

A new relationship with people and communities

Actions for delivering Chapter 2 of the
NHS Five Year Forward View

The report from the People and
Communities Board to the Chief Executive
of NHS England

February 2017

Foreword

In 2002 the late Derek Wanless made the economic case for a “*fully engaged scenario*”, demonstrating that healthcare costs would rise more slowly if people were fully involved in decisions that affected their health, and their care and treatment.

In 2014 the NHS Five Year Forward View restated Wanless, asserting that a “*new relationship with patients and communities*” was central to meeting the goals of NHS reform in the 21st century: better health, better care and greater financial sustainability. There is a solid and growing evidence base to back these claims – most recently brought together in the Realising the Value programme. Person- and community-centred approaches to health and wellbeing are right in practice as well as in principle.

Since 2002, despite many encouraging developments, the progress towards a “*fully engaged scenario*” has been frustratingly slow and is now at risk of being undermined or sidelined by the worsening financial state of social care and the NHS.

The advice in this report was commissioned by NHS England and the recommendations principally directed at that organisation. Stronger national leadership of this agenda is sorely needed.

But the job of making health and care services people-focussed is a shared one. It requires working in partnership with patients, carers and communities; a more strategic relationship between the third sector and statutory services; a stronger emphasis on fairness and inclusion, and smarter methods for adopting and spreading social innovations.

Whatever your role in the health and care worlds I therefore hope that this report speaks to you too, and that you will take inspiration and encouragement from it. As the NHS prepares for its 70th birthday, the time is long overdue to take the idea of the fully engaged scenario from ‘nice to have’ to ‘business as usual’. We all have a part to play in this.



Jeremy Taylor
Chair of People and Communities Board
Chief Executive, National Voices

Contents

1	Introduction	5
2	Summary of recommendations	6
3	NHS England's leadership role	11
4	A universal offer for people with long-term conditions	14
5	Working with the VCSE sector	21
6	Ways of making change	25
7	Thematic issues	28
8	The People and Communities Board and this project	31

Voluntary sector proposals

Annex

Introduction

In autumn 2016 the People and Communities Board (PCB), as part of the [NHS Five Year Forward View](#), was invited by NHS England Chief Executive Simon Stevens to recommend a set of 'high impact actions' for accelerating the adoption of person and community-centred approaches to health and care. More detail about the board, the terms of reference for this project, and the process adopted, is in section 8 of this report.

Why this matters

This project has arisen from the board's work to champion and support the delivery of Chapter 2 of the Five Year Forward View. Chapter 2 sets out the vision of a health and care system which fully engages people in their health, care and wellbeing, including by working in partnership with communities and the voluntary, community and social enterprise (VCSE) sector.

A growing body of policy, evidence, thinking and practice is now pointing the NHS to work in these ways. The reason is that they improve health; improve the outcomes of care and treatment; improve the allocation of resources; and build social value and community resilience. Health and care professionals are increasingly finding that these approaches enable them to practice their disciplines in more humane, holistic and rewarding ways.

As long ago as 2002, the [Wanless Review](#) made the case for such approaches as a fundamental means of improving outcomes and containing cost increases. Chapter 2 updates this case: "*a new relationship with patients and communities*" is not an add-on but necessary to achieving the goals of the Five Year Forward View. Despite progress, and NHS England's own leadership role, there is no delivery plan for Chapter 2: for systematically scaling and replicating the most effective person-centred and community-focussed approaches to health and care.

The result is to exacerbate the pressures currently being experienced in the NHS, especially unplanned emergency hospital admissions; increased demand on accident and emergency capacity; deteriorating waiting time performance, and delays in discharge from hospital. It also means worse care and worse outcomes, especially for people whose circumstances are further disadvantaged by a variety of social and economic inequalities.

There is an absence of consistent and coherent support for people with long term conditions, and inadequate engagement with the VCSE sector. We address these issues and more in our recommendations.

Summary of recommendations

In keeping with the terms of reference, this report is primarily aimed at NHS England, although as much as possible we have written it to have wider relevance.

We believe our recommendations go with the grain of what NHS England is trying to do to change the culture of healthcare; that they will resonate with local change-makers; and that they require at most a modest re-profiling of existing investment rather than new investment.

We have identified some of them as 'high impact actions' where we think they address key pinch points in the NHS; where substantial progress can be made in the next 12 months; and where the actions can build energy for the broader agenda. The full list of high impact actions and related recommendations is set out below:

1

High impact action: Make person-centred, community-focussed approaches part of normal business.

This entails a universal offer of support to people with long term conditions, as set out in section 4, based on a common framework for aligning and scaling up existing effort; a more strategic and collaborative approach to working with the VCSE sector as set out in section 5; and an approach to supporting locally and professionally-owned improvement as set out in section 6 (page 12).

We recommend: That key elements of the offer for people with long-term conditions are 'hardwired' more explicitly into the major engines of reform being driven by NHS England, especially Multispecialty Community Provider (MCP) and Primary and Acute Care System (PACS) contracts, the GP Forward View, Clinical Commissioning Group (CCG) assurance and payment mechanisms (page 25).

We recommend: That the various strands of NHS England support - e.g. for self-care, carers, personal budgets, and as part of the new care models team - are brought together more seamlessly and are more strongly harnessed to the main elements of system reform, with fresh thinking on the balance between what is done in-house by NHS England, and what is done in partnership (page 26).

We recommend: That NHS England identifies a single point of leadership for aligning Chapter 2 work across all the national system leading bodies, located either at senior management level or through a Five Year Forward View board (page 25).

We recommend: That NHS England takes forward the proposals in Section 6 for developing communities of interest and practice (page 27).

2

High impact action: Make a clear commitment to develop new, simplified, cross-sector outcome measures.

