Leicester City Council Scrutiny Review

Review of 'Voluntary & Community Sector Groups who have raised concerns about Funding, Commissioning and Tendering issues'.

A Report of Health & Community Involvement Scrutiny Commission

APRIL 2013

HEALTH & COMMUNITY INVOLVEMENT SCRUTINY COMMISSION
- Membership

Chair: **Councillor Michael Cooke**

Vice Chair: Councillor Deborah Sangster

Commission Members: Councillor Alfonso
Councillor Desai
Councillor Gugnani
Councillor Naylor
Councillor Singh
Councillor Westley

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Please note - due to the size of the appendices, they are not attached to this report, but are available in the scrutiny office to view.

Minutes from Health & Community Involvement Scrutiny Commission meetings:

The minutes in relation to this review:

'Review of Voluntary & Community Sector Groups who have raised concerns about Funding, Commissioning and Tendering issues' can be accessed on line at:

http://www.cabinet.leicester.gov.uk:8071/ieListMeetings.aspx?CId=658&Year=2013

Chair's Foreword

The Government's policy around the 'Big Society' and the new Localism Act is about putting more power, opportunity and responsibility into the hands of local people. The Government wants to give citizens, communities and local government the power and information they need to come together, solve problems they face and build sustainable local communities. At the same time, as a consequence of the government policies, the voluntary and community sector is experiencing budget cuts and commissioning challenges.

As the newly formed Leicester City Clinical Commissioning Group and the City Council's Health & Wellbeing Board, together with HealthWatch (patient participation group set up to replace LINKs) take centre stage at a local level, the Voluntary Community Sector faces a range of challenges and risks to reposition itself to play a leading role informing, shaping and delivering health and social care services in Leicester.

Leicester City Council will be making difficult decisions to deliver services in a variety of different ways, due to the increasing financial constraints that all public sector services are facing. The Health & Community Involvement Scrutiny Commission has a duty to examine, challenge and influence the decisions that are being taken by the City Mayor and his executive.

The key findings of this Review were submitted to the City Mayor to assist him in formulating the Council's budget in February 2013. These key findings now constitute the Executive Summary in this review, which together with the substantive report, are intended to assist the Mayor in reviewing the role of the voluntary and community sector.

Councillor Michael Cooke
Chair, Health & Community Involvement Scrutiny Commission

HEALTH AND COMMUNITY INVOLVEMENT SCRUTINY COMMISSION

‘Review of Voluntary & Community Sector Groups who have raised concerns about Funding, Commissioning and Tendering issues’

EXECUTIVE SUMMARY – key findings

SCRUTINY CHAIR’S COVERING MEMO TO THE CITY MAYOR:

To: The City Mayor, Sir Peter Soulsby

The Health & Community Involvement Scrutiny Commission present to you a summary paper highlighting the concerns raised by the voluntary community sector in relation to funding, commissioning and tendering.

The commission recommends that these key findings in the summary report be taken into account during the council’s forward planning and budget making process.

Councillor Michael Cooke, Chair
Health & Community Involvement Scrutiny Commission.
January 2013.

1) Introduction

In November 2012 the Health and Community Involvement Scrutiny Commission carried out a scrutiny review, following a letter from Leicester VCS with concerns raised about funding cuts, tendering and commissioning processes.

Voluntary Action Leicester on behalf of VCS stated: “*we know the city council is having its own budgets reduced by a government that has chosen a programme of austerity, but we do want to be part of the discussion on how the cuts happen and* ***there are real concerns that the city’s voluntary and community sector is in danger of collapsing / imploding in the current financial climate”.***

There are over 400 VCS groups in the city, employing around 1,600 people plus volunteers, who between them help thousands of people in the city. The letter states that some groups could fold if the city council makes further cuts to their grants. The VCS want the council to rethink its tendering process which they said often favored larger, private firms over more specialised local groups.

Leicester City Council is looking to make at least £8.4 million of cuts to services. The City Mayor stated "*Leicester historically has a proud record of support for the voluntary and community groups and historically has the highest level of funding of any large city"*

2) Possible Impacts of Funding Cuts – concerns raised by VCS

The commission heard evidence that many organisations receive funding from multiple sources, including the city council, for their main contracts and are currently at major risk of collapsing.

The commission heard evidence that many VCS groups are waiting to hear from the city council by the end of December 2012 whether contracts will be extended past 31st March 2013, otherwise, the threat of redundancy notices will have to be issued. This will result in groups having no funds to continue their services or the infrastructure to provide the services that any small independent grants may offer.

Commission members asked officers if some VCS contracts would come to an end in December 2012
RESPONSE FROM CLINICAL COMMISSIONING GROUP AND CITY COUNCIL LEAD COMMISSIONERS:
In February 2011 the Department of Health had issued a mandate that current contract arrangements could only be extended until the end of March 2013 as the Primary Care Trusts would cease to exist. This did not mean that the Clinical Commissioning Groups (the replacement bodies for the PCTs) would no longer continue to commission services from the VCS, or that the valued contribution the VCS made to the health and wellbeing agenda was not appreciated. It merely meant that contracts from 1st April 2013 would need to be issued in the name of the new CCGs. Therefore, both the Leicester CCG and City Council were in the process of sending out letters to VCS to inform them that existing contracts will be extended – the majority of these will be to 31st March 2014.

The commission heard evidence from Voluntary Action Leicester (VAL) on behalf of VCS organisations; VAL highlighted the value of VCS services:

a) The VCS was not just a provider of services but also had an advocacy role on behalf of clients who did not feel confident to engage with formal organisation and institutions.
b) The current trend of moving from grants to formal contracts had resulted in preventing small organisations from bidding for services as VCS bodies couldn't absorb costs for six months until contract payments were made in arrears. Commissioners needed to consider ways which would allow small organisations to submit tenders for contacted services.
c) Based upon minimum wage levels, the VCS in Leicester contributed the equivalent of £12.5m worth of voluntary hours.
d) The VCS provided good value for money. The VCS received £31.9m of public sector investment (Nov 2011) and provided over £113m worth of services – over 3.5 times the initial investment.

The Commission gathered evidence of how the funding cuts would impact on VCS organisations, EXAMPLES OF THIS:

a) Network for Change – specialist mental health organisation providing housing support, and early intervention and prevention work plus community resources. Supports people with severe and enduring mental health needs – one of the target groups in the city JSNA priority 'Improving mental health and emotional resilience'. Funding has been decreasing each year for the last 4 years and core contract is at risk due to a competitive market, which would result in closure. Currently there is a very high demand for housing related mental health support in the city.

b) LAMP – provides advocacy, information services and a community resource. Any cuts could force closure and 14 employee redundancies plus loss of 20 plus voluntary workers. Also loss of the heart of the mental health community which would affect the wellbeing of the city's population. The 'domino' effect of mental health VCS orgs losing their contracts at the end of March 2013 which will see the increase of risk significantly raised in the city.

c) Leicestershire AIDS Support Services (LASS) provides support, information and advocacy – Leicester City has the 6th highest rising rate of HIV in the country. Last year LASS supported 568 individuals living with or directly affected by HIV, over 60% were African women and currently working on a video targeted at the Asian communities. What makes LASS's community HIV testing service unique is the involvement and training of community volunteers to provide the service, enabling LASS to reach into different communities as volunteers take messages and services to their neighbourhoods.

d) Vista – a charitable company working to improve lives for people with sight loss in LL&R, reliant on funding from Leicester, Leicestershire and Rutland authorities. Leicester City Council for the current year provided £360,829 for early intervention and prevention work. Evidence suggests that 50% of sight loss is avoidable and for those that experience sight loss, there are likely to be long term health, social care and mental health implications. Vista reach in the LRI covers only 50% of eye clinics due to lack of funding, *for example, an estimate of some 7,000 people likely to benefit from the vista service in 2012/13 of which 65% are seen at the LRI, however, there may be as many again who are falling through the net at the LRI due to lack of appropriate funding.*

e) Adhar – a mental health project for south Asian community. The funding from Leicester city council in the last 3 years has been insufficient to run the basic services. Extra fund raising efforts have helped to provide activities and support to the community. Any further cuts will result in redundancies and have serious impact on the existing critical services to citizens in Leicester.

f) Emerald Centre – Any funding cuts would have an impact on ability to secure core funding and additional funding bids. The centre provides a range of sports and social activities to all age groups. Funding amounts to approx. £40k, this has the effect of levering to a great deal of other funding to the centre (e.g. last year secured £320k), such as recent successful funding bid to Sport England, which creates many local jobs and volunteer placement opportunities.

g) Leicester Counselling Centre – The counselling service lost its county council funding in March 2012 and has already been forced to cut its services. The city council currently grant funds £26,000 and charges £12,000 rent for premises. A cut or reduction in city council funding will mean that the service will have to move away from its central ethos of offering affordable therapy support providing in excess of 5000 hours per year, or to become a service for those people who can who can afford a market rate of £45 - £50 per session or the centre will be forced to close. The TLCC believes that there is a role for continuing to grant fund, using Service Level Agreements (SLA) to ensure effective and targeted outcomes.

h) Sikh Community Centre – Community centre providing a resource of activities to all age groups. Any cuts in funding would result in loss of clients, staff shortages and facing closure. Service users would be at risk of isolation, social exclusion and neglect. Service users would not be able to afford day centre services currently there is a high demand for this service.

i) Norton House – small org providing housing related support services. 98% of service users felt that during the past year they have better managed their mental health with the support of Norton House. Any further cuts will have to stop providing support service which will impact on service users becoming frightened and vulnerable, relatives of service users are also very concerned at potential impacts. Norton House services also facing competition from large national providers.

Commission members asked officers how much of the budget was allocated to Voluntary and Community Sector in the City?
RESPONSE FROM LEAD COMMISSIONERS:
Leicester CCG budget for VCS services is £2.96m. The Adult Social Care budget for VSC is £4.6m, plus a further £2.3m spent on Housing Related Support. Leicester CCG had applied a 1.58% reduction in 2011/12 and a further 1.87% in 2012/13 to all VCS contracts in line with the Department of Health Operating Framework mandate. No services had been decommissioned.

The Leicester CCCG would be in a position to outline its budget for 2013/14 early in 2013.

