

Tapping the potential

Lessons from the Richmond
Group's practical collaborative
work in Somerset

A report by New Philanthropy Capital
for the Richmond Group of Charities

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Supported by:



About the Richmond Group of Charities

The Richmond Group of Charities brings together 14 of the leading health and social care organisations in the voluntary sector, with the aim of improving care and support for the 15 million people living with long-term conditions that we represent.



Acknowledgments

With thanks to our project partners:

The Health Foundation, Guy's and St Thomas' Charity and New Philanthropy Capital

Forewords

Kieron Boyle, Chief Executive, Guy's and St Thomas' Charity

Within the next three years, one in four people in Somerset will be 65 years old and over. Where we work, in the London boroughs of Lambeth and Southwark, people are mostly young. Our area is a busy, diverse inner-city environment – seemingly far from the currents and patterns of the South West. Yet, go past the headline numbers and you discover two areas that share significant traits, including pockets of deep-seated deprivation and high prevalence of long-term health conditions.

These similarities are why we have supported the Richmond Group to explore their own learnings about the potential of voluntary organisations to help improve health. As a place-based health foundation looking to grow our impact through partnerships, understanding what great collaboration looks like is critical to us. We wanted to see what you learn when you zoom in on a specific place – with its embedded relationships, resources and dynamics.

Intuitively, we know the value of the voluntary and community sector and of cross-sector collaboration. We see it every day through our work. **What excites us most about this research is its clear articulation of the opportunities that focusing on a place brings:** helping to coordinate disparate actors and agendas, and making possible depth and not just breadth of relationships.

As ever, good research leaves you wanting more – in this case, further evidence on the impact of collaboration, systems change and complex interventions. We look forward to partnering with actors like the Richmond Group, The Health Foundation and NPC in building out and sharing that evidence base.

Jo Bibby, Director, Healthy Lives Strategy, The Health Foundation

Cross-sector collaborations in health and care services are not easy, as has been demonstrated many times over the years through successive attempts to achieve more integrated and joined up care. Usually these initiatives are top-down and led by statutory services.

The voluntary and community sector are sometimes involved, but are rarely the ones leading the change. Often they find themselves responding to a process and agenda set by others rather than to the communities themselves. And yet we know – from work by the Richmond Group and others, including the Realising the Value programme – that local voluntary and community sector (VCS) organisations can play a vital role in improving the health and wellbeing of the communities they serve and are well positioned to ensure that services are developed in ways that maximise their potential to create health in their communities. They often have deep roots in the places where they are based. They build strong relationships and trust with their local communities, because they can connect local assets and be responsive to local needs. After all, they are part of the community.

The work in Somerset provides an important opportunity to understand, from practical experience, what role the VCS can and should play in building collaborations to transform health and care services. **This work has identified the benefits of collaboration and system change led by the VCS who can combine both agility and stability in an ever changing health care landscape.** It has also highlighted some of the challenges, including around sustainability, measuring outcomes and ensuring involvement of large national charities is inclusive of the wider voluntary sector in a place. This work has shown that it is possible for successful change to be led and driven by the VCS but that, more than this, it also needs to be nurtured and supported in order to develop meaningful and sustainable cross-sector collaboration.

The report is timely and we hope will be helpful to local and national system leaders across statutory services and the VCS as the focus shifts to the development of Accountable Care, and Sustainability and Transformation Partnerships.

Introducing our work in Somerset

Lynda Thomas and Charles Alessi, Co-Chairs of the Doing the Right Thing Programme

Most people who work in health and care are driven by a passion to make things better for people. Yet we know that the system in which we operate often makes this hard to do. And we know what needs to change.

We agree that services should be preventative, should focus more on what people want and need to lead better, healthier lives, and should draw more effectively on the strength of partnerships and places. And yet the inspiring practice we find in some places, remains at the margins of our health and care system as a whole.

We can evidence the contribution that the voluntary and community sector makes to moving the health system in the direction it needs to go. But we know that making change happen at scale is hard. We wanted to understand better why this is, and to see whether we could start to change things – beginning in just one place: Somerset.

Our starting point in this work is that no single organisation can deliver change at the required scale. As this report makes clear, partnership and relationships are vital to delivering what people need to retain control of their lives, and so that their lives can continue to have meaning and purpose.

We believe we need to work together – with citizens, communities, charities, statutory agencies – to get on with making the changes we want to see. And we've been delighted to see our own commitment to collaborate – across the Richmond Group charities, and with Public Health England – matched by the Somerset Sustainability and Transformation Partnership (STP), South West Academic Health Science Network and wider Somerset Voluntary, Community and Social Enterprise sector.

Our aim in Somerset is to fill the gap between commitment and concrete delivery. We want to deliver practical change through collaboration, and in doing that we hope to inform the wider debate about place-based, person-centred health and care transformation.

Our work in Somerset is far from done, but we feel the process so far merits analysis and reflection. And we have been delighted that Guy's and St Thomas' Charity and The Health Foundation agreed with us and wanted to partner up for this learning report.

So, what have we learned? That alongside a general commitment to partnership working, you also need hard-nosed **investment**: in money, skills, time and people. That while the STP process and the moves to accountable care are starting to enable a different dialogue across health and care bodies, the **independence and headspace** afforded by the voluntary sector still help in making progress. That collaboration benefits from **bridging** organisations and people who make it their job to connect divergent cultures, languages, and priorities.

Importantly though, there will be more learning to come. As our work in Somerset continues we are exploring how different **funding** models might help us play to our collaborative strengths and meet our commitment to improve outcomes for people and the system. We are building practical learning about how you turn hard won trust and a shared vision into a **tangible offer** for people who might benefit from community support. And we are learning more and more about how to **maintain momentum** in a system in flux.

We will need your help to ensure this work has impact. If you are already working with us locally or nationally, please stay involved – we need your enthusiasm and advocacy. If you are new to our work, but want to know more, we'd love to hear from you.

Only together can we build a better future for our health and care.

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Nearly

15 million people

across England are living with a
long-term health condition and

**1.2 million older people are not
getting the help they need¹**

Introduction

Nearly 15 million people across England are living with a long-term health condition and 1.2 million older people are not getting the help they need.¹ As people's needs become more complex and pressure increases on services, the NHS and social care systems struggle to cope. There is widespread recognition that we need to move towards more integrated, person-centred models of health and care to better meet these needs.

In 2016, the *Untapped Potential*² report highlighted the need to bring the voluntary sector's strengths to health and care transformation. It made practical recommendations around properly integrating the voluntary and community sector (VCS) offer into the future health and care system, creating evidence-based solutions that will help to bring about the vision set out in the NHS Five Year Forward View,³ and doing so in the context of scarce resources.

The Richmond Group of Charities⁴ (The Group), supported by Public Health England, is now working with partners in Somerset to explore what a successful health and care collaboration between the VCS and statutory health services could look like in practice. NPC was commissioned to help capture early learning from the initial stages of this work. This report outlines our main findings, with the aim of supporting future decision making and understanding the potential to roll out this approach in other areas.

Who this report is for

The approach and lessons presented here will be of particular interest to those seeking to improve collaboration and commission services across the health and care system – including statutory system leaders at national and local levels, health and care commissioners, and voluntary sector leaders.

The practical insights into cross-sector collaboration may be of interest to a far wider audience – including national and local decision-makers, funders, policymakers, frontline providers, service users, and other commentators. The unique context for this work is important – a focus on health and care in a rural county of England – but the lessons about how collaboration happens could apply to many other areas.

GLOSSARY OF ABBREVIATIONS USED IN THIS REPORT

CCG: Clinical commissioning group

DTRT: Doing the Right Thing

NPC: New Philanthropy Capital

SRO: Senior Responsible Owner

STP: Sustainability and Transformation Plan

SW AHSN: South West Academic Health Science Network

The Group: The Richmond Group of Charities

VCS: Voluntary and Community Sector

VCSE: Voluntary, Community and Social Enterprise

What this report focuses on

NPC's research aimed to help capture early learning from the initial stages of the Group's work in Somerset. Our core research took place over the summer of 2017 and offers a snapshot of the Group's work in Somerset, against the background of a constantly changing local and national context.

In September 2017, we invited influencers from across the health and social care sector to a roundtable to review the findings and their wider implications. This report is also informed by subsequent conversations with the Group's programme team, the Doing the Right Thing (DTRT) Steering Group, the Richmond Group's CEOs, and national and local stakeholders in Somerset.

Throughout the period of our research, the Somerset programme was evolving. Evaluating a live collaboration like this is both exciting and challenging. This report includes a description of the journey so far and we highlight instances where our findings have a significant time dimension, such as the emerging focus on social prescribing. However, the programme's overall evolution is inevitably more dynamic and multi-layered than this report can do justice to. Our main objective with this report is to draw out insights that may be useful and interesting for others.

METHODOLOGY

Over the summer of 2017, NPC conducted in-depth interviews with stakeholders from across the statutory sector, the Group and the local VCS. Detailed analysis of these interviews was completed using Nvivo software.

In September 2017, NPC chaired a roundtable to review the findings, inviting influencers from across health and care. As well as testing the findings from Somerset, the roundtable explored how the approach might apply in other areas.

In October and November, we presented emerging findings to the DTRT Steering Group, the Group's CEOs, and a group of national and local stakeholders in Somerset. Reflections from all these events fed into this final report. The report is also informed by clarification interviews with the Group's programme team, who provided the detailed descriptions of what the Group did at each stage of the work.

Background

Untapped Potential

In May 2015, the Richmond Group of Charities joined forces with Public Health England and Mind to undertake a project known as Doing the Right Thing (DTRT). The project was borne of a collective determination to seize the opportunity of the Five Year Forward View and a concern that the full potential of the VCS to contribute to health and care transformation had yet to be fully understood and tapped. The DTRT partners set up the DTRT National Steering Group to oversee the project and commissioned NPC to bring together their evidence about the VCS role in health and care transformation.

This resulted in the 2016 publication of *Untapped Potential: Bringing the voluntary sector's strengths to health and care transformation*.⁵ *Untapped Potential* described the breadth of charity activities in health and social care, the value created by these activities, and the strength of evidence to support those findings. But the report concluded with three challenges for maximising this value: properly integrating the VCS offer into the health and care system, creating evidence-based solutions, and making progress within austerity.

Tapping the potential

The Group determined that the best way to learn more about how to forge effective collaborations – aimed at ‘tapping the potential’ – was to try to do it in practice. The Group hoped that demonstrating a different way of doing things in one locality would be a more effective route to influencing wider system change, than taking a purely theoretical approach.

The decision to work with an STP area was a response to the changes in the health and care landscape that have happened since the publication of *Untapped Potential*. The vision of the Five Year Forward View is being taken forward locally through 44 Sustainability and Transformation Plans (STPs) which propose wide-reaching changes in areas from prevention through to acute and specialist services.⁶ Stakeholders across the system recognise the need for collaboration, but this means working around legal frameworks designed to promote competition. Meanwhile, the NHS and local government continue to face significant financial and operational pressures.⁴

The work in Somerset aims to realise the potential of a place-based strategic partnership between the statutory sector and the VCS. The ultimate goals of the programme are better outcomes for people living with long-term health conditions and reduced demand on health and social care services. The Group hopes to achieve these goals through more collaborative design and delivery of services across and within the two sectors at scale.

While it is still too early to assess whether the programme has achieved its ultimate goals, the DTRT National Steering Group were keen to capture learning from the initial phase of work – during which they perceived that significant steps had been taken towards forging more collaborative ways of working. They hoped to provide more independent verification of this impression, and to establish what, if anything, could be learnt from this programme which might be applied to other localities undergoing transformation processes.

Why Somerset?

The Group settled upon working in Somerset due to a combination of factors, many of which were opportunistic, including:

- A warm pre-existing relationship with key leaders within the Somerset STP partnership, leading to an invitation to locate the experiment within this STP.
- Senior STP leaders convinced of the benefits of collaboration without reference to specific outcomes, and willing to commit energy to an experimental programme focussed in this way.
- The relative simplicity of the Somerset STP footprint – due to the coterminous CCG, Local Authority and STP.
- The local presence of a majority of the Group’s member charities, with 10 of the 14 member charities operating in the area.

