Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision

National surveys:
Healthwatch, Voluntary, Community and Social Enterprise Sector members of Health and Wellbeing Boards

Voluntary, Community and Social Enterprise Organisations involved in health promotion and prevention

Research Report 3
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Abbreviations

BME groups: Black and minority ethnic groups
BOS: Bristol Online Survey
CCG: Clinical Commissioning Group
DH: Department of Health
DsPH: Directors of Public Health
EAG: External Advisory Group
HIA: Health Impact Assessment
HWB: Health and Wellbeing Board
IAPT: Improving Access to Psychological Therapies
JSNA: Joint Strategic Needs Assessment
LGA: Local Government Association
LINks: Local Involvement Networks
NIHR: National Institute for Health Research
OSC: Overview and Scrutiny Committee
PCT: Primary Care Trust
PHOF: Public Health Outcomes Framework
VCF: Voluntary Community and Faith
VCS: Voluntary and Community Sector
VCSE: Voluntary, Community and Social Enterprise
VONNE: Voluntary Organisations' Network North East

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Executive Summary

Background

This report is the third in a series of four research reports carried out as part of an initial scoping phase of a project funded through the Department of Health Policy Research Programme. The project is entitled *'Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision'*.

The research project as a whole is designed to evaluate the public health reforms with particular reference to the use of the public health budget, commissioning public health services and the new public health role of local authorities. This report presents findings from one aspect of this research, the involvement of Healthwatch and VCSE organisations in prevention. It explores project themes of commissioning, innovation, changes in the provider landscape and engagement with local communities, especially underserved groups. These themes are explored through two related surveys, carried out concurrently in June/July 2015. The first survey is of local Healthwatch and Voluntary, Community and Social Enterprise (VCSE) sector members of Health and Wellbeing Boards (HWBs). A Healthwatch representative is a core member of HWBs, but VCSE representation is optional and variable. The second survey was targeted to VCSE organisations involved in delivering services or interventions to improve health and reduce health inequalities (and not the broad spectrum of VCSE organisations). While research activities carried out as part of the scoping phase are primarily intended to inform research instruments for the case study research, these surveys also make an independent contribution to project aims and objectives.

Methods

Bristol Online Survey (BOS) was used to create survey tools and each survey went through several iterations in consultation with the project team prior to piloting. The surveys were amended in the light of feedback from five pilots, three for survey 1, (including two from local Healthwatch members) and two for survey 2. Surveys were cascaded by 8 regional coordinators for Regional Voices (a strategic partner of DH) through their databases of Healthwatch and VCSE members of HWBs and wider VCSE networks. (Separate databases of VCS organisations involved in prevention were not available.) Through the support of a Healthwatch England member of the project External Advisory Group (EAG), local Healthwatch members were also contacted via a newsletter and on the Healthwatch intranet. Regional coordinators were followed up in order to confirm the distribution arrangements (169 members of HWBs and 3,293 VCSE organisations). The surveys were open for 19 days and 22 days respectively. Survey 2 was shorter, included more open questions and focused on approaches to, and examples of innovation while survey 1 included more questions on commissioning, reflecting the strategic role of HWB members. However, both surveys included questions on the impact of the public health reforms, funding, influences on commissioning preventive services, public

involvement, innovation, and enablers and barriers to greater involvement of the VCSE sector in prevention.

Results

There were 34 usable responses for survey 1 (21/152 Healthwatch respondents, 12 VCSE sector respondents (denominator unknown, as not all HWBs have VCSE members) and one member of the public (as a HWB member). All nine regions of England were represented. There were 39 usable responses from VCSE organisations for survey 2 with responses from six of the nine regions. The groups most commonly represented by VCSE organisations in survey 2 were families, people with mental health problems and older people. Respondents provided details of a total of 62 prevention projects that they wished to highlight. Both surveys had a low response rate and findings are therefore exploratory and should not be used as a basis for generalisation. The topics are further explored through fieldwork across 10 case study sites, where interviewees include local Healthwatch and VCSE members of HWBs and a representative of a VCS umbrella body in sites where there was no formal VCS representation on the HWB.

Across both surveys, local authorities were identified as the main funder of VCSE providers of preventive services. While there were differences between local authorities, respondents identified a number of changes needed to enable VCSE organisations and local Healthwatch to exert greater influence on commissioning preventive services. These included: capacity and resources**;** greater recognition by commissioners; more emphasis on co-design and community involvement in priority development; and changes in the ways that HWBs worked, including more recognition of local Healthwatch and the VCSE sector. Survey 2 included detailed responses on the complexity of contractual arrangements; the need to include smaller VCSE groups; and of grounding commissioning priorities in community needs. Specific suggestions included reflecting the spirit of the Social Value Act in the commissioning process and for VCSE organisations to work more closely in partnership, providing evidence of effectiveness and impact. It was suggested that contracts included elements of active engagement and that plans for preventive services be signed off by local Healthwatch.

Almost three quarters of respondents (survey 1) supported the public health reforms, but across both surveys the majority could not identify improvements in public involvement in commissioning, in co-design or across a wide range of factors related to the VCSE sector. However, for three areas, between 40% and 50% of respondents (survey 1) considered the reforms had enabled innovation: targeting services; addressing unhealthy lifestyles; and addressing social context and conditions. The concurrence of public health reforms and budget cuts was noted by many respondents with the suggestion that the effects of the cuts were potentially masking the benefits of the reforms.

In considering innovation, responses were similar across both surveys, especially in the way that innovative practice was seen as deriving from views of communities and service users. Both surveys also reflected a view that the term ‘innovation’ was

over-used and a potential smokescreen for budget cuts. Examples of innovative approaches included targeting, developing community networks, integrated approaches to wellbeing and prevention, a single referral route for health and social care workers for preventive services provided through the VCSE sector, and the use of smartphones and skype. There was little knowledge of VCSE sector involvement in wider public health issues on the part of local Healthwatch respondents while a few respondents from the VCSE sector highlighted cross-directorate approaches for improving mental health and addressing social isolation.

Views over enablers and barriers to greater involvement of the VCSE sector in prevention spanned a wide range of issues: budgets; capacity; better recognition of services provided through the sector and of the role of smaller organisations; earlier involvement in the commissioning process; flexibility on the part of commissioners; and the importance of recognising in contracts the core costs of the sector. While there was variation in the assessment of HWBs, and the extent to which they engaged with the VCSE sector, there were criticisms of their effectiveness as decision-making bodies. In survey 2, executive elected members were perceived as having less influence on commissioning preventive services than CCGs and were considered as a route for influencing the commissioning of preventive services by only 50% of respondents, while local authority public health teams were perceived as the most important influence.

Conclusions

In relation to project themes, responses to the surveys underlined key tensions which will be explored further through research in case study sites. There was little congruence between the activities described by respondents and public health budget reporting categories reflected in the ring-fenced budget: 25 of the 62 prevention projects highlighted by respondents in survey 2, for example, were specifically described as including a mental health focus or impact, and this focus was also implicit in many of the other highlighted projects concerned with health and wellbeing. However, this does not appear as a separate category in the public health budget transferred from the NHS. There was relatively little involvement of the VCSE sector in health checks, obesity, sexual health or smoking cessation services. For preventive services, there was greater emphasis on methods of engagement and integrated approaches to health and wellbeing than on single interventions as reflected in the evidence base for public health interventions. Advocacy, peer support and volunteering were often combined.

An emphasis on innovation as deriving from community views was marked: the wide range of initiatives reflected, especially in survey 2, provides a basis for developing an innovation framework for preventive services. Survey respondents provided relatively little evidence of changes specifically resulting from the reforms and HWBs were assessed as playing a comparatively limited role in the prevention agenda.

Different understandings of prevention are reflected in the projects highlighted, which cover a spectrum from prevention of hospital admission and holistic approaches for people with cancer to community-based wellbeing services and

asset-based approaches. This underlines the importance not only of clarifying different approaches to prevention and public health for HWB members and for the VCSE sector, but also of identifying the implications both for commissioners and providers in maximising preventive impact within each of these approaches. While exploratory in nature, analysis of the detailed comments provided by respondents provided useful pointers for how the preventive role of the VCSE might be further developed, relevant background for case study research and perspectives on innovation which will be developed in further reports.

Introduction

Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision is a research project funded by the Department of Health (DH) Policy Research Programme. Its purpose is to evaluate the impact of public health reforms set in motion by the Health and Social Care Act 2012 and the project is being carried out by a research team from the Universities of Durham, York and Coventry and from Voluntary Organisations' Network North East (VONNE). It began in January 2015 and ends in June 2017.

The reforms gave local authorities new responsibilities for improving the health of their populations, accompanied by the transfer from the NHS of Directors of Public Health (DsPH) and their teams along with a public health grant, initially ring-fenced for two years (with the ring-fence subsequently extended until 2015-2016, and further extended until 2018, following the Spending Review and Autumn Statement in November 2015). As the reforms built on pre-existing local government involvement in public health and on local partnerships, this study focuses on the impact of three new responsibilities that directly result from the reforms, reflected in three inter-related workstreams: (1) new budgetary responsibilities; (2) local authority responsibilities for commissioning preventive services through a range of providers; and (3) a leadership role for local authorities in promoting health and addressing health inequalities. Methods include surveys to provide a national overview, data analysis of spend and health outcomes and study of ten case study sites across England. Research outputs are intended to contribute to effective public health commissioning for the public health budget and across local authority services.

Evaluating the impact of the reforms is made more complex by variation in local authorities given differing local circumstances, and the range of partnership initiatives and innovative preventive services which predate the reforms. A previous National Institute for Health Research (NIHR)-funded study on commissioning for health and wellbeing in the former Primary Care Trusts (PCTs) (Marks et al., 2011) (which included public involvement in commissioning) provides a basis for comparison as well as a governance framework for public health on which this research project can build.

The study adopts an iterative approach and analyses from each of four research reports, carried out as part of an initial, scoping phase (January to September 2015) are intended to inform data collection in ten case study sites across England. The first report analysed interviews with national stakeholders (April 2015) and the second report focused on the public health budget (May 2015). This third report concerns two related national surveys, carried out concurrently. The first survey is of local Healthwatch and Voluntary, Community and Social Enterprise (VCSE) sector members of Health and Wellbeing Boards (HWBs), and the second survey was targeted more widely, to VCSE organisations involved in delivering services or interventions to improve health and reduce health inequalities.

Background to the surveys

While research activities carried out as part of the scoping phase are intended to inform research instruments for the case study research, the surveys reported here also make an independent contribution to project aims and objectives, in particular, in relation to innovation in how the public health budget is deployed; provider innovation; community engagement; the influence of the public in commissioning decisions; and improving access for underserved groups.

The 2010 public health White Paper, *Healthy Lives, Healthy People,* notes that local authorities are encouraged to commission through the public health budget 'a wide range of providers across the public, private and voluntary sectors and to incentivise and reward those organisations to deliver the best outcomes for their population' (para. 4.23). This can include 'grant funding' for local communities to 'take ownership of some highly focused preventive activities, such as volunteering, peer support, befriending and social networks' (ibid). Research on the clustering of health behaviours (Buck and Frosini, 2012) and the potential significance of integrated preventive initiatives for narrowing the health gap, underlines the importance of developing a range of innovative approaches. In research report one, for example, it was noted that the development of 'integrated wellness services' was a response to the fact that individuals had multiple risk factors combined with social disadvantage. Integrated services could provide a gateway to the range of local authority services, including housing and leisure services, as well as more specialised lifestyle management services. Through exercising their new commissioning responsibilities, therefore, local authorities have the flexibility to combine, target, and remodel preventive services, involve a wider range of providers and tailor services to local needs. However, it is also the case that 'discretionary' services are those most likely to be vulnerable in the context of large scale cuts and that housing and leisure services, for example, are typically contracted out.

At the same time, there is a long-standing recognition of the importance of community engagement if health inequalities are to be addressed and preventive initiatives are to be successfully implemented. This was reiterated in research report one, where it was emphasised that 'engagement with diverse communities, especially the most marginalised communities, needed a proactive approach by local authorities, rather than their relying solely on processes of democratic accountability' (Marks et al., 2015). It was argued that councils could build on community assets, recognising the role of VCSE organisations not only as providers but also as a route for connecting with community networks, given local knowledge. The reforms had made it easier to change providers for preventive services (with delivery of health checks offered as one example) and VCSE organisations could be commissioned to play a greater role in engaging with disadvantaged groups and in developing innovative approaches. Otherwise, programmes such as health checks, for example, could serve to exacerbate health inequalities.

The importance of identifying initiatives for fostering the co-design of services across different age groups and assessing how these were reflected in the commissioning process was emphasised through the review process for the original research proposal. The consumer voice is reflected through local Healthwatch as core members of HWBs, which may also include representatives from local VCSE organisations. As part of their remit, local Healthwatch members are intended to gather the views of local people and thus contribute to 'commissioning, provision and scrutiny' of health and social care services (Local Government Association (LGA), 2013), reflect the views of seldom heard groups and work across partnerships to maximise community engagement. Their role is in addition to that of elected members of the local authority and of local authority scrutiny committees in ensuring accountability to a local electorate.

Other recent research has considered the role of VCSE organisations in health and wellbeing. A national opinion survey of lead members for public health, conducted by the LGA (LGA, 2015) showed that, after CCGs and the HWB, the VCS was considered the main local partner for taking forward public health. Three surveys of local Healthwatch and VCSE members of HWBs, as well as of VCSE members interested in engaging with the HWB, were carried out by Regional Voices between 2013 and 2015 (Regional Voices 2013; 2014a; 2015). Funded through the DH Innovation, Excellence and Strategic Development Fund, the surveys were designed to assess progress in engaging with HWBs. While representatives reported a good understanding of their role, there was also evidence of underutilisation of the VCS by partners in health and social care, diminishing of influence as the commissioning cycle progressed and the need for clearer routes of engagement and better working across Healthwatch and local voluntary organisations. (Survey findings can be viewed at http://www.regionalvoices.org/hwb-reps/survey). In a further paper exploring localised commissioning (Whaley et al., undated), challenges faced by the VCS are described as follows:

The needs of communities are not being fully understood, (e.g. each Joint Strategic Needs Assessment does not pick up the needs of each community; the groups that are affected by the issue are not involved in commissioning decisions locally (e.g. shaping pathways) so there is little co-design; and VCS services are not being fully funded and it is a difficult funding environment.