3) Commissioning / tendering issues – concerns raised by VCS

The commission heard evidence relating to commissioning and tendering issues. Voluntary Action Leicester highlighted that there is scope for creative commissioning and partnerships with the VCS (e.g. presentation slides showing models of good practice of grants instead of tenders).

a) Equality – not a level playing field. Starting from a stance of discrimination as the larger/private competitors often have in-house law advice, and people employed write and submit tenders. For example, TLCC do not have easy access to advice on contract law and other complex areas associated with commissioning.

b) TUPE – essentially disqualifies small organisations from taking on contracts that involve staff transfers. Need better contracts giving more information so VCS can calculate risk as well as whether they can afford to take on potential liabilities.

c) Generic large tenders – capacity issues for small/med orgs. Discriminates against these orgs through ability to fulfill criteria related to this e.g. infrastructure and financial resources.

d) Generic large tenders – small specialist VCS with small management structures can't compete against big orgs. Small orgs may have to change their charitable constitution to be able to apply – this takes time.

Commission members asked officers how smaller organisations in the city can be supported to compete with larger tenders for contracts?
RESPONSE FROM LEAD COMMISSIONERS:
The weighting used to evaluate prospective service providers was traditionally 60% for quality and 40% for price. However, in order to support a wider market and to include smaller and medium sized enterprises, some recent procurement exercises had moved the weighting to 80% for quality and 20% for price.

Adult Social Care had also engaged 'Case-de' to work with all VCS providers to help them develop their business models to create sustainable services.

e) Working in partnership/consortia can involve more bureaucracy and management resources adding further pressure to the organisation.

f) Track record, years of experience, knowledge and skills of working in local community not taken into account.

g) De-commissioning of limited outdated services provided by Leicestershire Partnership Trust e.g. 'revolving door' services users, medication and maintaining. Distribute to VCS that can show improved outcomes for service users and carers.

h) Consider viability of grants Vs tendering contracts

i) A need to involve the VCS at the start of any process.
The VCS had a strong argument that involving representative groups from VCS in the design and delivery of services will ensure that the needs of clients are understood in a more rounded way, they call this process Co-Production of Services. The VCS in Leicester urges the city council to take this approach in the future, instead of the competitive approach with all of its inherent inequalities. Co-Production will deliver good value for money and if managed well increase the amount of social capital resources available to the city and its communities.

4) Options for future investment in the VCS – as identified by VCS

The commission heard evidence of how investment in the VCS would promote early intervention and prevention services which would have the potential to improve cost effectiveness and save statutory health and social care expenditure. The following suggestions for improvement were made:

a) Involvement of the VCS at the strategic planning stage of service development, so that their knowledge and expertise can be captured.

Commission members asked officers if good practice existed to support delivering services in a Voluntary Community Sector partnership approach?
RESPONSE FROM LEAD COMMISSIONERS:
Yes, recently the City IAPT (Open Mind) service went out for procurement – and prospective providers were actively encouraged to develop consortium bids with VCS organisations (a lead organisation in partnership with other VCS organisations). The local evaluation of the pilot had demonstrated that a partnership approach to delivering this IAPT had improved access to BME communities. The Local Partnership Trust had been awarded preferred bidder status and they would be delivering the IAPT Open Mind service in partnership with 3 local voluntary and social enterprise organisations: Adhar Project, Akwaaba Ayeh and Fit for Work Service.
This demonstrated that the Voluntary Community Sector could compete for and be successful in being awarded contracts.

b) Integrated Partnership Working which includes professionals from across all disciplines and enables shared decision making, *for example 'Vista' identified that If the city council and the city CCG could develop a co-operative partnership to address the funding gap for the information service in the LRI Ophthalmology clinics, the impact of this service could be doubled, which would result in many more people accessing the sight loss pathway which is already funded by the local authority; resulting in the number of people requiring intensive interventions to address falls, accidents or depression should be significantly reduced.*

c) Consider joint purchasing and commissioning across health and social care to enable imaginative early intervention approaches. Health personal budgets are currently being piloted in the city, therefore consideration be given to link to social care where vulnerable service users fall through gaps. Joint assessment and commissioning would be more cost-effective and better meet individual needs e.g. mental health outcomes.

Commission members asked officers what factors determined whether a service should be jointly commissioned?
RESPONSE FROM LEAD COMMISSIONERS:
Officers indicated that these could involve issues around value for money, especially if one service provider had contracts with two or more commissioning groups. The separate services could possibly be delivered more efficiently by dealing with one commissioning body for all the services. Also contract monitoring needed to be viewed in the context of the service needs. Monitoring may show that the service provider was performing at 100%, but the service may no longer be relevant to the needs of service users.

d) Adopt a person centered approach to service provision which maximises positive outcomes for individuals. This often results in an approach which is better for the person, but also cheaper in long run – effectiveness and efficiency to deliver excellence.

e) An agreement on outcome-focused monitoring targets which allow for robust measurement of results and better forward planning.

f) Explore options of partnership working with VCS to provide grant funding rather than go to tender (good practice examples in Bradford and Nottingham identified).

Voluntary Action Leicester provided the commission with this example from Bradford:
The 'Health Partnership Project' established in Bradford to tackle health inequalities could easily be replicated in Leicester through the VCS engaging with patients to provide health services in the community for problems ranging from loneliness, domestic abuse, debt problems and mental health issues. The Bradford experience had shown reductions in hospital admissions, earlier discharge and shorter stays in hospital with resultant reduced health related costs.

5) Conclusion of the Scrutiny Commission.

The commission recognised the importance of keeping services local and valuing the contribution of local people as volunteers. The commissioners need to recognize the value of the VCS by involving them in the early stages of service planning and through appropriate and fair remuneration, as this sector is best placed with the knowledge, skills and support to provide quality and value for money services to the local population.

The commission believes that the Health and Wellbeing Board and the City Clinical Commissioning Group needs time to establish themselves, beyond April 2013, at least till the end of 2013. In the meantime, the city council and lead commissioners have an opportunity to develop new ways of working with the VCS in Leicester. Therefore, the city council should not lose good council funded VCS activity in the city, some of which could well be sustained longer term through joint commissioning and specific grants.

The commission suggested that joint commissioning involving VCS be explored as a solution for the future. This option would prevent duplication of services, would identify gaps in service provision and offer greater value for money.

6) Written Submissions
– A log of evidence received by the commission is listed at the end of the full report.

END OF EXECUTIVE SUMMARY REPORT

HEALTH AND COMMUNITY INVOLVEMENT SCRUTINY COMMISSION

'Review of Voluntary & Community Sector Groups who have raised concerns about Funding, Commissioning and Tendering issues'

REPORT

1. Purpose

1.1 The Health and Community Involvement Scrutiny Commission carried out a review in response to a letter submitted from representatives of the voluntary and community sector, outlining their concerns relating to funding cuts and competitive tendering as a threat to providing high quality specialist services.

2. Conclusion and Recommended Actions

2.1 The work of the VCS in Leicester is wide-ranging, but much of the focus is on upstream preventative and wellbeing support, as well as advocacy and signposting. As such, this sector is an important partner to the City Council in its quest to meet the quality, innovation, productivity and challenge, while offering personalised care and patient choice.

2.2 The Health and Community Involvement Scrutiny Commission recognizes that the city council now faces a public sector funding challenge which will impact on the Voluntary Sector in Leicester.

2.3 **What is needed are the following actions:**

(i) Some clarity about the basis upon which Leicester City Council and Leicester City Clinical Commissioning Group engages with VCS.

(ii) Value for money from relationships with VCS, including positive partnerships, effective and efficient delivery of contracts, or no relationship where there is nothing to be gained from having one.

(iii) Fair, transparent and consistent approaches to VCS commissioning, procurement and funding arrangement across the council and lead commissioners

(iv) Some strategic alignment between the VCS and the city council in order to ensure that organisations are working towards similar outcomes.

(v) Recognition of the value of VCS, through appropriate and fair remuneration, as many VCS groups are best placed with the knowledge, skills and support to provide quality and value for money services in Leicester.

(vi) Recognition of the importance of keeping services local and valuing the contribution of local people as volunteers.

(vii) Some pooling of resources within the VCS, where appropriate and necessary.

(viii) Improved training programmes to assist VCS in securing contracts to deliver services, especially for smaller organisations to compete for public sector contracts.

(ix) Future Commissioning to include site visits to help commissioners understand the characteristics of an organisation, and future commissioning of contracts must not discount organisations that provide individualised care for marginalised groups. Contracts must allow for specialism and expertise to shine through.

2.4 The commission through this review found that many VCS groups in Leicester have built up trust and personal customer service within the services they provide. They are best placed to provide advice and support with an excellent knowledge and skills base. For this purpose, they should be better recognised and supported by the City Council and lead commissioners through improved collaboration and partnership working.

2.5 The commission believes that the Health and Wellbeing Board and the City Clinical Commissioning Group needs time to establish themselves, beyond April 2013, at least till the end of 2013. In the meantime, the city council and lead commissioners have an opportunity to develop new ways of working with the VCS in Leicester. Therefore, the city council should not lose good council funded VCS activity in the city, some of which could well be sustained longer term through joint commissioning and specific grants.

3. Introduction

3.1 From April 2013, Leicester City Council and the newly formed Leicester Clinical Commissioning Group, which has replaced the Primary Care NHS Trust, will be responsible for delivering health and social care services in the city. How the city council manages these relationships and develops new ones in the future is emerging as a critical issue.

3.2 Over the years Leicester City Council has developed good relationships with many community and voluntary organisations in the city that provide services on its behalf, or run services which benefit the communities they serve, which helps the council achieve its corporate priorities. However, in this climate of public sector budget cuts and with the transformation of health and social care services, many voluntary and community sector organizations are at risk of losing their key contracts and funding streams.

3.3 In November 2012 the Health and Community Involvement Scrutiny Commission carried out a review to establish the key issues. In January 2013, a summary report of the key findings was produced and sent to the City Mayor and his Executive with a covering memo stating '*The commission recommends that these key findings be taken into account during the council's forward planning and budget making process'*.

4. Method of Review

4.1 The commission carried out its review over 3 meetings during October and November 2012. The commission heard evidence from representatives of voluntary and community sector groups, and heard evidence from the lead officers for commissioners and procurers of services, Leicester City Council and Leicester Clinical Commissioning Group.

4.2 The commission gathered written submissions as evidence to support this review. The Voluntary and Community Sector Representatives in attendance were:

Kathryn Burgess	Executive Director, Community Advice and Law Service
Tony Cussack	Manager, Emerald Centre
Jenny Hand	Chief Executive LASS
Ben Smith	Policy Development Officer, Voluntary Action Leicester
Gabby Briner	Chief Executive Officer, Network for Change and Chair of the Voluntary Sector Partnership Forum for Mental Health.