As the programme progressed, it was shaped by several key features of the Somerset STP area – some of which had been anticipated at the start and others which had been less well appreciated. These included:

1 History of collaboration across the Somerset STP area. Before the STP process began, the partners were already working towards a shared outcomes framework with a shared set of measures and indicators, and had adopted a systems approach to change. While this in no way insulated the STP from the challenges associated with collaboration, it meant that the Group were able to come into a pre-existing collaboration, and benefited from a long-established commitment to working together, some previous work to develop a shared vision across Somerset, and an established precedent for reaching out to the VCS among those partners.

2 The presence of a well-organised and collaboration-ready VCS coordinating organisation. The Somerset VCSE Strategic Forum and Advisory Group proved a critical factor for success, allowing the programme manager to reach out to – and gain insight into – a very disparate community through one single point of contact. While the Group acted as a bridge between the statutory system and the voluntary sector, the Forum’s Strategic Coordinator also played the critical role of bridging between the Group and the wider VCS. Had the Forum not existed, building relationships with the wider sector would likely have represented a far more significant burden on the local programme managers’ time, and relationships with the VCS may have proved far more challenging.

3 Senior-level commitment to open engagement with the VCS. The STP leaders with whom the Group worked demonstrated a high level of commitment to working with the VCS, which was critical to the progress of this programme. The Group’s programme managers were introduced to the VCSE Strategic Forum and Advisory Group led by STP leaders. The Group’s local programme manager was also invited to participate in STP workstreams as an equal collaborator. This, coupled with the capacity of the Group’s dedicated programme manager, enabled the Group to play the role of ‘bridging organisation’ between the local VCS and the statutory sector because she had a seat at both tables.

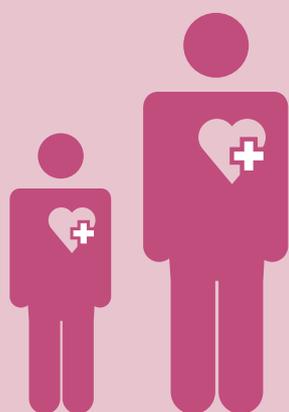
PROFILE OF SOMERSET

An ageing population: One in four people will be aged 65 and over by 2021, almost 30 years before the rest of England. **In some parts of Somerset one in two people will be aged 65 and over by 2033.** The Department of Health estimates average NHS spending for retired households to be nearly double that for non-retired.

Pockets of urban deprivation and lower incomes in West Somerset. **Twenty-five neighbourhoods in the 20 per cent most deprived areas Index of Multiple Deprivation (IMD) of England.**

An increasing health gap between healthy life expectancy and life expectancy. At a national level, healthy life gains seems to be experienced by the younger rather than older population.

While
28%
of people
in England have
a long-term
health condition...



44%
of people
in Somerset

live with a long-term health
condition and 4% live with
three or more

Nearly 10 per cent of the population (53,382 people) are unpaid carers (which is in line with the national average).

While nationally the most common reason for **delayed transfers of care** is awaiting non-acute NHS care, in Somerset it is **awaiting residential or nursing home. Somerset has 13 per cent higher than average permanent admissions to residential and nursing homes.**

Increasing demand for GP services and especially GP out-of-hours services. The second highest level of GPs aged over 55 of all STP areas, with **31 per cent of GPs intending to retire in the next three years. Around 50 per cent of GP vacancies remain unfilled.**

Around **2,800 registered charities**, plus many more community groups.

A health system funding gap of £33 million in 2016/17, rising to £175 million per year by 2020/21 if no action is taken.

Sources: The Somerset Sustainability and Transformation Plan,⁸ the Somerset Joint Strategic Needs Assessment⁹ and Somerset Intelligence¹⁰

Bringing the voluntary sector's strengths to health and care

*Untapped Potential*¹¹ set out five areas where charities bring additional value to the health and care system (Figure 1). In approaching the Somerset work, the Group's programme team set out to leverage these strengths – both within the Group and also within the wider VCS in Somerset. These five areas informed the core elements of the Group's approach to the work in Somerset.

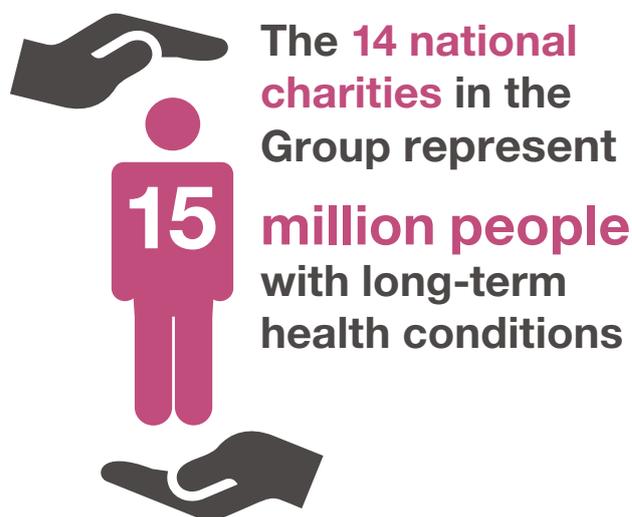
The 'sell' to the STP was that the Group combined the voluntary sector's **access and reach** within the community and its culture of **flexibility and innovation**, with the **brand and credibility** of a coalition of larger health charities, the **positioning and reputation** of a trusted intermediary with the power to convene others, and an ability to pool its **resource** and bear some risk.



Brand and credibility

The 14 national charities in the Group represent 15 million people with long-term health conditions and bring a deep understanding of people's needs, the communities they come from, and existing activities in different local areas. Collectively the Group brings significant experience of change programmes and service delivery; of working with individuals and communities; and of working within and alongside the statutory health system. Its members also bring local capacity, with several already involved in service delivery within the Somerset STP area.

The Group hoped that its combination of national profile, relatively strong finances and professionalised organisational structures, alongside local footprint, delivery credentials and grassroots connections would be an asset in forging new collaborations on the ground. The research bore out the significance of the association with the Group. For example, our interviews clearly showed that their collective expertise added credibility to the work in Somerset and helped to build links with national health and care policy-makers.



‘The Richmond Group have the ear of NHS leadership and high-profile organisations which means that people are willing to have the conversations with them.’

Local VCS organisation

‘The National Steering Group... showed that the opportunity was taken seriously. Because Richmond Group are key influencers, Richmond Group also provided a really useful stream of information about national context.’

Local authority

‘They’ve brought an understanding to the statutory service of the scale of what the VCS can offer, and how they can support the ambitions of the STP and of people taking control of their own health and wellbeing in the community.’

Member of STP leadership team

Positioning and reputation

Untapped Potential highlighted how charities bring independence, convening power and a reputation as a ‘trusted intermediary’. Their position outside the statutory system allows them to push different approaches and generate momentum for change.

‘Charities have an opportunity to use their freedom from institutional structures to push approaches which do not fit neatly within the health and care system’s structures and expectations, and statutory partners should capitalise on this to generate momentum.’

Untapped Potential (2016)¹²

In Somerset, the Group’s goal was to drive change from within the system – rather than creating something outside it. The Group’s leadership took the view that as individuals with long-term health conditions have little choice but to interact with the statutory system, voluntary sector organisations have a responsibility to continue to seek to improve it, no matter the challenges faced. However, at the same time the Group hoped that it would be able to capitalise upon its own freedom from the strictures of statutory systems, to drive change at pace.

‘[In Somerset] it was about doing something credible while working within a system [...] how can we use this learning to really improve things for people with health problems? Why is this hard and why is it so difficult to actually make change happen?’

Charlotte Augst, Richmond Group Partnership Director

Flexibility and innovation

From the start, the Group made a commitment to take risks and work in a flexible way in Somerset. It committed to a programme with very broad outcomes and invested in programme managers to work in an agile way without a pre-determined idea of what the programme was going to look like. The driving force behind the programme was a conviction that collaboration was, in itself, a positive force that would be likely to lead to better outcomes. This made the programme unusual in the sense that there was no particular product, nor any particular provider envisaged when the programme began. While open-ended conversations between the VCS and the health system are not unusual, the commitment of such significant resource to an open-ended conversation is a differentiating factor, and was felt to have opened up a different kind of conversation on all sides.

'It helped having an open conversation without a fixed agenda, for example about unmet need, differing perceptions of the service user experience, and opening up new links.'

Richmond Group charity

Access and reach

As noted above, the Group recognised that its own access and reach within local communities were a key asset in the programme. At the same time, the Group was strongly mindful of the need to balance this with a message to the statutory healthcare system and the wider local VCS that it was not representative of all of the community. The Group wanted to recognise the significant body of voluntary sector work which took place beyond its member charities. This was reflected in the Group's initial brief to its local programme manager to develop relationships with the Group's local member charities, the statutory system and the wider VCS and by the prioritising of the local VCSE Strategic Forum and Advisory Group as key contacts within the programme. Research interviewees recognised that the local programme manager worked hard to consistently convey this message.

'[The local programme manager] was clear and consistent in what she said and did in promoting the importance of the wider voluntary sector.'

Local VCS organisation



The driving force behind the programme was a conviction that **collaboration was, in itself, a positive force**

Leveraging additional resources

One of the strengths the Group brought to this programme was additional resource, deployed in a creative way. The Group pooled funds to bring in programme managers to work at both national and local levels to support collaboration in Somerset. This small team operated in an agile way to deal with issues as they arose, supported and managed through the Group's central secretariat. The two programme managers started in September 2016, working to drive forward local and national relationships, carry out research and identify priorities for the programme. The programme managers brought skills in both the 'soft art' of relationship building and the 'hard science' of data analysis and presentation. These roles were central to the initial stages of the programme, adding capacity, skills and expertise to the system.

The Group also brought a commitment to pooling further national and local resource and capacity from within the Group's member charities. The requirement or exhortation (depending on the formal structures of the charities) passed down to local leaders to participate in partnership activity provided the Group's local programme manager with a baseline partnership from which to build wider relationships with the local VCS beyond the Group. And the requirement on the Group's member charities' national staff to participate provided the Group's national programme manager with a source of expertise to inform the work and make connections to wider learning. This capacity and resource was clearly vital in enabling the programme to progress through its early stages.

'There has been quite a challenge in the voluntary sector and place-based work to undertake larger projects because of lack of capacity and narrow focus on delivery. I was pleased to get outside capacity to do some of this work, with a view to bring together ideas and have an open-ended conversation, rather than a preconceived idea about what to offer.'

Richmond Group charity

As the programme has continued, the resource provided by the Group has supported continuity to help weather the significant changes taking place within the Somerset STP leadership. The Group has remained in the driving seat of the programme as it has progressed and has continued to hold the programme independent of the STP process or timelines. The pace of change within NHS leadership and within the STP's structures has been so significant that now the Group's programme and its local programme manager are among the few areas of continuity within the wider STP programme.

'The nature of what the STP is trying to achieve will change in the next 18 months. DTRT is talking to people in Somerset about this. Even if plans change and leadership changes, the links are still strong.'

National stakeholder

The Richmond Group's approach in Somerset

This chapter describes the journey of the Somerset programme so far. This is told from the perspective of the Richmond Group and outlines what they were trying to achieve and how they went about it. In later chapters, we explore the achievements and challenges from a wider range of perspectives based on our interviews.

Through conversations with the Group's programme team, we articulated the value that it was trying to generate through each stage of the Somerset work. Figure 2 below shows the 'value chain' of activities, intended outcomes and goals from the Group's perspective.* The Group aims to catalyse local collaboration through a series of activities that help the VCS and statutory sectors become collaboration-ready, and then work together practically on projects that improve health and care.