Yet the report also highlights that VCSE organisations are likely to play a greater role in areas such as social prescribing, community development approaches to health, peer-led activities and dialogue between users of services and commissioners. A subsequent working paper (Regional Voices, 2014b) suggests 15 questions to explore at a national level, linked to the development of Joint Strategic Needs Assessments (JSNAs) and more effective engagement with commissioners. Despite interest in further developing the role of VCSE organisations in public health and prevention, in promoting innovation and in increasing public involvement and co-design of preventive services, these aspects remain relatively neglected. The two surveys described in this report allow us to explore these issues at a national level, although the case study research will allow for more detailed study. The surveys explore the

influence of local Healthwatch and VCSE organisations on commissioning preventive services and the contribution of the VCSE sector to innovation. In particular, the surveys allow us to explore views over what constitutes innovation in commissioning and providing preventive services and over the impact of the public health reforms. These themes will be discussed in more detail in project report six, *An innovation framework for public health commissioning.*

Methods

***Survey 1**: National survey of local Healthwatch and VCSE sector members of HWBs*
***Survey 2**: National survey of VCSE organisations involved in health promotion and prevention of ill health*

The surveys were intended to provide a national context and inform detailed research in ten case study sites across England. Survey design was carried out collaboratively by the research team between March and May 2015 and, in particular, Joanne Smithson, Co-investigator, led on the development of survey 2 and liaised with Regional Voices for distribution of both surveys. Findings from research report one (April 2015), *Views of national stakeholders,* (Marks et al., 2015) were taken into consideration when formulating the questions. (Interviewees for this report included a representative from Healthwatch England and from a national association for the VCSE sector.) Bristol Online Survey (BOS) was used to create the survey tools and each survey went through several iterations in preparation for piloting. At the end of May 2015, formal invitations to pilot the surveys were emailed to the following: survey 1, two Healthwatch contacts and three VCSE infrastructure organisation contacts; survey 2, four VCSE infrastructure organisation contacts. Reviewers were asked to consider whether the content of the questions was clear and relevant, if any additional questions were needed, and if the estimated completion time was accurate and acceptable. General feedback was also welcomed along with suggestions on how to encourage a good response to the surveys. In total, survey 1 received feedback from three contacts (including the two Healthwatch contacts) and survey 2 received feedback from two contacts. Adjustments were made accordingly to each of the surveys.

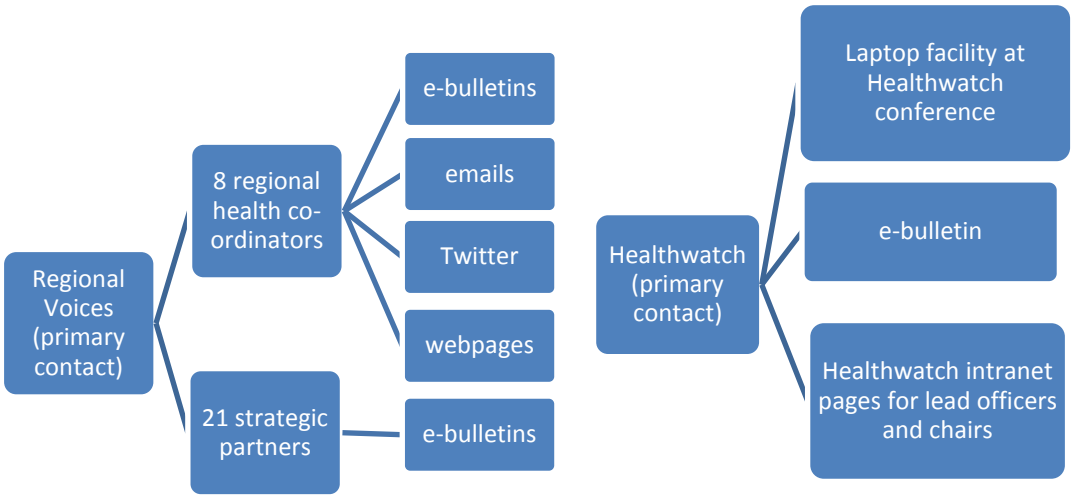
From 15th June the surveys were made live with survey 1 closing on the 3th July (19 days) and survey 2 closing on 6th July (22 days). As outlined in Figure 1, surveys were cascaded through 8 regional coordinators for Regional Voices (one coordinator covered two geographical regions). In addition, through the support of a Healthwatch England member of the project External Advisory Group (EAG), local Healthwatch members were also contacted via a newsletter and on the Healthwatch intranet. In order to avoid ambiguity over the focus of the surveys, distribution emails included a broad definition of prevention as follows:

We are interested in a broad range of services designed to improve health and address inequalities, including community development and wellbeing; lifestyle management services; health checks; preventive initiatives as part of services for particular client groups; and involvement in health-related initiatives across local authority directorates (such as environment, leisure, planning).

Each regional organisation was then followed up in order to confirm distribution networks: regional coordinators confirmed a total of 169 members of HWBs and 3,293 VCSE organisations (although the latter reflected all VCSE organisations and not the smaller number focused on prevention). There was wide variation in the

means of distribution (for example, as part of a regular email bulletin, twitter, direct emails or posted on a website). Databases also varied regionally, with different combinations of VCSE organisations included: members of HWBs were not always kept in a separate database, for example. The distribution approach reflected the number and diversity of VCSE organisations, but it was anticipated that most VCSE organisations would not necessarily interpret their activities as related to health promotion and prevention and a low response rate for survey 2 was therefore anticipated.

Figure 1: Distribution of surveys



Throughout the report, percentages are used to describe the findings (which may not add up to 100 per cent due to rounding). Care should be taken when interpreting these percentages as small differences can seem magnified and the response rates were very low. Actual numbers of respondents are included for each figure to avoid misinterpretation of results. The majority of survey questions were mandatory but for optional questions, the number of respondents who answered the question is provided. Where qualitative responses were incomplete, this is also indicated.

Survey 1: national survey of local Healthwatch and VCSE sector members of HWBs

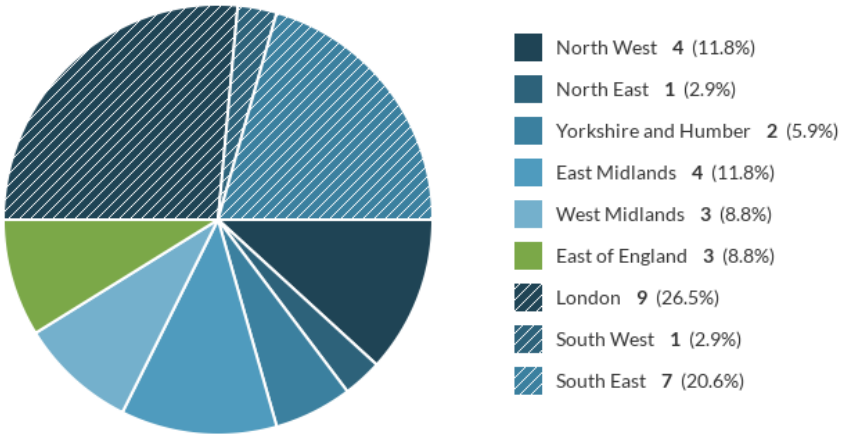
Survey 1 targeted local Healthwatch and VCSE sector members of HWBs. Despite historical connections between the former Local Involvement Networks (LINks) and Healthwatch, established as a result of the reforms, there are clear distinctions between the roles of Healthwatch and of VCSE members of HWBs. Whereas a local Healthwatch representative is a statutory HWB member, not all HWBs include the VCSE sector as members and if they do, representation may be through a single issue organisation or through an umbrella organisation. We therefore analysed responses of Healthwatch and VCSE sector respondents separately, despite the small numbers involved, and where there are marked differences of view (defined for this purpose as greater than 25%) these are identified in the analysis. Results reflect the order of survey questions: respondents and their organisations; commissioning preventive services; influence of VCSE organisations on commissioning; changes since the relocation of public health responsibilities to local authorities in April 2013; defining innovation; and enablers and barriers to greater involvement of the VSCE in providing preventive services.

Respondents and their organisations

In total, there were 36 responses of which 34 were included in the analysis. Two respondents (an elected member of HWB and a CCG Chair) did not meet the inclusion criteria. Respondents identified themselves as being either a Healthwatch or a VCSE member of a HWB, with the exception of six people who selected the 'Other' category. However, through their description of their role, all but one of these respondents could be re-categorised into one of the two primary groups, with the exception of one HWB member, described as a member of the public. This response remained part of the analysis. Consequently, the survey responses consisted of 21 Healthwatch respondents (61.8%), 12 VCSE respondents (35.3%) and one member of the public (3%). While all 152 HWBs include a member of local Healthwatch (response rate: 13.8%), the number of VCSE members of HWBs is unclear as some HWBs have one (or more) and others have none. It is, therefore, not possible to identify a response rate for this group or for the survey as a whole.

At least one response was received from each of the nine regions (see Figure 2). The highest proportion of responses was from London (26.5%) followed by the South East (20.6%). The lowest response rates were from the North East (2.9%) and the South West (2.9%). Over half of the respondents had been a member of the HWB for more than two years (58.5%), 14.7% reported a membership of one year and 26.6% less than one year. This meant that, for some respondents, changes since the reforms may have proved difficult to identify.

Figure 2: Geographical distribution of responses



Survey respondents were asked to identify the main purpose of their organisation. The most common answer from the 21 Healthwatch respondents reflected their statutory role, that is, to act as a consumer champion for health and social care. Some respondents provided more detailed accounts: gathering the views of local communities in relation to their needs, priorities and experience; influencing commissioners and providers to make continued improvements in the design, quality and delivery of care; promoting consumer involvement and inclusion in decision-making; signposting consumers to services; undertaking service reviews following feedback from local consumers; making use of 'enter and view' powers to observe services; and referring any significant issues to the Care Quality Commission for special enquiry. There were, therefore, slight differences of emphasis over whether patients or the local community were profiled.

Of the 12 VCSE respondents, six belonged to an infrastructure organisation, described as providing training, networking, fundraising and representation and support for capacity-building for local VCSE organisations. The remainder described the beneficiaries of their organisation as younger people (one respondent), people with long-term conditions and carers (two respondents) and older people (two respondents). One respondent provided an incomplete answer.

Commissioning preventive services

In this part of the survey, respondents were asked to indicate the importance of factors influencing preventive services commissioned in their local authority area, which organisations commissioned preventive services from the VCSE sector, routes through which Healthwatch and the VCSE sector could influence commissioners, routes for influencing JSNAs and any changes required.

Influences on the commissioning of preventive services

Table 1 shows that each of the factors listed were considered to be ‘important’ or ‘very important’ by the majority of respondents, with the exception of three factors:

VCSE organisations; members of overview and scrutiny (OSC) committees; and Members of Parliament. For the latter two groups, respondents were more likely to choose the 'somewhat important' or 'neutral' categories. Whilst respondents were not asked to rank the factors, more than three quarters of respondents agreed that the following factors were 'important' or 'very important': local authority public health team; JSNA; CCGs; and the joint health and wellbeing strategy. Four factors had a comparatively high proportion of 'not important' responses: Members of Parliament (23.5%); VCSE organisations (20.6%); consultation with local communities (17.6); and OSC members (11.8%). Nearly all of the factors had some 'don't know' answers, the highest being related to historical provision, OSC members and the public health outcomes framework (PHOF). Frontline elected members were viewed as 'important' or 'very important' by 53% of respondents, compared to 85.3% who chose these options for local authority officers (the public health team).

Table 1: Influences on the commissioning of preventive services

	Important / very important	Somewhat important / neutral	Not important	Don't know
Local authority public health team	85.3	11.8	0	2.9
JSNA	82.4	14.7	0	2.9
CCG	82.4	14.7	2.9	0
Joint health and wellbeing strategy	76.5	20.5	0	2.9
Public health outcomes framework	68.1	23.6	0	8.8
National policy/government priorities	67.7	26.5	0	5.9
NHS priorities	67.7	26.5	0	5.9
HWB	58.8	35.3	2.9	2.9
Executive elected members of the local authority	53	35.3	5.9	5.9
Consultation with local communities	52.9	26.5	17.6	2.9
Historical provision	52.6	35.3	0	11.8
VCSE organisations	44.1	29.4	20.6	5.9
OSC members	32.3	44.1	11.8	11.8
Members of Parliament	32.3	38.3	23.5	5.9

% of respondents (N=34)

There were notable differences in responses from Heathwatch (n=21) and VCSE (n=12) respondents (25% or more difference) for the following:

- National policy/government priorities: Healthwatch respondents placed greater emphasis on this factor being 'very important' or 'important' (76.2%) in comparison to VCSE respondents (50%);

- VCSE organisations: VCSE responses were weighted towards this factor being 'very important' or 'important' (75%) when compared to Healthwatch responses (28.5%).