Denise Chaney	Executive Director of LAMP
Jenny Pearce	Chief Executive of VISTA and Chairman of the Vision Strategy Group for Leicestershire, Leicester and Rutland
Sallyann Robinson	Care and Repair (Leicester)
Phil Wilson	Vice-Chairman of the Board of Governors of the Leicester Counselling Service

Voluntary and Community Sector Representatives – as observers:

Chino Cabon	The Race Equality Centre
Iris Lightfoot	The Race Equality Centre

The Lead Commissioners in attendance were:

Katherine Galoppi	Head of Commissioning
Nicola Hobbs	Head of Planning and Commissioning
Mercy Lett-Charnock	Lead Commissioner, Early Intervention and Prevention
Tracie Rees	Director of Commissioning, Adults & Communities
Caroline Ryan	Lead Commissioner, Supported/Independent Living
Yasmin Sidyot	Leicester City Clinical Commissioning Group
Yasmin Surti	Lead Commissioner Mental Health/Learning
Sarah Prema	Leicester City Clinical Commissioning Group

4.3 The chair thanked all the VCS representatives and the Lead Commissioning Officers who attended the review meetings. The chair also conveyed his thanks to those who participated in the review by submitting written evidence and documents.

4.4 The report of findings includes minute extracts of the 3 review meetings. The commission agreed that the minutes captured an excellent summary of the main issues and key evidence heard by the commission.

5. Findings of the Review

5.1 Background

5.2 Voluntary Action Leicester on behalf of VCS stated: "*we know the city council is having its own budgets reduced by a government that has chosen a programme of austerity, but we do want to be part of the discussion on how the cuts happen and* ***there are real concerns that the city's voluntary and community sector is in danger of collapsing / imploding in the current financial climate".***

5.3 There are over 400 VCS groups in the city, employing around 1,600 people plus volunteers, who between them help thousands of people in the city. The VCS letter submitted to the health & Community Involvement Commission states that some groups could fold if the city council makes further cuts to their grants. The VCS want the council to rethink its tendering process which they felt often favored larger, private firms over more specialised local groups.

5.4 Health and Adult Social Care Services in Leicester.

5.5 The Health Scrutiny Commission noted that the information provided by lead officers is only in relation to Adult Social Care (ASC) and Leicester City Clinical Commissioning Group (CCG) Adult Commissionig.

5.6 Health and Adult Social Care services have a key role in improving the health and wellbeing of local people. Arrangements already exist to jointly commission and develop services for a range of vulnerable adults to prevent or delay them from needing acute services or long term support.

5.7 The Health and Social Care Act (2012) provides the platform for greater joint working between health and social care. This includes the creation of a Health and Wellbeing Board for the City and the development of a Health and Wellbeing Strategy, which details the joint priorities for improving the health and wellbeing of the people of Leicester.

5.8 **The VCS informed the commission *'that they had no representation on the membership of the Shadow Health & Wellbeing Board'*.** VCS organisations voiced strong concerns about a lack of presence at this high level of partnership working and decision making board.

5.9 **In response city council lead officers explained:**
Leicester City's Health and Wellbeing Board has been operating in shadow format since July 2012, pending its formal implementation on 1st April 2013 to comply with the requirements of the Health and Social Care Act.

5.10 The board is unique in the way it brings together representatives of the local NHS commissioners, the local authority, and representation from patients and the public. They work together to create a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy. However, the board does not have jurisdiction over its constituent bodies.

5.11 There are current Terms of Reference for the Shadow Health and Wellbeing Board (*Appendix 26/27*). Secondary legislation is expected for the formal establishment of the Health and Wellbeing Board, which is due to be published in January 2013, and the Terms of Reference are likely to be amended after that. The Board is due to be formally established from 1 April 2013. As it is not yet formally established there are no formal sub-committees.

5.12 At the moment there are two working groups supporting the Shadow Health and Wellbeing Board: the Joint Strategic Needs Assessment Programme Board (chaired by Rod Moore) and the Transition Programme Management Group (chaired by Deb Watson).

5.13 Over the last few months the shadow board has been developing a draft Health and Wellbeing Strategy, which reflects the joint health and social care priorities for the City. The development of the strategy has included engagement with stakeholders, including the Voluntary and Community Sector (VCS). The Shadow Health and Wellbeing Board had also set up an electronic network for stakeholders and a number of voluntary sector bodies have joined this network.

5.14 **Delivering Health Services**

5.15 In Leicester, Leicestershire and Rutland (LLR) there are 3 Clinical Commissioning Groups (CCG's) currently in shadow form that will be responsible for commissioning health services from 1st April 2013 *(Appendix 28).* The NHS Commissioning Board will be responsible for GP practices, dentistry, pharmacy, optometry, offender health (prisons) and specialist services. Public health responsibilities have been transferred to Local Authority.

5.16 Leicester City CCG will take on their full commissioning responsibilities by April 2013 pending authorisation. The City CCG is in the first wave for authorisation. The authorisation process is complex and must evidence a set of standards that demonstrate the organisation's abilities to take on the commissioning responsibilities. The City CCG has developed a Clinical Commissioning Strategy, which mirrors the draft

Health and Wellbeing Strategy and outlines the organisation's key strategic objectives under each clinical priority as follows:

Cardio Vascular Disease (CVD)
- NHS Health Checks
- Patient education
- GP education programme
- Reduce prevalence rates for CVD

Chronic Obstructive Pulmonary Disease
- Patient education
- Improve prevention and condition management
- Increase community based support services

Mental health
- Improve dementia management (timely detection and management)
- Expand the access to psychological therapies
- Improve outcomes for people experiencing crisis

Older people
- Develop integrated care-pathways and improve end of life care
- Expand the integrated health and social care team
- Improve quality of care in nursing/residential homes and for those that are housebound

Maternity, children, young people and families
- Improve early access to maternity services
- Expand access to the healthy child programme
- Improve access to child and adolescent mental health services
- Review pathways for children and young people with disabilities and long-term conditions

The priorities will be reviewed in light of the recent publication of the NHS Mandate.

5.17 **Delivering Adult Social Care Services**

5.18 The vision for Leicester's ASC service, which is being driven and overseen by the Transformation Programme Board, also reflects the priorities of the draft Health and Wellbeing Strategy to enable individuals to be active citizens by:

- supporting people to access mainstream and universal services to meet their needs;
- ensuring people are provided with opportunities to maintain or regain their independent living skills;

- ensuring that people who have on-going risks to independence are fairly assessed and are allocated resources (individual budgets) to meet their needs;
- enabling people to exercise choice and control over the way in which they use their individual budget to meet their desired outcomes; and
- Supporting people who are at risk of harm and abuse to stay safe.

The following information provides an overview of the priorities for Adult Social Care:

People
- Improve customer experience
- Increase staff/ management confidence at all levels
- Develop more effective communication – internal and external

Transformation
- Deliver financial efficiencies
- Coordinate changes taking place so they make sense to users, carers, elected members, staff and partner agencies

Process
- Streamline key processes – direct payments, Quality Assurance
- Make sure decision making takes place at the right level

Prevention and Investment in the future
- Work with partners to further develop integrated services and commissioning

5.19 Both Organisations are committed to working together and with partners to improve joint commissioning and partnership arrangements. This can be demonstrated by the development of several joint health and social care commissioning strategies, including Dementia, Mental Health, Learning Disabilities and Carers.

5.20 These relationships will be enhanced further with the introduction of a Joint Integrated Commissioning Group. The board consists of senior officers from health and social care, who are committed to working collaboratively to ensure that resources are used in the most effective way. This is an imperative within the current financial climate at a time of financial constraints and cuts to budgets across health and social care.

5.21 **Funding and Budgets**

5.22 **The commission heard evidence 'that the city VCS is in danger of collapsing/imploding in the current financial climate'.** The commission heard evidence that many organisations receive funding from multiple sources, including the city council, for their main contracts and are currently at major risk of collapsing.

5.23 Ben Smith, Policy Development Officer, Voluntary Action Leicestershire (VAL) gave an overview presentation of VAL's work and its support for other voluntary and community sector (VCS) groups involved in the health sector. Ben submitted a paper as evidence 'A Voluntary & Community Sector (VCS) Perspective *(Appendix 3).*

5.24 In making the presentation the following points were made:-

- The CCG's were predicting an overspend in Accident and Emergency (A&E) budgets and the VCS were ideally placed to deliver preventative measures and support patients so that early discharge from hospitals could be achieved. The numbers of patients being treated in the A&E were at levels that the VCS could deal with.
- The VCS was not just a provider of services but also had an advocacy role on behalf of clients who did not feel confident to engage with formal organisation and institutions.
- The current trend of moving from grants to formal contracts had resulted in preventing small organisations from bidding for services as VCS bodies couldn't absorb costs for six months until contract payments were made in arrears. Commissioners needed to consider ways which would allow small organisations to submit tenders for contacted services.
- Based upon minimum wage levels, the VCS in Leicester contributed the equivalent of £12.5m worth of voluntary hours.
- The VCS provided good value for money. The VCS received £31.9m of public sector investment (Nov 2011) and provided over £113m worth of services – over 3.5 times the initial investment.
- VCS organisations that received funding from multiple sources were at greater risk, especially if one funder removed/reduced funding as this impacted upon delivery capability and viability and could put at risk the support received from other funders. Joint funders should consult each other and involve the provider in discussions about funding changes so that the likely consequences of funding withdrawal could be assessed.
- VAL urged the Commission to:-
    - Fully understand the effects of any cuts upon services received by local people;
    - Offer proactive support to maintain services.
- Prioritise re-investment to VCS organisations where a disproportionate reduction of services in the community would arise from reduced/withdrawn support.

Following a Member's questions relating to what 'voluntary' meant and why was a voluntary sector needed, Mr Hall submitted the following responses:-

- Although the VCS was largely led by volunteers and services delivered by volunteers, it needed management structures to be in place to support the volunteers, achieve outcomes, provide training and safeguarding and provide professional advice etc.
- In challenging economic times the VCS were good at identifying unmet needs. The VCS were similar in history to Registered Charities that were established to provide a specific need that was not provided elsewhere. The VCS was passionate about their areas of interest. The VCS had a good track record of delivering preventative services that ultimately saved money.
- The VCS dealt with a number of issues that could not be accessed through, or were provided by religious organisations and institutions. In some instances, the people needing services were reluctant to contact religious organisations for a variety of reasons and preferred to contact the VCS which had a reputation for having a non-judgemental approach.