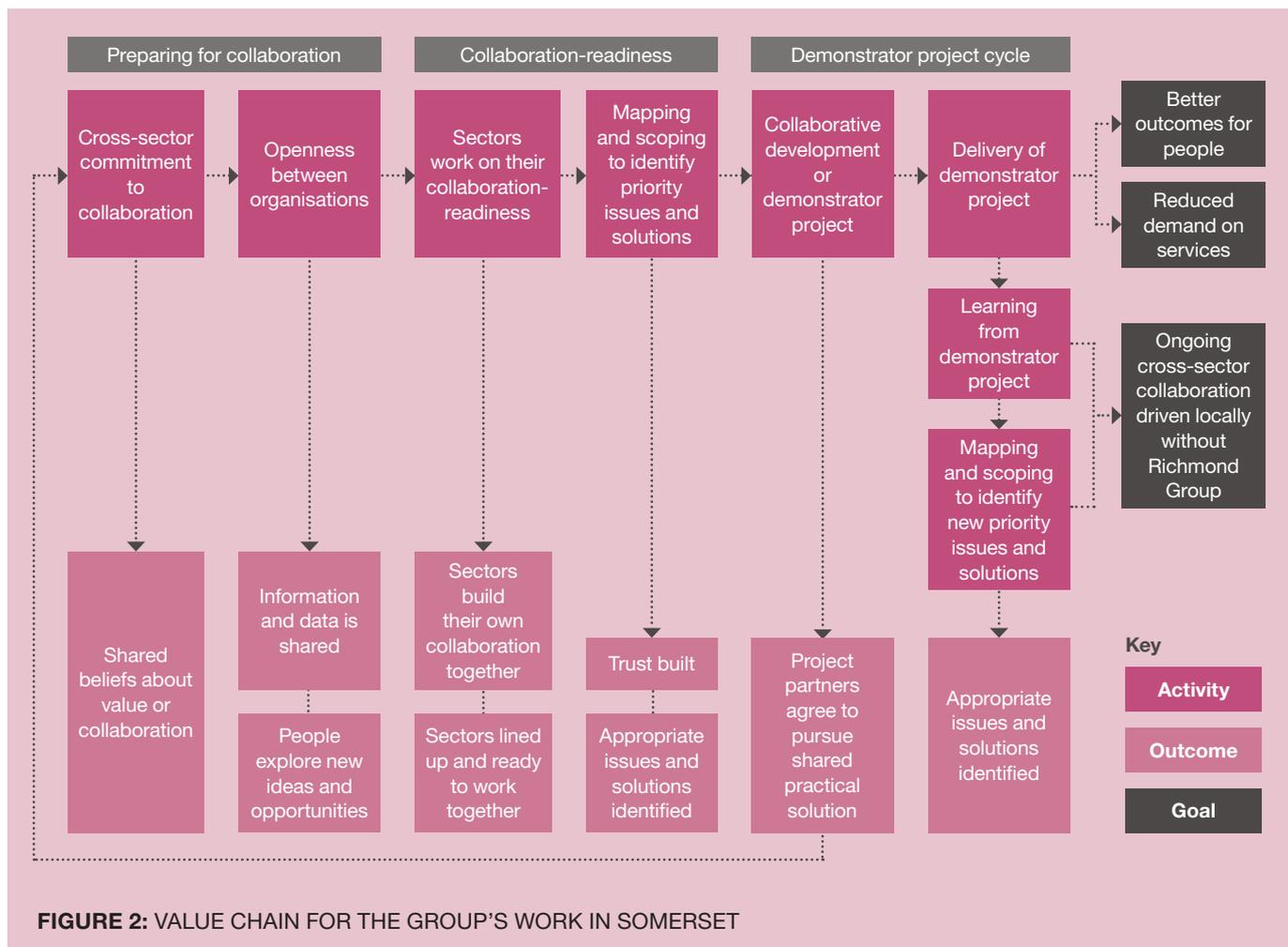


FIGURE 2: VALUE CHAIN FOR THE GROUP'S WORK IN SOMERSET

The process starts with a **preparation** stage: building cross-sector commitment to collaboration and promoting openness so that information is shared and new ideas explored. This is followed by a **readiness** stage: ensuring the sectors are lined up and ready to work together, then mapping and scoping key priority issues and new ways of working. These activities were completed in Somerset by summer 2017 and are the focus of this research.

Having completed the preparation and readiness stages, the Group and partners are now moving into the demonstrator stage of the work in Somerset. This includes developing and delivering practical demonstrator projects to improve health and care. Alongside this work, effort continues to nurture the existing collaboration, and to foster new areas of collaborative activity. The goal is to get the VCSE and statutory sectors into a place where they drive place-based mapping, scoping, and practical solutions on an ongoing basis without intervention from the Group, ultimately resulting in better health and care outcomes for people and reduced demand for statutory services. If this is successful in Somerset, the approach has the potential to be rolled out in other areas.

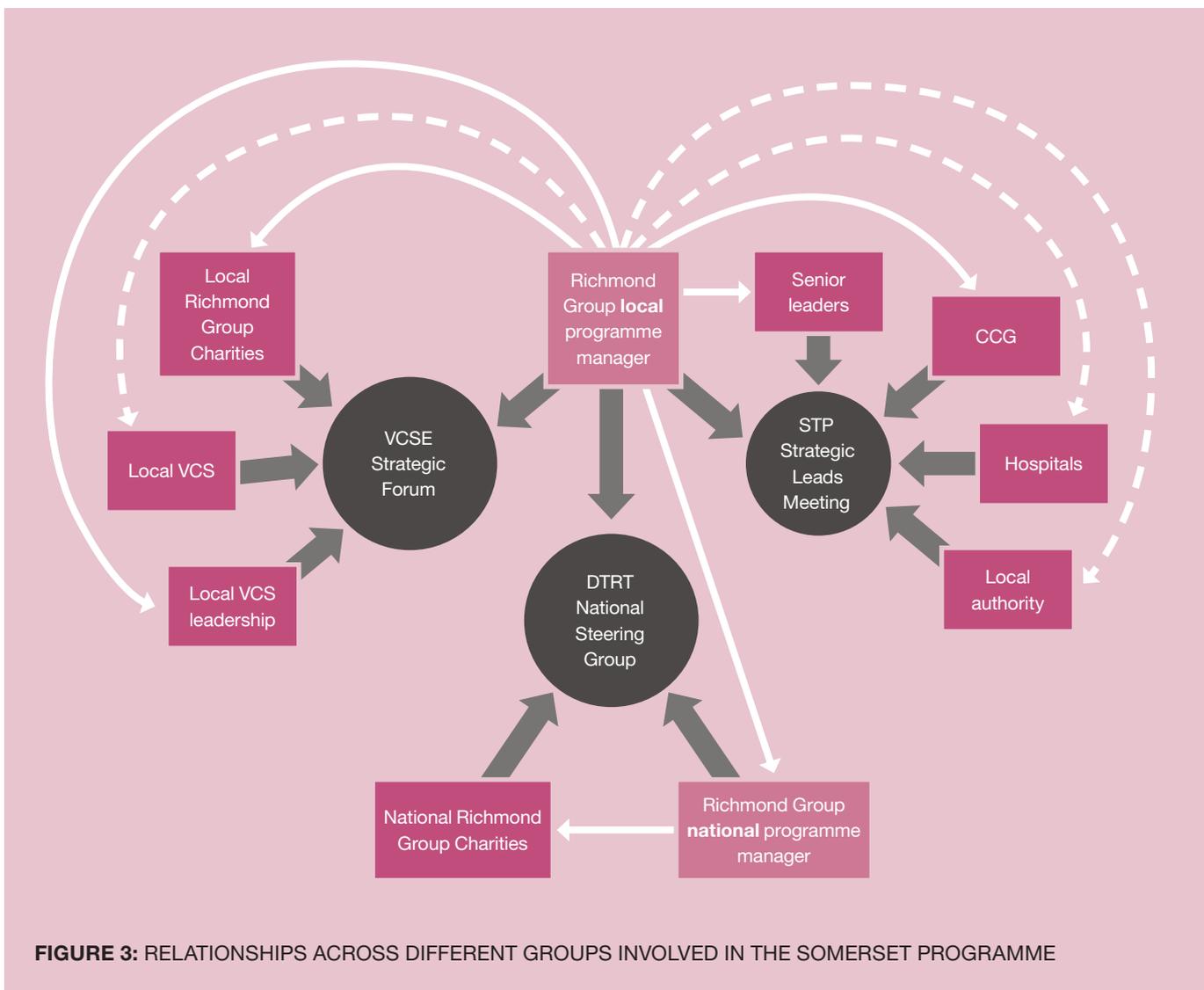


**The goal is
better health and care
outcomes for people
and reduced demand
for statutory services**

* This diagram is informed by a theory of change approach, but we did not undertake a full robust theory of change process with stakeholders. Rather, the value chain articulates the value of the programme from the programme team's perspective. For more on theory of change, please see Kail, A, and Lumley, T. (2012) *Theory of change: The beginning of making a difference*.¹³

Preparing for collaboration

To build commitment to collaboration, the Group harnessed its existing relationships and made new connections. Building on the initial connections the programme had with the STP SRO Matthew Dolman and with the Group's local member charities, the programme team invested time in identifying key players, building relationships, and assessing points of leverage for influencing decision-makers. Significant thought and time was invested into considering how and when to engage local and national stakeholders, to drive the programme forward. Figure 3 shows how connections across different groups in Somerset developed in person (grey lines) and the strength of those relationships (white lines, undashed=strong, dashed=less strong).



The local programme manager worked closely with senior leaders in the local STP, who played a key role in 'opening doors'. The programme manager invested time in the initial stages of developing new relationships and met people on their own terms: going to their offices or meeting them in more informal settings. This worked particularly well in bringing in harder-to-engage groups or those, such as some members of the STP, less familiar with the work of charities.

'In all cases I worked to try and develop relationships and communications in a way that was easiest and most productive for the individuals involved. I was flexible and willing to put the time in to meeting with people if they wanted to meet, and did a fair amount of legwork around the county consequently.'

Aimie Cole, Local Programme Manager

The national programme manager supported the local work through undertaking policy monitoring and analysis and acted as a link between local and national Group activities. More information on the two programme manager roles can be found in Appendix 1.

One of the most critical relationships which was forged through the STP SRO was with the leader of the local VCSE Strategic Forum and Advisory Group, Liz Simmons. The Group made a firm commitment to working collaboratively not only across its own membership, but with the wider VCS, and were very conscious of the potential sensitivities that might arise about the Somerset programme from the VCS organisations outside of the Group. Over 2,800 VCS organisations operate across Somerset, so building relationships with all of them would have proved extremely challenging, had the Group not been able to tap into infrastructure bodies like the local VCSE Strategic Forum and Advisory Group, who have links across this wider sector, and pre-existing structures for collaboration.

The Richmond Group's Director also played a critical role in connecting national and local conversations and ambitions, such that they fed into each other. She presented the Somerset work at national conferences and committees and held a high number of one-to-one meetings with senior stakeholders across the health and care landscape. This placed the Somerset work in a wider discussion about the potential role of the VCS in health and care.

In addition, the Doing the Right Thing National Steering Group ensured good governance of the programme and maximised the it's influence. This group of senior leaders from health and social care guided the direction and shape of the programme and provided recommendations on how to maximise its impact.



WHAT DID THE RICHMOND GROUP DO?

During summer 2016, informal discussions took place between the Somerset STP and the Group. This resulted in an agreement that there was sufficient shared ambition and willingness to collaborate and to locate the Group's proposed collaboration programme in Somerset. The Somerset STP SRO facilitated early discussions between the Group secretariat and a number of key figures within Somerset including the SW AHSN lead, the VCSE Strategic Forum and Advisory Group lead and others within the STP.

In the same period, discussions across the Group's member charities and with Public Health England led to an agreement on the allocation of a pooled budget. These funds were intended for the recruitment of a local programme manager for an initial six-month period to undertake scoping and development work towards a plan of action, and to support this work, a national steering group and national programme manager would also be resourced. These roles were designed to provide a conduit through which knowledge and expertise garnered nationally could be fed through to the local level to complement existing knowledge and expertise.

The DTRT National Steering Group already brought together senior leaders in health, social care and the Group's member charities, but the membership was refreshed to ensure it had the expertise to steer the programme, including knowledge of Somerset's health and care systems.

In September 2016, the local and national programme managers were appointed and promptly started their initial scoping work. The local programme manager was briefed to spend an initial six months scoping out potential for collaboration between the local voluntary sector and the statutory health system. Her brief was relatively open and included a requirement to gather data on local need and community assets and establish links with the STP, across the Group's member charities and with the wider voluntary sector.

That month, a kick-off meeting and dinner hosted by the Group's CEOs was held in London with the Somerset STP leadership team and the SW AHSN. The meeting helped formalise the start of the collaboration, providing an opportunity for everyone to get to know each other in both a formal and informal setting. It opened up discussions about the shared problems that the programme aimed to solve. This was organised by the Group's central secretariat, with briefing papers compiled by the national programme manager.