These would give equal status to key person-centred metrics alongside 'system' metrics, better enabling local systems including the VCSE sector to work collaboratively for health and wellbeing outcomes that matter to people (page 13).

We recommend: That this work includes aligning all the national system bodies around a single, simplified cross-system outcomes framework (page 25).

3

High impact action: Support a small number of super demonstrator sites willing to develop person- and community-centred approaches at scale (page 15).

We recommend: That NHS England explores the proposal submitted by Year of Care Partnerships, an NHS organisation that supports GP practices to establish care and support planning. It could form part of the offer to the super demonstrator sites (page 17).

4

High impact action: Clarify the key success factors for social prescribing, including how to make it systematic and equitable, benefiting from the current interest in this family of approaches (page 18).

We recommend: That this work is carried out as a process of co-production involving CCGs, the VCSE sector and those driving the GP Forward View (page 18).

We recommend: That, as part of this work, a thorough exploration is made of the VCSE sector proposal that social prescribing should be implemented through a Single Point of Contact with the community sector in each local area (page 18).

5

High impact action: Revive and champion the Inclusion Health agenda.

NHS England has the opportunity to fill a much-needed national leadership gap for this agenda, fostering effective local actions and the engagement of VCSE organisations that reach excluded groups (page 20).

We recommend: Further work in partnership to develop NHS England's leadership role in relation to equality and health inequalities more broadly (page 20).

High impact action: Commission under a framework agreement a pool of preferred VCSE partners able to support person-centred, community-focussed interventions in defined geographical areas.

Local commissioners, vanguards and others should be encouraged to draw upon the services offered, including support with delayed discharge; the development of social prescribing; interventions to support people in the community, improve population health and community wellbeing, and approaches to improving community engagement within the 44 Sustainability and Transformation Plan (STP) footprint areas (page 22).

We recommend: That NHS England makes a clear and public commitment to working in co-production with patients, carers and VCSE organisations (page 22).

We recommend: Creating a new channel to speed the adoption and spread of tested VCSE programmes and approaches. This would be a non-procurement mechanism to help the most promising innovations get to scale quickly and thereby demonstrate their value when mainstreamed (page 24).

We recommend: Action to develop the capabilities of health commissioners to mainstream Chapter 2 approaches (page 19).

Recommendations on specific themes:

We recommend: That NHS England now steps up the priority, energy and detailed work needed to embed the Ambitions for Palliative and End of Life Care in the new care models, working closely with partners including the National Council for Palliative Care (page 28).

We recommend: That NHS England promotes the systematic use of the carers' Memorandum of Understanding across all STP areas and new models of care to improve coordination and move towards the goal of identifying and supporting carers appropriately (page 29).

We recommend: That NHS England and NHS Improvement jointly prepare and carry out a national survey on commissioners' approach to volunteering and social action (page 30).

We recommend: That NHS England identifies funding and establishes a new drive to recruit exemplar areas to develop advanced coordinated services for children and young people with difficult lives (page 30).

NHS England's leadership role

"There's a lot happening, but it's not high profile enough, it's not seen as mission critical, and it's not well aligned. We need rocket fuel behind this agenda."

- Participant in a People and Communities Board/NHSE workshop

The role of NHS England

Across the English health and care systems, many individuals and organisations are creating new kinds of relationships with people and communities which give people more voice and control. This is part of a generational culture change driven by many economic and societal factors. NHS England plays only a part in this, but as a national system body, deploying the majority of the NHS budget, its role is vital and people look to it for leadership.

NHS England leads many relevant programmes and activities in this area, notably in relation to new models of care, personal health budgets and person-centred care. Since the publication of the [Five Year Forward View](#):

- NHS England sponsored the [Realising the Value programme](#), which has updated [Wanless \(2002\)](#), producing evidence, economic tools, test-bed sites, experiential learning and practice tools for implementing person and community focussed approaches to health.
- The Department of Health-sponsored [VCSE Review](#) and the [Untapped Potential](#) report for the Richmond Group of charities have thoroughly reviewed the role of the voluntary sector and its relationships with statutory health and care services.
- The People and Communities Board has developed [six principles](#), now reflected in NHS guidance, which clarify the approaches that exemplify Chapter 2.

Despite NHS England's leadership role, progress in relation to Chapter 2 has been slow. There is not an overall delivery plan and the separate initiatives do not add up to a well-understood, high-profile, systematic or consistent approach, especially for people with long-term conditions and complexities in their health and care needs. These are the people who are increasingly the 'core customers' of the NHS and who account for 70% of its costs.¹

In particular efforts are typically:

- **Small scale:** happening in a small number of places and for relatively few people.

¹Department of Health (2012) [Third edition of Long Term Conditions Compendium](#)

Often, they are designed for small cohorts (such as ‘the most complex patients’), although evidence, e.g. from Realising the Value, suggests that large numbers can benefit from relevant interventions.

- **Fragmented or silo-based** around distinct themes (personal health budgets, self-care, [Right Care](#), etc.); specific health conditions; different test-sites (e.g. [integrated care pioneers](#), [vanguards](#), [Integrated Personal Commissioning sites](#), the GP Forward View programme), or different methodologies of support, evaluation and engagement.
- **Insufficiently focused on reducing the social gradient of ill health** by identifying and targeting those who have the greatest burden of ill health and higher levels of disadvantage, and often have worst access either to formal care or to the benefits of community provision.

In short, we agree with the sentiment expressed in the quote at the head of this section.

That is why the first of our recommended high impact actions is:

1

High impact action: Make person-centred, community-focussed approaches part of normal business.

This entails a universal offer of support to people with long-term conditions, as set out in section 4, based on a common framework for aligning and scaling up existing effort; a more strategic approach to working with the VCSE sector (section 5), and a conscious approach to supporting locally and professionally-owned change and improvement (section 6).