5.25 **Further examples of Evidence provided to the commission:**

a) **The Emerald Centre** has been able to successfully access other funding streams and work in partnership with other organisations, but this is due to the core funding it receives. This core funding has the effect of levering a great deal of other funding to the centre which has created many local jobs and volunteer placement opportunities.

b) **LAMP (mental health project)** stated that they receive funding from multiple sources for their main contracts and are at major risk of collapsing unless they hear otherwise by the end of December 2012 whether or not contracts will be extended beyond March 2013. No funding would result in at least 14 employee redundancies and loss of over 20 voluntary workers. Lamp deals with in excess of 1000 service user and carer mental health advocacy cases per year. Any risk of closure would be a loss to the heart of the mental health community affecting the wellbeing of the city's population (Appendix 12).

The Genesis project informed the commission that with one paid worker it seeks to involve and represent the views of all mental health service users and carers in the city.

c) **NETWORK FOR CHANGE** a local mental health organisation with 20 years of experience working with hard to reach groups, managing risk and safeguarding vulnerable adults. This service has endured 4 years of decreased funding which has resulted in a reduction in staffing capacity. The housing related support service was funded at a cost of £22 per hour in 2003, but a recent mental health housing tender had reduced the cost to £13 per hour. As a result, Network for Change felt unable to bid or compete for that tender, therefore funding concerns have been raised that if the housing related service was re-tendered at the same low rates next year, the service may have to close.

Network for Change have a 'A' quality rating in the QAF 2010 City Supporting People Supported Housing Service. Anecdotal evidence offered to the commission suggested that services provided by Network for Change, including their Resource Centre, provided an early intervention, prevention and re-ablement function which may prevent hospital admission and therefore produce cost savings, although no figures were presented to the commission. (The centre stated that it receives no statutory funding and supports over 100 people with severe/complex mental health needs).

The Government's mental health strategy for England, 2011 'No Health Without Mental Health' states that: *mental health problems account for almost one quarter of the ill health in the UK and their prevalence is rising, with the World Health Organisation predicting that depression will be the second most common health condition worldwide by 2020. Poor mental health affects people of all ages, yet, with effective promotion, prevention and early intervention its impact can be reduced dramatically. There is often a circular relationship between mental health and issues such as housing, employment, family problems or debt.*

Leicester Community Advice and Law Centre stated that changes to the Welfare benefits system next year would impact most on those with lower incomes and the more vulnerable in society and this would subsequently increase the likely incidence of mental health issues through stress, anxiety and depression etc.

d) **The Leicester Counselling Centre (TLCC)** lost its County Council funding in March 2012 and has been forced to cut its already scarce core support service. This funding loss has already led to the director having to cover the admin support service, instead of supporting the clinical support and counselling staff and building business expertise for the future of commissioning and bidding for external funding.

   The City Council currently grant funds the TLCC £26,000 and charges £12,000 rent for premises. Any cuts in City Council funding will mean that TLCC will not be able to offer affordable counselling therapy (currently in excess of 5000 hours per year) to those who need it, but sadly will become a service for those people who can afford a market rate of £45-£50 per session (IAPT currently costs approx. £75). Funding cuts may result in the TLCC Trustees forced to close the centre.

e) **Care & Repair (Leicester) Ltd** was established in 1987 and served the city and the county carrying out home improvement works and providing advice to help older, vulnerable and disabled people. However, after 25 years of service with 12,000 service users in the city, this organisation is no longer supported by the city council due to lack of resources and non protection for staff, under TUPE. The service has had no alternative, but to ask the city council to novate the city contract to Papworth Trust.

f) **Jigsaw** an Autism Support Group of over 20 years experience supporting families with children with ASD has for many years received funding from both, city and county councils. Jigsaw has also been running a well respected Ofsted registered

summer playscheme for the past 13 years, which has been oversubscribed, and caters for the most severely autistic children who are typically excluded from all other playschemes. The County has maintained financial support, but the City has not, so the playscheme has had to become exclusively County. Jigsaw continues to get enquiries for places from distraught parents in the city.

g) New Futures Project is a 'trusted' specialist targeted service which supports women at risk of sexual exploitation. Its provides a complete support package around issues of housing, drugs and alcohol, emotional support, benefits advice etc.. If funding was reduced or withdrawn, the project would be as risk, resulting in reduced referrals to GPs, Social Services and mainstream services with an increased costs to the NHS and Police.

h) Adhar Mental Health Project has supported people with chronic mental health conditions and has maximised individual ability to live in their homes, thereby reducing re-admissions to hospital. However, the funding from city council over the last few years has been insufficient to run the services. Any further cuts will result in staff redundancies and reduced services and have serious impact on the existing critical services to South Asian citizens in Leicester (Appendix 19).

VCS stated that Leicester is in the highest quarter nationally for prevalence of severe mental illness. According to the Joint Strategic Needs Assessment 2012 – Leicester has a significantly higher proportion of the population registered with a mental illness than in England or the East Midlands and the trend is worsening.

5.26 The health scrutiny commission members recognises that funding pressures have come at a time of growing demand for services, reduced statutory funding and the way that public services are delivered. This is the source of much concern for the VCS. The Commission gathered evidence that illustrated a level of concern within the voluntary sector over funding issues, and its ability to adapt to change and work within an increasingly complex and demanding environment.

5.27 **The commission heard evidence from Lead Officers of Adult Social Care and Leicester City Clinical Commissioning Group (CCG) Adult Commissioning in relation to the Budget Position:**

5.28 **Health Budget**

a) The Leicester City CCG budget for the VCS services is £2.96m. In 2011/12 and 2012/13, the CCG applied a 1.58% and a 1.8% reduction respectively to all VCS contracts in line with the DH Operating Framework mandate. No services have been decommissioned.

b) Leicester City Clinical Commissioning Group Officers informed the commission that it will be in a position to outline its budget for 2013/14 when the Operating Framework is issued in December 2012.

5.29 **Adult Social Care Budget**

a) The ASC budget in 2012/13 for VCS is £4.3m. This is after applying the reduction of £710k agreed for 2012/13 as part of the council's budget strategy. The reduction increases to £845k in 2013/14.

b) Due to time constraints it was not possible to develop a consistent methodology for applying the required reduction in 2012/13, or to determine the social value of these contracts. The Best Value Guidance 2011 requires local authorities to take account of the added value that voluntary sector services provide when considering budget reductions or de-commissioning services.

c) As part of the formal consultation process all services were asked if they could make a 15% efficiency saving for 2012/13 and to model the impact of the reduction on their services. 41 written responses were received and individual meetings were held with 37 providers.

d) The outcome of the consultation exercise, in terms of actual cashable savings offered, was £35k from a total of 12 providers. From this Officers felt that only £23k was affordable for providers and this was reduced to £19k to protect current service levels. This equates to a 0.4% reduction for 2012/13.

e) The Council recognises there will be a shortfall against the VCS savings requirement in 2012/13; however the full savings of £845k will need to be met in 2013/14. All VCS services are under review and some of the existing contracts, such as day care, are not being fully utilised and therefore there are opportunities to make savings within these contracts.

f) Last year the council also approved a reduction across all Housing Related Support Services of £600k in 2012/13 rising to £2,330k in 2013/14. The budgets have subsequently been disaggregated across the different divisions of the council with ASC needing to reduce expenditure in 2012/13 by £179k rising to £890k in 2013/14. For 2012/13 it was agreed that negotiations would take place with all providers to reduce the contract values. These negotiations resulted in a total saving of £191k which is slightly higher than the required amount for 2012/13. Again a review is being completed to ensure that future spend is aligned to ASC priorities.

g) ASC has a net budget of £86.9m and, as part of last year's budget strategy was required to make budget reductions of £16.5m, between 2012/13 and 2013/14. Further very substantial reductions are likely to be required in future as government grants are cut further.

h) <u>Officers informed the commission that no further budget reductions have been proposed for the Adult Social Care VCS services as part of the Councils budget setting process for 2013/14 to 2014/15.</u>

5.30 Members of the health scrutiny commission were concerned about the shortfall in budget savings, officers reported that some savings had been achieved from contracts

that were not fully spent and that others had been backfilled to fill the deficit. There was still a deficit of £300k and this was currently being reviewed to achieve the savings. For example, providing day care services was a statutory requirement, but with the growing trend of people using their personal budgets to buy health care packages that did not include day care services; there was an opportunity to review the service to achieve further saving as a result of the reduced demand upon it.

5.3.1 **VCS raised concerns *'that the city VCS are aware that city council commissioners have recently committed to undertaking reviews, which is welcome, however, as yet it has not been confirmed that this process will allow existing contracts to be rolled over until at least October 2013'.***

5.32 The commission heard evidence that many VCS groups are waiting to hear from the city council by the end of December 2012 whether contracts will be extended past 31st March 2013, otherwise, the threat of redundancy notices will have to be issued (for example at LAMP, it could affect 14 staff being made redundant and losing over 20 volunteers). This will result in groups having no funds to continue their services or the infrastructure to provide the services that any small independent grants may offer.

5.33 LAMP, on behalf of VCS stated that the practice of rolling contracts over with minimal contact was not considered an ideal way of conducting services.

5.34 **Responses from City Council Lead Commissioners and Leicester Clinical Commissioning Group in relation to Current Contracting Arrangements for Health and Adult Social Care:**

5.35 **Health**

a) Current NHS arrangements have been based on historical arrangements that have been in place for a number of years. Grant contracts were used as they facilitated a more flexible approach to the management of contracts on an annual basis that were not too onerous on the provider given their capacity to provide the level of monitoring information that would be required if the providers were moved to a standard NHS contract template.

b) As PCTs will no longer exist as statutory bodies from April 2013 Department of Health issued a mandate that current contract arrangements could only be extended until the end of March 2013. This does not mean that the CCGs will no longer continue with commissioning from the VCS nor that it does not value the contribution to the VCS makes to the health and wellbeing agenda. It merely means that contracts from 1st April 2013 need to be issued by the CCG.

c) CCG leads have been meeting with VCS representatives to inform and engage the VCS regarding the future arrangements and the potential developments in strengthening engagement with the VCS.