Following the kick-off meeting, an in-principle agreement to collaborate was reached between the Group, the Somerset STP leadership team and the Somerset VCSE Strategic Forum and Advisory Group. A formal Memorandum of Understanding was considered, but was decided against on the grounds that its creation would divert significant resource and add little value to the programme. Alongside this, the SW AHSN offered to contribute some of their voluntary sector lead's time to the programme; this was taken up and capitalised upon throughout the programme.

During the first six weeks of the programme, the local programme manager met all system CEOs, the CCG leadership team, STP workstream leads, the Public Health Director and Director for Communities, the Group's member charity leads, other VCS local leaders and the SW AHSN lead for VCS partnerships. Initial introductions came through the Group's member charity leadership, the head of the Somerset VCSE Strategic Forum, and the STP SRO. The local programme manager used these meetings to introduce the programme, build relationships and develop an understanding of Somerset and its people. This included understanding the Somerset health and social care system, its pressures, and the work already underway in partnership with the Group and wider VCS, supported by the sourcing of relevant documents and datasets.

The national programme manager organised a roundtable with local and national stakeholders, which was subsequently hosted, written up and published by the Health Services Journal. This signalled a public commitment to the programme, and explored the opportunities for collaboration.¹⁴



The partners decided against creating a formal Memorandum of Understanding, on the grounds that this would divert resource and add little value

Collaboration readiness

A mapping exercise helped the Group better understand Somerset's population, health and social care systems, their pressures, and the work already underway in partnership with the VCS. The objectives of this exercise were to ensure the programme focused on building on, rather than replacing, work already done in Somerset. It also focussed on ensuring that the programme was addressing a need, aiding transformation in the system and offering meaningful support to people.

Two things became clear from the mapping exercise. On the one hand, there were significant pressures in the health and care system, and many areas in which additional voluntary sector capacity and input was perceived as a potential solution. On the other hand, there was a lot of activity already going on to address these needs across Somerset, albeit in a patchy, inconsistent way. These included programmes being rolled out as part of NHS England's New Care Models initiative.¹⁵

The mapping and engagement process uncovered a number of potential areas for collaboration between the local VCS and statutory sector. The area that emerged as one which best joined up the identified needs and solutions was to develop stronger links between the VCS offer and primary care.

A number of schemes which aim to link people with practical and emotional support from the voluntary and community sector via their GP, were already up and running and working well in Somerset. However these were only available in a few parts of the County. At the same time, due to GP shortages and ailing secondary preventative services, there was a growing need to relieve pressure on primary care across the County. The Richmond Group chose to adopt the phrase 'scaling up social prescribing' as a shorthand way of describing a project which would draw together and build upon the existing enthusiasm for adopting this approach from the bottom up across Somerset, and meet significant current need. The term 'social prescribing' was chosen because it was felt to be well-understood by national and local statutory partners.

WHAT IS SOCIAL PRESCRIBING?

Social prescribing is an approach which seeks to address people's needs in a holistic way and support individuals to take greater control of their own health. It enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Social prescribing schemes can involve a variety of activities which are typically provided by VCS organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports. There are different models for social prescribing, but most involve a link worker or navigator who works with people to access local sources of support.

For more information, see The King's Fund (2017)

*What is social prescribing?*¹⁶

WHAT DID THE RICHMOND GROUP DO?

The local programme manager worked with knowledgeable local VCS leaders to identify existing practice and gaps in local services and geographic variations. She also worked with SW AHSN, who were able to provide information from various local research projects and datasets, and offered insight into how those datasets were collated and how they related to each other.

As themes in the existing research began to emerge, the national programme manager undertook further desk-based research to understand the relevant policy contexts and published evidence. Guided by the DTRT National Steering Group, she also spoke with health and care experts from across the country to gather learning about what had worked and not worked in other areas.

Two months into the programme, the local and national programme managers collated what they had learnt into a 'snapshot' document. This summarised learning about Somerset's geography, population, health and social care system, including new models of care, and included contextual comparisons with national trends, with the opportunities and challenges for collaboration.

In November 2016, people were brought together to feed into this snapshot document, with workshops for the Group's local member charities and an event with cross-sector representatives. Local statutory and VCS leaders (including the Group's local member charities), the Group's CEOs and Directors, and the DTRT National Steering Group reviewed early drafts of the snapshot and the emerging themes and priorities. These included prevention, the pronounced workforce challenges within primary care, emerging successes of new 'social prescribing' models of care, and the opportunity for the VCS to further support patient pathways in and out of hospital. It is important to note that these themes and priorities were specific to the Somerset context and may well vary in significance from one area to another.

The local programme manager subsequently focused her conversations and research on improving understanding of these themes and priorities across Somerset. This included having conversations with hospital discharge managers and visiting new care model projects across Somerset.

At this point, the Group felt that social prescribing represented the 'sweet spot' between the identified problems and solutions. It was a concept that was familiar to many in Somerset, as well as being a way of connecting up the needs and activities revealed by the mapping and scoping exercise. 'Social prescribing' was a way of labelling or packaging up existing activity, but it also encapsulated the solutions that were needed.

The national programme manager, reviewed social prescribing services outside Somerset looking at models, pathways, costs and evidence of outcomes. The national programme manager then compiled a briefing on her learning, including the five common components of 'good' models of social prescribing.

The Group commissioned Britain Thinks to hold a workshop with 12 Somerset residents who might use 'social prescribing'. The aim of this was to better understand people's experiences of using their GP surgery and find out what they thought about new services that help GPs give people non-medical advice and the additional support that they need. The workshop attendees were overwhelming positive about this type of service. They also described key features they felt it should have, as well as the language that should be used to talk about and describe it.

The local and national programme managers shared their learning with Somerset's statutory sector and VCS leaders, the Group's CEOs and Directors, and the DTRT National Steering Group throughout. This allowed ideas to be discussed and evolved with a range of perspectives. It also ensured ongoing local and national commitment to the programme.

'The Britain Thinks workshop with Somerset patients really strengthened our commitment to social prescribing. It also gave us quite a good idea about how to talk about these kinds of services in a way that makes more sense than "social prescribing".'

Chloë Reeves, National Programme Manager

Proposing an initial demonstrator project

Drawing on the knowledge and learning developed up until this point, a report was put together which facilitated an agreement between the Group and local partners to collaboratively develop a proposal for rolling out social prescribing services across Somerset. A joint Expression of Interest was then put to the government funded Life Chances Fund,¹⁷ which provides a portion of payment-by-results contracts to locally developed projects.¹⁸ These services were envisaged to be community-based and would link people with health problems into social, emotional and practical support. This was the first point in the programme at which any formal commitments to specific activities were made across the collaboration.



A joint Expression of Interest was then put to the government funded Life Chances Fund which provides a portion of payment-by-results contracts to locally developed projects

WHAT DID THE RICHMOND GROUP DO?

With support from the national programme manager and the Group's central secretariat, the local programme manager drafted a report bringing together findings from the scoping work and proposing three workstreams to take forward (see Appendix 2). This included a recommendation to explore an outcomes-based contract, backed by social investment, as a potential funding option for the third workstream of scaling social prescribing across Somerset. The Life Chances Fund was suggested as a potential source of funding for this. The report also included a request to the STP for a statutory resource to work with the Group to further develop the proposal for the Life Chances Fund.

The report was developed through discussion with Somerset's statutory sector and input from VCS leaders including the local Richmond Group member charities, CEOs and Directors from the Group, and the DTRT National Steering Group.

In April 2017, Somerset's VCSE Strategic Forum and Advisory Group discussed the report and committed to continue collaborating to deliver the proposed workstreams and to work with the local programme manager to explore the feasibility of an outcomes-based contract and social investment.

The Group's partnership director and local programme manager presented the final report and its proposed workstreams at a formal meeting of the STP leadership team. They agreed to continue collaborating to deliver the proposed workstreams, to explore the feasibility of social investment, and to make a staff member available two-days-per-week to work with the local programme manager on the next stages of the programme and ensure close coordination across STP workstreams.

The local programme manager convened a group to work on the Expression of Interest (EOI) to the Life Chances Fund. This 'EOI team' included the NHS project manager made available by the STP, the SW AHSN VCS lead, as well as representatives from the VCSE Strategic Forum and Advisory Group, public health, adult social care and community development in the council, and clinicians and commissioners from the CCG. Together they drafted the EOI, while linking in discussions and decision-making within their own organisations.

The national programme manager organised two events to facilitate further learning to inform local and national discussions. One focussed on social investment, to ensure the Group's member charities were ready to take informed decisions about this type of funding. The second event looked at outcome measures and tools for social prescribing.

With neither the Group nor the STP being legal entities, the Group's central secretariat and EOI team worked to identify lead signatories to the EOI while ensuring risk and opportunity were pooled across the participating organisations. The EOI was submitted at the beginning of August 2017.

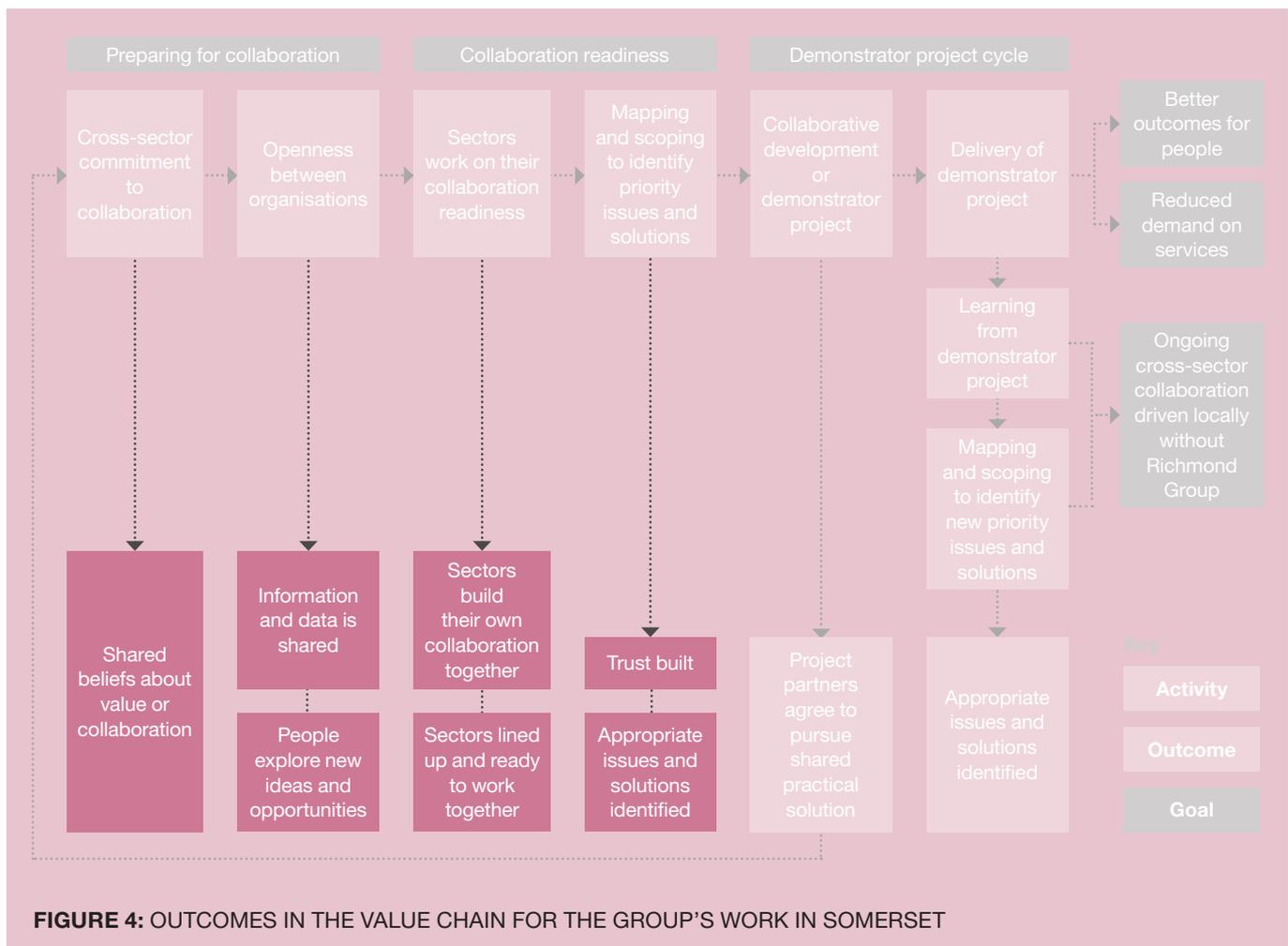
At the time of writing, the bid had been successful and match funded by the SW AHSN. Work has now begun on the development phase of the programme. As well as being a key workstream through which tangible change for individuals may be achieved, it is hoped that this work will act as a demonstrator project through which wider lessons can be learnt about the benefits of collaboration locally.

