

THE
GOOD
ECONOMY

Innovation in Health and Care: the Opportunity for VCSEs – a South West Perspective

March 2016

A report by The Good Economy Partnership in association with
Common Capital, Real Ideas Organisation and South West Forum.

COMMON CAPITAL



Foreword

Our regional health system is under unprecedented demographic, financial and capacity pressures. Overcoming these pressures will require a radical change in the way we deliver health and care: increasing the focus on wellbeing, preventing ill-health and enabling individuals to take greater control of their own care.

We believe the voluntary, community and social enterprise sector (VCSE) has the potential to play a significant role in this future model of health and care, harnessing the knowledge deep within communities to develop innovative, person-centred responses to the needs of our population.

Realising this potential will require change in itself. New approaches to partnership and collaboration will be required and new sources of funding and finance will be needed to develop, test and scale innovative VCSE models of care.

This report explores the role of three key actors in this context with the aim of strengthening the connection between the supply and demand for funding and finance for VCSEs:

- i) the VCSEs developing innovative models of care;
- ii) the organisations commissioning health and care in our region and;
- iii) the suppliers of finance from the social investment market.

Five key areas of opportunity are identified, potential challenges associated with each area explored, the demand and supply for social investment analysed and recommendations proposed. These recommendations will form the basis of our future work with members and partners to support innovation from the VCSE sector in the South West.

I would like to thank our local authority partners who co-commissioned the research and the project team for producing such a useful and informative report. I would also like to thank all those who generously gave their time to participate in this research through interviews and/or workshops. The breadth and depth of the research is without a doubt the product of your openness and willingness to support this work.

I look forward to working with members and partners to take forward the recommendations from this report and helping the South West to realise the opportunity for innovation from the VCSE sector.

Jon Siddall

Director of Investment Partnerships
South West Academic Health Science Network



Report Authors

Sarah Forster – The Good Economy Partnership

Dan Gregory – Common Capital

Project Team

Sarah Forster – The Good Economy Partnership

Dan Gregory – Common Capital

Matt Little – Real Ideas Organisation

Simon Mayell – South West Forum

Kirsten van den Hout – independent consultant

Sue Cooper – independent consultant

Contents

Executive Summary	4
I. Introduction	7
Context	9
Purpose of this Study	8
Our Approach	8
Structure of the Report	8
II. Context & Opportunity for VCSEs	9
National Context and Policy Drivers	9
Priority Regional Health and Care Needs	10
III. Realising the Opportunity – Challenges for the South West	12
Commissioner Perspective	12
VCSE Perspective	13
IV. A Way Forward: Five Routes to VCSE Innovation and Scale-up	16
1. Developing community-based micro-providers	16
2. Scaling up existing VCSE organisations	21
3. Outcomes-based commissioning models	25
4. New forms of consortia and partnerships	27
5. Co-creating new asset-backed social enterprises	30
Summary of Opportunity Area and Financing Gap	32
V. Conclusion and Recommendations	33
APPENDIX 1: List of interviewees	35
APPENDIX 2: Regional context	37
APPENDIX 3: Regional and local initiatives	39
APPENDIX 4: Funder/support provider list	43
Grants and low cost finance	43
Specialist social investment finance providers	44
EU funding	45

Executive summary

Background and purpose of this study

Our health and social care system is under unprecedented demographic, financial and capacity pressures. This has led to an increasing recognition that greater focus is needed on early intervention, preventing ill-health and delivering integrated person-centred care in the community – both to improve individual health and well-being and to reduce demand and pressures on the NHS.

There is a widely held view in many parts of the health and care system that the voluntary, community and social enterprise (VCSE) sector has something more to offer beyond the role it currently plays to help address the challenges faced by the health and care system. Many VCSE organisations are highly trusted and able to connect with people others may find ‘hard to reach’. Their services are often praised for taking a holistic, person-centred approach to individual need.

This view is strongly held by the South West Academic Health Science Network (SW AHSN), working on behalf of its eighteen NHS and university members; and five local authorities in the South West – Cornwall, Plymouth, Devon, Torbay and Somerset. In order to substantiate this view and examine how practically to support VCSE development these organisations came together to commission this study.

The original purpose of the study was to explore the feasibility of establishing a regional social investment fund to support the development and scale-up of innovative VCSE-led models of health and social care in the South West region.

The study was led by Sarah Forster of The Good Economy Partnership in collaboration with Dan Gregory (Common Capital), Matt Little (Real Ideas Organisation), Simon Mayell (South West Forum), Kirsten van den Hout (independent consultant) and Sue Cooper (independent consultant).

National context and regional health priorities

In Chapter 2 we examine the policy drivers that affect VCSE development and the regional priority needs areas where commissioners believe VCSE organisations can play a greater role in service delivery.

Within the NHS, we are seeing an increasing emphasis on integration of services (of health and social care, physical and mental health, acute, community and primary care), ever-greater personalisation of services and a focus on outcomes-based commissioning, all of which potentially drive new opportunities for VCSE organisations. Regionally, pioneering commissioning models are already emerging in response.

Devolution is also an important trend that brings the potential to give local authorities more freedom to tailor local services to local needs.