5.36 **Adult Social Care**

a) Historically, the arrangements for a large number of VCS ASC services were based on grant aid. In 2008 the City Council undertook a review of all grant aid arrangements across the Council and moved, in the main, to a model of contracting for services. As part of this exercise VCS ASC services were reviewed with the large majority being moved to a contractual basis, which were directly negotiated with the provider on the same financial value. These services were offered two year contracts from 2009 and have since been extended for a further year pending a review of services.

b) A small number of services where it was felt there was market interest were competitively procured on either a framework agreement or block contracting arrangements. VCS providers are encouraged to compete in competitive tenders; for example in November 2012 a procurement exercise for Supported Living and Respite Service Framework. Of the 31 potential providers, 14 identified themselves as a VCS provider. A summary of current arrangements excluding this framework are: VCS Providers 60, delivering 106 services with 15 on grant aid including minimum funding agreements and 60 contracts.

5.37 Members of the health scrutiny commission were reassured that both Leicester CCG and City Council were in the process of sending out letters to VCS groups to inform them that existing contracts will be extended – the majority of these will be to 31st March 2014.

5.38 **Tendering and Procurement**

VCS groups raised a number of concerns about tendering and procurement processes. The commission heard evidence relating to commissioning and tendering issues. Voluntary Action Leicester highlighted that there is scope for creative commissioning and partnerships with the VCS (e.g. presentation slides showing models of good practice of grants instead of tenders). The main issues raised by VCS:

- The VCS felt that some tender consideration panels did not understand the technical side of delivering some niche services and did not consider the track record of organisations submitting tenders. The VCS were concerned that if the current trend of awarding contracts on lowest price continued then it would result in more national or regional organisations being awarded contract which would squeeze out local VCS bodies. There should be a greater focus on value rather than cost in contracts.

- **Care & Repair, Leicester** stated that Leicestershire County Council issued a tender earlier in the year to establish a Housing Improvement Agency covering the 7 county district areas. The tender was won by the Papworth Trust and it affected part of Care and Repair (Leicester) as it covered Blaby district and all of Care and Repair (West Leicestershire). As these two organisations already shared a Director and other staff and resources, Care and Repair (Leicester) had to request the City Council to novate its contract to the Papworth Trust in order that the Care and Repair (Leicester) services

could continue to be provided as a viable operation. Care and Repair (Leicester) now no longer existed.

- **Equality** – not a level playing field. Starting from a stance of discrimination as the larger/private competitors often have in-house law advice, and people employed write and submit tenders. For example, TLCC do not have easy access to advice on contract law and other complex areas associated with commissioning.

- **TUPE** – VCS was not able to bid for contract services if TUPE was involved because the VCS generally had lower wage levels and pension/benefits schemes. This essentially disqualifies small organisations from taking on contracts that involve staff transfers. Therefore, need better contracts giving more information so VCS can calculate risk as well as whether they can afford to take on potential liabilities.
- **Generic large tenders** – There was concern at the apparent trend of large organisations winning tenders and then establishing 2-3 staff working from home with little resources or support. There was a danger that the community might not see the service as being visible or accessible. Small specialist VCS with small management structures are unable to compete against big organisations. Small orgs may have to change their charitable constitution to be able to apply e.g. infrastructure and financial resources – this takes time.

- **Bureaucracy** - working in partnership/consortia can involve more bureaucracy and management resources adding further pressure to small/med organisations.

- **Recognition and Track record**, years of experience, knowledge and skills of working in local community is not taken into account. Local VCS organisations had significant knowledge of local communities and a third of clients were from BME communities, this could be lost if contracts were awarded to national or regional organisations.

- **De-commissioning of limited outdated services** provided by Leicestershire Partnership Trust e.g. 'revolving door' services users, medication and maintaining. Distribute to VCS that can show improved outcomes for service users and carers.

- **Viability of Grants V's Tendering Contracts** – A service provision based purely on contracts excluded small and medium sized groups from competing for the contracts because of the risks involved. It was important to have a mixed and vibrant sector of service provision and grants did not allow small groups to grow and develop in order to take on contracts in future years.

- **Lack of VCS involvement** - consider involving the VCS at the start of any process.

5.39 Commission members asked officers how smaller organisations in the city can be supported to compete with larger tenders for contacts. Officers replied that the weighting used to evaluate prospective service providers was traditionally 60% for quality and 40% for price. However, in order to support a wider market and to include smaller and medium sized enterprises, some recent procurement exercises had moved the weighting to 80% for quality and 20% for price. Adult Social Care had also engaged

'Case-de' to work with all VCS providers to help them develop their business models to create sustainable services.

5.40 **Responses from City Council and Clinical Commissioning Group in relation to Procurement Processes:**

5.41 Both the City Council and the CCG must adhere to procurement guidance that outlines the legal requirements. The CCG and Leicester City Council commission procurement support for the VCS from VAL, ACCF and Case-da. The total amount paid to VAL for supporting the VCS by the City Council and Health is £391.000 per annum. When procuring services both health and ASC commissioners place significant emphasis on the quality of service compared to price.

5.42 **Health**

5.43 City CCG abide by the principles of procurement as set out in the NHS Procurement Guidelines (Appendix 32). These are:

- Transparency
- Proportionality
- Non-discrimination
- Equality of Treatment

5.44 The procurement decision process consists of the following:

- Undertake service reviews in line with the CCG commissioning Strategy
- Apply benchmarking to existing services
- Undertake healthcare market analysis to determine the market and identify potential providers
- Engage early with providers, staff and representatives to assess the potential impact/deliverability of the service
- Engage with service users and local communities and key stakeholders
- Give all potential providers fair and equal opportunity to bid
- Have regard to equality considerations in the procurement process
- Have regard to any sustainable development aspects of the procurement

5.45 The weighting used in contract award decisions by the CCG are based on "value for money" principles and weighting is applied as 60% quality and 40% price. It is statutory for providers to be able to meet the NHS quality standards which requires providers to be CQC registered.

5.46 Recently the City IAPT (Open Mind) service went out for procurement – through the procurement process prospective providers were actively encouraged to develop consortium bids (lead organisation in partnership with other organisations) with voluntary sector organisations as the local evaluation of the Pilot demonstrated that a partnership approach to delivering this IAPT improved access to BME communities

5.47 Furthermore the service had more flexibility re: venues that people could access the service from. During the consultation on the development of future service provision service users valued this and hence through the procurement process we were able to encourage this approach.

5.48 The commission were informed that the IAPT service (recently re-tendered) is now delivered in partnership by Leicester Partnership Trust and vcs groups, such as Adhar and Akwaaba Ayeh.

5.49 **Adult Social Care**

5.50 The weighting used to evaluate prospective service providers by the Council is considered as part of each procurement exercise, and historically the 'standard' was 60% quality and 40% price. However, in recent procurement exercises the weighting has moved to 80% quality and 20% price. This includes the Supported Living and Flexible Respite Service Framework and Healthwatch contracts. In the current tender exercise for advice services the weighting was moved to 90% quality and 10% price.

5.51 Alongside the support provided by VAL and the ACCF for providers ASC has also engaged Case-da to work with all VCS providers to help them develop their business models to create sustainable services.

5.52 On-going dialogue is maintained with the provider market to ensure we understand their current services, the quality of these and also any issues either side has. This is undertaken through regular contract management arrangements with the providers, regular provider forums and through commissioning reviews.

5.53 During commissioning reviews ASC will confirm if any support is needed for potential providers in the market in order to enable them to take part in future procurement activities. This will also enable us to plan any actions to support this. When required ASC also undertake soft market test exercises where providers can have the opportunity to comments pre procurement on proposed models of services and any issues that they might identify in the delivery of these.

5.54 <u>In addition the City Mayor has developed a Task Force to implement new procurement processes for the Council that support a wider market of providers for small and medium size independent organisations, including social enterprises and voluntary organisations.</u>

5.55 The commission members recognise that there has been significant changes to the way in which funds are provided from local authorities. From the traditional model of grant funding, there has been a shift to a commissioning model approach with a stronger emphasis on outcomes. The benefits of this approach are about achieving value for money and using a competitive tendering process to find the best service to achieve specific outcomes.

5.56 **Recognition for VCS Services**

5.57 **The commission heard *'that the city VCS is undervalued in its ability to provide early intervention and prevention services that offer good value for money and save significant costs on statutory health and social care budgets, the VCS are asking that such value is properly reviewed, including additional charitable/non-statutory funding that the VCS bring into the city'.***

5.58 ***EXAMPLES OF EVIDENCE PROVIDED:***

a) **The Leicester Counselling Centre (TLCC)** stated that the VCS are much more than service providers for many people from the poorer and most disadvantaged parts of the city, or from disadvantaged groups (mental health), VCS are the only effective means they have to be heard. It is very difficult to put a quantitative value on this role but there can be little doubt that this advocacy type role played by much of the sector is invaluable if the council want to stay connected with all the citizens in the city.

b) **The Leicestershire AIDS Support Services (LASS)** is unique in its involvement and training of community volunteers to provide an outreach service, enabling LASS to reach into different communities as volunteers give talks and provide services into their neighbourhoods. So far the Zimbabwean and Congolese communities have benefited from this strategy and other communities are now approaching LASS, providing community peer leadership is really important in a city as diverse as Leicester. LASS HIV testing is supported through a clinical governance group and has saved the health service over £3,250,000.

   Leicester City has an above average number of people with diagnosed HIV, with a current prevalence of 3.2 per 1000. Leicester City has the 6th highest rising rate of HIV in the country. LASS HIV testing has been delivered at the Merlyn Vaz Health Centre and provided training to practice nurses in Beaumont Leys. LASS is currently compiling a video on HIV testing for Asian communities with Dr Dhar, a GU HIV consultant. The majority of LASS is with people from BME population of the city and also considerable work with gay men who also experience discrimination.

c) **Vista** is a charitable company and works to improve lives for people with sight loss in Leicester and the county. A range of services are provided including befriending service, social activities, transport support and resources centre. There are particular issues for Leicester City because people from Afro-Caribbean backgrounds are four times more likely to develop Glaucoma, and people from the South Asian community are more at risk of developing diabetes, which can cause diabetic retinopathy, resulting in blindness.

5.59 **Voluntary Action Leicester** explained that the VCS has over 656 groups that specialised in providing health and social care services in Leicester and was generally well placed to know what worked for clients and what services clients required.

5.60 The commission heard that the VCS organisations were well placed to work with new communities (Somali and Eastern European) and with existing BME communities.

These communities were often isolated and did not engage with services because they thought there was a cost to them.

5.61 The VCS works closely with such communities to break down language and understanding barriers. For example, the commission heard that Network For Change has over 20 years of experience and provides a valuable early intervention, prevention and enablement role for between 110-140 service users with severe and enduring, often complex problems, including those who have disengaged from statutory services and those from BME communities *(Appendix 13)* .