How well did the programme meet its aims?

In this section we assess the extent to which the Somerset programme achieved the outcomes it set out to achieve in these early phases. We have separated our analysis into two groups of outcomes relating to the preparation and readiness stages respectively.

For each group of outcomes, we look at both achievements and challenges to the programme meeting its aims and briefly look ahead to the outcomes of the demonstrator stage.

These are not linear processes, so there are overlaps between the stages in practice. For example, collaboratively developing a shared practical solution (in the demonstrator project stage) should further reinforce the cross-sector commitment to collaboration (in the preparation stage).



Preparing for collaboration

By the time we conducted our research, these early outcomes had largely been achieved. Stakeholders expressed shared beliefs about the value of cross-sector collaboration and understood each other better. They were open to sharing information and exploring opportunities together. Nonetheless, challenges remain about the depth of engagement and different perceptions of what success looks like.

Shared beliefs
about value or
collaboration

Information and
data is shared

People explore
new ideas and
opportunities

Achievements

Clarity on aims and value: Everyone appeared to be on board with the aims of the work and there was clarity about the value of involving the VCS in the health and care system. Stakeholders expressed a shared commitment to the ideas that were being developed through the programme.

‘At one meeting where representatives from 14 organisations came, where Aimie [the local programme manager] presented her draft paper, there was a sense that they all had a similar view and were joined up in their thinking.’

Local health leader

Stakeholders did not necessarily think that this clarity around the value of the VCS was a result of the Group’s work and some pointed to existing local efforts. Nonetheless, the Group’s work appears to have genuinely captured the aims and values of the different local players involved and there was a sense that it was ‘in harmony’ with existing initiatives.

‘On a Somerset level, [we had] already started to do a lot of learning about the true value of the VCSE sector and were already having a mature conversation about collaboration with VCSE sector – hence the project has not done much to change understanding as that understanding was already there.’

Local authority

‘The VCSE sector has been working collaboratively with the public sector for a while – I don’t think the Richmond Group has been influential in creating change in that sense.’

Local VCS organisation

‘The Richmond Group were pushing at an open door and in harmony with what we wanted to do. We were already a fair way ahead in terms of strategy when Richmond Group came in. We’re on a journey towards person-centred care and have done a number of pilots in that area already.’

Local health leader

Energy and excitement: Even if interviewees felt that the Group had not initiated a commitment to new ways of working, there was a sense that they were galvanising action in this area. This was reflected in a shared sense of energy and excitement around the programme.

‘First impressions: very excited. Somerset has a very complex geography of providers and it was exciting to have an organisation like the Richmond Group involved.’

Local authority

‘Once you understand what is out there and what is done, it’s really energising. Statutory services are desperate for energy and that is where the Richmond Group feeds us and allows us to work together.’

Local health leader

Senior-level engagement: Involvement of senior leaders from the statutory health system in Somerset and the DTRT National Steering Group was integral to driving the programme forward. A handful of senior leaders worked behind the scenes to help open the right doors, at the right time. Their personal authority and commitment to the programme was crucial to engaging people from the STP and statutory health system and getting their buy-in to the work.

‘Senior level engagement was key in getting people in STP enthusiastic about the project and helping them realise the value in participating. It also helped the Richmond Group make links and establish relationships with the STP.’

Local health leader

Better understanding of challenges faced and ways of working: Representatives from both the VCS and the health and care system reported an improved understanding of how each other works. Statutory health stakeholders felt they have a much better grasp of what value charities can bring to health and care transformation, and the opportunities that this presents. Charities also became more aware of the workings and motivations of statutory health and local government, and the challenges they are facing.

‘Most of us have been in a room together a few times, which would not normally happen other than at commissioning meetings. That’s been really useful, I now have a greater understanding of... the scale of what the statutory services are handing down and the challenges the local authority are facing.’

Richmond Group charity



**Representatives from both the VCS
and the health and care system
reported an improved understanding
of how each other works**

Charities leading the way: The fact that the Somerset work has been led by the charity sector has given local VCS organisations a sense of hope and confidence. The programme has helped to bring the Group's member charities closer together and has forged links between the Group and the wider VCS. For example, the Group's local member charities have been holding market place events for their operational staff, so they can familiarise with what each can contribute as a group. This suggests charities are making progress towards the *Untapped Potential* vision of a sector that is clear where individual organisations have strengths and where others can add more value.

'The programme has led to an increased interaction between charities in a positive way... Some of the local service delivery members had become very negative, especially in the current funding environment. This collaboration helped them interact in a more positive way and in a sense, give them some hope.'

Richmond Group charity

Challenges

Engaging local VCS sector: Some local VCS organisations not in the Group and members of the local authority in Somerset had concerns that communication about the work did not cascade down to smaller local charities. There was also some initial suspicion from local charities about the Group's motives in undertaking this work. The national profile and ambitious nature of the programme meant that there were concerns that the Group were advancing the interest of larger charities. While the local programme manager's work was felt to have been effective in assuaging these concerns to some extent, it has not been possible for the programme manager to connect directly with all local organisations. It is therefore likely that some concerns will remain.

'Local charities were worried that Richmond Group charities wanted to take over contracts. However, over time [the local programme manager] has managed to build relationships with the local sector and alleviated some of their concerns... Opinions on the project within the local sector have changed to some extent, but feelings about competition haven't completely disappeared.'

Local VCS organisation

Resource constraints: Some interviewees were worried that a lack of resources prevented smaller charities from being more involved in the programme. Involvement was inevitably easier for some of the larger charities with a wider remit and greater resources. While the Group's programme managers were able to work creatively, others had to fit the project around their existing work.

'Resource has been a big challenge in getting involved with this project. There have been challenges in bringing all the partners together as this project is mapped on top of everyone's daily work.'

Richmond Group charity

Difficulty in seeing the value of relationships in and of themselves: Different people had different perceptions of success in relation to this programme. While the Group had an underlying interest in meeting the challenge posed by *Untapped Potential* to properly integrate the VCS offer into health and social care, for others this more abstract question was of little interest. For some of those involved in the programme locally, there was a sense that collaboration could only be a means to an end, and that the ‘proof is in the pudding’. This limited some participant’s willingness to engage in discussions about lessons learnt at this stage.

‘The true test is going to be where we will be in six to 12 months’ time and will it be translated into something that will make a difference.’

Local authority

‘The jury is out to whether anything will change as a result – it will depend on the wider health and social care system, the financial pressure and resource constraint it’s facing.’

Local VCS organisation



The programme has helped to bring the Group’s member charities closer together and forged links between the Group and the wider VCS

Collaboration readiness

Significant progress has been made to get the health system and the voluntary and community sector ready to collaborate, and identify appropriate issues and solutions to tackle. Nonetheless, external pressures and cultural factors continue to provide challenges to building trust and embedding collaboration.



Achievements

Improved VCS profile: The Group’s national profile and engagement with senior stakeholders helped to increase the profile of the VCS sector with local statutory decision-makers. Stakeholders reported that the Group brought increased credibility and gravitas. Some felt that they hadn’t said anything particularly new about the charity sector’s role but had packaged it in a way that made it more attractive to senior leaders.

‘The Richmond Group have got an understanding of how the wider system works and how senior leadership in the system works and have been able to package up their work to make it easier to understand and palatable for decision-makers.’

Local health leader

Robust mapping: The mapping process was regarded as robust and comprehensive, showing a good understanding of the needs of service users. Having dedicated resource in the form of the local and national programme managers was key to making this happen and making the right connections both locally and nationally, in terms of including the right people and existing research. Stakeholders across the board agreed that the right issues were being identified.

‘Built from the grassroots, the scoping phase had led to a good understanding of the needs of service users.’

Richmond Group charity

‘The process has been robust so far, it was done thoroughly and by consulting widely, listening to key players, it was a comprehensive exercise which took some time.’

Local health leader

Commitment to ongoing joint working: A key milestone for the programme was the commitment by the STP of their own resource to the ongoing collaboration. While the STP leadership had devoted significant time and energy to the programme, the primary operational resource committed was provided by the Group and leads from the VCSE Strategic Forum and Advisory Group, and the SW AHSN. In signing off a proposal for ongoing collaboration, the STP leadership then committed operational resource in the form of a project manager to work for two days a week on the programme. The Group felt this was a concrete shift in attitude from the STP towards them recognising the value charities could offer to local health services.

‘Getting the STP to commit programme management time to this work felt like a really significant milestone for the project. It showed they were serious about what we were doing, and felt it was worthwhile.’

Aimie Cole, Local Programme Manager

It is also significant that by the time of our research the local programme manager had been invited to join the Somerset Commissioning Academy with 50 other local leaders. This may be an indication that the programme manager personally – and by extension the Group’s presence in Somerset – is increasingly seen as part of the wider landscape in Somerset.

Challenges

Statutory health’s flexibility for change: While the Five Year Forward View and other subsequent initiatives have signalled an intention to create a shift in the way the NHS perceives value, the reality is that NHS services are funded with a greater focus on outputs over outcomes and are facing significant challenges with funding. So, while the work in Somerset has created changes in the tone and type of conversations that are happening, there are concerns about the extent to which this work can make a real difference to how the system will operate in future.

‘The way [the NHS] thinks about the world is very much driven by contractual activity and what goes on in hospitals... They are used to looking at numbers of people with hip operations; now they have to think about social value, it’s quite a different way of thinking about the world.’

Local health leader

Ongoing commitment from statutory partners in health: Although key decision-makers from the statutory health system are on board with the programme in principle, some felt that a more concrete commitment needs to be made by them in taking the work forward. The flipside of the charity sector’s leadership in this programme is that it may be easier for skeptical statutory partners to disengage from the programme with fewer consequences. Though engagement was generally positive from those working in the STP, there were concerns that this had not yet been matched by a more tangible commitment.

‘All the energy for the project is coming from the voluntary sector rather than the statutory system. In the statutory system, it is acknowledged more collaboration is important, but talk doesn’t turn into action.’

Richmond Group charity

‘One concern is that NHS England hasn’t put money in. All the relationships have been made, however when it comes to actually commissioning services on a larger scale all the conversation dries up.’

National stakeholder

Changes within the STP: Another significant challenge to the programme has come, and will continue to come, from the ever-changing personnel and governance structures of the statutory bodies within the STP and within the NHS organisations. This required a significant amount of work to build new relationships with new senior leaders, and has led to significant change in the wider health system structures and programmes into which the Group’s programme fits. These factors pose significant risks to the programme.

‘Turnover in the local statutory sector made collaboration quite difficult, but we were lucky to have [the STP SRO] who was committed to working across hierarchies to bring people together and have a genuine conversation.’

Chloë Reeves, National Programme Manager

Cultures of competitiveness: The initial suspicions about the Group’s motives stem in part from a wider culture of competitiveness, which has placed some limitations on the nature of relationships that can be developed. Charities are often forced into a situation where they need to compete with one another. Moreover, the dominant commissioning model is focused on a strict purchaser-provider relationship, making it harder to collaborate across sector boundaries. This is likely to prove even more challenging when the programme moves towards more concrete plans for collaborative activity which will inevitably result in some VCS organisations gaining more than others.

‘Getting people to work together was challenging because of the purchaser-provider split, so collaborative working was new. They still have confrontational mechanisms of haggling over money etc. which didn’t make for an easy life.’

Local health leader

Overlap with existing initiatives: Some felt that the programme overlapped with existing initiatives, and that better coordination would ensure there was no duplication. In some cases, the overlap proved positive, in helping support new links and think through new approaches, for example with the proposal. In other ways it was felt there was an element of reinventing the wheel and stepping on toes happening through the replication of existing work.