We think these approaches together offer the best basis for informing board-level leadership of this agenda; the aligning of disparate programmes and activities; and the deployment of NHS England’s principal levers, incentives and mechanisms of change.

Most of the ingredients of this approach already exist, and are being partly implemented. The approach needs to become ‘business as usual’. It does not require a new direction or new programmes for NHS England. Nor should it require new spending. It does mean giving greater priority to Chapter 2 – what one contributor called applying a “*corporate rocket*” to the agenda.

Alongside this is the need for clearer signals of intent. These could include, for example, a recommitment to the six principles developed by the PCB, a reaffirmation of the NHS Constitution, and a high profile endorsement of the recommendations of Realising the Value.

NHS England could commit to adopting the six value statements produced by the Realising the Value programme:

We value the creation of health and wellbeing

We value people feeling supported, in control, socially connected and independent

We value the outcomes that are most important to people and their communities

We value people's contributions (their strengths, time, effort, and skills)

We value sustainable outcomes over time, achieved through working together, as services and in partnership with people

We value equity, and the gains to be made by targeting and tailoring our approaches to people with greater need for our partnership.

Closely related is the measuring and valuing of person-centred outcomes. The national system leading bodies have jointly announced their intent to produce a new shared outcomes set, as one of the actions under the [Think Local Act Personal \(TLAP\) Shared Commitment to Engaging and Empowering Communities](#). Realising the Value made a very similar call. We recommend as a high impact action:

2

High impact action: Make a clear commitment to develop new, simplified, cross-sector outcome measures.

These would give equal status to key person-centred metrics alongside 'system' metrics, better enabling local systems including the VCSE sector to work collaboratively for health and wellbeing outcomes that matter to people.

A universal offer for people with long-term conditions

The lack of a systematic approach to helping people with long-term conditions is a fundamental gap in the delivery of [Chapter 2](#). People are not sufficiently helped to plan their care, treatment and support², and not supported to manage their conditions and the impact of those on their lives³. This, despite the fact that people with long-term conditions and complexities in their health and care are increasingly the 'core customers' of the NHS and account for some 70% of its costs.¹

A fundamental plank of the effort to mainstream Chapter 2 therefore must be a universal offer for people with long-term conditions, which is based on evidence and existing practice, and which serves to align and scale-up existing efforts around a common framework. It has **four interrelated elements**.

Element A:

A universal offer of personalised **care and support planning** for all people with long-term conditions and other complexity, working through an annual cycle, and ideally based in primary care to ensure it addresses both clinical and non-clinical aspects.

Element B:

A **systematic approach to referring people** from their care planning consultation to both the clinical and non-clinical sources of care and support that will help them to achieve their goals ('social prescribing').

Element C:

Skilled, collaborative **commissioning for wellbeing**, capable of developing community-based assets to support health, and to provide people with a menu of non-clinical support options on an equitable basis.

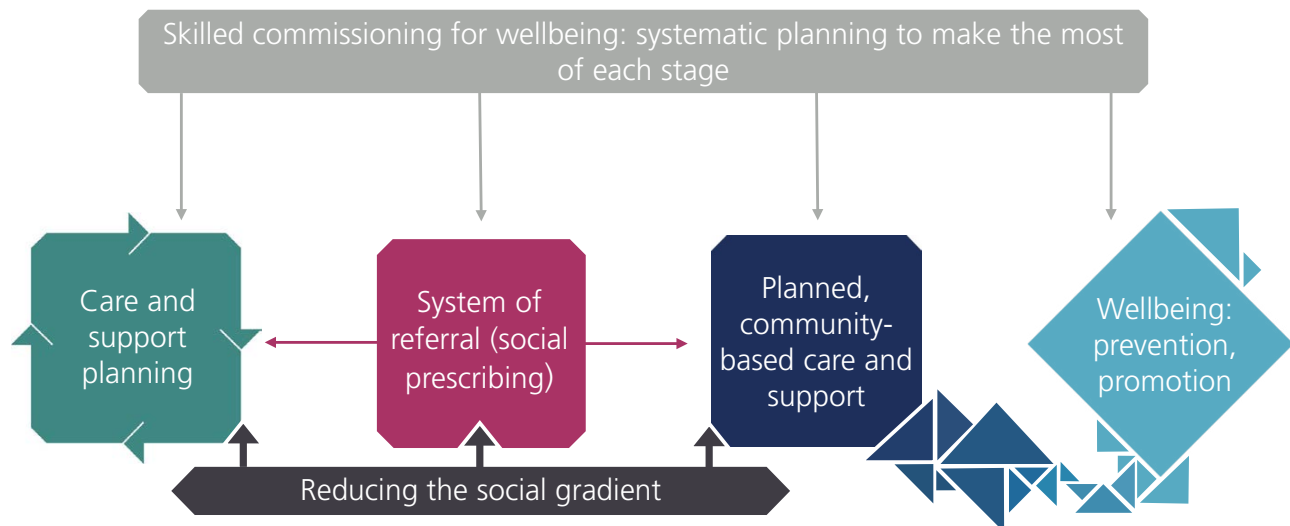
Element D:

Planning, throughout this pathway, to identify, target and support those people who have the lowest health literacy and the greatest potential to benefit (thereby **tackling the social gradient** in health and reducing health inequalities).

²[General Practice Patient Survey](#) (2016): less than 5% of people with a chronic condition have been involved in creating a plan

³[Healthwatch England's survey of patients in primary care](#) (2017) identified the lack of self-management support as the biggest deficit

We have pictured these elements in the diagram below. It takes account of models which have been developed for integrated personal commissioning and person-centred care within NHS England, and of the systematic approach illustrated in the Realising the Value final report - [Ten actions to put people and communities at the heart of health and wellbeing](#).