5.62 The commission were informed that the Joint Commissioning Strategy for Mental Health 2011–2013 states *"there is a lack of market capacity for all levels of community support. Based on a continuum, supported living needs to include a full range of options, from low level floating support to more intensive specialist out reach support… The Opportunities Assessment case file analysis identified a risk averse culture that is leading to over provision (of residential care), which fails to stimulate the market to offer low level support options"*

5.63 VCS informed the commission that they were concerned that longstanding over investment in residential care has led to failure in invest in more cost effective supported living and low level VCS preventative community support.

5.64 Following questions from Members, representatives of VCS bodies offered the following comments and statements:-

- VCS services provide niche services that would not otherwise exist. Care and Repair had originally been established 27 years earlier to provide services that were not available through the Council.
- Charitable and not for profit organisations required funding to cover the costs of qualified staff to manage their volunteers. Volunteers, although giving their time free of charge, required travelling expenses to undertake their work. VCS organisations also required funding for a management structure, office accommodation and business expenses such as printing and telephones etc.
- There was a strong partnership between the City Council and the VCS community which had developed over a long period of time.
- The VCS worked closely with the people for the services that they required. This relationship was being strained through the change in the commissioning model from deep rooted community based to accounts/budget based commissioning.
- There was a need to invest in the VCS in order to save greater funds elsewhere, particularly in relation to the harder to reach groups where VCS was particularly skilled in identifying gaps in service provision and delivering services to meet those need more effectively.
- Savings could be achieved by providing services through VCS organisations in view of their lower pay structures and pension schemes.

- The VCS recognised the changing political landscape of reduction in local authority funding from central government but the VCS was invaluable in meeting the needs of people who were easiest to ignore and not to hear.
- VISTA considered that partnership working also included having respect and recognising what each partner brought to the table.
- VSC organisations brought a voice to the table that would not otherwise be heard. They represented the views of people who distrusted establishment organisations and represented a collective voice for people who did not have a natural voice. There were numerous examples of complaints being made to VCS bodies instead of the Police or other national or local government bodies surrounding serious investigations of national importance.
- There was some evidence to suggest that VCS services could save £10-£20K per person on wider health costs.
- Some insurers required at least two qualified members of staff to be present before some activities were carried out. This could add to costs and be prohibitive for some service provision.

5.65 Jenny Hand, Chief Executive of **Leicestershire Aids Support Service** (LASS) submitted a written statement *(Appendix 4/5/6/7/8/9/10/24)* and gave the following evidence and comments:-

- LASS provided support, information and advocacy to people affected by HIV/AIDS working in partnership with others to promote positive sexual health, raise awareness about HIV/AIDS and empower people who were affected to live safe and fulfilling lives.
- LASS worked closely with faith based organisations to give extra specialised training they required to support their work.
- There was sometimes a negative impact from faith based organisations about the lifestyle of people with HIV. LASS were able to get closer to clients with their specialised knowledge built up over many years and also through working with faith based organisations. The emphasis was on complementary provision and not an either or approach to service provision.
- Organisations such as LASS could provide commissioners with evidence of what outcomes had been achieved and what outcomes were needed to meet specialist niche service needs.
- Grant funding could be used by organisations such as LASS to sub-contract work to smaller groups providing specialist services, which also helped them to grow and develop in the long term. LASS had a number of such projects and the example of supporting a small African-Caribbean Group in Corby was described as an illustration of this.
- The evaluation of one of the specialist projects, Personalisation for People (P4P), illustrated that for each £1,000 spent on individual support the health service could save £10,000 from re-admission bed spaces, missed appointments and wasted medication.
- The HIV testing programme delivered by LASS was estimated to have saved the Health Service an amount in excess of £3.25m. Over 800

tests had been completed, with over 50% to BME communities and 65% to men, both traditionally hard to reach client groups for clinical services. An African Communities football tournament had been organised to promote HIV testing and resulted in 30 tests on the day. This also resulted in a number of tests being conducted subsequently as clients came forward based upon word of mouth recommendations from those at the tournament.

- People often went out of their neighbourhood and faith organisation area to access advice and services. Service delivery, therefore, needed to be flexible to meet the needs of differing communities and the VCS was well placed to provide this.
- Ideas for increasing health outcomes for people in Leicester which could save money for health and social care in the longer term were outlined in full in the paper submitted as evidence. This was, however, dependent upon continued or extending funding.

Case evaluations of several projects supported by LASS were also submitted as part of the evidence *(Appendix 4/5/6/7/8/9/10)*

Kathryn Burgess, Executive Director of the **Community Advice and Law Service** (CALS) presented the following comments:-

- Social Welfare Law Advice was identified as an outcome of social care and not health.
- 30% of the 2,600 clients that received advice had a disability or long term health conditions.
- Evidence from similar service provisions in Leeds demonstrated that 41% of 527 clients that received debt advice resulted in benefits to health through reduced levels of stress, leading to fewer visits to GP's and fewer prescriptions being issued for depressive illnesses. The costs of these savings, however, were not directly linked to the advice provision.
- Early intervention in debt counselling prevented escalation into serious health problems. The difficulty was that often clients only came for advice when they were at crisis point and the earlier the advice could be given the sooner the benefits to health could be achieved.
- Commissioners needed to have a greater understanding of how the advice service worked with health so that services could be designed to improve access and target service users.
- GP's needed greater awareness of the benefits to health improvement that could be achieved by the advice and early intervention offered by CALS.

Tony Cusack, Manager of **the Emerald Centre**, presented a paper on the benefits to health that the Centre provided through its programme of activities *(Appendix 2*). The Centre also delivered a wide range of training and community development programmes. Although the Centre evolved from its links with the Irish Community, its primary role was now to meet the needs of

the all the local community. Eleven of the activities supported by the Centre were outlined in the paper, together with the health benefits of participating in sporting and other community activities. One in particular, an armchair aerobics programme for disabled people and the elderly, had produced improvements in health to those taking part, but this was not easily measured in outcomes to the health service. It was also difficult to measure the beneficial impact of befriending services and the services delivered to vulnerable elders.

The Centre was a Charity and as such it accessed funding from a number of national, regional and local funding sources e.g. Big Lottery, Sport England and Comic Relief, which enabled it to support initiatives that had benefited thousands of people each year. The Centre was ideally placed in the local community and had a proven track record of delivering projects that promoted health and well-being. The Centre felt it was a unique organisation in the City delivering a wide range of services for people of all backgrounds and diversities. The Centre addressed specific needs in specific groups that were not being addressed elsewhere.

Gabby Briner, Chief Executive Officer, **Network for Change and Chair of the Voluntary Sector partnership Forum for Mental Health** submitted a written statement *(Appendix 13/14)* and gave the following evidence and comments:-

- The Network for Change (NFC) was a specialist service with 20 years of experience and had a good track record for working with hard to reach groups, managing risk and safeguarding vulnerable adults. The NFC was a local VCS mental health organisation providing housing related support, outreach, self-directed support and resource centre services to adults with severe, enduring and/or complex needs.
- The service had an 'A' quality rating in the QAF 2010 City Supporting People Supported Housing Service. The service had also received national and regional awards for quality.
- All its services could demonstrate an early intervention and prevention role which saved costs on more secondary health and social care provision through reducing the frequency and length of stay of hospital admissions.
- The Resource Centre had run for 9 years providing an early intervention, prevention and re-enablement role for 110-140 service users with severe and enduring problems including those that have dis-engaged from statutory services and those from BME communities (approximately 30 % of the users). The cost of the service was £100k per year and it prevented people from falling into crisis and reduced the costs of statutory support.
- A 2 year review of Health Services identified that only 27% of clients wanted a hospital based service. There was no new money currently available to provide the VSC support for clients wanting community based services.
- The service had endured 4 years of decreased funding which had

resulted in a reduction in staffing capacity, terms and conditions, including pay and increased working hours, in order to deliver the service within the funding available.

- The housing related support service was funded at a cost of £22 per hour in 2003 but a recent mental health housing tender had reduced the cost to £13 per hour. The service felt unable to bid or compete for that tender and there were concerns that, if the housing related service was re-tendered at the same low rates next year, the service may have to close.
- Competition for lottery/charitable funds were fierce with only 1 in 18 applications being successful.
- It was estimated that savings from delivering intervention and prevention services saved 10 times the value of the investment in not having to deliver secondary health care services.
- NFC was a user led service and it needed to be involved in the strategy and commissioning of services.
- The service needed to be involved in the proposed new Mental Health Partnership Board.

Sallyann Robinson, **Care and Repair (Leicester)** submitted a written statement *(Appendix 16*) and gave the following evidence and comments:-

- Care and Repair were established to work with older and disabled people in private sector housing and to administer local authority grants for major and minor works.
- Major works were no longer carried out as there had been no local authority money available for over 18 months. Funding requests were now being made to charitable organisations.
- There were approximately 1,200 service users in the City and a similar number in the County.

Jenny Pearce, Chief Executive of **VISTA and Chairman of the Vision Strategy Group for Leicestershire, Leicester and Rutland** submitted a written statement *(Appendix 11)* and gave the following evidence and comments:-

- VISTA along with other public health colleagues strongly supported the partnership approach which aimed to shift the focus of Clinical Commissioning Groups towards an early intervention approached and promoting integrated partnership responses.
- 50% of sight loss was avoidable, and four times as many people from African Caribbean backgrounds were likely to develop Glaucoma. Loss of sight could lead to long term health issues, social care and mental issues. Sight loss is a major cause of falls and could result in mental health problems through loneliness and isolation.
- VISTA lead on the UK Vision Strategy (2009) which focused on key outcomes of improving eye health, prevention of avoidable sight loss and including participation and independence for people with sight loss.

- VISTA had always worked closely and effectively with the Council and were keen to explore ways of working more imaginatively.
- VISTA were disappointed that the Local Professional Network (LPN) had targeted its priorities towards Optometrists, guided by the CCG, with emphasis on eye care and eye problems.
- The Vision Strategy Group had subsequently made representations and VISTA were currently preparing a needs assessment to be presented to the LPN Steering Group to try and shift the primary focus from eye care to eye health, in order to support long term effectiveness and efficiency.
- VISTA provided an information service in 50% of eye clinics of UHL clinics and nearly all community hospital clinics in Leicestershire and Rutland. The information service provided information on retaining independence and was well received by patients. The gap in service provision could be addressed if the City Council, Leicestershire County Council and the CCG's could develop a co-operative partnership to address the funding gap for this service. VISTA estimated that the impact of the service could be doubled by more people accessing the sight loss pathway and significantly less people requiring intensive interventions to address falls, accident and depression.
- VISTA felt that, in view of the above, the VCS should be involved in strategic planning and joint purchasing across health and personal care.