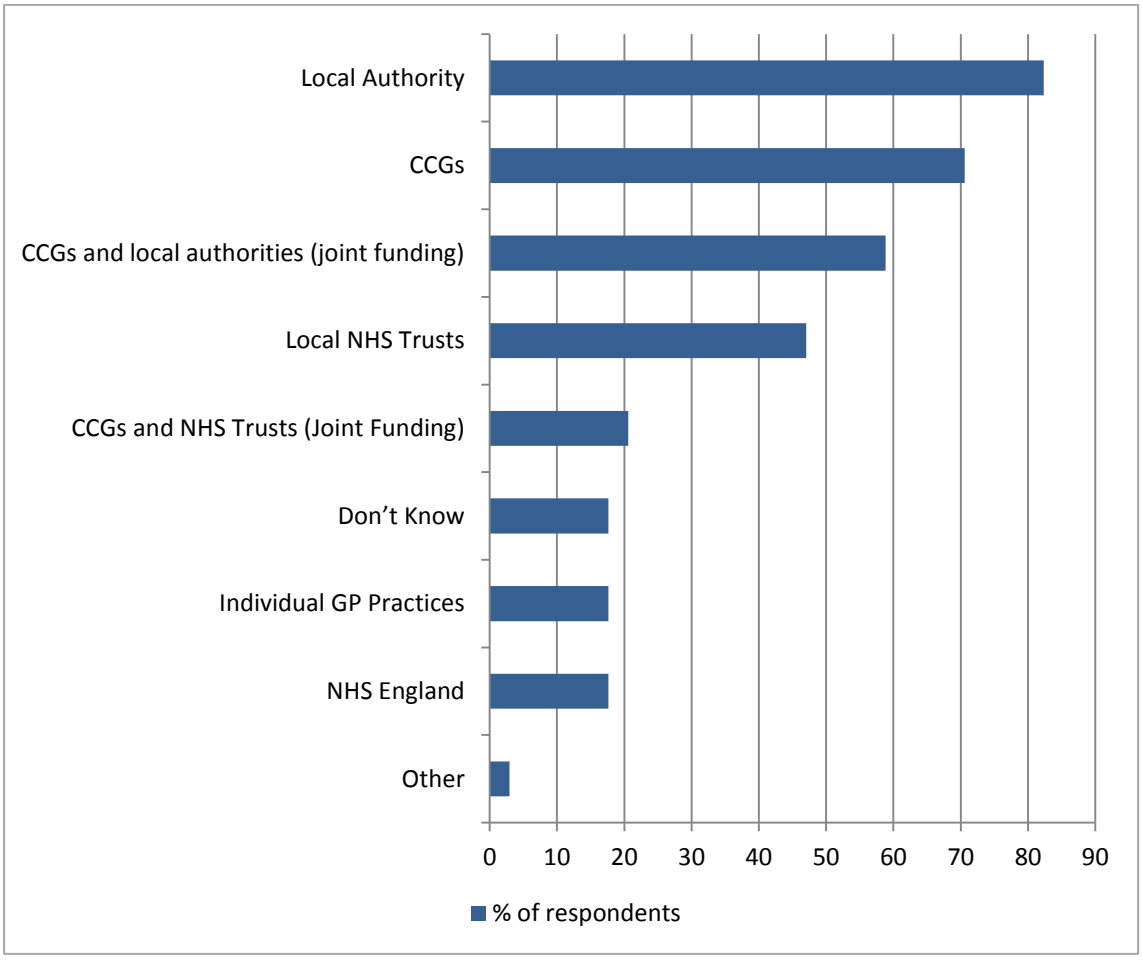
Across the responses collectively, the proportion of 'not important' responses did not considerably differ between the two groups (Healthwatch 4.8% compared with VCSE 3%). Similarly, there was little difference in the proportion of 'don't know' responses (Healthwatch 5.4%; VCSE 4.2%).

Respondents were asked to list any factors that were missing from the list provided. This resulted in eight respondents highlighting the following: social housing; the social care outcomes framework; the Safeguarding Board; social care commissioning of preventive services through personal budgets/grant aid; executive officers (NHS and local authority); local enterprise partnerships; and 'media panics'.

Commissioning preventive services from the VCSE sector

Respondents were asked to identify which organisations currently commissioned preventive services from the VCSE sector in their local authority area. Respondents could select as many of the options as applied. The percentage of respondents that identified each of the factors is displayed in Figure 3. The four main organisations identified were: local authority (82.4%); CCGs (70.6%); CCGs and local authorities (joint funding) (58.8%); and local NHS Trust(s) (47.1%). One respondent selected 'Other' which referred to the Fire & Rescue Service and the private sector (unspecified).

Figure 3: Who commissions preventive services from the VCSE sector?



N=34

Routes for influencing the commissioning of preventive services

Respondents were asked to assess routes through which their organisation could influence the commissioning of preventive services in relation to a list of factors shown in Table 2. Each of the factors listed was considered to be 'important' or 'very important' by 50% or more of respondents, with the exception of the HWB and Members of Parliament. The survey did not require respondents to rank the factors but more than three quarters of respondents agreed that the local authority public health team and CCGs were important or very important. Four factors had a comparatively high proportion of 'not important' responses: VCSE infrastructure body (23.5%); Members of Parliament (20.6%); OSC members (17.6%); and executive elected members of the local authority (14.7%). All of the factors had some 'don't know' answers, the highest being related to sub-groups of the HWB. Officers are seen as more important routes of influence than elected members.

Table 2: How can Healthwatch and VCSE members influence the commissioning of preventive services?

	Important / very important	Somewhat important / neutral	Not important	Don't know
Local authority public health team	79.4	14.7	2.9	2.9
CCG	76.5	17.6	2.9	2.9
Local authority forums	64.7	14.7	11.8	8.8
In-house discussion with directorates	61.8	20.6	8.8	8.8
Sub-groups of the HWB	52.9	26.5	8.8	11.8
OSC	50	23.5	17.6	8.8
Executive elected members of the local authority	50	32.4	14.7	2.9
VCSE infrastructure body	50	20.6	23.5	5.9
HWB	47.6	20.6	8.8	2.9
Members of Parliament	26.4	47	20.6	5.9

% of respondents (N=34)

Responses from Heathwatch (n= 21) and VCSE (n=12) respondents were not notably different (25% or more difference) for individual questions. There were, however, some differences collectively in the proportion of 'not important' responses (Healthwatch 14.3% compared with VCSE 6.7%).

Respondents were asked to list any factors that were missing from the list provided. This resulted in five respondents providing details of nine additional factors (none of which were duplicated). Routes of influence described as 'very important' were Leaders, Boards/Panels, a local Fairness Commission and Integration/Vanguard Boards, while the following were categorised as 'important': NHS Trusts; Care Quality Commission; Healthwatch England; and local Policy Commissions.

Influencing Joint Strategic Needs Assessments

Respondents were asked to assess the importance of a number of factors for enabling their organisation to influence the JSNA. Table 3 shows that each of the factors listed were considered to be 'important' or 'very important' by the majority of respondents, with the exception of VCSE partnerships. While respondents were not asked to rank the factors, more than three quarters of respondents agreed that direct involvement with local authority commissioners, the local authority public health department and direct involvement with CCGs were 'important' or 'very important'.

VCSE Health Partnerships stood out as having a comparatively high proportion of 'not important' responses (23.5%) which was followed by the HWB (14.7%) and

public consultation mechanisms (11.8%). Only two factors had 'don't know' answers: VCSE Health Partnership (11.8%) and direct involvement with local authority commissioners (2.9%).

Table 3: Routes for influencing Joint Strategic Needs Assessments

	Important / very important	Somewhat important / neutral	Not important	Don't know
Direct involvement with local authority commissioners	88.2	5.9	2.9	2.9
Local authority public health department	82.3	11.8	5.9	0
Direct involvement with CCGs	76.4	20.6	2.9	0
HWB	73.5	11.7	14.7	0
Through public consultation mechanisms	67.7	20.5	11.8	0
VCSE Health Partnership	47.1	17.6	23.5	11.8

% of respondents (N=34)

Healthwatch (n=21) and VCSE (n=12) responses notably differed (25% or more difference) in the answers provided in related to the following:

- Public consultation mechanisms: Healthwatch respondents placed greater emphasis on this factor being 'very important' or 'important' (76.2%) in comparison to VCSE respondents (50%). VCSE respondents were more inclined to consider this factor 'somewhat important' or 'neutral' (41.7%) (Healthwatch 9.6%);
- VCSE Health Partnership: a greater proportion of Healthwatch respondents considered this factor to be 'not important' (33.3%) when compared to VCSE respondents (8.3%). Conversely, a greater percentage of VSCE respondents considered this factor to be 'important' or 'very important' (66.7%) compared to Healthwatch respondents (33.3%).

There were four additional factors cited by four different respondents (there were no duplicated responses) that were considered to be 'very important', that is, a HWB sub-group for the JSNA; direct involvement with the JSNA team; local groups representing local people; and 'data' groups.

Changes required to influence commissioning of preventive services

Respondents were invited to comment on this question and answers are grouped and analysed thematically. Responses fell into four main categories. In order of frequency, these were: capacity and resources; greater recognition; more emphasis on co-design and on the public voice in commissioning; and better decision-making in HWBs. Other issues raised included the role of a Fairness Commission in focusing attention on preventive services; the need for better engagement with

commissioners and for public health commissioning to be better synchronised with other local authority commissioning processes; more feedback on the JSNA; and less in-house procurement.

Capacity and resources: lack of capacity and resources were the topics most commonly raised (10 respondents). It was emphasised that relationships 'take time to build and maintain' and, in one example, a VCSE sector respondent described a local context which included four CCGs, two local authorities, four NHS trusts and three separate integration programmes. Given the demands of health and social care services, resources were inadequate to focus on prevention, as noted by one Healthwatch respondent:

At present, we have insufficient resource to engage effectively with the cycle of commissioning of mainstream services, let alone preventive services.

From the perspective of smaller VCSE organisations, contracts were described as 'cumbersome', which meant organisations were not just less viable but also less responsive.

Greater recognition: 10 respondents emphasised the need for more recognition from statutory services of the value of both Healthwatch and the VCSE sector and of the public as 'partners in the solutions', although this aspect was more evident in VCSE sector respondents. One VCSE respondent commented that all contracts should have 'a mandatory element for active engagement and provision by community groups'. There was a plea for 'genuine listening by someone, somewhere' and more engagement from the health and social care system, including the public health team. There could be more engagement, for example, in working groups of the CCGs, NHS Trusts and the local authority. A local Healthwatch respondent suggested that guidance was needed so that 'any preventative plan/framework would require sign off and evidence of involvement of local Healthwatch'.

Co-design and the public voice: the extent to which local Healthwatch and the VCSE sector could influence commissioning was premised on a system where the public voice was recognised as 'important and essential in knowing what works and what doesn't'. Four respondents highlighted the importance of co-production and of involvement of appropriate groups of service users in service design.

Changes in the working of HWBs: three respondents voiced criticism of HWBs, not only over their lack of decision-making power but also over how decisions within the Board were reached. One Healthwatch respondent described it as a 'traditional County Council Committee in which all decisions are taken outside the Board meeting'. Another respondent emphasised the need for HWBs to provide routes for those 'outside the tent', moving away from 'clandestine conversations with the 'right person'. (Responses to other questions (see Table 2) demonstrate that there is variation in respondent views about the working of HWBs and of its sub-groups).

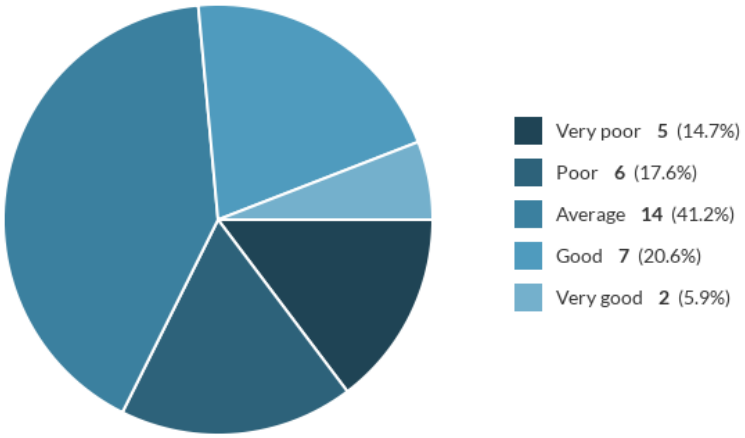
Influence of VCSE organisations on commissioning

In this section of the survey, respondents were asked to assess the HWB as a forum for reflecting views of the VCSE sector, whether the HWB discussed the role of the VCSE in providing preventive services and whether the VCSE played a role in health impact assessment or in developing a public health approach across directorates.

The HWB as a forum for reflecting views of the VCSE sector

Respondents were asked to rate the HWB as a forum for reflecting views of the VCSE sector (see Figure 4). 'Average' received the largest proportion of responses (41.2%), followed by 'good' (20.6%), 'poor' (17.6%), 'very poor' (14.7%), and finally, with the fewest proportion of responses, 'very good' (5.9%). There were no notable differences (that is 25% or more difference) between the responses given by Healthwatch and VCSE sector respondents. However, a larger proportion of the 'poor' and 'very poor' responses were given by Healthwatch (38%) when compared to VCSE respondents (16.6%).

Figure 4: How does the HWB rate as a forum for reflecting views of the VCSE sector?



Respondents were provided with the opportunity to explain their answer in more detail. There were both positive and negative assessments of the influence of the VCSE sector on HWBs from both groups, with many comments inseparable from views of the responsiveness of the HWB in general.

On the positive side (10 responses), examples were provided of a 'new willingness to engage', where, for example, HWBs included the VCSE sector as voting members, where they were allocated time to express their views which were acknowledged by statutory partners.

More critical responses were provided by 21 respondents. Scepticism was expressed by some VCSE sector respondents over how far they were considered as equals. However, problems of representativeness, diversity of views and competitiveness in the sector were also recognised and one Healthwatch respondent considered that the VCSE sector did not operate at the strategic level required by the HWB. The size

of the VCSE sector made it difficult to achieve representation and another Healthwatch respondent described the situation as follows:

No one person can represent the VCSE as it doesn't have a system of representation. Diverse and competitive it is easy to ignore.