3

High impact action: Support a small number of super demonstrator sites willing to develop person- and community-centred approaches at scale.

The NHS does not need yet another family of pilots. These sites could be drawn from existing exemplars where there is already energy and commitment to build on.

We suggest that this approach starts with current NHS England plans to support a subset of the vanguards.⁴ However, there needs to be sufficient scale and ambition for this initiative to build the next level of evidence about the value and effectiveness of these approaches (see [Realising the Value](#)'s recommendations). It might make sense for one or more of the super demonstrators to cover a whole STP area.

The support offer to these sites needs to: align the elements of various separate support offers from NHS England, and of the regional arms of NHS England and other arm's length bodies; integrate the offer of the VCSE partners, and build in sufficient evaluation and learning.

⁴See Samantha Jones' blog on the National Voices website (2017), [Helping people to help themselves](#)

Element A:

Personalised care and support planning based in primary care

People with long-term conditions and other complexity are now the 'core customers' for the NHS, using 70% of its resources, including two thirds of primary care consultations.¹ But much primary care is still providing a 'legacy model' of care: reactive, episodic and more or less paternalistic. Little personalised care planning is happening.

The result is too much unplanned and uncoordinated use of health services which adds pressure to the NHS, diminishes care quality and reinforces patients' dependence.

The care planning consultation helps people to identify what matters most to them, what their health-related life goals are, and what kinds of care and support they want to draw upon to support them in managing their lives and conditions.

Personalised care and support planning is now the governing mode of adult social care, under the [Care Act 2014](#). In the NHS it is in use in some of the integrated care pioneer areas, in the 'extensivist' approach in [MCP vanguards](#) and [PACS vanguards](#), and for everyone in the [Integrated Personal Commissioning \(IPC\) programme](#). So far these developments are limited. They are applied to quite small cohorts and professionals may still default to providing people with a plan, rather than working in partnership to help people identify their own goals and preferences.

Outside these test site areas, an increasing number of GP practices have implemented the [Year of Care](#) approach. Evidence from these practices indicates that:

- GPs and their staff are able to adapt and modify their roles and processes.
- GPs and staff find the new mode of care more professionally satisfying, because they are more able to focus on the person and what matters to them, rather than specific episodes or treatments, and can see the benefits for their patients.
- Leaving aside initial set-up costs (training, changing administrative and IT systems), the change of mode can be cost-neutral, as it reduces the number of episodic consultations the person uses per year, and enables the practice to reduce other activities such as single disease clinics. Potential system savings arise from the individuals' reduced use of unplanned and emergency care.

The principal barrier to accelerating, spreading and scaling this crucial underpinning of person-centred care is the lack of consensus over who should or could carry out the care planning consultation, and how can this be embedded in overstretched primary care.

NHS England is now well positioned to remove this barrier.

We recommend: That NHS England explores the proposal submitted to our exercise by Year of Care Partnerships, an NHS organisation that supports GP practices with implementation and training to establish care and support planning. This is a fully worked and costed proposal to start with the most mature areas and spread the model to all CCG areas, in order to reach 80% of people with long-term conditions and other complexity. It could form part of the offer to the super demonstrator sites.

Alongside these steps is the need to work with clinical champions to build the appetite, capacity and skills for this approach. Within NHS England itself this will entail close working between those leading, respectively, on person-centred care, long-term conditions and the GP Forward View.

Element B:

Systematic referral to sources of non-clinical care and support

Social prescribing is now a 'must do' in the [GP Forward View](#) and for MCPs. But to implement it fairly will require greater definition, so that local tailoring can be done with reference to agreed principles and criteria for success.

Primary care practitioners are increasingly recognising the need for non-clinical as well as clinical referral. There is a very wide range of linking or signposting initiatives now under way. [The Social Prescribing Network](#) estimates that around half of all CCG areas now have some kind of linking offer. However, in many places the approach is relatively unplanned, arbitrary, underfunded and inequitable (for service users, staff and VCSE organisations alike). There is a lack of clarity about which linking models work most effectively.

In a smaller number of local areas, there is a more developed system for referral to groups, activities and interventions that support people's self-management and resilience.

These are the areas that can best be described as offering genuine social prescribing. A good example is the evaluated model in Rotherham, where referrals have been planned and designed in partnership with a single VCSE 'broker' organisation.⁵

The VCSE Review recommended that "*NHS England, working with key partners such as the Department of Health and NICE [National Institute for Health and Care Excellence], should publish good practice guidance on social prescribing which includes advice on different models and recognition that prescriptions should be appropriately and sustainably funded*".

⁵Sheffield Hallam University Centre for Regional Economic and Social Research (2013) [Evaluation of the social and economic costs and benefits of Voluntary Action Rotherham's Social Prescribing Pilot being delivered on behalf NHS Rotherham CCG](#)

Building on this, we recommend as a high impact action that NHS England:

4

High impact action: Clarify the key success factors for social prescribing.

Immediate work here will support the longer term development of effective commissioning for wellbeing; the better integration of the VCSE sector (the sustainable funding of which is a key requirement for social prescribing); and the implementation of the GP Forward View.

We recommend: That this work is carried out as a process of co-production involving CCGs, the VCSE sector and those driving the GP Forward View. There is an opportunity also to align this work with the Department of Health's current interest in using grant funding for the voluntary sector to support social prescribing.

We recommend: That, as part of this work, a thorough exploration is made of the VCSE sector proposal that social prescribing should be implemented through a Single Point of Contact with the community sector in each local area (page 18).