Denise Chaney, Executive Director of **LAMP** submitted a written statement *(Appendix 12)* and gave the following evidence and comments:-

- Many VCS receive funding from multiple sources for their main contracts and were at major risk of collapsing. LAMP provided specialist mental health advocacy and support.
- LAMP produced a Directory of Mental Health Services and was the first to achieve the Advice Quality Standard Mark and the Information Quality Standard Mark.
- LAMP had led on mental health advocacy for 23 years and had raised quality and standards and promoted the advocate qualification. LAMP was considered to have a good management structure with well managed volunteers.

- LAMP's good practice and risk alerting had also been commended in major inquiries such as Hundleby (2001) and Butler (2010).
- LAMP had dealt with 155 service users and carers and a further 144 in hospital. In addition 120 requests had been received for information and this did not include the web-site enquiries or the 600 requests for leaflets.
- LAMP felt that the issues of specialist versus generic services provision was not being viewed or considered as it should be. There should be a Mental Health tender for information/advocacy that can deliver a generic service as well.
- LAMP had an unprecedented local knowledge base which played a key role in addressing risk and safeguarding issues. All LAMP advocates

were trained to the Independent Mental Health Advocacy level.
- LAMP worked with clients with complex needs whose care involved both health and social care issues. This distinction did not exist in LAMP, and, as its statistics were collected on a joint basis, it was increasingly more difficult to bid for some tender as they were either health or social care.

Phil Wilson, Vice-Chairman of the **Board of Governors of the Leicester Counselling Service** submitted a written statement *(Appendix 15)* and gave the following evidence and comments:-

- Following the loss of County Council Funding in March, the service had been forced to cut its scarce administration support staff down to 1 administration officer, losing two part time staff.
- VCS services bring a roundness to service delivery which is not often found elsewhere.
- The Service currently supported 140 clients and it was expected that each client would need a maximum of 8 sessions to get better. The waiting list of 80 had doubled over the last few months.
- The service currently delivered over 5,000 hours of counselling therapy and if the there was a cut or serious reduction in the current funding, the service would either have to move away from its ethos of affordable counselling to become a service for those that could afford the market rates of £45-50 per session; or the Trustees may be forced to close the centre altogether.
- There was concern that the value of the VCS won't be known or appreciated until it was not there.

The chair thanked the representatives of the Voluntary Community Sector for taking part in the review and providing supporting evidence.

5.66 **Joint Commissioning**

The commission heard *'that there is a need to recognise the VCS input into providing social care services and consider that there is great scope for the local authority and health funders to work in partnership and invest in joint commissioning of our services'.*

5.67 **EXAMPLES OF EVIDENCE PROVIDED BY VCS:**

a) LASS have worked successfully in partnership with Leicester Partnership nhs Trust for work in Gartree Prison and are part of many other partnerships and partnership bids. Partnership working has helped us to help smaller organisations to access funding, however, they do take far longer than bidding alone to put together and to manage in terms of reporting structures.

b) **Health Partnership Project in Bradford** was set up to tackle health inequalities and works with local VCS groups and GP Practices. Provides information on VCS services that can help patients in their community. Problems range from loneliness to domestic abuse and debt problems to mental ill health. Directory of resources available to GP's through 'System One' the GP prescribing system. This Partnership approach has lead to a reduction in GP's 'frequent flyers'. This project could be replicated in Leicester to tackle health inequalities through the VCS engaging with patients to provide health services in the community.

c) **Vista** (paper appendix 11) describes a partnership approach which is being promoted by Vista together with Public Health colleagues, with the aim of shifting the focus of Clinical Commissioning Groups towards early intervention approaches and promoting integrated partnership responses. The paper also describes an example of a potential joint funding opportunity which would strengthen an existing and proven early intervention service.

5.68 Commission members asked what factors determined whether a service should be jointly commissioned. Officers indicated that these could involve issues around value for money, especially if one service provider had contracts with two or more commissioning groups. The separate services could possibly be delivered more efficiently by dealing with one commissioning body for all the services. Also contract monitoring needed to be viewed in the context of the service needs. Monitoring may show that the service provider was performing at 100%, but the service may no longer be relevant to the needs of service users.

5.69 The commission heard that there was a need for joint commissioning e.g. within mental health services the city council and health commissioners should work towards joint assessment, planning and investment. Health personal budgets are currently being piloted in the city and there is a need to find ways to link these to social care, rather than the continual dilemma of 'health versus 'social care' where vulnerable service users fall through the gaps. Joint assessment and commissioning would be more cost-effective and better meet mental health outcomes and individual needs.

5.70 **Responses from Adult Social Care (ASC) and Leicester City Clinical Commissioning Group (CCG) Adult Commissioning in relation to JOINT COMMISSIONING:**

5.71 There are a number of VCS organisations that the CCG already jointly commissions with Leicester City Council, Leicestershire County Council and with the 2 County CCGs via Section 256 arrangements. Below is a breakdown of this:

Section 256 arrangements with Leicester City Council

Council Contract	Voluntary Action Leicester	Support to voluntary sector organisations and compact
Council Contract	Leicester City Council	Remit - City PCT – Mental Health
Council Contract	Leicester City Council	Alzheimer's Advocacy Project – Mental Health older People
Council Contract	Leicester City Council	Rethink – Carer Support Workers – Mental Health
Council Contract	Leicester City Council	Genesis – Mental Health – service user carer involvement and engagement
Council Contract	Leicester City Council	Visamo Day Centre – mental health older people

Section 256 arrangements with Leicestershire County Council

Council Contract	Leicestershire County Council S256 Agreement	Welfare Rights – mental health
Council Contract	Leicestershire County Council S256 Agreement	Hospital In Reach – mental health

Joint LLR contracts with East Leicestershire & Rutland CCG and West Leicestershire CCG

STEPS (Leicestershire Conductive Education Centre)	Structured development programme for pre-school children with disabilities and their families	Children's Health
COPE - The Laura Centre	Support for adults and children affected by the death of a child and for children and young people up to the age of 25 affected by the death of a significant adult.	Children's Health
COPE - Children's Trust (Rainbows Children's Hospice)	Provide respite, palliative and terminal care to children and young adults with life limiting conditions	Children's Health
Barnados	CareFree Services – support for young carers	Children's Health
Leicester Housing Association Support Services	Compass project (Old long stay clients)	Mental Health Services (Adult)
Coping with Cancer in Leicestershire and Rutland	Information, Emotional and Practical Support for People who are Coping with Cancer	Cancer and Palliative Care
LOROS	Palliative Care services	Cancer and Palliative Care
Inspired (2009) CIC	Inspired	Inter-Agency Training
Rethink -Focusline	Focusline - Mental Health Telephone Support Line	Mental Health Services (Adult)

5.72 In order to reduce the burden on VCS providers to provide monitoring information to both health and ASC commissioners and to develop more streamlined processes to the management of VCS contracts – the CCGs and LCC have agreed to jointly review their VCS contracts. The aim of this will be to transfer the management of the health contracts to LCC via the existing Section 256 arrangement we have already in place, with a view to having new contracts in place by 1st April 2014. In the meantime existing contracts are likely to be extended.

5.73 The CCG recognise that if they continue to manage the contracts the existing contracting arrangements will have to be transferred to Standard NHS Contracts arrangements and templates and this will be onerous to the VCS especially where the organisations are small and they do not have the sufficient infrastructure to be able to meet all the requirements of a Standard NHS Contract.

5.74 Based on discussions with the VCS commissioners in the City, the CCG acknowledge that the VCS also want health and social care to develop and strengthen joint commissioning arrangements and we are responding to this through the work programme outlined earlier in the report.

5.75 **The commission heard *'that there was a lack of engagement with VCS from city council and lead commissioners'.*** The commission heard that at present there was a lack of information from the new Leicester Clinical Commissioning Group.

5.76 Response from the LCCCG was that 'from an engagement perspective, the involvement of VCS is high on our agenda and a dedicated engagement manager has been appointed'

5.77 Whilst both the Council and the CCG had taken on board the issues raised by the VCS in relation to their concerns about the reduction of Health and Adult Social Care preventative services, as well as the lack of engagement; the evidence provided by both organisations supported their view that they had listened to the sector and adhered to the Best Value Guidance, particularly in relation to the steps already taken over budget reductions to date.

5.78 Lead commissioners informed the review that there had always been a strong commitment to involving the VCS in the development of commissioning strategies and priorities. The sector had been involved in the development of the Joint Commissioning Strategy for Mental Health, Learning Disabilities, Carers and Dementia and the CCG had involved the VCS in the development of their Clinical Commissioning Strategy.

5.79 Leicester LINk also organised an engagement meeting in July 2012 to discuss the development of the draft Health and Wellbeing Strategy. It was attended by 76 people, including VCS representatives The examples of engagement activities demonstrated that the VCS had been involved in developing the draft Health and Wellbeing Strategy

for the City. Lead officers explained that these examples of involvement highlighted that mechanisms were in place to seek the views of the VCS.

5.80 The lead commissioners for mental health were working together to develop structures to facilitate the involvement of Mental Health VCS partners, service users and carers that would work on a similar model to the Learning Disability Partnership Board and ultimately sit under the governance of the Health and Wellbeing Board. The initial draft Terms of Reference were shared with the Mental Health Provider Forum and a paper was currently being taken to Leadership Teams to agree the revised Terms of Reference and timescale

5.81 The Chief Corporate Affairs Officer from the CCG had met with VAL to discuss how the CCG could strengthen engagement and develop a working model on how the CCGs could work with the wider VCS, especially developing access to BME communities and seldom heard groups.

5.82 Whilst both the Council and the CCG had taken on board the issues raised by the VCS in relation to their concerns about the reduction of health and ASC preventative services as well as the lack of engagement; the evidence provided by both organisations supported their view that they had listened to the sector and adhered to the Best Value Guidance, particularly in relation to the steps already taken over budget reductions to date.

5.83 **Responses from Adult Social Care and CCG in relation to Engagement with the Voluntary Community Sector:**

5.84 **Health**

5.85 The City CCG has identified a GP Lead who represents the CCG at the VCS Adult Health and Social Care Forum and ASC has a regular slot on the forum to update providers on key developments in the City.