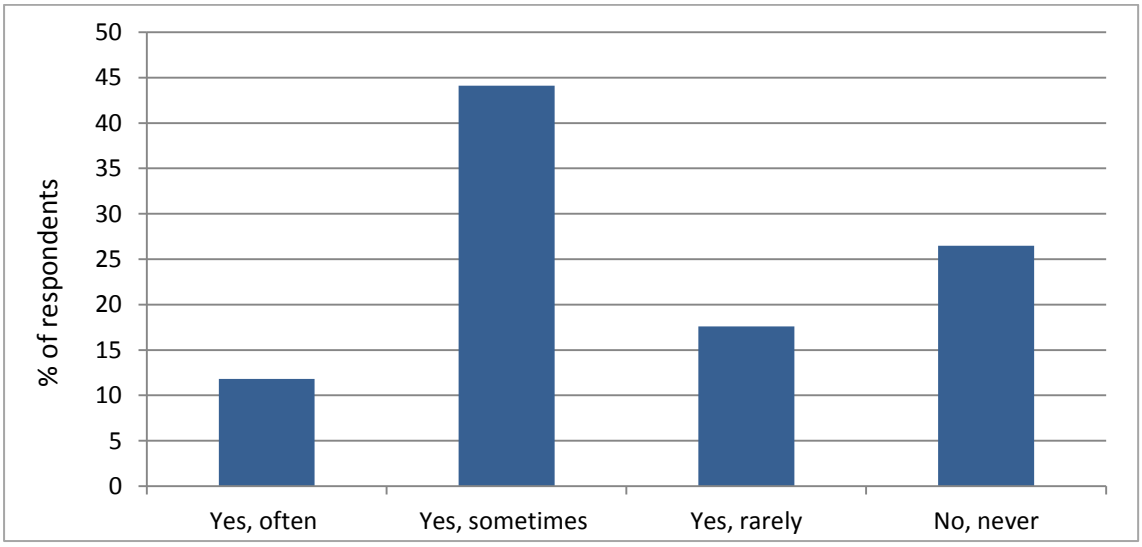
Recognition of this diversity had led, in one case, to the decision that involvement in the HWB was likely to be 'tokenistic' and, therefore, alternatives consisting of stakeholder meetings and an annual meeting with the HWB had been established. Others emphasised the importance of an effective infrastructure organisation to bring together views across the sector, although it was also recognised that cuts had affected capacity to share information across smaller 'but still valuable' groups. While an example was provided of how mechanisms were being developed to enable local Healthwatch to represent views of the VCSE sector on HWBs, another respondent described some resistance to sharing information across both organisations.

There were also negative assessments of the HWB as a forum for VCSE sector views. Those who had criticised HWBs in an earlier question reiterated those criticisms. For example, one respondent noted that 'when the VCSE asks to put items on the agenda we are told those need not be discussed because they are being handled elsewhere at a subcommittee to which we have no access'. Another respondent stated that: 'our local HWB rushes through business without apparently taking the views of VCSE or local community into account'. One respondent claimed that it took 'months' to get anything on the HWB agenda, 'meaning the board cannot respond to current issues', a second respondent noted that the board usually just 'receives and notes reports and decisions already made by the CCG and LA' and a third that it worked with agenda that was 'too large and complex', with changes happening far more quickly than they could address, with 'key decisions being taken via other bodies'. One example was given of a HWB that had repeatedly refused VCSE representation. HWB meetings were also described as too late in the decision-making process for the VCSE sector to exert much of an impact.

The HWB and discussion of the preventive role of the VCSE sector

Respondents were asked if, in their experience, their HWB discussed the preventive role of the VCSE sector (see Figure 5). The greatest proportion of responses belonged to 'yes, sometimes' (44.1%). 'No, never' received the next largest proportion of responses (26.5%), followed by 'yes, rarely' (17.6%) and 'yes, often' (11.8%). Healthwatch responses accounted for a higher percentage of 'yes rarely' and 'no, never' responses when compared to VCSE responses.

Figure 5: Does the HWB discuss the preventive role of the VCSE sector?



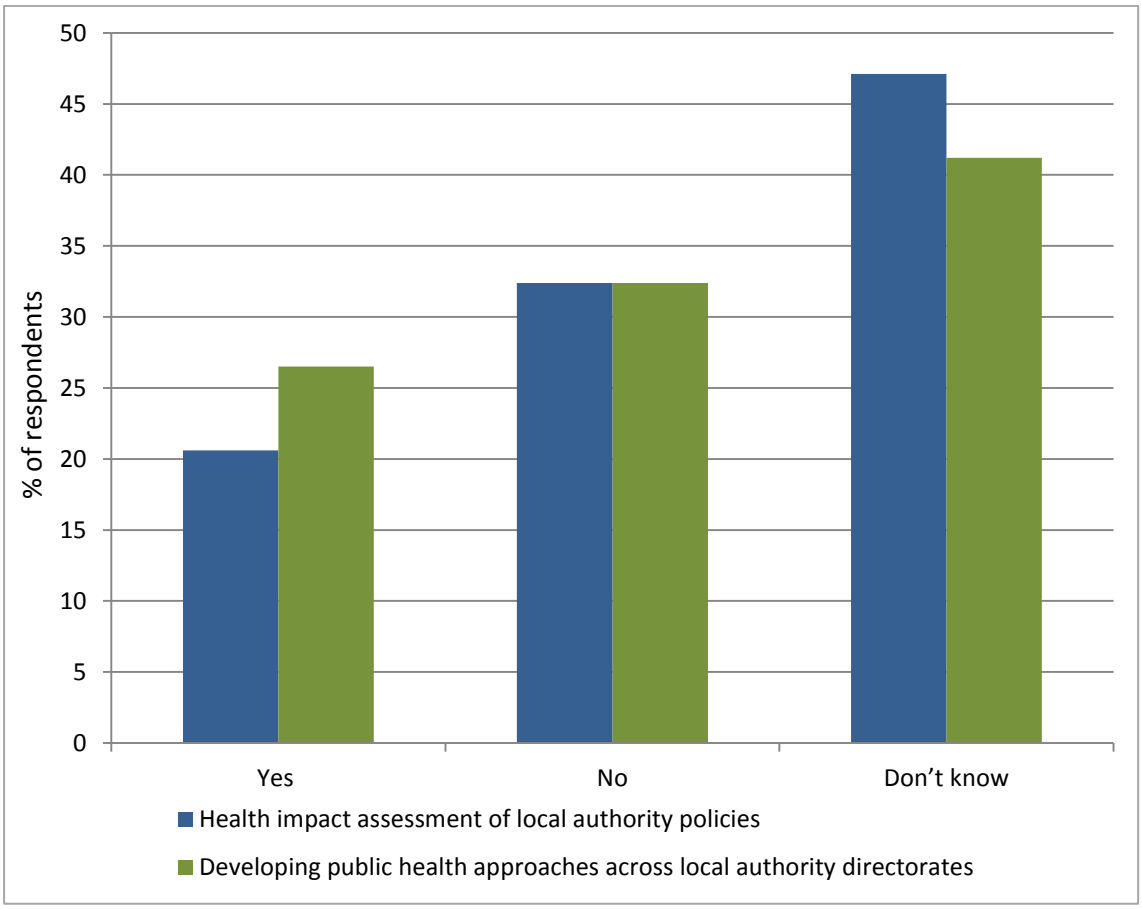
N=34

VCSE sector role in Health Impact Assessment and in developing public health approaches across directorates

Respondents were asked to consider if VCSE organisations currently play a role in Health Impact Assessment (HIA) of local authority policies. Figure 6 shows that most of the respondents answered 'no' or 'don't know' (77.8%). Comparatively, VCSE responses accounted for a higher percentage of 'yes' answers whilst 'don't know' responses were proportionately greater in the Healthwatch respondent group. Respondents were given the option to provide examples to support their response which six respondents completed. One respondent noted that this activity had occurred with the former PCT and another commented that in the context of continuing cuts to services, 'local authorities have significantly less money and influence on the big health issues'.

Respondents were also asked to consider if VCSE organisations currently play a role in developing public health approaches across local authority directorates. Figure 6 shows that 72.5% answered 'no' or 'don't know'. However, there were differences in the answers given by the two groups; Healthwatch responses (n-21) accounted for the greatest proportion of 'don't know' answers whilst the VCSE responses (n=12) accounted for a large proportion of the 'yes' answers. 'No' responses were proportionately the same between the two groups.

Figure 6: VCSE sector involvement in health impact assessment and public health approaches across local authority directorates



N=34

As in the previous question, respondents were given the option to provide examples to support their response, which nine respondents completed. Respondents commented on how public health approaches were being developed across directorates in relation to addressing social isolation, mental health problems and in addressing lifestyle issues. Public engagement was also mentioned in this context, but no specific examples were given. In one case, a Fairness Commission was being developed to promote cross-directorate public health approaches and the Social Value Act was being used to 'embed prevention in commissioning across directorates'.

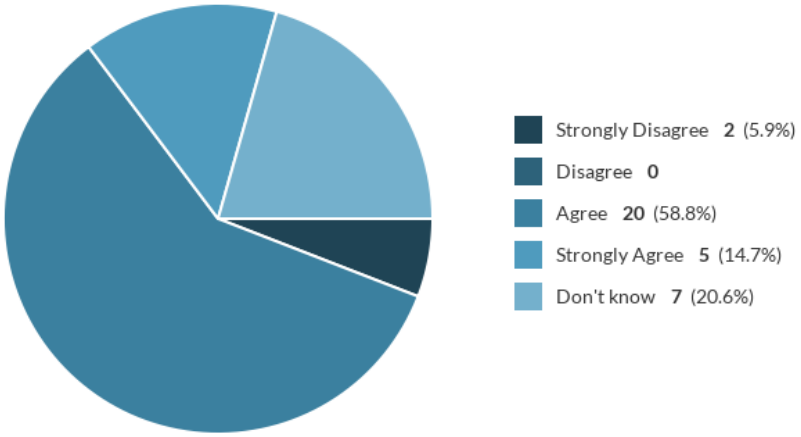
Changes since the relocation of public health responsibilities to local authorities

Respondents were asked to consider a number of questions related to the public health reforms, including their views of the changes (and whether their views had changed over time), the strength of public involvement, the effects on the VCSE sector, the impact of the financial climate and their awareness of the public health budget and how it had been deployed.

Views of the public health reforms

Respondents were asked to indicate to what extent they agreed or disagreed with the changes set in motion by the public health reforms. Overall, the majority of respondents 'agreed' or 'strongly agreed' (73.5%), 5.9% strongly disagreed and 20.6% selected 'don't know'. There were no notable differences in the answers given by the two groups. Figure 7 shows the overall responses provided.

Figure 7: Views of the changes introduced by the public health reforms



Respondents were invited, in an optional question, to explain their answer in more detail, and 24 respondents provided information (15 Healthwatch, 9 VCSE and one other HWB member).

The most common reasons given for supporting the reforms included a recognition of local authority as the 'natural home' for public health given the wider determinants of health; public health teams being well placed with potential to develop improved links with the local authority and the delivery of services; and a greater element of local control. There was an opportunity to 'align commissioning with development', examples of more collaborative ways of working and the potential for greater integration, not just across health and social care but across health, wellbeing and social care. The importance of working as a system was particularly important at a time of financial constraint.

While the reforms were considered sound in principle, two respondents argued that the cuts to local authority services undermined benefits of the reforms. One respondent noted that 'clinicians [are] leaving local authority roles and with money being siphoned off to address council under-funding', and another that much depended on 'leadership within public health and the response of the local authority which often sees the acquisition of this area [as] propping up funding they have lost'. The same respondent noted the need for 'greater innovative thinking and a much more adaptable approach to developing services to respond to need'.

Six respondents were sceptical or neutral, seeing little difference in practice and in one case criticising a 'dysfunctional divorce' between prevention and the

NHS/primary care. Respondents were then asked if their views of the public health reforms had changed since 2013. Overall, 82.4 % of respondents indicated that their opinion had not changed, although Healthwatch responses (90.5%) were considerably more weighted towards 'no' than VCSE responses (66.7%). Again, respondents were provided with the option to explain their answers further, resulting in 16 usable responses (9 Healthwatch; 7 VCSE).

In commenting on the previous two years, respondents noted positive developments in HWBs, in inclusion, more integrated working with greater VCSE sector involvement, and a stronger role for Healthwatch in relation to CCGs and social care commissioners, as opposed to the LINks which preceded it. A number of concerns over implementation were highlighted, the main concern being budget cuts and in one case, a local authority culture which was described as 'less creative' than that demonstrated by the public health team.

Strength of public involvement since the public health reforms

Respondents were asked to assess the strength of public involvement across a number of factors since the public health reforms. Table 4 shows that 'about the same' was the most likely option to be selected. However, community engagement in preventive initiatives was considered to have increased by 35.3% of respondents. All of the factors had some 'don't know' responses with co-design of adult health and wellbeing services receiving the greatest percentage. Across each of the factors overall, 'about the same' received the highest proportion of responses (37.7%). This was followed by 'more' (28.9%), 'don't know' (17.2%) and finally 'less' (16.2%).

There was no notable difference (25% or more) in the responses for any of the factors between Heathwatch (n=21) and VCSE (n=12) respondents. However, collectively across the responses, the proportion of 'don't know' responses differed somewhat between Healthwatch (22.2%) and VCSE respondents (8.3%).

Table 4: Public involvement since the reforms

	Less	About the same	More	Don't know
Influencing commissioning priorities	11.8	44.1	26.5	17.6
Identifying local public health needs	17.6	41.2	23.5	17.6
Influencing JSNAs	11.8	38.2	35.3	14.7
Co-design of adult health and wellbeing services	17.6	38.2	23.5	20.6
Co-design of health and wellbeing services for younger people	17.6	35.3	29.4	17.6
Community engagement in preventive initiatives	20.6	29.4	35.3	14.7

% of respondents (N=34)

Impact of the public health reforms on the VCSE sector

Respondents were asked to assess the impact of the public health reforms on the VCSE sector across a number of factors. Table 5 shows that the most often selected option, with the exception of one, was considered 'about the same'. Availability of funding had an equally high proportion of responses for 'about the same' and 'less'. 'Don't know' responses were received for each of the factors, with coordination of views across VCSE networks receiving the highest percentage. Across each of the factors overall, 'about the same' received the highest proportion of responses (40.6%). This was followed by 'don't know' (25%) 'more' (19.4%) and finally 'less' (15%).