Element C:

Skilled, collaborative commissioning for wellbeing

Both the [VCSE Review](#) and Realising the Value confirmed that healthcare commissioning is still at a very low base when it comes to working in coproduction with the VCSE sector, and to taking a wellbeing approach to commissioning. For example, very few are actively using social value principles in procurement. Indeed, very few procure from the community sector at all.

VCSE organisations have told us that healthcare commissioners who wish to commit further to Chapter 2 approaches feel unable to take risks. They demand immediate and often unrealistic cost savings, and struggle to invest in innovation.

Both the VCSE Review and Realising the Value make a range of recommendations for action in this space.

We recommend: Action to develop the capabilities of health commissioners to mainstream Chapter 2 approaches, building on the VCSE Review and Realising the Value. CCGs need a support programme to develop the knowledge, skills and confidence to commission for wellbeing, working in equal partnership with service users, communities and the VCSE sector. Within this programme, commissioners need help to 'carve out' investment funds to build their community assets and innovation.

Skills for Care has now approved a [Commissioning for Wellbeing qualification](#) for delivery, and this could help form part of the learning resources.

Element D: Reducing the social gradient in health

The strongest correlation to ill health – stronger than education level, deprivation, age or ethnicity – is health literacy.⁵ Health literacy tools such as the [Patient Activation Measure](#) can therefore be used alongside other population health data to stratify, segment and target these individuals and groups.

In our framework the following elements can help with this targeting:

- A universal offer of care planning will address all individuals with long-term conditions and other complexity and enable measurement of their health literacy and targeting of extra care and support.
- Systematic referral to non-clinical support, with equity as one of its key principles, can open up equal access to support for groups who may otherwise use fewer support options.
- Planned and skilled development and commissioning of community assets can ensure the menu of options is comprehensive for all groups and communities.

Our exercise has in the short time available not been able to do sufficient justice to matters of equality and health inequalities. We nevertheless see a clear opportunity for a high impact action relating to the most marginalised groups. NHS England has inherited the [Inclusion Health](#) agenda. This has stalled and needs a much more visible and effective drive into local areas.

⁵Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association (1999) [Health literacy: report of the Council on Scientific Affairs](#)

5

High impact action: Revive and champion the Inclusion Health agenda.

This is to address a key pinch point, where people struggle to access early supportive interventions as a result of the complexity of their needs or their disadvantage, exclusion or experience of discrimination, creating significant pressure and unnecessary costs in emergency and acute care.

We recommend: Work to develop a coherent overall approach that addresses: (a) inequalities that arise primarily from socio-economic factors; (b) those that are best seen through the lens of the Equality Act protected characteristics, and (c) those which relate to especially marginalized groups such as Gypsies and Travellers, homeless people and migrants.

Key themes include:

- The collection and use of relevant data for commissioning and monitoring, and for the evaluation of new care models
- How best to draw on existing expertise and evidence, eg from the VCSE sector, the Faculty of Public Health and the Care Quality Commission (CQC).
- How best to build on existing partnerships with VCSE organisations, and patients and carers from under-represented and often-marginalised groups, to co-produce support, services and information.

Working with the VCSE sector

There is no single voluntary sector 'offer' to the formal healthcare system.

The sector is highly diverse in the nature, size and capacity of its organisations; their missions and values; their reach into different communities, and the degree to which any organisation may combine a range of different roles.

Austerity has adversely affected the sector. There has been a significant reduction in grants as a consequence of shrinking local authority funding. Commissioning carried out through competitive tendering has excluded or disadvantaged many smaller organisations. Infrastructure bodies have shrunk, and in some areas disappeared.

If the NHS is serious about getting the best out of the VCSE sector, it also needs to get serious about addressing threats to the sector's viability, and avoid basing plans on the assumption of a VCSE capacity that might be disappearing.

Nor should the sector be seen through a single lens, such as 'providers', or a handful of household name charities. The graphics reproduced on page 23 from the [Untapped Potential](#) report by New Philanthropy Capital, commissioned by the Richmond Group of charities, paint a richer and more realistic picture. For the formal sector to be able to make the most of this potential, it needs to get far better at three things:

- Working in co-production to build trusted relationships.
- Creating funded, open, fair and mutually beneficial partnership opportunities at a range of levels.
- Recognising the importance of voluntary sector 'infrastructure', and the organisations that provide it, as trusted brokers for the inclusive involvement of the sector as a whole and the communities it supports, works with and champions.

This ground has been well covered by the [VCSE Review](#), [Realising the Value](#) and [Untapped Potential](#). A number of the high impact actions recommended in this report will help build on this work. Here are some further recommendations:

Co-production

Co-production should be an integral part of the overall commitment to [Chapter 2](#). The [Health and Social Care 2012](#) gave NHS England duties to involve people both in decisions about their own care and treatment, and in the design of changes to health services.

Co-production has now succeeded 'patient and public engagement' as the gold standard

for defining relationships between the statutory bodies on the one hand and citizens, communities and the VCSE sector on the other. There are various models to draw upon, such as the ones developed by the [IPC programme](#), the Coalition for Collaborative Care's (C4CC) [Coproduction Model](#) and TLAP's [ladder of participation](#). At its best NHS England has shown it can work well with the VCSE sector, but overall it really needs to up its game.

We recommend: That NHS England makes a clear and public commitment to working in co-production with patients, carers and VCSE organisations – and follows through.

This could include an explicit commitment to working in partnership with the VCSE sector in some or all of the NHS England ten business priority areas, taking existing relationships to a new level.

NHS England could provide an example to CCG, and STPs; it would be reflected in the planned revision of the [Transforming Participation guidance](#) and in the minimum expectations of areas adopting new models of care ([MCPs](#) and [PACS](#)), as well as STP footprint areas.

All the other recommendations in this report entail a next phase of work in co-production with relevant VCSE partners.