5.86 At the VCS Adult Health and Social Care Forum on November 6th the CCG GP lead provided an update regarding the CCG and the authorisation process that the CCG are undergoing in order to become a statutory organisation by April 2013. Further information was provided on the CCG's priorities, the health checks campaign and the participatory budget project in COPD.

5.87 The CCG now has an Engagement lead that represents the CCG at the Leicester City VCS and Public Sector Strategy Group. Furthermore the Chief Corporate Affairs Officer from the CCG has met with VAL leads to discuss how the CCG can strengthen engagement and develop a working model as to how CCGs can work with the wider VCS and especially developing access to BME communities and seldom heard groups.

5.88 A recent project that the CCG is engaging with VAL on is the participatory budgeting project to improve services for people with Chronic Obstructive Pulmonary Disease (COPD). Participatory budgeting involves local people making decisions on the spending and priorities for a defined public budget. £30,000 has been made available for the project and will be split into 3 areas covering the City. Bidders will be asked to propose relevant health schemes and interventions for each area to tackle COPD in the City based on set criteria. The proposed successful schemes will be put to a public vote during a decision making event. The Engagement Lead from the CCG is working with VAL to provide support to VCS by promoting the project to the wider VCS and providing bidder support to the VCS to bid for funds. This will include application support and constitution development support for the VCS.

5.89 **Adult Social Care**

5.90 The VCS is also represented on the Adult Social Care Transformation Steering Group which has the responsibility of working in co-production with the Council to shape the future commissioning and delivery of services in the city.

5.91 ASC acknowledge that this is an anxious time for many providers and communication in relation to contracting arrangements. However, the sector was first informed of the Councils desire to work with providers to redesign services in line with personalisation, which was followed up by a series of information gathering meetings with individual providers. In July 2012 an indicative time scale for procurement was also shared with the sector.

5.92 **The Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy**

5.93 Two engagement events were held during the development of the Joint Strategic Needs Assessment (JSNA), and VCS representatives were invited to both of meetings. The first was on 5th October 2011 and was attended by 30 representatives of the VCS. The second was on 1st May 2012 and was attended by 37 people, including representatives of the voluntary sector. Changes and additional sections were added on the advice of these events.

5.94 During the second of the JSNA event, delegates were also asked to comment on what they thought priorities should be for the draft Health and Wellbeing Strategy, based on the information in the JSNA. This information was passed on to the Shadow Health and Wellbeing Board and helped them decide on priorities for the strategy.

5.95 The Board then attended two further Health and Social Care Forums organised by VAL, and invited comment on the developing strategy. After the first forum, on 3rd July 2012, the strategy priorities were modified. At the second forum, on 6th November 2012, delegates were asked how they could be part of the implementation of the strategy.

5.96 The Leicester LINk also organised an engagement meeting on 12th July 2012 to discuss the development of the draft Health and Wellbeing Strategy. This was attended by 76 people, some of whom were from VCS.

5.97 Representatives of the Shadow Health and Wellbeing Board also attended various Partnership Board meetings where they shared and discussed the priorities and took feedback. The VCS is represented on these boards. The Shadow Health and Wellbeing Board has also set up an electronic network for stakeholders and a number of voluntary sector bodies have joined this network.

5.98 A questionnaire was sent out during the summer asking for feedback on the priorities for the strategy, and this was distributed via VAL to voluntary sector bodies, and to members of the electronic network.

5.99 **The commission *heard 'that time should be taken to properly explore options around future funding and new ways of engaging with VCS'.***

5.100 The health scrutiny commission recognised that the city council and Leicester City CCG need to better engage and build a stronger relationship with the vcs. This can be achieved through better communication of its future plans, its funding priorities and the intended outcomes. For example 'Vista' who works to improve lives for people with sight loss in Leicester is promoting a partnership model with public health colleagues, with an aim of shifting the focus of CCGs towards early intervention approaches (Appendix 11).

5.101 **Responses from Adult Social Care and CCG on the future arrangements:**

1. **VCS – Future Arrangements**

Leicester City Council and Leicester City CCG commission services from local and national VCS organisations across a number of areas that include mental health, drug and alcohol, children's, older people, learning disabilities, physical and sensory disabilities, carers and palliative care. Our aim is to strengthen VCS commissioning through working in partnership to develop joint commissioning arrangements and deliver integrated health and social care services to meet local need.

A process has been agreed to jointly review the VCS contracts to ensure that they are aligned to the commissioning priorities for each organisation. An indicative timeline for the joint review and transfer has been agreed and shared with current service providers in relation to ASC contracts. Relevant current service providers will be informed about the intention to transfer to joint commissioning arrangements. VCS Providers will be formally consulted about the decisions.

2. Involving the VCS in Commissioning Decisions

There has always been a strong commitment to involving the VCS in the development of commissioning strategies and priorities. The sector has been involved in the development of the Joint Commissioning Strategy for Mental Health, Learning Disabilities, Carers and Dementia and the Leicester City CCG have involved the VCS in the development of their Clinical Commissioning Strategy.

ASC and the CCG actively engage with providers, carers, service users and other relevant agencies via a number of established forums. For example, The Carers

Reference Group, The Learning Disability Partnership Board, DISCUSS (customer stakeholder group for transformation) and the Forum for Older People.

Mental Health commissioning leads are working together to develop structures to facilitate the involvement of Mental Health VCS partners, service users and carers that will work on a similar model to the Learning Disability Partnership Board and ultimately sit under the governance of the Health and Well Being Board. The initial draft Terms of Reference were shared with the Mental Health Provider Forum and a paper is currently being taken to Leadership Teams to agree the revised Terms of Reference ***(Appendix 7)*** and timescales for implementation.

Leicester City CCG will share its commissioning intentions with the all providers including the VCS in early 2013, once the DH Operating Framework for 2013/14 is released which will outline the mandate for the year for CCGs including CCG allocations.

Leicester City Council initiated a series of meetings to share its intention and rationale to review the sector on 27th May 2011.

3. Conclusion from lead officers (Adult Social Care and Clinical Commissioning Group)

Whilst both the City Council and the Leicester City CCG take on board the issues raised by the VCS in relation to their concerns about the reduction of health and ASC preventatives services and the lack of engagement.

The information provided by both organisations clearly shows that some VCS budgetary reductions have not been achieved after discussions with the Local Authority, highlighting that the Council has listened to the sector and adhered to the Best Value Guidance.

Examples of engagement activities has also been provided that shows the VCS have been involved in developing the JSNA, which is the key document used by health and ASC to determine commissioning priorities. They have also been engaged in the development of the draft Health and Wellbeing Strategy for the City, which highlights that mechanisms are in place to seek the views of the VCS.

5.102 **The commission were informed of 'The Kings Fund' report:**

The King's Fund 2011 'Transforming our Health Care System' report highlights the 10 priorities for lead commissioners to be aware of (Appendix 1), these are:

1. *Active support for self-management*
2. *Primary prevention*
3. *Secondary prevention*
4. *Managing ambulatory care sensitive conditions*
5. *Improving the management of patients with both mental and physical health needs*
6. *Care co-ordination through integrated health and social care teams*
7. *Improving primary care management of end-of-life care*

8. *Managing elective activity – referral quality*
9. *Effective medicines management*
10. *Managing emergency activity – urgent care*

5.103 The VCS recognize that in this climate of financial pressures, there is a need to find new ways of surviving. For example, the commission heard that 'Care & Repair' with the reduction in funding have pooled resources and merged 2 of their agencies, Leicester and West Leicestershire branches. They now share a director and staff, making the service more cost effective and offering a more holistic service to clients (Appendix 16).

6. Conclusion of the Scrutiny Commission.

6.1 The commission recognised the importance of keeping services local and valuing the contribution of local people as volunteers. The commissioners need to recognize the value of the VCS by involving them in the early stages of service planning and through appropriate and fair remuneration, as this sector is best placed with the knowledge, skills and support to provide quality and value for money services to the local population.

6.2 The commission believes that the Health and Wellbeing Board and the City Clinical Commissioning Group needs time to establish themselves, beyond April 2013, at least till the end of 2013. In the meantime, the city council and lead commissioners have an opportunity to develop new ways of working with the VCS in Leicester. Therefore, the city council should not lose good council funded VCS activity in the city, some of which could well be sustained longer term through joint commissioning and specific grants.

6.3 The commission suggested that joint commissioning involving VCS be explored as a solution for the future. This option would prevent duplication of services, would identify gaps in service provision and offer greater value for money.

7. Legal Implications
None identified.

8. Financial Implications
None identified.

9. **Report Author**
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10. LIST OF SUBMISSIONS (copies of these are not att to this report, but are available from the scrutiny office to view).

VOLUNTARY BODY	FORMAT	No	DATE RECEIVED
KINGS FUND	PAPER	1	30 Oct
EMERALD CENTRE	SUBMISSION TO SC	2	30 Oct
VAL	SUMISSION TO SC	3	30 Oct
LASS – JENNY HAND	E-MAIL SUBMISSION TO SC ANNUAL REPORT HIV TESTING PROJECT LASS – P4P ACLF BOLD	4 5 6 7 8 9 10	
VISTA	REPORT	11	
LAMP	LETTER	12	12 Nov
NETWORK FOR CHANGE/VOLUNTARY SECTOR PARTNERSHIP	LETTER	13	
NETWORK FOR CHANGE	PRESS CUTTINGS	14	
LEICESTER COUNSELLING CENTRE	LETTER	15	
CARE AND REPAIR	LETTER	16	19 Nov
SIKH COMMUNITY CENTRE/JIGSAW	LETTER	17	

NEW FUTURES	LETTER	18	
ADHAR	LETTER	19	21 Nov
GIVING WORLD	E-MAIL	20	25 Nov
STAFFORD EMPLOYMENT AND SOCIAL CLUB	E-MAIL	21	27 Nov
NORTON HOUSE	E-MAIL	22	26 Nov
TRADE SEXUAL HEALTH	E-MAIL	23	26 Nov
LASS – JENNY HAND	E-MAIL	24	27-Nov
COMMISSIONERS (Leicester City Council and Leicester City Clinical Commissioning Group Lead Officers)	SUBMISSION TO SC SHWB MEMBERSHIP SHWB TERMS OF REF. LC CCG UPDATE PARTICIPATORY BUDGETING FOR COPD REVIEW OF VCS IN ADULT SOCIAL SERVCIES MENTAL HEALTH PARTNERSHIP TOR PROCUREMENT GUIDE NHS LCC CONTRACT PROCEDURE RULES	25 26 27 28 29 30 31 32 33	14 Dec

END OF FULL REPORT.