specific issues about contracts, move onto operational issues like looking at pathways and finish with a strategic discussion.
- An assembly could provide an opportunity for statutory and VCSE colleagues to discuss commissioning. Although it was noted that it's worth bearing in mind that many VCSE organisations aren't commissioned to provide services.
- Beyond health, councils and VCSE colleagues, it was suggested that businesses or the Local Enterprise Partnership, councillors and funding organisations, such as the national lottery and Norfolk Community Foundation, could be part of an assembly.
- It was felt that regular and concise communications would be important, focusing on what has changed and the difference that has been made.
- Overall, an assembly would need to feel democratic.

Priorities from Great Yarmouth, King's Centre, 16 October 2019

- 'Assembly' model needs to reflect existing locality and VCSE networks – and should link to Primary Care Networks / Local Delivery Groups as they develop
- The model requires clear shared outcomes – how will we know this has made a difference to how the sectors work together, and improved the health outcomes of individuals and communities?
- Involve District / Borough / City councils – have a vital role in supporting delivery and local coordination between the sectors
- 'Grassroots' VCSE representation is important – risk of model being dominated by medium to large VCSE organisations

Power, role and responsibility of an assembly

It was felt that the VCSE sector would need to lead on the delivery of an assembly, as this would help to address the balance of power from the outset. And that it would be important to define clear medium and long term programmes of work, with space for flexibility.

It was suggested an assembly could:

- Have responsibility for an 'intervention' budget, to encourage colleagues to collaborate when developing solutions.
- Focus on outcome-based commissioning – creating a shared outcome measurement model and an agreed model for measuring the impact of prevention and wellbeing.
- Redefine the 'Compact' between the sectors, in relation to commissioning as well as wider relationships.
- Define an integrated approach to how the sectors will consult with each other, both formally and informally.
- Be a vehicle for continual strategic planning and assessment – not just defined by health / social care planning timelines / commissioning cycles.

Attendees questioned:

- Would an assembly have a distinct function delegated to it?
- What role would it have in commissioning?
- Where would an assembly fit in the ICS governance structure?

Attendees at the Lowestoft event in particular highlighted that an assembly would need to have buy-in at all levels of the statutory organisations involved. There was a concern that the assembly sounded like the old Suffolk Congress, which no longer exists. It was felt that there had been buy-in for the Suffolk Congress at chief executive level, but not from commissioning managers. An assembly would need to have buy-in at all levels.

Balance between big / medium / small VCSE groups and organisations

Attendees said that it's important that an assembly gives equal voice to organisations of all sizes, and that it is not dominated by the biggest.

It was suggested that having a virtual element could support engagement of organisations / groups where attendance at meetings or managerial backfill is less realistic.

Having 'acknowledged representatives' from different sector organisations could help to ensure that there is representation from different types and sizes of organisations.

Priorities from Lowestoft, Kirkley Centre, 28 October 2019

- Learn from previous examples where similar forums have not worked – like the Suffolk Congress
- Recognise Waveney as distinct, and ensure the model does not become centred around Norfolk / Norwich
- Risk that an assembly approach is easier for health and social care, but not reflective of VCSE needs / capacity, e.g. cost implications for backfilling managerial time
- The agreed model needs to 'do' as well as 'plan' – it can drive collaborative solutions to commissioning with the VCSE

Memorandum of Understanding (MOU)

There was broad support for developing an MOU to outline the buy-in from each sector and the expectations between sector partners of how we work with each other.

It could set parameters for how tiers of local government, the VCSE sector and NHS bid for external funding, and outline expectations around consortium approaches.

There was support for an MOU to define how resources (e.g. data / business intelligence / professional knowledge) can be shared between the sectors.

There was a concern that if we tried to agree an MOU before establishing an assembly that it could be perceived to be top down and not truly representative of those involved.

Attendees suggested that an MOU is usually between a few organisations and questioned how it would work with the whole VCSE sector and whether an MOU is the right document to use.

One group summarised that more important than developing an MOU, is spending time building relationships between colleagues working in the statutory and VCSE sectors.

Priorities from King's Lynn, Town Hall, 31 October 2019

- Commitment to be a part of the 'assembly' model is important – shows that sectors value the relationship and ways of working
- Effective communication is needed to underpin the model – responsive, accessible and relevant to all audiences
- 'Assembly' needs to have a role in coordinating commissioning and the best use of resources, as well as planning bids for external funding
- How would this model interact with existing VCSE networks in localities / Sector Leadership Group?

What will happen next

Thank you again to everyone that contributed by attending the events and taking part in the discussions. We have been pleased with the level of engagement, challenge and interest shown.

Developing a five year plan for health and care in Norfolk and Waveney

We have used your feedback to develop our draft five year plan, which will be reviewed by NHS East of England and the final version published in early 2020.

We have made changes to our plan as a result of what VCSE colleagues told us at the events. Notably, we amended two of our three goals:

- One of the key themes from the events was that there needs to be a greater focus on prevention and the wider determinants of health. As a result, we have changed our first goal so that it encompasses prevention and tackling the root causes of poor health, as well as addressing health inequalities in Norfolk and Waveney.
- We are also changing our third goal to better reflect our whole workforce and everyone who provides health and care in Norfolk and Waveney. VCSE colleagues told us that not all volunteers and carers identify as health and care professionals. As a result, we have changed our third goal to say: “To make Norfolk and Waveney the best place to work in health and care”.

Following the publication of the plan in early 2020, we will work with the VCSE sector to follow-up on some of the detailed elements of the plan.

Developing a Voluntary Sector Health and Social Care ‘Assembly’

Feedback from the four events will be considered in detail by the Voluntary Sector Health and Social Care Assembly Steering Group.

Informed by the feedback received, the Steering Group will work with the Voluntary and Community Sector to lead and develop the components of how an ‘assembly’ could operate, as well as discussing the principles that could form the basis of a Memorandum of Understanding between the sectors.

The Steering Group will coordinate further VCSE engagement opportunities with the sector and wider partners during over the early months of 2020, where we will present what an assembly could look like and how it could work, and start to develop and agree a Memorandum of Understanding.