Making the most of VCSE offers

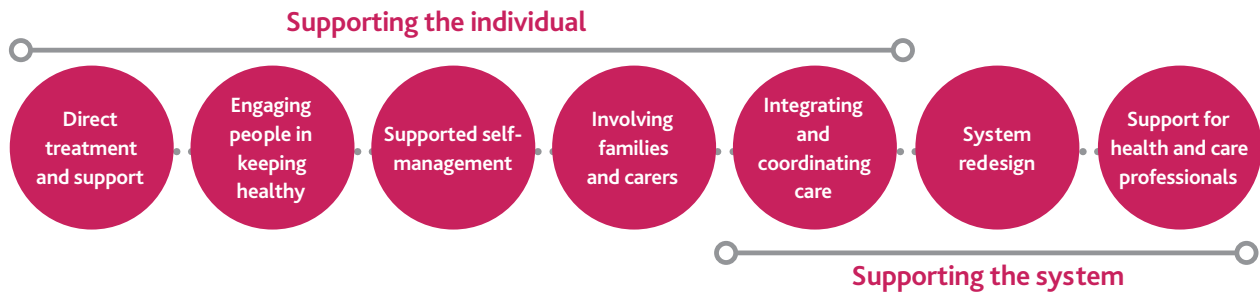
We received a range of proposals for innovative VCSE interventions (including one NHS proposal) that address pinch points in people's care and exemplify person-centred approaches. They are summarised in the annex. Many have been positively evaluated and have potential for systematic adoption and spread.

At present an adequate mechanism does not exist for making sense of such offers in ways that can best aid local adoption and spread. We therefore recommend to NHS England the following high impact action:

6

High impact action: Commission under a framework agreement a pool of preferred VCSE partners able to support person-centred, community-focussed interventions in defined geographical areas.

We suggest that the procurement framework under which VCSE partners have been commissioned to support the IPC programme provides a good model to follow. Local commissioners, vanguards and others should then be encouraged to draw upon the services offered. This should include, for example, support with delayed discharge; interventions to support people in the community, improve population health and community wellbeing, and the development of social prescribing.



Area of work	Associated concepts	Definition
Direct treatment and support	<ul style="list-style-type: none"> Emotional support Psychological support Practical support 	Health and care treatment / support delivered directly to people (includes wider non-medical support services such as financial and employment support).
Engaging people in keeping healthy	<ul style="list-style-type: none"> Prevention Addressing the social determinants of health 	Activities that are designed to reduce the likelihood of people becoming unwell. This includes, for example, behaviour change campaigns, information services, outreach work with specific at-risk communities.
Supporting self-management	<ul style="list-style-type: none"> Helping people understand their condition Signposting available support 	Activities that are designed to help manage an existing condition appropriately. This includes, for example, information services, signposting available support, health coaching.
Involving families and carers	<ul style="list-style-type: none"> Support for families and carers Involving families and carers in service delivery and design 	Services that provide support to families and carers to improve their health and wellbeing, that provide information to families and carers, or work to integrate families and carers into treatment processes and decisions.
Integrating and coordinating care	<ul style="list-style-type: none"> Helping patients navigate the system Convening agencies and individuals 	Coordinating care through statutory actors and organisations (eg, relaying information along the patient pathway or conducting research) as well as through patients (eg, equipping patients with knowledge and advice about available services).
System redesign	<ul style="list-style-type: none"> Piloting and mainstreaming innovative approaches Contributing to service design 	Activities that work to inform the way that services and whole pathways are designed and delivered—through research, pilots and relaying the views of beneficiaries to commissioners and policymakers.
Support for health and care professionals	<ul style="list-style-type: none"> Training Knowledge sharing 	Activities designed to train health professionals in specific areas, to bring them together with patients and other interested actors, to provide capacity relief.

This framework could also be the vehicle for addressing community engagement within the 44 Sustainability and Transformation Plan (STP) footprint areas. It is widely recognized that this got off to a bad start last year, posing both a reputational and material risk to the success of the plans. VCSE partners could help broker and support improved arrangements for engagement.

This procurement could be funded, in part or whole, from savings from the resources that NHS England's devotes to its in-house support, performance management and assurance functions directed at local commissioners. Alongside this:

We recommend: Creating a new channel to speed the adoption and spread of tested VCSE programmes and approaches. This would be a non-procurement mechanism to help the most promising innovations get to scale quickly and thereby demonstrate their value when mainstreamed. There are various possible routes to this, such as the funding model used for Shared Lives Plus, or an expansion of the NHS Innovation Accelerator.

Ways of making a change

Sector alignment

[Realising the Value](#) recommended that all the national system leading bodies need to align around the [Chapter 2](#) agenda. Indeed, they have pledged to do this under the TLAP [Shared Commitment to Engaging and Empowering Communities](#), which promises an action plan.

We recommend: That NHS England identifies a single point of leadership for this work either at senior management level or through a Five Year Forward View board.

We recommend: That this work includes taking forward the Realising the Value recommendation to build a consensus on a new, single, simplified cross-system outcomes framework, based on what matters most to people and communities and therefore likely to focus on the collective impacts of sectors working together to achieve health and wellbeing. (See also high impact action 2, page 13).

Within NHS England, our proposed universal offer for people with long-term conditions creates a frame for more seamless alignment of existing programmes and activities.

We recommend: That key elements of the offer, for example, personalised care planning and social prescribing, are 'hardwired' more explicitly into the major engines of reform being driven by NHS England, especially MCP and PACS contracts, the GP Forward View, CCG assurance, payment mechanisms etc.

