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Clarity, communication and reciprocity: key ingredients for productive relationships with voluntary and community sector organisations in the new health and social care commissioning environment

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Introduction: a new environment

The Health and Social Care Act 2012 is effecting major changes in the way in which NHS and public health services are commissioned and organised in the UK. April 2013 saw the country's 152 Primary Care Trusts (PCTs) being replaced by 211 Clinical Commissioning Groups (CCGs), 152 Health and Wellbeing Boards and local Healthwatch organisations. New national level bodies have also been established as part of the changes: NHS England has responsibility for specialist commissioning and ensuring the whole architecture is efficient and coordinated; Public Health England has a remit to improve the health and wellbeing of the population and support the transfer of public health to local government; and Healthwatch England is intended to give a national voice to key issues that affect people using health and social care services, and to support local Healthwatch groups.

The government's stated aims for these changes include 'putting patients at the heart of everything', giving them more choice and control over their care; empowering clinicians and professionals; and 'commissioning wellbeing' and tackling health inequalities and disadvantage at a local level. But what of voluntary and community organisations in this new environment? Many such organisations play an important part in improving the health and wellbeing of individuals and communities, and the emphasis on local solutions and the concern with wider determinants of health within the new arrangements suggest that the voluntary sector could contribute much to this agenda. Indeed the Government's 2010 Public Health Strategy, *Healthy Lives, Healthy People*, acknowledged that:

'Charities, voluntary organisations and community groups already make a vital contribution. They provide services to individuals and communities, act as advocates for excluded groups and catalysts for action. The Government will encourage partnership working and opportunities for providers from all sectors to offer relevant services.' (p. 25)

However, attention needs to be given to how this is done at the local level. For organisations previously commissioned by PCTs, the switch to CCGs may entail a new commissioning geography, with new competitors and potential collaborators, as well as different priorities and processes for procuring services. New relationships with commissioners will have to be forged, and some organisations will need to consider forming consortia in order to bid for larger scale contracts.

Aside from delivering services under the new arrangements, there may also be greater opportunities for voluntary organisations to influence wider commissioning processes, and Public Health England have identified roles for the sector in promoting the inclusion of 'hard to reach' communities and helping represent communities' (patients and the public) views. However, in order to be able to engage effectively with the new structures, voluntary organisations will need to be appropriately informed, supported and resourced.

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This paper draws on the findings of an evaluation of a pilot project commissioned by Sandwell and West Birmingham CCG to support the development of productive relationships between the voluntary sector, the CCG and General Practitioners (GPs). The project was initiated at an early stage in the development of the CCG, four months prior to the new arrangements 'going live' in April 2013.

About the 'Infrastructure Support Project'

Two local voluntary sector infrastructure support organisations were commissioned to deliver the project, which included four main areas of activity:

1. Developing a scalable model of support and intervention, working with identified geographical 'clusters' of GP practices and with voluntary and community sector (VCS) organisations in these areas, with a view to brokering good engagement and procurement and service development relationships between GPs and the VCS.
2. The development of a data portal to put information about VCS services at GPs' fingertips.
3. Delivering training for the CCG and its GPs to enable them to better engage with the local VCS.
4. Establishing a Contractors Network for VCS organisations, to promote their involvement in service design and provide a reference point for the CCG Board and for GPs.

The evaluation included interviews with two members of staff from each of the two voluntary sector infrastructure support organisations and the CCG. A short telelpone interview was conducted with one GP practice manager and questionnaires were completed by 24 organisations involved in the Contractors Network or VCS engagement activities. This paper highlights some of the key learning points that emerged from the pilot project and are of broader relevance to policy makers, commissioners and VCS leaders.

Appropriate channels of communication

The infrastructure organisations were tasked with engaging both VCS organisations and GPs, in order to support the development of productive relationships between them. In both cases there were challenges in terms of building trust, but this was much more pronounced in relation to GPs. The intention had been to interview GPs to baseline their understanding and awareness of the local VCS, and provide them with information about relevant local organisations. However, it did not prove possible to engage GPs in this way. A small number of practice managers agreed to be interviewed, but in general the involvement of GP practices in the project was very limited, in spite of considerable efforts to secure this.

One reason for this was that whilst the infrastructure organisations already had relationships and reputations amongst the VCS, they did not have pre-existing relationships with GPs. GPs' limited time availability and differing priorities are also likely to have contributed. That this was the case, in spite of the project being strongly backed by the CCG, supports the view put forward by one respondent that:

'A lot of the GPs, I think, are still to be convinced of the new CCG set up… I don't think there's that relationship yet whereby the CCG can email a GP and say, "We think you ought to be involved with this" and the GP sits up and listens…'

Whilst the early timing of the pilot seems to have been a factor, the lack of GP engagement suggested that a further intermediary was required to help broker relationships with GP practices and communicate effectively with them on behalf of the local VCS. This would need to be an individual or organisation that could command the respect of clinicians and understand their operating environment sufficiently to ensure that communications were relevant and specific to patients' needs, and presented in a language that made their benefits for patients immediately obvious to practice staff. The local commissioning groups (LCGs) that had been set up in Sandwell and West Birmingham CCG were identified as a possible such intermediary, and as these become more established over time they could become an effective point of contact for the local VCS in seeking to communicate with GPs and inform them about the services they can offer, particularly around contributing to the wider determinants of health, for example.