Table 5: Impact of the reforms on the VCSE sector

	Less	About the same	More	Don't know
Emphasis on addressing health inequalities	11.8	47.1	14.7	26.5
Provision of incentives for achieving improved health outcomes	17.6	44.1	11.8	26.5
Variety in the services commissioned	8.8	44.1	26.5	20.6
Coordination of views across VCSE networks	11.8	44.1	11.8	32.4
Emphasis on place-based initiatives	8.8	41.2	23.5	26.5
Complexity in funding	8.8	38.2	29.4	23.5
Availability of funding	38.2	38.2	0.0	23.5
Complexity of contractual arrangements	8.8	38.2	32.4	20.6
Influence on commissioning priorities	20.6	35.3	20.6	23.5
Involvement in providing preventive services	14.7	35.3	23.5	26.5

% of respondents (N=34)

Perhaps reflecting the question's focus on the VCSE sector, Healthwatch (n=21) and VCSE (n=12) respondents notably differed (25% or more difference) in the answers provided in relation to the following factors:

- Influence on commissioning priorities: VCSE respondents placed greater emphasis on 'about the same' (75%) in relation to this factor in comparison to Healthwatch respondents (28.6%). Healthwatch provided a greater proportion of 'don't know' responses (38.1%) (VCSE 8.3%);
- Complexity of contractual arrangements, coordination of views across VCSE networks and emphasis on addressing health inequalities: for each of these three factors 33.3% of Healthwatch responses were 'don't know' whereas no 'don't know' responses were received from VCSE respondents;

- Variety in the services commissioned: VCSE respondents placed a greater emphasis on 'less' (25%) when compared with Healthwatch responses (4.8%). Also, a comparatively higher proportion of responses for 'more' were received from VCSE respondents (Healthwatch 4.8%);
- Involvement in providing preventive services: there were no 'don't know' answers given by VCSE respondents, whereas this response accounted for 42.9% of the Healthwatch responses;
- Complexity in funding: 38.1% of the Healthwatch responses provided were 'don't know' compared to none from the VCSE responses;
- Availability of funding: only 8.3% of the VCSE responses were 'don't know' in comparison to Healthwatch responses (33.3%);
- Emphasis on place-based initiatives: none of the VCSE answers was 'don't know' in comparison 42.9% of Healthwatch responses.

Collectively across the responses the proportion of 'don't know' answers differed considerably between Healthwatch (37.1%) and VCSE respondents (5%).

Impact of the financial climate on VCSE sector involvement in preventive services
All respondents commented on this question, except for a Healthwatch respondent whose role post-dated the reforms. While eight respondents were unsure or felt the question did not apply to the VCSE sector, which was described by one respondent as not generally involved in providing preventive services, the remainder highlighted the effects of budget cuts on the sector, which coincided with (but were unrelated to) the reforms. There was less capacity to engage; the same outputs were expected for less money; reduced services were being commissioned in the light of budget cuts; and smaller organisations had folded. One respondent claimed that the VCSE sector was being expected to 'plug the gaps, taking on more preventative, awareness raising, support and general care roles than ever before but with less funding or acknowledgement.'

A small number of positive effects was also described: while small organisations had folded, there was greater collaboration among other VCSE organisations, which could lead to innovation. One respondent argued that the financial climate had required the public sector and the VCSE sector to think differently about commissioning, as follows:

'*…need to blend funding approaches – such as connecting commissioning with new social investment forms, social philanthropy/part charging, social franchising, utilising VCSE sector ability to attract external resources/private sector'.*

In one example, the VCSE sector had developed links with public health 'to access funding that is available through public health initiatives, especially as they have lost significant funding through other routes'.

Changes in providers of preventive services

Respondents were asked to assess changes in the type of providers of preventive services in their local authority area since the public health reforms. Table 6 shows that 'about the same' was the option most often selected for NHS Trusts and VCSE organisations. 'Don't know' received the highest proportion of answers in relation to private/commercial providers and social enterprises. GP practices received the largest percentage of 'more' answers. Local authority (in-house) had an equal percentage of answers for 'about the same', 'less' and 'more' (26.5% each) with 'don't know' receiving slightly less responses (20.6%).

'Don't know' responses were received for each of the sources with private/commercial providers receiving the highest percentage. Across each of the factors overall, 'about the same' received the highest proportion of responses (31.9%). This was followed by 'don't know' (29.4%) 'more' (23.5%) and finally 'less' (15.2%).

Table 6: Changes in providers of preventive services

	Less	About the same	More	Don't know
NHS Trusts	11.8	44.1	14.7	29.4
Private/commercial providers	8.8	32.4	14.7	44.1
VCS organisations	23.5	32.4	23.5	20.6
Social Enterprises	11.8	29.4	23.5	35.3
Local authority (in-house)	26.5	26.5	26.5	20.6
GP practices	8.8	26.5	38.2	26.5

% of respondents (N=34)

Heathwatch (n=21) and VCSE respondents (n=12) notably differed (25% or more difference) for the following factors:

- GP practices: 38.1% of Healthwatch responses were 'don't know', in comparison with only 8.3% of VCSE responses;
- VCSE organisations: greater emphasis was placed on 'more' in VCSE responses (41.7%) than in Healthwatch responses (9.5%).

Collectively across the responses the proportion of 'don't know' answers differed somewhat between Healthwatch (38.1%) and VCSE sector responses (16.7%).

The category where most respondents saw evidence of increased provision since the reforms was through GP practices (a surprising finding, given the nature of the reforms). Other changes in provision of preventive services included by respondents were less day centres (private providers) and cuts in domiciliary care (local authorities), but more 'health buddies' for reaching out to communities, the ability to provide information on new communities (through the VCSE sector) and expansion by NHS Trusts in preventive services, for example, for vulnerable groups

and to reduce admission (sometimes through arm's-length commercial services). GP practices were described as carrying out more prevention in relation to risk factors. Additional categories mentioned were national voluntary sector organisations, housing associations and pharmacies.

The public health budget

Respondents were asked if they were aware of how the ring-fenced public health budget had been spent in their local authority area. Table 7 shows that, overall, the greatest proportion of respondents selected 'to some extent' (67.6%). However, this contained a larger percentage of Healthwatch responses. Proportionately, 'no' was the second greatest answer given (20.6%) followed by 'yes' (11.8%) which included a higher percentage of VCSE responses.

Table 7: Awareness of local spending from the public health budget

	Yes	No	To some extent
All responses	11.8	20.6	67.6
Healthwatch responses	4.8	14.3	81
VCSE responses	25	25	50

% of respondents (N=34)

Respondents who answered 'yes' or 'to some extent' (total of 79.4%) were asked if they thought that the ring-fenced public health had been reshaped to meet local health priorities. The greatest proportion of responses indicated 'yes' (63.6%), followed by 'unsure' (32.1%) and 'no' (4.4%). When the answers from the two groups were compared there were no considerable differences. However, a higher percentage of 'yes' responses were given by VCSE respondents and Healthwatch responses accounted for a greater proportion of 'unsure' answers.

Defining innovation

The public health reforms emphasised innovation in the provision of preventive services at a local level. Therefore, respondents were asked to describe in a few sentences or a few key words, how they defined innovation. (One incomplete response was excluded from the analysis.)

Most respondents highlighted some combination of creativity, flexibility, focusing on outcomes rather than on processes and 'thinking outside the box' - doing new things or doing the same things in a different way. Adaptation to changing needs, learning from creativity elsewhere (and not just in developed countries) and new ways of working were all emphasised. However, there were other common themes. First was an emphasis on the community and working jointly with communities, using co-design, 'agile design' and a combination of deficit and asset-based models. Innovation was described as being about ways of meeting needs of local people, developing 'bottom up community initiatives' with less 'top down modelling of preventive services'. One respondent framed innovation as follows:

Innovation for me is where we really listen to local residents to see how they view their local needs and priorities ... a more personalised approach which may be more costly initially but will be the only way to achieve the behaviour change required over the longer term.

A second theme, mentioned by a quarter of respondents, was to provide more cost-effective services, achieving greater impact for individuals and the community for less cost.

A third theme was that innovation required a change in the services traditionally being delivered, working with new providers, including the VCSE sector, and providing 'opportunities/platforms for organisations from all sectors to collaborate to design and deliver local services'.

However, as also reflected in survey 2, there was some scepticism about the use of the term 'innovation', and concern over its being used as a smokescreen for budget cuts or leading to effective, but traditional services being discontinued. One respondent noted:

What is really meant by innovation? Don't we just mean doing more despite massive funding cuts ... innovation means space to be creative and you can't take risks with creative ideas in a climate where there is so little funding.

Have the public health reforms enabled innovative approaches to be developed?
Respondents were asked if the public health reforms had enabled innovative approaches to public health services in their local authority area for a list of activities (see Table 8). For most of the activities listed, many of the respondents indicated that they were unaware of any impact. However, over 40% of respondents reported a positive impact for three activities: targeting services to under-served groups and areas; addressing unhealthy lifestyles; and addressing social context and conditions. Developing community networks was the only activity where 'no' received the highest percentage of answers.

'Don't know' responses were received for each of the factors with use of incentives receiving the highest proportion of responses. Across each of the activities overall, 'don't know' received the highest proportion of responses (42.1%). 'Yes' accounted for 25% of the answers provided, which was closely followed by 'no' with 28.2%.

Table 8: Public health reforms and innovation

	Yes	No	Don't know
Using incentives	5.9	29.4	64.7
Co-design of services (other groups)	17.6	26.5	55.9
Accessing services	23.5	23.5	52.9
Co-design of services (younger people)	23.5	32.4	44.1
Targeting services to under-served groups and areas	41.2	20.6	38.2
Co-design of services (older people)	29.4	32.4	38.2
Addressing unhealthy lifestyles	44.1	20.6	35.3
Involving community champions	32.4	32.4	35.3
Developing community networks	32.4	38.2	29.4
Addressing social context and conditions	47.1	26.5	26.5

% of respondents (N=34)

Responses of the two groups were compared as follows:

- Developing community networks: 58.3% of VCSE responses (n=12) were negative in comparison to 23.8% of Healthwatch responses (n=21). Conversely, Healthwatch responses accounted for a greater proportion of 'yes' answers (42.9%) than VCSE responses (16.7%);
- Addressing social context and conditions: a larger proportion of 'don't know' responses was received from Healthwatch (33.3%) when compared to VCSE sector responses (8.3%). Also, the percentage of 'no' answers was considerably higher in VCSE responses (50%) (Healthwatch 14.3%);
- Addressing unhealthy lifestyles: 42.9% of Healthwatch responses were 'don't know' in comparison with only 16.7% of VCSE responses;
- Involving community champions: 'no' responses were proportionately higher in VCSE respondents (50%) than Healthwatch respondents (23.8%);
- Co-design of services (younger people): 58.3% of the VCSE responses accounted for 'no' answers, compared to 19% of Healthwatch responses. No VCSE respondents gave 'yes' answers in contrast to Healthwatch (38%).
- Co-design of services (older people): a larger proportion of 'no' responses were given by VCSE respondents (58.3%) when compared to Healthwatch responses (19%);
- Co-design of services (other groups): a larger percentage of 'don't know' answers were received from Healthwatch respondents (66.7%) (VCSE 33.3%). A considerably larger proportion of 'no' answers belonged to the VCSE group (50%) when compared to VCSE respondents (14.3%);
- Using incentives: this was viewed more negatively by VCSE respondents (50%) than by Healthwatch respondents (19%).

Collectively across the responses the proportion of 'don't know' answers differed somewhat between Healthwatch (47.1%) and VCSE respondents (29.2%). There was

also a notable difference on the overall 'no' responses between the groups (Healthwatch 18.1%, VCSE 47.5%).

Respondents were provided with additional opportunity to highlight examples. They highlighted a number of services they considered to be innovative, although some, such as Improving Access to Psychological Therapies (IAPT) services, or co-design of services, were unrelated to the public health reforms. Initiatives included:

- Targeting services by reaching communities affected by HIV, working with specialist groups to identify needs of new communities and meeting needs of traveller communities;
- Developing community networks through local area coordinators, 'well man' projects, partnership forums, including 'people's partnerships' and the HWB;
- Addressing unhealthy lifestyles through 'health and wellbeing practices';
- Community champions were being used as 'community navigators' in GP practices. 'Health buddies' were also being commissioned to deliver health messages;
- Local Healthwatch was cited as developing co-design of services with younger people. There were also examples of co-design of falls services, services for disabled service users and mental health services.

There were examples of public health teams working with elected members and being integrated into different directorates, thereby helping to address social conditions and contexts. One respondent cited an example of the public health team offering funding for developing innovative services. Respondents also highlighted VCSE sector involvement in DH Pioneer projects; exercise projects; a co-production network across the VCS, Healthwatch and the county council; and a single referral route for health and social care workers to 'the range of preventive services provided through the [VCSE] sector'. One respondent mentioned an initiative where the local authority and CCG had pooled commissioning resources for the Voluntary Community and Faith (VCF) sector and where they were 'commissioning through a consortium model to enhance added value, and promote joined up working and complementary services rather than duplication'.

Enablers and barriers

Respondents were asked to indicate main enablers and barriers to greater involvement of VCSE organisations in providing preventive services. For enablers, seven respondents had no comments and two respondents considered this question was not applicable as they fell outside the VCSE sector. For barriers, three respondents had no comments and one considered it not applicable.

As might be expected, funding (or the lack of it) was the most frequently cited enabler (or barrier) for the VCSE sector to become more involved in delivering preventive services, although respondents emphasised different aspects, including the importance of implementing the Compact (a voluntary agreement across government and the VCSE sector). Moreover, commissioners needed to recognise the limitations of volunteer organisations and that 'volunteers are not free'. The second most cited issue was the need for greater recognition by the statutory sector

of the wide range of services already being provided and of the 'effectiveness of the sector and the trust the public has in it'. This needed to be reflected in being 'valued by system leaders and partners' as core partners, greater power around the negotiating table, and by earlier involvement of the sector in strategic decision-making. It could also be reflected in GPs' signposting to services provided by the VCSE sector. These changes depended on support of senior management teams across public health, social services and CCGs and also a commitment of the local HWB to prevention. While one respondent described how this was already happening through a CCG and VCSE sector alliance that was focused on needs of vulnerable groups, four respondents commented on inaccessible county councils, or a propensity towards in-house provision by the local authority. Two further respondents commented on misperceptions over VCSE competence or over duplication in the VCSE sector.