We recommend: That the various strands of related support - e.g. for self-care, carers, community partnerships, personal budgets, and as part of the new care models team - are brought together more seamlessly and are more strongly harnessed to the main elements of system reform, with fresh thinking on the balance between what is done in-house by NHS England, and what is done in partnership.

More broadly there is scope for work relating to Chapter 2 to be better integrated with work on innovation and improvement, and to rethink the balance of resources devoted to improvement and innovation within the NHS, as compared with assurance and performance management.

Energising change makers in the system

Making a reality of Chapter 2 requires action throughout the NHS. It also requires the critical input of local government, other public services, business and the actions of citizens and communities themselves.

NHS England has formal levers at its disposal but also needs to help foster an environment that is receptive to change; that encourages local change-makers; values a diversity of approaches; spurs improvement, and avoids the downsides of many existing and previous NHS change management processes. In short, it needs to foster the spirit of "*the NHS as a social movement*" that was described in Chapter 2 of the Five Year Forward View.

We have examined a number of approaches to creating a system of sharing and learning for change at scale which need further development.

A change platform is a space (physical or virtual) for people to collaborate to achieve a common purpose, tackle a challenge or improve a situation.⁶ We would like to see the rapid prototyping and testing of a virtual and face to face learning platform to enable people to connect, share ideas and learn together at scale.⁷ This change platform could be a mechanism for spreading the work of the super demonstrators, through a series of interactive digital broadcasts, as currently being tested by the new care models team. It would connect clinicians, managers, patients, carers, VCSE professionals and many others.

⁷A recent digital broadcasting platform sponsored by the People and Communities Board and accredited by Stanford Medicine X made 20,000 plus connections. Examples in the VCSE sector globally include the Robert Wood Johnson [Flip the Clinic](#) and [Open IDEO](#).

⁸Conversation and interaction are [14 times more effective](#) as ways of influencing and sharing knowledge than best practice databases, toolkits, guides and written documents.

The change platform could host ‘improvement challenges’⁸ linked to the high impact actions. They could run as a series of multi-day challenges of varying length (e.g. 30, 60 or 90) depending on the complexity of the issues. They would enable people to interact, share ideas, distil solutions and mobilise for action.

A community of interest is a group of people that come together because they share a common interest, experience and/or identity. A community of practice is a group of practitioners who share a concern or a passion for something they do and learn how to do it better as they interact regularly. Realising the Value identified the need for such communities around person-centred and community-based approaches to health and wellbeing to be supported and sustained.

These three components of the learning and sharing system (change platform, improvement challenges and communities of practice/interest) can be aligned so as to be mutually reinforcing.

We recommend: That NHS England takes these ideas forward. There is a strong case to commission external partners with relevant expertise to help develop and deliver an explicit shared learning model containing the elements described above.

⁸For more information see NHS Academy for Large Scale Change (2013) [Leading large scale change: A practical guide](#)

Thematic issues

In this section we make recommendations on a number of key thematic issues that were raised with the PCB during this project – and where further work is required.

End of life care

End of life care is the stage of care where coordination and good care planning is most needed. It is the time when the spending on patients is at its highest and the time when discontinuities and poor transitions are most costly both for the person and their carer(s) and for the system. The four-step universal offer for people with long-term conditions outlined in this report (section 4) is fully relevant to people approaching the end of life.

NHS England has been notably successful in working in genuine partnership with other system leading bodies and in co-production with the voluntary sector through the national [End of Life Care Partnership](#). This produced a new national narrative based around the person, which supplements National Voices and TLAP's [Narrative for person-centred, coordinated care](#). This in turn has been used to co-design six new evidence-based [Ambitions for Palliative and End of Life Care](#). A new programme board is identifying the actions needed to underpin these. However, these Ambitions have yet to be embedded in the new care models.

We recommend: That NHS England now steps up the priority, energy and detailed work needed to do so, working closely with partners including the National Council for Palliative Care.

One of the Ambitions is to develop more community based palliative care, working with community assets. This would fit with our overall framework for care planning, social prescribing and community support (page 15), and we recommend that NHS England initiates a stream of work to develop this approach.

Carers' memorandum of understanding

Principle four of the [six principles](#) is that carers are identified, supported and involved.

There are around 5.4 million carers, of all ages in England, whose unpaid support to families, relatives and friends has been calculated as being broadly equivalent in monetary terms to the budget of the NHS.⁹

Carers have gone up the agenda in recent years. The [Care Act 2014](#) and [Children and Families Act 2014](#) set out an important framework that is meant to provide parity of esteem for carers; entrench the right to have their needs assessed, and to ensure that carers of all ages are identified early and are provided with information and advice. Despite this, experience suggests that there is still a great deal of scope to improve the offer for carers.

NHS England has worked successfully with VCSE carers' organisations to develop a [Memorandum of Understanding](#) for local services and systems to embed these functions. It has been tested in primary care, acute settings, and across a number of larger areas such as [Greater Manchester Health and Social Care Partnership](#), where it helps to align goals for carers across the city region and deliver a universal offer to them. It allows local diversity and adaptability.

We recommend: That NHS England promotes the systematic use of the carers' Memorandum of Understanding across all STP areas and new models of care to improve coordination and move towards the goal of identifying and supporting carers appropriately.

Volunteering and social action

The potential for better and greater use of volunteering and social action to create value in health and wellbeing remains underexplored.

Volunteering is time given freely for the benefit of others. It takes many forms and may take place through organisations (formal) or with friends and neighbours (informal). In health and care, it can happen in any services including GP surgeries and hospitals.

Social action is time freely spent with others to tackle local problems, negotiate with public services, and improve conditions that benefit all. It is often carried out through independent community groups. Social action can be aimed at improving the health of individuals or the community, but it can also help the people involved to keep well, and improve their wellbeing.