‘There is too much going on in terms of transformation in Somerset and many groups are all talking about the same thing. The case needs to be made on how the forthcoming project is particularly adding value.’

Local authority

Looking ahead to the demonstrator project

We are already seeing early signs that outcomes for this stage of the value chain are being met. However, the research has identified some significant challenges here which should be kept in mind whilst developing, delivering and learning from the demonstrator project.

Project partners agree to pursue shared practical solution

Appropriate issues and solutions identified

Achievements

A tangible proposal for new ways of working: The process of the mapping and scoping, alongside the development of a proposal for the Life Chances Fund, helped to develop relationships and ultimately led to a proposal that reflected the aims and values of all the local players. It seemed sensible to the Group that rolling out social prescribing at scale across Somerset would be the best approach for the proposal, because it had the potential to meet existing need, and would be a good way of building on existing voluntary sector effort in Somerset. The proposal also provided a rationale for formalising the relationship between the STP and VCS in a way that had not been considered a priority before, and also provided deadlines to work towards, helping to progress the programme.

'It was a useful coming together of conversations and understanding through the Life Chances Fund, in helping people understanding what social prescribing means and how it could work in Somerset. This has helped move things on and prompted the bringing together of different workstreams.'

Local stakeholder

Bringing together new groups to find solutions together: While the social prescribing proposal is the most prominent of the activities now being undertaken in collaboration, the programme has also helped inspire other smaller scale collaborative projects. The Group's local member charities identified the need to develop a better understanding of each other's work so held a market place event to start to address this. Work has also explored ways that patients receive help before and after treatment in a hospital. One local Group member charity has developed a new assisted discharge service, and through this is testing how cross-charity referrals, record keeping, and tracking works operationally, to improve support for patients coming out of hospital.

'In terms of the assisted discharge service, we're currently seeing how that can work operationally, which is really exciting.'

Richmond Group charity

Increasing local ownership: As the Somerset work progresses, the vision is that local partners gain increasing ownership of the work and it is eventually driven by them with the Group playing a less prominent role. This has already started, where for example, the Life Chances Fund expression of interest was collaboratively developed by a Somerset bid team with representatives from the Group, local VCS not in the Group, STP, public health, adult social care, community development, and SW AHSN, in coordination with primary care leads and the out of hospital STP workstream.

Challenges

Securing funding for new ways of working: The work in Somerset has, to date, largely been funded by the Group, with other partners providing in-kind investment, most notably in the form of two days per week of programme management time by the STP. However, as the demonstrator project moves into delivery, further funding is crucial to maintain the engagement of those involved in the programme, particularly smaller charities. Stakeholders were enthusiastic about the potential of the Group to bring in funding to the system through the Life Chances Fund application, but challenges to their ongoing engagement remain, due to the uncertainty of the funding, ongoing financial pressures on health and social care, and difficulties associated with investing in change while simultaneously running services.

‘The big challenge is the money, or trying to balance the books and transform services simultaneously. You need to invest for change. Being able to fund that is very, very challenging for us to agree.’

Local health leader

Demonstrating impact: Many feel that demonstrating tangible outcomes will be critical to the success of this programme and securing further funding in the future. Taking forward the social prescribing proposal was seen as an important opportunity to learn and to test whether the programme has worked. Because of new relationships that have developed, some are also hopeful about developing new ways of working that genuinely help patients, however others are tentative about the results of this so early in the programme.

‘The project offers a big opportunity. If the bid is successful, the Richmond Group then needs to prove it can create impact. If they can do this, the uptake of this model in other areas will be quicker.’

Local health leader

Proving the potential for financial savings: Beyond demonstrating outcomes, several people mentioned that evidence that the programme specifically results in financial savings is needed to sustain stakeholder engagement. In particular, key statutory health stakeholders need to be convinced of this to further invest in the programme financially. Demonstrating the cost savings resulting from social prescribing approaches like the one planned can be incredibly difficult. There are challenges around both measuring outcomes and knowing which part of the NHS is benefiting from the cost savings. Efforts to measure the economic value of programmes like this need to be balanced with a wider understanding of what value means to people and communities affected by the issues.

'A key factor of success is having a clear sense of the impacts and benefits of the work. This is important and the clearest expression of it is money. You can use system measures or distance tools, but knowing the cost will allow you to see the full benefit brought by the social prescribing model. It's a really important success factor to it and may help with the argument that this needs to be unlocked.'

Local stakeholder

Accessing the right data: Commitment to collaboration and open sharing of information has sometimes been thwarted by barriers to sharing data. This challenge may have even more serious implications in later stages of the project, for example in demonstrating the impact of the work in Somerset, particularly the outcomes of the social prescribing proposal. Any delays may affect the level of different stakeholders' engagement with the work over time.

'We are collectively looking at how we can use data to identify cohorts, sounds simple but it isn't... Since we started, the whole data situation has been stuck in an information governance situation, meaning data can't be shared. There is also a lack of analytical capacity in the local authority and CCG, who tend to outsource to academics and private companies.'

Local stakeholder



**Commitment to
collaboration and open
sharing of information
has sometimes been
thwarted by barriers to
sharing data**

What can we learn from this programme?

While it is too early to judge this programme in terms of its ultimate goals, there are already some positive signs that the interim outcomes that the Group set out to achieve are on track. It is therefore helpful to reflect on what contributed to these outcomes, and to consider what we have learned about the risks the programme may face in future.

In Table 1 (page 40–41) we look at achievements, challenges and learning in relation to the core elements of the Group’s approach. First, it is worth highlighting some of the cross-cutting themes and differences in perspectives that emerged from our conversations about wider lessons from the Somerset programme.

Depth vs breadth of relationships

The Group’s initial approach in Somerset focused on intensive senior engagement to gain buy-in and generate momentum for the work. It is clear from our interviews that this was critical to the achievements of the programme so far. However, there is also a recognition that as the programme moves into a new phase it is essential to broaden relationships. Some interviewees thought that a broader set of relationships would have been helpful from the start, although several recognised that there were pros and cons to both approaches.

This diversity of perspectives is reflected in the following quotations:

‘What made it work was using senior influence and having a conversation at the start with key stakeholders and explaining why it is in their interest to be part of this.’

National stakeholder

‘There was some messiness at the beginning and there was little clarity around who had made the decision and who the Richmond Group was. It is important to be very clearly engaged with sector leaders right from the beginning.’

Local VCS organisation

‘If they can get better engagement at the local level, it will act as an extra enabler. However, there is a sense that as the Richmond Group is a large national organisation it can dictate what the local organisations should do. They need to work much more at the local level.’

Local authority

‘By fostering strong links with the leadership they got a bit of an inside track. But after securing this they had to do some leg work with people lower down. This is probably a canny move, but it is debatable which way round to do it. There are pros and cons to each.’

Member of STP leadership team

Open-ended collaboration vs practical goals

The Group's approach centred on an initial commitment to a programme with very broad outcomes. This commitment was matched by the Somerset STP leadership and other key stakeholders, meaning that the programme did not get sidetracked early on by negotiating formal institutional or contractual arrangements. For example, the partners proceeded without a formal Memorandum of Understanding as it was considered that this would divert resource rather than add value to the programme.

Our interviews reiterated the value of this open-ended approach to collaboration, with an initial focus on building relationships and holding more exploratory conversations. However, they also showed that some stakeholders had struggled with the perceived lack of a practical focus. Smaller charities in particular found it difficult to commit resource to a process that was so open-ended. Focusing on a few 'early wins' could have helped the Group to better balance these different perspectives and keep stakeholders on board with the aims of the collaboration.

'You have to spend time to build relationships and have positive conversations first. You may end up somewhere different, but that's fine because there was genuine engagement.'

Local stakeholder

'As a frontline practitioner, there were some missed opportunities in terms of some early wins which could have shown some of the short-term benefits. For example, quick interventions in addition to the current ambitious, bigger projects.'

Richmond Group charity

Bridging role vs barriers to collaboration

The Group's work in Somerset demonstrates the power of bridging. The Group's programme managers were able to bridge gaps within and between different sectors, as well as between the local and national levels. Our interviews found that the Group had helped to align different interests, make connections, and 'package' the VCS offer in a different way for a statutory audience. Nonetheless, various barriers to collaboration have limited the power of this bridging role. These include a wider environment of competition, cultural differences between sectors, suspicion of the Group's motives, and a concern that the Group was reinventing the wheel. Despite these challenges, most interviewees recognised that the Group had built on existing initiatives and brought stakeholders closer together.

'It's easy to recognise the challenges of bringing together 14 big charity organisations and statutory organisations with tensions, barriers and cultural differences.'

National stakeholder

'[The programme managers] did a good job in trying to align the Richmond Group work with what others were doing and clearly there was much common ground.'

Local VCS organisation

'[The local programme manager] made a real difference by having relationships in the area and understanding the subtleties of these... Doing this on both a local and national level was also very useful in bridging gaps.'

Richmond Group charity

Table 1 summarises our findings about achievements, challenges and learning in relation to the core elements of the Group's approach, identified above (pages 12–13).

ELEMENT	ACHIEVEMENTS	CHALLENGES	LEARNING
Brand and credibility: the Group's national profile and collective expertise.	<p>Facilitated buy-in from statutory partners who considered this a high-profile piece of work of national importance.</p> <p>Brought profile and national connections to local VCS.</p> <p>Senior level involvement and decision making suited statutory health culture, which helped to ensure the work was heard and decisions were made.</p>	<p>Association with the Group's brand may have acted as a barrier for involvement of other charities outside the Group.</p> <p>Led to fear that larger charities may dominate.</p> <p>Senior level involvement and decision making was perceived by some as too top-down and less suited to smaller charities' bottom-up decision making.</p>	<p>National profile and credibility can be an advantage, but needs to be balanced with effort to reach out to wider sector.</p> <p>Need to develop space in the programme to allow others – especially smaller charities – to input.</p> <p>Consideration should be given to the impact of the Group's high-profile involvement on local sustainability.</p>
Positioning and reputation: the Group's focus on convening others as a relatively independent player.	<p>Beneficial to locate ownership of the programme outside NHS hierarchies, at least for the scoping period – insulates programme from near constant churn.</p> <p>Emphasis on convening key stakeholders has led to conversations and connections that would not have happened otherwise.</p>	<p>The Group's ownership of the programme meant local players didn't need to show leadership to start with.</p> <p>Emphasis on building relationships with key stakeholders runs the risk of people moving on. Operational-level relationships are also needed to embed the work.</p>	<p>Handover points need to be worked towards where statutory and other local partners step into leadership roles.</p> <p>It is important to build relationships at all levels as the programme progresses. This means going beyond senior champions to ensure sustainability at an operational level.</p>

ELEMENT	ACHIEVEMENTS	CHALLENGES	LEARNING
<p>Flexibility and innovation: the Group's open-ended approach and commitment to a programme with very broad outcomes.</p>	<p>Avoided getting delayed early on by issues of formal institutional structures, contractual arrangements, and governance.</p> <p>Responsive to local needs and changing circumstances. Able to accommodate a wide variety of perspectives and being them closer together over time.</p> <p>Got people thinking and acting in different ways – e.g. holding a market place event to understand each other's work; testing cross-charity referrals for a new assisted discharge service.</p>	<p>Questions around institutional structures and governance will need to be addressed as the programme progresses, particularly as outside investment is made.</p> <p>Harder to identify how to reach ultimate goals – and may lose people in the process. May be missed opportunities for practical 'early wins'.</p> <p>So far, the work has led to pockets of innovation but people are waiting to see whether the bigger demonstrator project can bring change at scale.</p>	<p>Getting an open-ended commitment to collaboration before considering formal structures can kickstart new ways of working, but needs to be formalised as the programme progresses.</p> <p>Flexibility is good, but need to keep on board those stakeholders who want concrete outcomes.</p> <p>Taking people outside their normal constraints can lead to new ways of working but serious investment is needed to scale and sustain these.</p>
<p>Access and reach: the Group's efforts to build on its existing links in the community and engage with the wider VCS.</p>	<p>Working through existing local VCS infrastructure enabled the Group to engage with parts of the wider VCS.</p> <p>Comprehensive mapping exercise enabled a shared understanding of local need, existing initiatives and how to bring them together and scale them.</p>	<p>Larger charities were better able to pick up and run with the programme. Smaller local charities were not as intensively involved due to resource constraints and some suspicion of the Group's motives.</p> <p>As the programme is building on existing initiatives, some feel it needs to do more to demonstrate how it adds value.</p>	<p>Future work needs to do more to engage smaller charities – both within the Group and beyond.</p> <p>New models of care need to connect very local and/or partial solutions that smaller charities provide. Bridging organisations like the Richmond Group can coordinate and scale up these solutions to meet the statutory sector's needs.</p>
<p>Leveraging additional resource: pooling the Group's resource to invest in dedicated programme managers and take on risk.</p>	<p>Added resource and capacity to the system and drove work forwards.</p> <p>Provided access to the Group's national expertise and knowledge of programmes in other areas.</p>	<p>Need to ensure there is sufficient local capacity to match national ambition.</p> <p>External resource and expertise may have decreased the sense of local ownership.</p>	<p>Pooling resources and risk can be a powerful way to drive more creative collaborative programmes.</p> <p>Consideration should be given to the impact of external resources on local ownership.</p>

TABLE 1: ACHIEVEMENTS, CHALLENGES, AND LEARNING IN RELATION TO THE CORE ELEMENTS OF THE GROUP'S APPROACH

Beyond Somerset: wider reflections

Our research has implications beyond Somerset. It raises issues around health and care transformation, place-based collaboration, and evidence for complex interventions.