The third area was the problem of complex commissioning and contracting arrangements that worked against the capacity of smaller organisations; short-term schemes; and reporting mechanisms that were not geared to identifying impact. One respondent called for 'clearer and more accessible commissioning processes that have proportionate monitoring and evaluation requirements, valuing and recognising the role that communities play in prevention' and another pointed out the reluctance of large providers to take on VCSE organisations for small contracts as 'part of the delivery plan'. It was also important to undertake evaluated work 'rather than everything having to be contract-based'.

Some comments were directed at changes needed within the VCSE sector, including more emphasis on 'demonstrating and evidencing impact and influence'. One respondent noted a lack of knowledge or resources about 'technology, data use/sharing ... and the ability to blend financial models'. There was also a need for 'innovative VCSE infrastructure support'. Other enablers mentioned were involvement in DH Pioneer projects and responding to JSNA priorities.

One respondent mentioned the importance of an agreed definition of prevention across statutory agencies and providers and this point is returned to in the discussion.

Comments on the survey

Respondents were invited to comment on the survey. Two respondents did not consider the survey relevant for recent Healthwatch members and one respondent considered that reforms had not changed anything, given previous joint working. One respondent noted that 'it has made me aware that I don't fully appreciate the range of activities that public health undertakes' and that prevention was open to multiple definitions.

Survey 2: national survey of VCSE organisations involved in health promotion and prevention of ill health

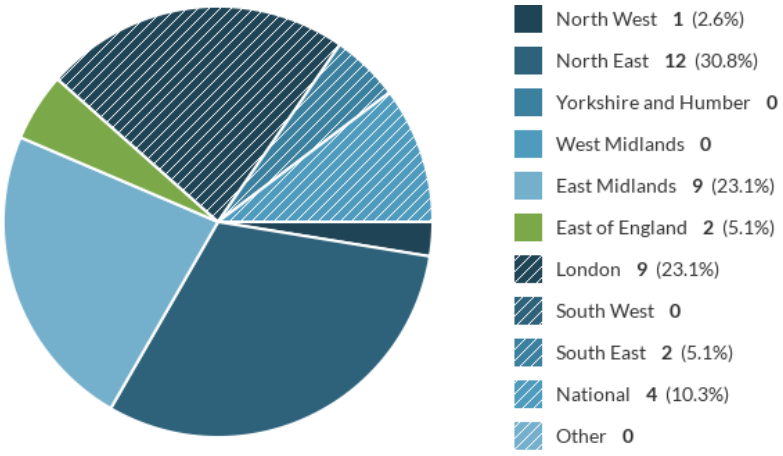
In survey 2, the emphasis was on open questions and this is reflected in the survey analysis. The analysis follows the structure of the survey. It begins with a description of respondents, the services provided by their organisations, and how the projects are funded. There follows a section on factors which could enable the VCSE sector to play a greater role in public health commissioning. Respondents are then asked for their views about the strength of the 'local voice' since the reforms and on the impact of the reforms on the VCSE sector across a wide range of factors. Enablers and barriers for the greater involvement of VCSE organisations in providing health and wellbeing services are described. Finally, views over what constitutes innovation and examples of innovative projects are described.

The denominator for this survey is unclear as many VCSE organisations have limited involvement in preventive services, and a high response rate was therefore not anticipated.

Respondents and the services provided by their organisations

There were 39 responses in total (46 respondents began the survey but 10 did not meet the inclusion criteria and were therefore directed out of the survey). All respondents included in the survey described themselves as providing projects, services or a forum related to Marmot recommendations (which were listed in the survey). Figure 8 shows that the highest proportion of responses was from the North East (30.8%) and there were no responses from three of the nine regions (South West, Yorkshire and Humber and West Midlands).

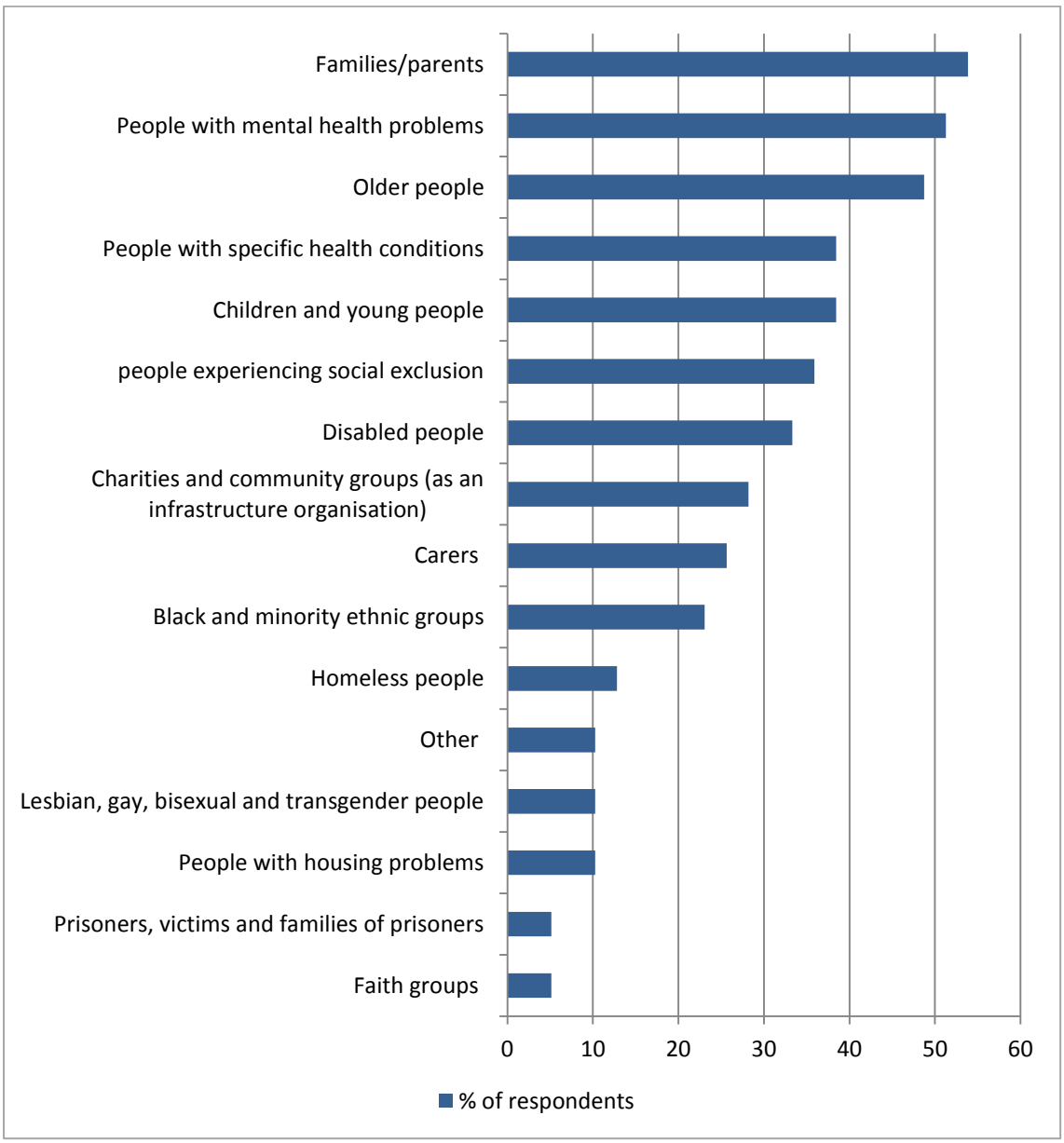
Figure 8: Geographical distribution of responses



When asked about the geographical focus of their organisation, 77% of respondents covered one or more local authority area while the remainder were national (10.3%); regional (2.6%); or international (2.6%).

The beneficiaries most commonly mentioned by respondents were families/parents (54% of respondents), people with mental health problems (51%) and older people (49%). The next most common groups were children and young people (38%), those with specific health conditions (38%), and people experiencing social exclusion (36%). Four respondents mentioned other groups not included in the survey: those affected by rape and sexual abuse; alcohol and substance abuse; domestic violence; and volunteers.

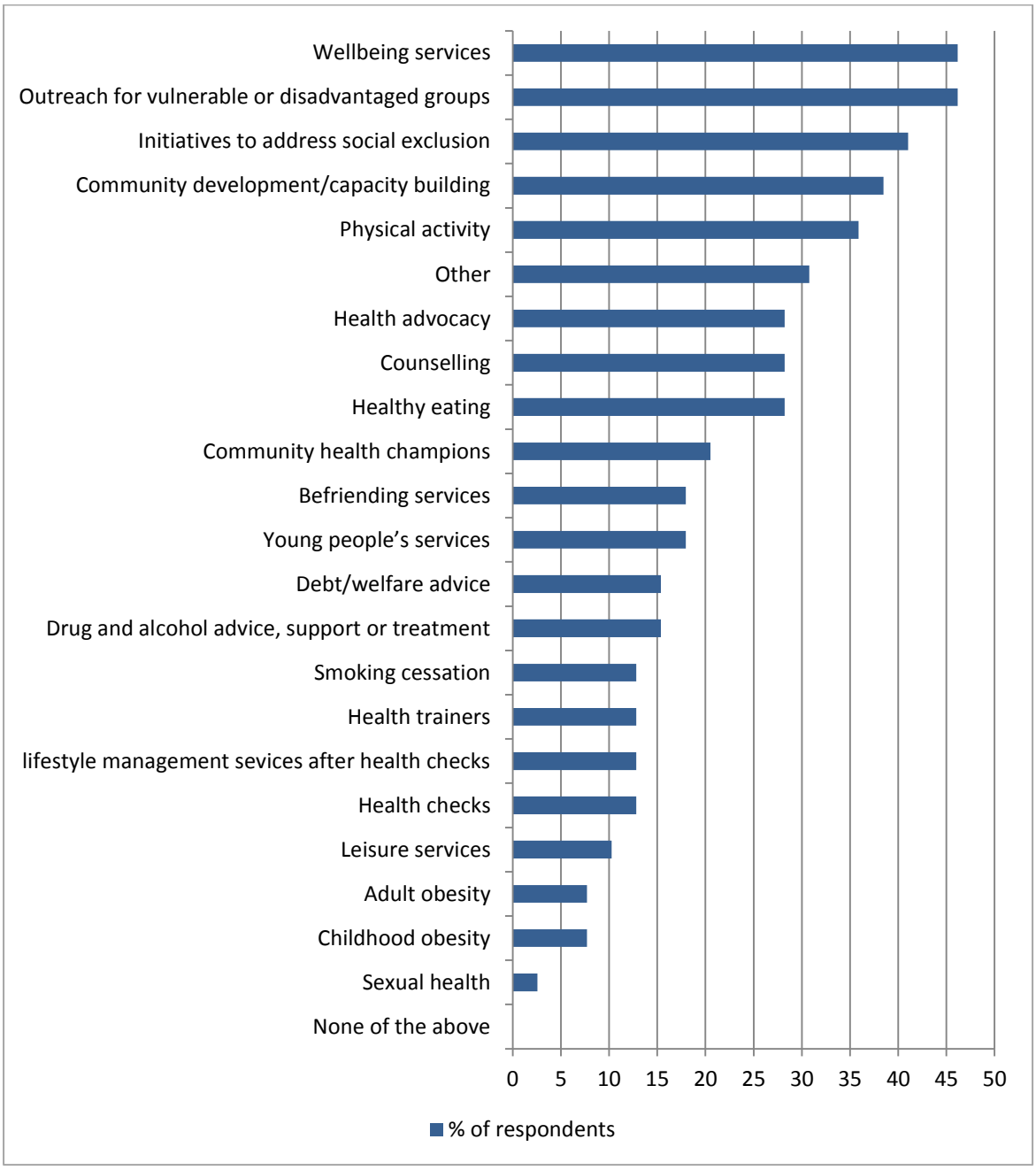
Figure 9: VCSE organisations and their beneficiaries



N=39

In relation to topic areas, Figure 10 shows that while there were overlapping areas of interest, the most cited areas were: outreach services for vulnerable or disadvantaged groups (46% of respondents); wellbeing services (46%); social exclusion initiatives (41%); and community development (38%). There was little involvement in specific services for obesity (adult or child) (8%); delivery of health checks (13%); smoking cessation services (13%); or sexual health services (3%), but some involvement in healthy eating and counselling services (28% for each).

Figure 10: Preventive services provided by the VCSE sector



N=39

Twelve respondents cited services not included in the options: these included domestic violence counselling; complementary therapies; Vitamin D

supplementation; mental health awareness; justice system; self-advocacy; homework clubs; and strategic/supporting organisations.

Preventive services highlighted by respondents

Thirty seven respondents provided detailed information about local public health-related projects they wished to highlight, with 17 of these 37 respondents describing two separate projects and eight describing three separate projects, a total of 62 projects. Some respondents described projects in detail. Projects are highly diverse and adopt different approaches. Box 1 summarises the 62 projects highlighted and indicates the range of projects and approaches.

It should be emphasised that many projects provided a range of services. An integrated and holistic approach was common to many projects, combining mental health and social wellbeing, while some (e.g. alcohol services) formed part of wider programmes. Advocacy was often combined with peer support and volunteering. Access to cancer screening services, for example, could be developed through training local people to act as volunteers, encouraging earlier take up of services. Activities (such as gardening, cooking or physical activity), as well as being therapeutic in their own right, could provide a way in to a wider range of services and support for vulnerable groups, including those with mental health problems. One project for homeless people offered 'cookery, arts and crafts, gardening, walks and educational day trips', addressing issues such as access to a wide range of services, poor housing, lifestyle choices and self-confidence.

The preventive aspect of some of the projects was also described as relevant to the family group. For example, a project designed to support the health of fathers, using an asset-based approach, was described as reducing social isolation and having effects not just on alcohol use and mental health for the men involved, but also on the wellbeing of their children.