Principle six of the six principles is that volunteering and social action are key enablers to health and wellbeing. The People and Communities Board recognises the importance of

¹⁰Carers UK (2015) [Policy briefing: Facts about carers](#)

volunteering. These points are implicit in the six principles publications:

- Better health and wellbeing for those volunteering and taking social action
- New life and work skills for those volunteering and taking social action
- Enabling people to take more control over their lives and communities
- Supporting the health and care system to do better, and people to recover more quickly

These activities can be among the contributors to the “*planned, commissioned community-based approaches*” that form Element C of our framework for people with long-term conditions (page 16).

To frame further action and offers in this space requires good data. We currently do not have information about how commissioners approach volunteering and social action; the scale or type of volunteering that is already happening in local health economies, or how volunteering is used within different health organisations.

We recommend: That NHS England and NHS Improvement jointly prepare and carry out a national survey on these issues, co-designed with volunteer organising groups, during 2017-18.

Children and young people

The particular needs of children and young people, including those with complex lives, have been left out of the development of integrated care both in the pioneer programme and in the more recent new care models. As well as the risk of sub-optimal care and poor transitions to adulthood, this also threatens children’s education and development.

Significant groundwork has been done on a [narrative for person-centred coordinated care for children](#); on [transition to adulthood](#) across services, and on outcomes and indicators for integrated children’s services. What is needed now is a new drive for implementation.

We recommend: That NHS England identifies funding and establishes a new drive to recruit exemplar areas to develop advanced coordinated services for children with difficult lives.

The People and Communities Board and this project

People and Communities Board

It exists to:

1. Champion the [Five Year Forward View](#) vision and commitments and more broadly ensure that person-centred care and community-centred services are embedded in the Five Year Forward View programme.
2. Harness the expertise of patients, service-users, engaged citizens, the voluntary sector, and other stakeholders, providing a support and challenge function in relation to the delivery of the commitments across the whole of the Five Year Forward View, including those that relate to prevention and new models of care.

The PCB brings together people from the voluntary and community sector, NHS England, the CQC, NHS Confederation, the Association of Directors of Adult Social Services (ADASS), and the Local Government Association (LGA). It also has three members who are experts by experience. As at February 2017, the members are:

- Jeremy Taylor (Chair), Chief Executive, National Voices
- Caroline Abrahams, Charity Director, Age UK
- Vicki Nash, Head of Policy and Campaigns, Mind
- Emily Holzhausen, Director of Policy and Public Affairs, Carers UK
- Neil Cleeveley, Chief Executive, National Association for Voluntary and Community Action (NAVCA)
- Duncan Tree, Head of Policy and Performance, Volunteering Matters
- Laura Bennett, Senior Policy Manager, Carers Trust
- David McCullough, Chief Executive, Royal Volunteering Service (RVS)
- Colin Brown, Director of Crisis Response and Independent Living, British Red Cross
- Duleep Allirajah, Head of Policy, Macmillan
- Anu Singh (sponsor), Director of Patient and Public Participation and Insight, NHS England
- Abigail Gallop, Local Government Association (LGA)

- Martin Farran, Association of Directors of Adult Social Services (ADASS)
- Christine Morgan, Expert by Experience
- Mandy Rudczenko, Expert by Experience
- Mike Grady, Expert by Experience
- Warren Escadale, Regional Voices, Chief Executive Voluntary Sector North West
- Helen Bevan, Chief Transformation Officer, NHS Horizons Group, NHS IQ
- Phil McCarvill, NHS Confederation
- Chris Day, Care Quality Commission (CQC)

Observer

- Alexandra Ankrah, Office for Civil Society

Secretariat

- Sarah Hutchinson, Policy Advisor, National Voices

How we did our work

In September 2016, the PCB was invited by NHS England Chief Executive Simon Stevens to undertake a short exercise. The purpose was to recommend a limited set of high impact actions that would help to add speed and scale to the delivery of Chapter 2 of the Five Year Forward View, with a particular focus on actions that NHS England itself could help implement and support.

The actions would help:

- Exemplify the “*new relationship with patients and communities*” set out in Chapter 2 of the Five Year Forward View and further articulated in the PCB’s six principles.
- Provide solutions to key problems, challenges and ‘pinch points’ for the health and care system, as they impact on population health, care quality and sustainability of services.
- Address key issues for patients, service-users and the voluntary sector.
- Address issues of equality.
- Support those driving system reform, e.g. in the STP footprints.
- Help clarify and strengthen the contributions from the VCSE sector can make to help deliver Chapter 2.

The work was led by the PCB, with support from a core working group brought together by NHS England. Policy and drafting support was provided by National Voices (since the PCB chair is Chief Executive of National Voices). Within the limitations of time and resource, the

PCB sought to be as inclusive as possible.

The first step taken was to invite brief proposals from a number of targeted voluntary and community sector (and other) stakeholders. We received over 40 proposals from around 30 different organisations, and they are outlined in the annex. These proposals in turn formed the basis for the framework set out in the report. To develop and test the framework, the PCB held a number of stakeholder events and conducted a continuing dialogue with a number of key stakeholders from within NHS England, other national bodies and across the voluntary and community sector.

On 26 October the board held the first of two workshops. Attended by around 40 people, this brought together members of the PCB, representatives from the wider voluntary sector and representatives from the arms-length bodies. The emerging framework was presented, and feedback sought. The discussions from the workshop fed into the refinement of the framework, and the development of the high impact actions.

The board also held two webinars, the first aimed at people working in the voluntary and community sector, the second at those working in local health and care services. The emerging framework was presented and feedback and ideas sought for high impact actions, and how these could be implemented. More than 70 people took part in total.

A second workshop, bringing together the PCB and the arms-length bodies was held on 2 December to further hone the recommendations.