A clear offer to the sector

Whilst engaging VCS organisations in the pilot was less problematic, there were nevertheless challenges in gaining their trust and helping them see the relevance of the project. This was more the case with those identified through local clusters than through the contractors network, perhaps because

the latter included organisations who were already aware of (and in many cases involved in) commissioning under the PCT. One of the challenges in working with the organisations in the clusters was the lack of clarity about what they could expect the benefits of engaging with GPs and the CCG to be. For instance, raising GPs' awareness of their services, and encouraging GPs to signpost patients to them may increase the 'footfall' to their services, but is this likely to be accompanied by funding to help provide for larger numbers of service users? If not, providers may be faced with capacity problems.

Because this pilot took place at an early stage in the changes to commissioning arrangements, the information that could be passed on to VCS organisations about future opportunities was limited. There was uncertainty about whether GPs themselves would be able to commission services from the VCS at a local level, and what the balance would be between the commissioning responsibilities of the CCG and LCGs. This made it more difficult for infrastructure bodies to present a clear case to VCS organisations about what kind of benefits they might expect to accrue to their intended beneficiaries through investing time and resources in engaging with the CCG and with GPs, and about what resources they might be able to secure through such involvement. As one representative put it:

'We've got to sell something to the GPs and the voluntary sector, we've got to sell them a vision for good working together and it's very hard for us to know exactly what that vision is.'

One would expect that greater clarity will emerge as the new arrangements become more formalised; however, this highlights the need for commissioners at all levels to communicate clear messages to VCS organisations about opportunities to be commissioned to provide services, to influence the commissioning process, to be a conduit to help other providers access hard to reach groups, and about the funding (or not) associated with these.

Such messages became somewhat clearer towards the end of the project, and in particular, organisations that were involved in the network for contractors appreciated the attendance of CCG staff at these meetings, and felt that this was crucial, both for keeping the sector informed about developments and opportunities, and for enabling VCS organisations to talk to commissioners about what they are able to offer.

A clear offer from the sector

The training provided by the infrastructure organisations at a protected learning time event for GPs and Practice Managers suggested that there were widespread misconceptions amongst them about the nature of the VCS. In particular, there was a lack of recognition of the professionalism with which many VCS organisations operate and the fact that many of their services are delivered entirely by paid staff.

Consultation with a GP practice manager about the VCS data portal highlighted another important issue: GPs would need to be assured of the quality of the services listed if they were to signpost or refer patients to them. In many cases these organisations will have already been subject to quality assessment or inspection schemes, and it may be that these could be used as the basis for a simple quality mark scheme within the portal.

The portal itself was a means of providing greater clarity for GPs and other health care professionals about what the VCS can offer. However, in addition to this, there may be a need for further training, communication and relationship-building work in order to establish trust, and also to raise awareness about the different types of services that different types of VCS organisations can offer. For instance, whilst some provided highly specialised professional services for those suffering from specific conditions, others offered more informal social activities which can benefit patients where loneliness or lack of confidence is contributing to their ill health.

The VCS engagement sessions that formed part of this project helped organisations begin to consider what they might be able to 'offer' to GPs or commissioners, but for many, further support will be needed to articulate this and find the appropriate channels through which to communicate it. Again, another intermediary such as the LCG may be a more appropriate means by which to provide this kind of information to GP practices, or indeed to filter it up to the CCG where appropriate.

Sensitivity to role and resource constraints

This project has highlighted the importance of taking into account the strengths and limitations of individuals and organisations, in view of their roles and the resources (time, money, skills and people) they are working with, when seeking to develop productive relationships that could lead to service

delivery arrangements. This applies to the relationships between the infrastructure organisations and the VCS, as well as to those between the CCG, VCS and GPs. Involvement in the commissioning process is likely to absorb a significant amount of time and resources for VCS organisations, and as such it is important that events to support them in this are highly focused and well-informed.

Similarly, GPs require information to be presented to them in a way that acknowledges that they have very limited time with each patient and that engaging with the voluntary sector is not something that they can necessarily prioritise within their working hours. It was suggested, for example, that the VCS data portal might be better used by health care assistants, with whom patients can have longer appointments. This may indeed be a more appropriate and cost-effective way of using such a tool.

There are of course also constraints on the CCG staff and board. Sandwell and West Birmingham CCG were reported to be more open and active with regards to working with the VCS than other local CCGs. However, ensuring that such enthusiasm for the sector is translated to the LCG and GP Practice level, as well as to the CCG Board themselves will involve much work. VCS organisations in other areas may have to work harder to find ways of engaging.

Conclusions

From this study, a number of key conditions can be identified that could promote effective relationships between commissioners, VCS organisations and NHS practitioners as the CCGs and other new bodies become more established:

- **Clarity:** both about what the sector can (and can't) offer to GPs and commissioners that will benefit patients and help achieve the outcomes they are required to deliver on, but also about what opportunities there are for the VCS to get involved and how these will be funded and commissioned.
- **Communication:** exchange of well targeted information and the development of trusting relationships between the different parties involved is essential if they are to work collectively to deliver health outcomes.
- **Reciprocity:** in relation to funding, it is important that commissioners and government bodies do not expect VCS organisations to provide free services. In relation to dialogue, there is a need for two way exchanges between the sector and commissioners, in which both parties acknowledge that each has something to gain from – and to give to – each other, in working towards the broader task of securing better health and wellbeing outcomes for patients and local communities.

These conditions cannot be met without significant investment of time and resources, from both commissioners and VCS organisations alike. Intermediary organisations, such as voluntary sector infrastructure bodies, can play an important part in brokering relationships between these two parties, and in raising awareness and understanding between them. The challenges highlighted in this paper attest to the need for such support, and suggest that CCGs would be wise to invest in programmes to assist VCS organisations with the transition into the new commissioning environment, ensuring that they are able to understand and engage effectively with new institutions, geographies and processes and to position themselves most appropriately within this new environment.

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