Second, there was evidence of joint initiatives across the VCSE sector and statutory partners across national and local organisations within the sector, and partnerships across the local VCSE sector. One project was described as working in partnership with Age UK to help recruit volunteers and another as a joint endeavour across the VCSE sector and local authority Health Scrutiny to address health inequality in the BME community. Another project worked in a partnership model across the VCSE sector in order to develop the capacity of smaller organisations and provide services over a wide geographic area. In another example, funding had been lost following the NHS reforms and volunteers re-established the project under a host arrangement with a local voluntary organisation. The relevance to the Social Value Act of the work carried out by the VCSE sector in relation to commissioners securing added economic, social or environmental benefits for their local area was emphasised.

Third, the diverse mix of projects reflects difficulties of defining preventive or health and wellbeing services. Most projects were concerned with secondary prevention in

that groups involved were often already receiving services. However, support could lead to the primary prevention of problems for children and family members.

When asked to identify which area of health and wellbeing projects were seeking to improve, 25 of the 62 projects were specifically described as including a mental health focus or impact, although this was also implicit in many other projects concerned with health and wellbeing.

Box 1: Projects highlighted by survey respondents

Addressing inequalities	Black and Minority Ethnic (BME) communities
Advocacy	BME communities; people with learning disabilities; migrants
Asset-based approaches	Men's health (with effects on children's heath)
Befriending and mentoring initiatives	General; older people; families with children under 5; vulnerable families
'Coaching'	Helping men with low self esteem/depression; people with multiple health related lifestyle issues through 'Being Well' coaches and an approach which puts clients in control of their action plans
Community champions recruited from local communities	Families in disadvantaged communities; working with sports clubs to support exercise
Complementary medicine	For people with cancer
Counselling services (sometimes including a wide range of therapies)	Women; people with addictions; people with mental health problems; families where there is substance misuse; part of after-school activities; bereavement; victims of rape and sexual abuse (including through the criminal justice system); migrants; people with a cancer diagnosis
Discharge support	Addressing delayed discharge and providing post-discharge support; vulnerable people; homeless people and 'frequent fliers'
Improving access	Primary care; healthy eating advice; community transport to hospitals for people with mobility problems; improving uptake of cancer screening services through training local people from diverse backgrounds; helping homeless peoples access services
Improving services and collecting views of services	Healthwatch
Information about services	Healthwatch
Facebook groups for providing information and advice	Diet; Vitamin D supplementation
'Green' activities	Gardening for homeless people with mental health problems; people with dementia; people with mental health problems; people with head and brain injuries
Integrated lifestyle support	For those with multiple lifestyle issues
Outreach	Alcohol misuse; socially excluded women
Play schemes	5-14 year olds
Peer support	Families were there is substance misuse; homeless people
Self help groups	Mental health
Social prescribing from a pooled CCG and LA budget	
Specialised support	Families supporting people with advanced dementia
Support and advice services	For victims of domestic violence; migrants; survivors of FGM; to prevent hospital admission; people with cancer and their families; people with lung conditions and other long term conditions; socially excluded people; crisis financial support

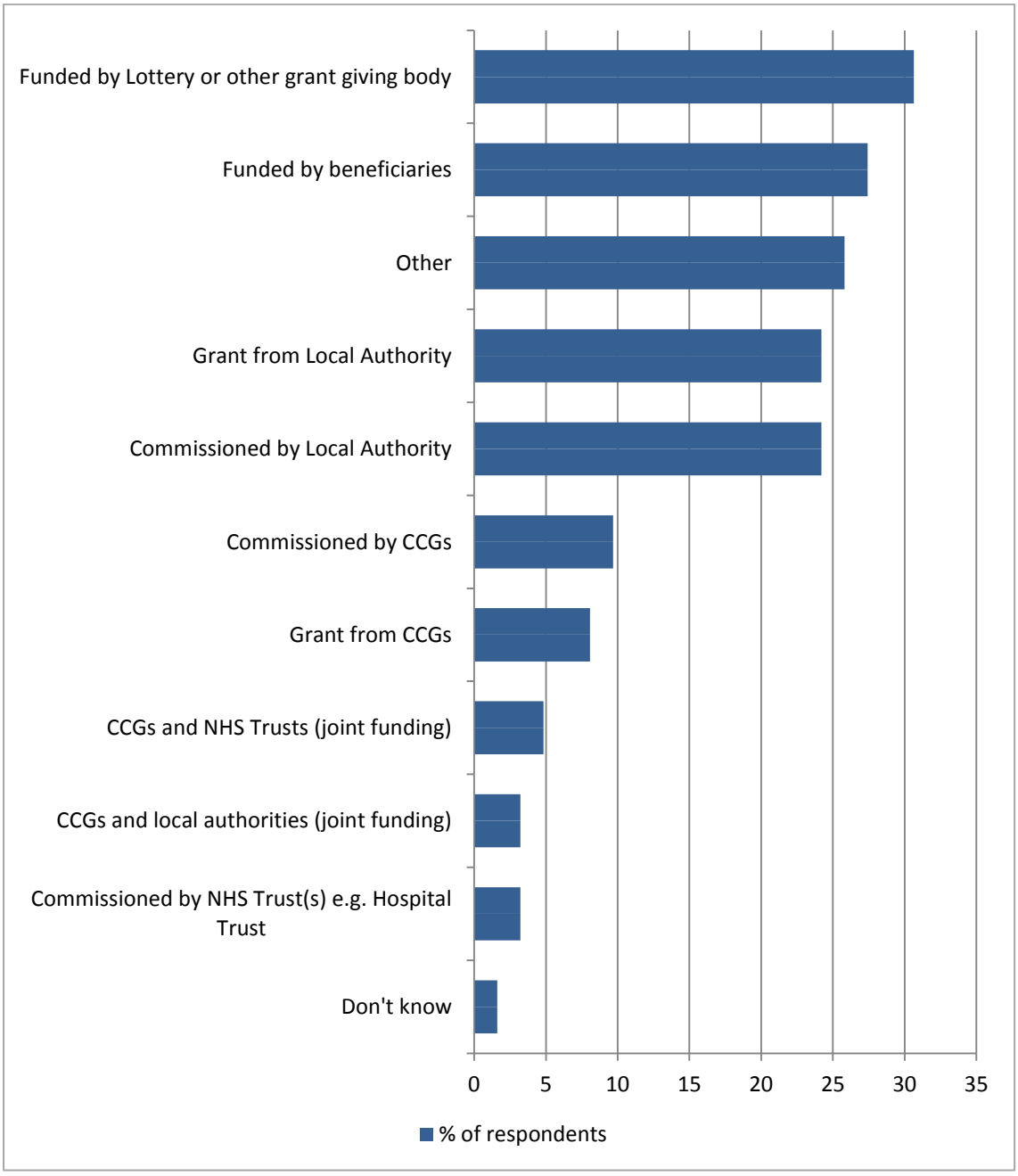
Supporting personal budgets and identifying implications for commissioning	
Weight management services	Women
Work and vocational opportunities	Disadvantaged people
Volunteer support	Families and children; vulnerable or isolated older people; exercise for men over 50; uptake of screening services; mental health
Yoga/meditation	For recovery from addiction and developing friendship networks

Funding of preventive services

Respondents were asked how the projects were funded. Figure 11 summarises the proportion of projects funded through each source. (Some projects were funded by more than one source, for example, partly by beneficiaries). Projects were funded through a wide range of sources with the Big Lottery and the local authority being most commonly cited.

Other funding sources identified were charity shops, NHS England, charitable trusts, volunteers and small local grants, Police and Crime Commissioner, through selling services to local authorities and reinvesting, and voluntary contributions through a range of sources, including users of services.

Figure 11: How preventive projects are being funded



Base: all projects (N= 62)

Influencing public health commissioning

Respondents were asked whether their organisation and its users knew how to influence public health priorities and whether they did, in fact, do so. In answer to the former question 43.6% 'strongly disagreed' or 'disagreed' while 48.7% 'agreed' or 'strongly agreed'. However, service users were described as more likely to know the routes for influencing services than for services to be changed as a result, and only 43.6% of respondents 'agreed' or 'strongly agreed' with the latter statement. Predictably, most respondents (89%) wanted greater influence on commissioning. Thirty nine respondents provided further details on changes that would need to

occur for VCSE organisations to have a greater influence on commissioning. These changes are summarised below.

Greater engagement
Respondents called for greater NHS understanding and interest in what the VCSE sector could offer, the opportunity to attend more meetings, an increase in direct contact and greater opportunities for discussion. Better access to commissioners was needed, working as equals and being included in consultations that were less rushed and took place before priorities had been agreed. On the other hand, meetings were also described as too formal and time-consuming and the sector did not have the capacity to attend all the meetings. One respondent commented 'show some interest, visit us, show some appreciation and acknowledge the work we do'.

There was a need for more information on the process of policy development with a link person for the VCSE sector in the relevant authorities. One respondent mentioned the importance of providing opportunities to sit on, or to make presentations at HWBs.

Changes in commissioning arrangements
Commissioners were described as not always aware of the services available and commissioning arrangements were described as complex and protracted. One respondent argued that there could be 'more transparency to the public health commissioning process linked to the council's commissioning process' and others argued for better information on how funding worked.

It was argued that commissioners should focus less on commissioning services from large organisations or working through gatekeepers but instead focus on smaller organisations that could fill 'gaps in local services'. If commissioners developed a consortium-based approach, for example, smaller groups could be included. It was also suggested that a specialist from the VCSE sector should sit on commissioning teams. Ways needed to be found to communicate to commissioners the results of successful VCSE projects.

Changes in the VCSE
Some changes were also needed within the sector. It was argued that VCSE organisations needed to work more closely together, work in partnerships and across networks and organise more networking events to allow the VCSE sector to build alliances. VCSE organisations also needed to be more representative. The sector needed to provide evidence of impact and 'quantify the social value they generate'. At the same time, political realities had to be acknowledged and commissioner priorities recognised.

Changes in commissioning priorities
Commissioning needed to build on insights from community development work, focusing on community needs and responding to them. The need to build on asset-based approaches and to place greater emphasis on prevention were also emphasised. There was criticism over excessive use of volunteers and 'community

champions'. The activities of VCSE organisations were in line with the spirit of the Social Value Act and it was argued that this needed to be taken account of in procurement processes.

In summary, the survey revealed variation in the role of VCSE organisations and in the opportunities available to influence public health commissioning. One respondent described a situation where the VCSE sector was involved 'at every level of co-production' in the local authority and CCG on commissioning and service delivery with change through engagement and challenge'. Another described strong influence 'at the table' of the VCSE. However, this could vary from authority to authority and one respondent, whose organisation spanned two local authorities, described a situation where 'we have excellent links with one, as do other agencies in the voluntary sector. With the other there is no apparent consultation or engagement and services are provided in-house.'

Changes since the relocation of public health responsibilities to local authorities

Questions were asked about the impact of the public health reforms in relation to 'local voice' and over the impact of the public health reforms on the VCSE sector.

Local voice

In relation to the influence of the 'local voice' in identifying health needs, Table 9 shows that only 25.6% saw more evidence of this, 12.8% saw evidence of greater involvement in the JSNA and 35.9 % saw less evidence of influence on local commissioning priorities. Likewise, a majority of respondents considered co-design of services for adults was 'less' or 'about the same' while for younger people, 36% of respondents didn't know. Surprisingly, 64% thought that community engagement in prevention was 'less' or 'about the same' and only 23% of respondents thought that reforms had led to more influence of the local voice on commissioning priorities for either local authorities or CCGs.

Table 9: Evidence of local voice

	Less	About the same	More	Don't know
Identifying local public health needs	28.2	25.6	25.6	20.5
Influencing the JSNA	28.2	35.9	12.8	23.1
Influencing commissioning priorities	35.9	23.1	23.1	7.0
Co-design of adult HWB services	25.6	41	20.5	12.8
Co-design of young people's HWB services	17.9	28.2	17.9	35.9
Community engagement in preventive initiatives	30.8	33.3	17.9	17.9

% of respondents (N=39)

Impact of the public health reforms on the VCSE sector

Questions were also asked over the impact of the public health reforms on a range of factors, summarised in Table 10. In relation to the complexity of contractual arrangements, 46% of respondents thought they were about the same and 62% thought that ease in coordinating views across the network were 'less' or 'about the same'. Only 23% of respondents considered there was more variety in services. Forty six percent of respondents thought there was less funding available for preventive services, the use of incentives was described by the majority of respondents as 'less' or 'about the same' (67%) and only 28% thought there was more emphasis on addressing health inequalities.

Table 10: Impact of the public health reforms on the VCSE sector

	Less	About the same	More	Don't know
Influence on LA commissioning priorities	38.5	30.8	10.3	20.5
Influence on CCG commissioning priorities	38.5	23.1	20.5	17.9
Complexity of contractual arrangements	15.4	46.2	17.9	20.5
Coordination across VCSE networks	30.8	30.8	23.1	15.4
Variety in services commissioned	35.9	17.9	23.1	23.1
Involvement in providing preventive services	35.9	17.9	23.1	23.1
Funding complexity	17.9	33.3	23.1	25.6
Availability of funding	46.2	25.6	5.1	23.1
Incentives for improved health outcomes	33.3	33.3	5.1	28.2
Emphasis on health inequalities	25.6	35.9	28.2	10.3
Emphasis on place-based initiatives	25.6	30.8	23.1	20.5

% of respondents (N=39)

The overall picture is of no change since the reforms – or of a deterioration in preventive activities in the sector.

Enablers and barriers

The survey included open questions on enablers and barriers to VCSE sector involvement in preventive services. The following section provides an overview of comments made by respondents. As for other questions, this question was notable for the extensive comments offered. However, as mentioned by a number of respondents, there is great variation across local authority areas and this survey is therefore not representative but does provide an exploration of the issues involved in developing the VCSE sector contribution to health promotion and prevention.