Health and care transformation

The Group's work in Somerset responds to *Untapped Potential's* challenge to draw on the strengths of the VCS in health and care transformation. Our research shows the potential of the Group's approach, but it also highlights a number of ongoing wider challenges within the health and care system, many of which are likely to be beyond the capacity of any individual organisation or even any collaboration of organisations to resolve. These include:

- The challenges created by churn in NHS leadership and programmes, leading to loss of focus and relationships, which are often driven by changes in national strategy.
- The short termism generated by funding pressures and insecurities in both statutory health services and the VCS.
- The inherently anti-collaborative legal frameworks in which the current health system operates and engages with the VCS.
- The significant distance still to be travelled before the VCS, but also the NHS and wider health and care system, can speak with one voice in any given location.

Across the country, the pressures identified in *Untapped Potential* show no signs of abating: since we conducted our research, the Care Quality Commission's annual assessment of health and social care concluded that 'services are at full stretch'.¹⁹ Prioritising new ways of working is made harder by the fact that so much management and clinical time is focused on reducing financial deficits and meeting waiting time targets.²⁰ Participants at our roundtable also raised concerns that poorly implemented models of collaboration could lead to statutory health 'throwing people over the fence' into the VCS when they don't have the capacity or appropriate expertise to deal with those people.

The Group's work in Somerset shows the potential for the VCS and statutory sectors to collaborate constructively to meet these challenges. This research shows how the Group's work has increased local understanding of how the VCS can support the ambitions of the STP – now the main vehicle for delivering the NHS Five Year Forward View vision of integrated, person-centred care.²¹ Members of the STP told us they have a much better grasp of what value charities can bring – to the extent that they have committed a project manager to work for two days a week on the programme. Charities also became more aware of the workings and motivations of the statutory sector, and the financial and operational pressures they are facing.

This complements other initiatives that are exploring VCS engagement in health and care transformation. NCVO and The King's Fund are working²² to increase voluntary sector involvement in health transformation by bringing the two sectors together for action learning and to understand their individual challenges and develop responses, with a focus on systemic change. Meanwhile the Realising the Value Programme²³ funded by NHS England and jointly led by Nesta and the Health Foundation has strengthened the case for person and community-centered approaches to health and wellbeing. Working with the Health Foundation and the Institute of Health Equity, NPC is also exploring the role of charities in addressing the social determinants of health.²⁴

Place-based collaboration

With the devolution agenda and a move towards place-based approaches in health, there is increasing interest in, cross-sector collaboration in place. Our research highlights some of the opportunities and challenges around making this a reality. The unique context for this work is important – a focus on health and care in a rural county of England – but the lessons about how collaboration happens could apply to many other settings.

The Somerset work demonstrates the power of a 'bridging' role. The Group's programme managers were able to bridge gaps within and between the VCS and the statutory health and care sectors. Previous research into cross-sector collaboration has shown how benefits stem from 'drawing synergy from the differences between organisations'.²⁵ The way that the local programme manager worked creatively across sectors meant that she was able to navigate those differences, open up conversations, and build relationships. Similar approaches have worked well in other areas:

'Working with senior people and others across the system can result in significant impact. Being a bridge not in the system but sympathetic of it, can help make change happen quite quickly.'

Director, Health Lab, Nesta

The Somerset work also shows just how challenging it can be to achieve meaningful place-based, cross-sector collaboration. The dominant commissioning model means that charities are often competing for scarce resources, while the strict purchaser-provider split makes it harder to collaborate across sector boundaries. Successful place-based collaboration means overcoming or bypassing some of these tensions.

Some place-based collaboration programmes have found that detaching themselves from the workings of the NHS allowed them to achieve more. For example, the Bromley-By-Bow Centre began without backing from the NHS but worked around this and set up their own community GP practice, funded by the NHS. Others feel that involving the statutory sector slows things down and communities should take the lead to force change:

'Independence from the statutory sector gives residents more power over making things happen and gives communities power. This happened in Balsall Heath²⁶ and then the statutory health sector will have to get involved. Taking the lead from the NHS will drain energy and drive.'

Director of Transformation, Southwark CCG

There are advantages to taking this grassroots approach. However, there are also important disadvantages to note, such as being dependent on individual champions who can move on, and difficulties in replicating local models like this to benefit larger groups:

‘There’s a disparity across local areas and the STP wants to roll out this sort of activity to places where it doesn’t exist. It’s also reasonable that they want a common measure of quality, whilst still retaining local ownership. Ultimately, we all want equity of provision. And some areas need a lot of help to achieve this.’

Aimie Cole, Local Somerset Programme Manager

Evidence for the impact of complex interventions

The importance of evidence came up time and again in our research. Stakeholders highlighted the importance of demonstrating the impact of collaboration – ideally with evidence of associated financial savings. Yet several interviewees admitted the challenges around this: accessing the right data to measure outcomes, accounting for the time lag between activities and outcomes, understanding which bit of the system benefits from any cost savings, and attributing change to the programme.

The challenges around evidence go well beyond this programme. There is widespread recognition of the limitations of classical accounting for the use of public funds – which often focuses on rewarding activities and outputs rather than outcomes – and the importance of taking full account of value as it is experienced by people and communities.²⁷ Other research has also pointed to the challenges of gathering evidence for complex ‘systems change’ interventions.²⁸

Some emerging models, like that of Guy’s and St Thomas’ Charity, are proactively using a focus on place as a means of understanding complex interventions in the round. This deliberate focus helps them draw insights on how different factors interact to influence health, and therefore what approaches might be relevant in other similar areas.

Making better use of existing data and evidence can be part of the solution to these challenges. The Richmond Group’s My data, my care²⁹ report highlights how better use of data can help to identify areas which need the most support, reach groups that are most at risk, and provide joined-up care.³⁰ NPC’s recent report Towards an Evidence-led Social Sector³¹ points out the shortcomings of our current evidence systems and the need to move towards more collaborative approaches where evidence is openly shared and used for learning and improvement.³²

This research highlights the need to open up a wider conversation about evidence for the impact of collaboration, systems change, and complex health and care interventions.



**This research highlights the
need to open up a wider
conversation about evidence**

Conclusions

The Group's work in Somerset is ambitious and wide-ranging. If successful, it has the potential to transform health and care across Somerset with new ways of working across sectors, better outcomes for patients, and reduced demand on services.

This research presents a snapshot in time of how successful the work has been so far in making progress towards these ambitious aims. From this vantage point, we can conclude that:

The Group's early work has put in place the foundations for successful cross-sector collaboration in health and care in Somerset. Stakeholders express a shared commitment to new ways of working and they now understand each other better. This is beginning to translate into practical and tangible collaboration with the development of the first demonstrator project focused on social prescribing.

Collaboration is resource intensive, and this approach requires significant time, money, and senior involvement. The Group invested in dedicated local and national programme managers who worked flexibly across sectors and opened up conversations that might not otherwise have happened. The work also drew on the expertise of the wider Group, its national profile, and its access to senior leaders in health and care. These all brought credibility and national connections to the work.

However, this approach has its drawbacks. The agile programme team and senior leader involvement meant that decision-making was perceived by some as exclusive or top-down. There were times when decisions had to be made quickly, which inevitably meant that the programme drew less intensively on the expertise and capacity of a wider group. While larger charities could pick up and run with the programme, smaller charities struggled at times to see how it fitted with their priorities and resources.

Looking ahead, the programme faces challenges around demonstrating the practical impact of new ways of working. Many stakeholders are looking for tangible outcomes such as reduced demand on services, better patient outcomes, or more funding for the health and social care system. These outcomes will take time to materialise and are difficult to evidence. The demonstrator project is important as it will show the practical potential of collaboration. But other ways of working together are already emerging organically – and these may prove to be equally impactful in bringing the strengths of the VCS to health and social care transformation.

This report has also highlighted practical insights into cross-sector collaboration, which may be of interest to others looking to collaborate across a range of settings.

These include:

Bridging organisations like the Richmond Group can build connections across sectors and between local and national work. The national profile and credibility of an entity like the Richmond Group needs to be balanced with effort to reach out to the local sector and create a wider sense of ownership at a local level. Handover points are also needed where statutory and other local partners step into leadership roles.

Senior champions can be vital for getting a programme off the ground, but it is important to build relationships at all levels as the programme progresses. This includes creating space for smaller charities to input, and building operational-level relationships to ensure sustainability as senior leaders move on.

Getting an open-ended commitment to collaboration before considering formal structures can kickstart new ways of working and avoid delays due to contractual negotiations. Nonetheless, more formal structures and mechanisms need to be developed as the programme progresses. Flexibility also needs to be balanced with practical early wins to keep on board those stakeholders who want concrete outcomes.

Beyond Somerset, our research raises wider issues around health and care transformation, place-based collaboration, and evidence for complex interventions.

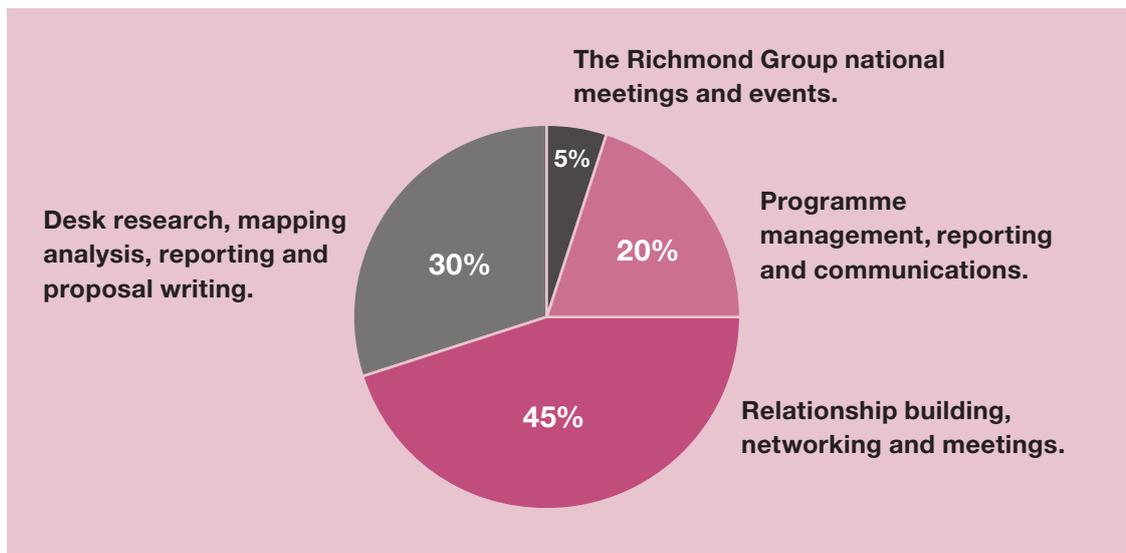


APPENDIX 1:

Programme manager roles

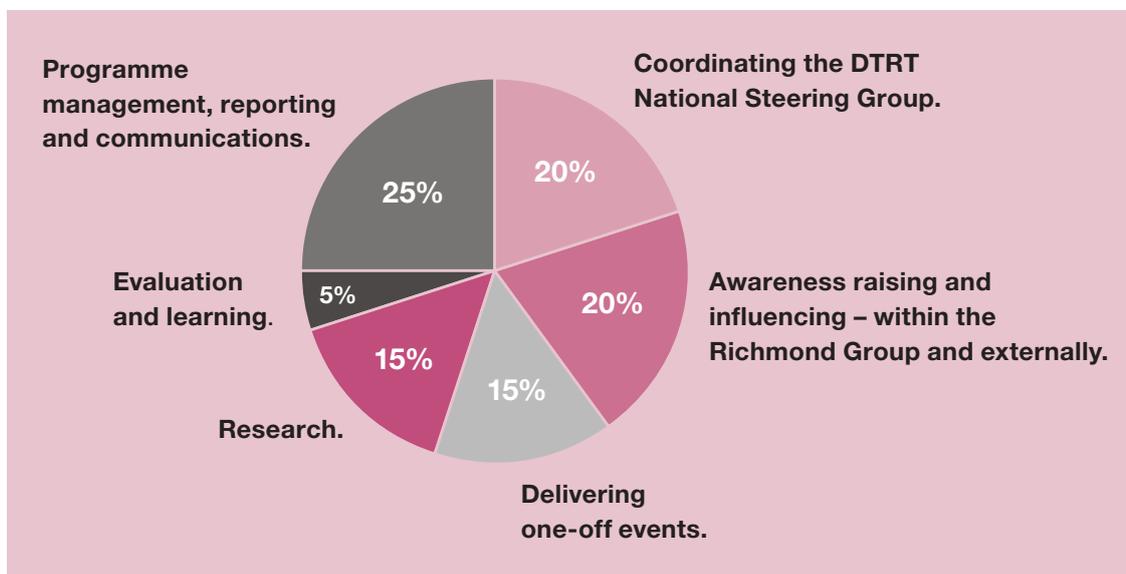
Local programme manager role

The local programme manager was a dedicated independent resource on the ground, able to invest time in building relationships and developing a robust understanding of what mattered to stakeholders across the system. Over an eight month period, costing approximately £40,000, the role focussed on the following things:



National programme manager role

The national programme manager acted as a crucial link between the national and local activities of the Somerset programme. This involved raising awareness both internally within the Group and externally with national stakeholders, by coordinating the DTRT National Steering Group and conducting research (e.g. on social prescribing). Over an eight month period, costing approximately £22,000, the role focussed on the following things:



APPENDIX 2:

Scoping and proposal

Ambitions from the scoping exercise

Working with the STP and local partners, the Group put forward three distinct ambitions for Somerset:

- 1 Building on existing Group local services:** through practically collaborating and working in partnership. The ultimate aim of this workstream is to make a positive difference to people using health services, e.g. integrating referral processes to streamline support provided by local Group members to people moving in and out of hospital.
- 2 Linking Group national and local expertise into NHS change processes:** by combining the voices of local and national representatives from the Group and DTRT National Steering Group, with the voices of patients, to support and influence change in services in a way that reflects what people really want. For example, early on, the Group commissioned focus groups with patients in Somerset, inviting a member of the STP, to identify how people think and feel about the health system as it is, what pressures it faces and what they think needs to change.
- 3 Transforming the system by integrating and mainstreaming local VCS support with primary care:** the aim of this was to develop a 'tapestry of support' for patients by connecting statutory services with VCS services in a way that offers generic, consistent and accessible services via the NHS which can become specific, tailored and personalised when required by the patient, via VCS organisations.

Proposal for three collaborative workstreams

In May 2017, the Group summarised the three workstreams in its Report to the Somerset STP leadership team. The following is an extract from that paper:

Workstream 1: Build on existing local services of the Group – through practical collaboration and partnership working – to make a positive difference to people coming in and out of health services and to ease patient flow throughout the system.

- This is the workstream through which we will offer our expertise into delivering the best support we can to people coming in and out of hospital, e.g. Delayed Transfers Of Care (DTC) and Accident & Emergency (A&E) services.
- This workstream is already underway and being led by the Group's local members, supported by Aimie.

By April 2018, we aim to have developed an integrated referral process to signposting between the Group's local members for people coming in and out of hospital.

Workstream 2: Link the Group's national and local expertise and insight into STP service and pathway redesign priorities as they develop and utilise our ability to bring patient voices and perspectives to these efforts.

- This will come from:
 - local representatives;
 - the wider Group's member charities at a national level; and
 - our DTRT National Steering Group.
- We can help organisations who aim to redesign services and pathways make sure they know what the people using these services think and want.
- This workstream is ongoing and the linking requires continued facilitation and support in the short-term. The longer term aim is for it to become self-sustaining.

Workstream 3: Progress system transformation through a specific outcomes-based delivery-focused initiative that mainstreams the VCS emotional and practical support offer into primary care.

- We propose to do this first by helping facilitate social prescribing at scale, across the whole of Somerset, for people with long-term conditions.
- This is about connecting statutory services with a generic, consistent and accessible scheme that then unfolds into a myriad of specific, tailored and personalised support from the VCS.
- We do not assume that the Group will 'run' the social prescribing service itself, or that the Group's member charities will provide all the required support that people need – the wider VCS and others will be involved.
- Our aim is for every GP practice to have access to a social prescribing service – through a number of sustainable hubs – by April 2019.
- We believe there is a strong case for testing the feasibility of an outcomes-based contract, potentially financed through a social impact bond, to roll out provision of social prescribing at scale.
- We are pursuing a joint application to the Cabinet Office Life Chances Fund, as a potential outcomes funder, and development partner. This is a time limited fund. The next call, due to be issued in June 2017, is focused on health. If successful, the fund will support £30k of the technical development needed to explore the feasibility of a social impact bond, and link us into wider support available to enable the development of a full application. The SW AHSN have an open offer to match the £30k development funding.

Proposal for the Life Chances Fund

The Expression of Interest (EOI) to the government funded Life Chances Fund³³ proposed several core principles for the model, including:

- A person-centred preventative approach based around a conversation focused on people's own ambitions and assets, which promotes health and wellbeing rather than just patching people up when things go wrong.
- Recognition that community has a central role to play in creating health and that VCS services are not always free, so that some investment in community-building infrastructure is required.
- Getting GP buy-in, whilst also ensuring that GPs are not the only route of access and that new working relationships are enabled between different parts of the health and care system.
- Flexibility to make it possible to build upon existing approaches and spreading good practice to enable equity of provision across Somerset.
- A desire to catalyse a fundamental change in the way citizens and professionals view, receive and deliver health and care across Somerset.

Building on these principles, the proposal outlined an approach to facilitate Somerset-wide roll-out of local services that link people with health problems into the social, emotional and practical support within communities and the VCS when there is no purely clinical or medical solution available for them. There are three key elements to this: social prescribing, community building and primary care transformation. To date, the approach has been left open to allow for locally-led models to develop at a sub-county level.

Acknowledgements

This report would not have been possible without valuable support from The Health Foundation and Guy's & St Thomas' Charity. We are also grateful for the participation of the following interviewees and roundtable attendees.

Interviewees

NAME	ROLE	ORGANISATION
Aimie Cole	Richmond Group Doing the Right Thing Somerset Programme Manager	Richmond Group
Charles Alessi	Public Health England Senior Advisor and Co-Chair of the Richmond Group Doing the Right Thing National Steering Group	Public Health England / Richmond Group
Chloë Reeves	Richmond Group Doing the Right Thing National Programme Manager	Richmond Group
Deborah Fisher	Director for Crisis and Independent Living, South England	British Red Cross
Derek Dodd	Operations Manager Somerset	Alzheimer's Society
Doreen Smith	Business Development Manager in Taunton & West Somerset	Mind
Jacqui Cuthbert	Regional Director, South West	Stroke Association
Justin Parsons	Service Development Manager, South West	British Lung Foundation
Katherine Nolan	Manager	SPARK
Liz Simmons	Coordinator of Somerset VCSE Strategic Forum and Non-Executive Director at Somerset Partnership NHS Foundation Trust	Somerset VCSE Strategic Forum / Somerset Partnership NHS Foundation Trust
Matt Bell	Programme Manager for Innovation and VCS partnerships	South West Academic Health Science Network
Matthew Dolman	Former Chairman of Somerset CCG & STP Clinical Lead	Somerset CCG / STP
Michael Bainbridge	Head of Primary Care Development	Somerset CCG
Nick Broughton	CEO of Somerset Partnership NHS Foundation Trust & Chair of STP New Models of Care Workstream	Somerset Partnership NHS Foundation Trust / STP
Pat Flaherty	CEO	Somerset County Council
Paul Corrigan	Professor of Health Policy	Imperial College London
Paul Mears	Chief Executive	Yeovil District Hospital NHS Foundation Trust
Raj Singh	Staff member	The Community Council for Somerset
Sam Barrell	CEO / Chair	Taunton Musgrove Hospital Trust / STP Out of Hospital Workstream
Tim Baverstock	Strategic Commissioning Manager, Adults & Health	Somerset County Council
Trudi Grant	Public Health Director	Somerset CCG

Roundtable on place-based collaboration in health attendees

NAME	ROLE	ORGANISATION
Aimie Cole	Richmond Group Doing the Right Thing Somerset Programme Manager	Richmond Group
Amy Galea	Deputy Director, Strategy Group	NHS England
Charles Alessi	Public Health England Senior Advisor and Co-Chair of the Richmond Group Doing the Right Thing National Steering Group	Public Health England / Richmond Group
Charlotte Augst	Director	Richmond Group
Chloë Reeves	Richmond Group Doing the Right Thing National Programme Manager	Richmond Group
Christina Cornwell	Interim Director, Health Lab	Nesta
Christine Hancock	Founder and Director	C3 Collaborating for Health
Clare Devine	Executive Director of Strategy and Design	Design Council
Dan Corry	Chief Executive	NPC
Dan Hopewell	Director of Knowledge & Innovation	Bromley by Bow Centre
David Buck	Senior Fellow, Public Health and Inequalities	The Kings Fund
Emma Easton	Patient and Public Partnerships Lead	NHS England
Iona Joy	Head of Charities	NPC
John Towers	Head of System Redesign	Macmillan Cancer Support
Kate Jopling	Policy and Strategy Consultant	Richmond Group
Katie Boswell	Deputy Head of Charities	NPC
Kieron Boyle	Chief Executive	Guy's and St Thomas' Charity
Mark Kewley	Director of Transformation	Southwark CCG
Nicola Close	Chief Executive	The Association of Directors of Public Health
Richard Taunt	Founder	Kaleidoscope Health & Care
Sarah Day	Senior Strategic Finance Lead, Personalised Care Group	NHS England
Sarah Lawson	Policy and Programme Support Officer	The Health Foundation
Satdeep Grewal	Senior Consultant	NPC
Sonali Patel	Consultant	NPC

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'What excites us most about this research is its clear articulation of the opportunities that focusing on a place brings.'

Kieron Boyle, Chief Executive, Guy's and St Thomas' Charity

'This work has identified the benefits of collaboration and system change led by the voluntary and community sector, which can combine both agility and stability in an ever changing health care landscape.'

Jo Bibby, Director, Health Lives Strategy, The Health Foundation

'At a time when the shortfall of resources is being highlighted, NHS provision needs all the extra help it can get. Civil society provides a wide range of day to day activities that the NHS needs to tap into – this report on work in Somerset shows how that can be achieved.'

Paul Corrigan, Adjunct Professor of Health Policy at Imperial College & Non-executive Director of the Care Quality Commission

'This approach reflects the LGA's priority to invest in community and preventative services, and empower people through non-medical models to have choice and control over their lives. These are essential, and underpin everything that helps local populations stay well.'

Fiona Russell, Senior Advisor, Local Government Association

'This report highlights the value of partnerships and relationships to deliver what people need – retaining control of their lives, meaning and purpose.'

Charles Alessi, Senior Advisor, Public Health England and Co-chair, Doing the Right Thing

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Tapping the potential

Lessons from the Richmond Group's practical collaborative work in Somerset

A report by NPC for
the Richmond Group of Charities

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