Enablers could largely be grouped under the response of one respondent, that is 'communication, respect, financial support'. As in the earlier section on what needed to change for the VCSE sector to exert more influence, respondents cited better recognition by CCGs and local authorities of the VCSE sector contribution and of their role as enablers, commissioners 'engaging listening and learning', listening to feedback, meeting the local VCSE organisations and being willing to engage. In particular, smaller VCSE organisations needed more information from commissioners. Public health commissioners could engage more closely, attending strategic meetings on issues such as sexual violence, for example. At the same time, the VCSE sector needed to engage with commissioner and HWB priorities, evaluate projects, and include evidence of social value.

Commissioners could work with infrastructure organisations, and jointly with VCSE organisations in a spirit of co-production. Respondents emphasised the importance of commissioners understanding the benefits of working in partnership across statutory agencies and the VCSE sector (and local Healthwatch could also play an enabling role). VCSE organisations also needed closer involvement with multi-agency planning systems and data sharing could be improved.

Locally-based VCSE infrastructure required further development through, for example, Councils for Voluntary Services and local 'Community Assemblies'. In particular, respondents emphasised the importance of local relationships, partnerships, consortia and networks – both across the VCSE sector and with other agencies. They could also form closer links with 'altruistic providers' and other third sector organisations. There was a role for training and development of VCSE organisations in the tendering process, to enable them to respond quickly.

Commissioners could make more use of grants, and take account of locality-based issues and specialisms. The contracting process could be simplified, made more proportionate to the nature of the contract and full cost recovery contracts developed. Projects needed to be funded over the longer-term if change was to be identified and respondents commented on the 'funding wheel' of constant bidding for small pots of funding for short periods.

Only one respondent specifically mentioned the JSNA for demonstrating need but considered it ineffective and out of date. The importance of dialogue with communities, monitoring community needs, locality mapping and a picture of the 'supply and demand' of both commissioned and non-commissioned VCSE services in relation to changing needs and priorities was highlighted. A more holistic approach was required on the part of commissioners.

One respondent noted the importance of surveys such as the present one, noting that it was important to collate 'information like this in a quantitative way so this can be analysed and then thoughts collected qualitatively for deeper insights'. This should be fed back in 'open forums' and feedback taken into account.

Apart from issues of recognition of, and engagement with the sector from both the NHS and local authorities, main barriers included: lack of resources in general; a lack of core funding for small organisations (so they could send representatives to forums/meetings) and for VCSE sector infrastructure; an emphasis on short-term funding which made evaluation difficult; lack of advance notice of opportunities and inadequate time to respond; and lack of investment in capacity-building and in developing partnerships. There was a lack of capacity to write bids at the same time as providing services. As mentioned earlier, the emphasis on large and generic contracts for corporate organisations was criticised. One respondent noted that organisations with 'large development teams' could 'tick boxes' but not necessarily deliver better outcomes. It was important to maintain 'specialisms of interest or geography'. Inclusive leadership was important and one respondent considered that equality and diversity programmes were required for commissioners to prevent a focus on the 'easy to engage'. Adherence by commissioners to the Social Value Act and the Localism Act were important for the VCSE sector.

Some barriers were identified within the sector and respondents mentioned competition across the VCSE sector, a lack of in-depth expertise or of a clear route for learning from successes of others in order to avoid reinventing the wheel. A lack of 'creative de-commissioning' or of taking risks to innovate was mentioned by one respondent. The VCSE sector needed to be able to contribute to monitoring and evaluation and also respond to priorities agreed by the HWB. Liaising across the VCSE sector in order to develop a coordinated response was considered important.

The contracting process was seen as a major barrier: procurement procedures were described as 'daunting', complex and bureaucratic, and beyond the capacity of small user-led or community-based providers. This was particularly the case when several contracts were released simultaneously. Core costs were not covered, which inhibited the capacity to respond and the potential to expand. Many services were provided in-house without a clear procurement process.

Commissioners were described as focusing on national initiatives and even with outcomes-based commissioning, outcomes were described as 'very prescriptive'. The process for gaining support for projects was not clear and one respondent described the NHS as suspicious of the VCSE sector and reluctant to refer. It could be difficult to engage with individual CCGs and one respondent noted that in London CCGs all worked differently and engaged in different ways, which could lead to a drain on resources. One respondent noted the 'complexity of public health and not knowing who to talk to about it'.

Defining innovation

Innovative approaches are a key theme of the research study and the survey asked an open question to identify how respondents interpreted innovation. All 39 respondents answered this question. Terms most commonly used included: flexibility, adaption and change; integration; new ways of achieving outcomes or of achieving change; developing streamlined approaches; and added value. One respondent described innovation as a 'marriage of creativity and effectiveness'.

Some respondents considered different categories of innovation (social innovation, societal innovation and innovation that encourages capacity to act) and another referred to different models of innovation (incremental, adaptive, radical and disruptive). 'Blue sky' innovation and 'early adopters' were also mentioned. However, respondents often mentioned innovation in the context of new ways of meeting community needs, focusing on client perspectives, meeting community needs 'from a social, cultural and spiritual/ethical perspective' and of developing holistic approaches. This meant 'not following trends or perceived wisdom but listening to the end user' and 'working with people on their own terms and being responsive to people's experience and to deficits in services'. One respondent spoke of the need to develop shared solutions to long-standing problems.

A number of respondents were more critical of the term, describing it as over-used and a 'hollow buzz word'. It was noted that innovation should not be sought for its own sake, to cut costs, or to displace projects already shown to be effective. Where there were new methods, technologies or providers they should be adopted 'not for the sake of newness but because they offer a better way of doing what needs doing'.

Respondents provided further details of 26 projects they considered innovative. As illustrated in Box one, projects were highly diverse and included the following:

- Affordable meals for school holidays;
- 'Wellbeing for life' projects;
- Cancer support and holistic care and early diagnosis.
- Using drama to reach diverse groups;
- Working with young male victims of domestic violence;
- Using smartphones, apps and skype to support alcohol reduction;
- Combining resources across different groups (for example, for mental health);
- Using volunteers to raise awareness of heart health and cancer prevention.

Individual projects are not described in detail as part of this research report, but selected projects will be followed up separately in order to inform the development of an innovation framework for preventive services.

Additional issues to consider

The survey provided opportunities for examples and comments throughout. At the end of the survey, respondents were asked to make comments or mention any areas not covered in the survey and 21 respondents made additional comments. Issues raised included the following:

- The impact on the VCSE sector of commissioners with different priorities and budget-setting processes;
- More emphasis on support needed for group leaders;
- Costs not being factored in (including core costs and additional costs such as training and support of volunteers in rapidly changing environments);
- CCGs not responding adequately to Patient Participation Groups;
- Lack of emphasis on mental health promotion.

In relation to survey design, one respondent pointed out the difficulties of responding if more than one local authority was covered; another considered that questions were less relevant for a national organisation with numerous projects; and one respondent thought it included too much jargon. However, one respondent welcomed the opportunity to highlight constructive relationships between the VCSE, local authority and CCG and another considered it 'excellent' that this new research was being conducted.

Strengths and limitations

As not all HWBs have membership from the VCSE sector, it was decided to carry out two national surveys, one of local Healthwatch and VCSE members of HWBs and another of VCSE organisations involved in prevention. There was a degree of overlap across survey questions which allowed for comparison. There are also some overlaps with the national survey of CCG members HWBs and Directors of Public Health carried out as part of the scoping phase (and summarised in research report 4).

While comments were invited in both surveys, open questions were a feature of survey 2. Moreover, in survey 2, details of 62 preventive projects were highlighted by respondents. Through qualitative analysis of the detailed comments received across both surveys, a picture has emerged of the influence of Healthwatch and the VCSE in commissioning and providing preventive services. Strengths of the research therefore lie in the relevance of the topic area, the breadth of the VCSE sector surveyed and the ability to compare different perspectives across the VCSE sector and local Healthwatch.

The main limitation, however, is the low number responding to each survey (34 respondents for survey 1 and 39 for survey 2). While it is difficult to identify the response rate for survey 2, as the number of VCSE organisations involved in preventive activities is unknown, the response rate for local Healthwatch (14%) in survey 1 was disappointing. This means that the analysis is descriptive and we are unable to generalise from the results. In order to avoid misleading extrapolation from results, we include numbers of respondents for each figure and where we compare views of Healthwatch and VCSE sector members of HWBs we reiterate the total numbers for each group.

It should be emphasised, however, that these surveys form part of the scoping phase of the project, and helped inform research instruments for field work. Survey topics are explored in more detail across case study sites which include interviewees from Healthwatch, VCSE members of HWBs and representatives from the VCSE sector locally if these are not already members of the HWB. Findings of both surveys will be interpreted in the context of the study as a whole.

Discussion and implications for the study

While there was some overlap across questions included in the surveys, they were intended for different target groups: survey 1, directed to HWB members, included more detailed questions on commissioning, while survey 2, directed to VCSE organisations in general, was shorter, included a greater number of open questions and was focused on approaches to, and examples of innovation. However, respondents to both surveys provided extensive comments. There were common threads running through responses to the following topics included in each survey, that is: impact of the public health reforms; funding of preventive services; influences on commissioning preventive services; public involvement; innovation; and enablers and barriers to greater involvement of the VCSE sector in prevention.

Both surveys highlighted the need for more recognition by commissioners and HWBs of the value of local Healthwatch and the VCSE sector and of the public as 'partners in the solutions'. While there were differences between local authorities, respondents identified a number of changes needed to enable VCSE organisations and local Healthwatch to exert greater influence on how preventive services were commissioned. These included: greater capacity and resources; more recognition by commissioners; and an emphasis on co-design and community involvement in priority development, although how best this might be achieved was not discussed. The problem of a lack of co-terminosity across CCGs and local authorities and its impact on the capacity of the VCSE sector to engage was also highlighted. A few respondents also noted the influence of broader initiatives, such as Fairness Commissions, on prioritising preventive services.

Both surveys (and especially survey 2) highlighted integrated and networked approaches to addressing lifestyle issues, in contrast to lifestyle interventions as reflected in the evidence base for public health interventions. Notwithstanding a definition of prevention being circulated with the surveys, it was clear that prevention was broadly defined and encompassed services concerned with health and wellbeing, ranging from prevention of hospital admission to the promotion of mental health in vulnerable groups. Services designed to address risk factors such as smoking or obesity, or social determinants of health across directorates of the local authority formed a small proportion of the activities described. While this may simply reflect respondents and the services they provided, it is likely that different understandings may also influence the parameters of health, wellbeing and public health debates in HWBs and how the potential role of the VCSE sector in promoting prevention is conceptualised.

When asked to identify which area of health and wellbeing projects were seeking to improve, 25 of the 62 projects highlighted in survey 2 were specifically described as including a mental health focus or impact, and this was also implicit in many other

projects concerned with health and wellbeing. This tallies with a recent LGA 'Public Health Opinion Survey' which showed that 79% of respondents wanted the council to do more on mental health while less than 30% of respondents considered more needed to be done in relation to sexual health (19%), smoking (29%) or drug misuse (17%). There is, therefore, little congruence between the activities described by respondents and the main public health budget reporting categories reflected in the ring-fenced budget transferred from the NHS. Respondents described little involvement in health checks, obesity, sexual health services or smoking cessation, and for preventive services, there was an emphasis on methods of engagement where advocacy, peer support and volunteering were often combined.

Across both surveys, local authorities (sometimes jointly with CCGs) were identified as the main funder of VCSE providers of preventive services. Survey 2 included detailed responses on the complexity of contractual arrangements; the need to include smaller VCSE groups in broader contracts; and of grounding commissioning priorities in community needs. Specific suggestions included reflecting the spirit of the Social Value Act in the commissioning process and for VCSE organisations to work more closely in partnership, providing evidence of effectiveness and impact. It was suggested that contracts included elements of active engagement and that plans for preventive services be signed off by local Healthwatch.

Almost three quarters of respondents (survey 1) supported the public health reforms, but across both surveys the majority could not identify improvements arising from the reforms across a range of factors including public involvement in commissioning, co-design of services or commissioning services from the VCSE sector. However, innovation arising from the reforms was described as more likely in the areas of targeting services, addressing healthy lifestyles and social context and conditions. The concurrence of public health reforms and budget cuts was noted by respondents across both surveys and suggestions that cuts are undermining the benefits that could be gleaned from the reforms.

A number of respondents to both surveys considered that innovative practice derived from views of communities and service users. Both surveys also reflected a view that the term 'innovation' was over-used and a potential smokescreen for budget cuts. Examples of innovative approaches included targeting, developing community networks, integrated approaches to wellbeing and prevention, health buddies, a single referral route for health and social care workers for preventive services, provided through the VCSE sector, and the use of smartphones and skype for contact and support. There was little knowledge of VCSE involvement in wider public health issues by Healthwatch respondents. Some VCSE respondents highlighted cross-directorate approaches to mental health promotion, social isolation and lifestyle change.

Views over enablers and barriers to greater involvement of the VCSE sector in prevention spanned resources, capacity, better recognition of services provided through the sector, earlier involvement in the commissioning process, flexibility on the part of commissioners, reflecting core costs in contracts and including smaller

organisations. While there was variation in the assessment of HWBs, and the extent to which they engaged with the VCSE sector, the effectiveness of HWBs as decision-making bodies was criticised by a number of respondents and their influence on preventive services was less than might have been anticipated. In the same way, in survey 1, executive elected members were perceived as less influential on commissioning preventive services than local authority officers or CCGs and were perceived as a route for influencing the commissioning of preventive services by only 50% of respondents.

Survey findings will inform the development of research instruments for the 10 case study sites, where interviewees will include local Healthwatch and VCSE sector members of HWBs. Innovative approaches to prevention, including approaches developed through new providers, will form part of case study snapshots.
Many respondents (n=45) wished to be kept in touch with the research and we will direct these contacts to the project website as reports become available. There were also indications that VCSE sector organisations wished to develop their role in the public health agenda and there was one specific offer of support through providing a focus group of local VCSE sector organisations to discuss the research.

We also intend to follow up a selection of case studies highlighted in the surveys to inform an innovative framework for preventive services, due for submission in August 2016.

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