As is the case across many parts of the UK, our research found that smoking cessation, alcohol misuse and obesity are priority problems across the region. These were followed by: supporting independent living for those with long term conditions; emotional wellbeing and depression; dementia care; and support for carers.

However, commissioners stressed the need to focus less on specific health conditions and instead, suggested two broader priority areas where they see a clear role and opportunity for VCSE organisations:

1. **Care for the elderly and ageing better** – a clear response to demographic changes which are particularly strong in the South West. Commissioners are interested in services and interventions which offer care in the community and closer to home, enabling people to live more independently and in their own homes for longer while reducing their isolation. They want to prevent unplanned admissions, support recovery and reduce the severity of long-term conditions.
2. **Healthy lifestyles** – there was widespread recognition that the underlying socio-economic determinants of health, such as unemployment and poor housing conditions, have a significant influence on behaviours, such as alcohol misuse, smoking, physical inactivity and unhealthy diets. These underlying determinants, in turn, cause conditions and diseases which lead to deaths and health problems. So commissioners would like to see services and interventions which address these underlying causes through improvements to job opportunities, housing, transport, and economic circumstances and which encourage people to take greater control over and responsibility for their own health and wellbeing

Realising the VCSE opportunity

Chapter 3 sets out the challenges to realising the VCSE opportunity from both a commissioner and VCSE point of view.

Commissioner perspective

The commissioners interviewed all had experience of working with VCSE organisations and there was a strong interest in building on the strengths of VCSEs, particularly preventative, person-centred services.

The ‘social enterprise’ model was of interest among commissioners for its combination of a business-like approach, public service ethos, focus on achieving long-term financial sustainability and reinvestment of the majority of profits.

Commissioners, however, highlighted the challenges to realising the potential which VCSE organisations promise. Perceptions exist that the VCSE sector is sometimes fragile, consists of a large number of very small organisations and faces challenges in terms

of collaboration, evidencing appropriate outcomes, professional capability to deliver, and meeting regulatory requirements.

At the same time, commissioners recognised that they themselves will need to change their way of working if they are to successfully leverage the potential of VCSE organisations. Commissioners interviewed expressed a need for improved market intelligence, new commissioning processes to support co-design and co-production models, new contracting arrangements and deepening their understanding of the opportunity offered by social investment.

VCSE Perspective

VCSE organisations are often ambitious about playing a greater role in service delivery and believe that VCSE-led models can deliver both better outcomes for individuals and cost savings. However, they perceive that the policy rhetoric – for example a move towards a focus on prevention – is not always matched by reality.

The high degree of instability in the public sector landscape and funding cuts is a major challenge for many VCSE organisations, particularly smaller organisations. Some interviewees expressed frustration at an absence of meaningful strategic engagement and appropriate commissioning relationships between VCSE organisations and commissioners. They believe they can improve their marketing, their technology expertise, their leadership and skills and develop partnership and consortia relationships.

Despite the challenges, what came across from our interviews was an increasingly shared view and sense of common purpose among commissioners and VCSE organisations about the system-wide problems and what's needed to address them. There is a will to work more closely together; now is the time to find a way forward.

Leadership is required on both sides to engage in a more committed and strategic way if we are to see deep systemic change and new VCSE-led health and care service models develop.

A Way Forward: Five Routes to VCSE Innovation and Scale-up

In Chapter 4 we put forward five areas where we believe there is strategic opportunity for a greater role for the VCSE sector in health and social care in the South West. For each we explain the opportunity and related care model, provide concrete examples, present the challenges to development and look at the demand and supply of social investment.

These five opportunity areas are:

1. **The development of community-based micro enterprise providers** – driven Integrated Personal Commissioning (IPC), providing support or care to people in their community paid for by personal budgets.
2. **Scaling up existing VCSE organisations** – a number of existing organisations in the South West region are providing high quality services and are ambitious to grow.
3. **New, outcomes-based commissioning models** – which are already relatively well advanced in the region. These may be investor-led outcomes-based commissioning models or provider-led models.
4. **Developing new forms of consortia and partnerships** – as new and bigger integrated care organisations emerge and contracts are aggregated, the VCSE sector will increasingly miss out on opportunities if VCSE organisations don't work in partnership with themselves and others. Already there are partnerships in development in the South West.
5. **Co-creating new, asset-backed social enterprises** – the creation of entirely new, relatively large social enterprises, established to meet a specifically targeted market opportunity, backed by property assets or contracts, such as community hospitals or telecare models.

We found that the existing source of supply of finance is relatively well-developed for VCSE organisations looking to scale-up where there is a proven business model and revenues and for outcomes-based commissioning models. What is lacking are (i) easy access to very small affordable loans for micro-enterprises, (ii) patient, risk capital suitable for funding the development and scale-up of new models of health and care, including partnerships and consortia; and (iii) larger equity-like investment willing to back new, larger social enterprises or property-based developments.

Recommendations

The original thinking behind this research was to set-up a single fund to support VCSE innovation in health and social care in the South West. Our research has led us to believe that a single regional 'fund' is not the best approach for three main reasons:

1. **The diversity of financing needs** – from micro-loans to large-scale, risk capital investment – would be very difficult to meet within a single fund model.
2. **Leverage existing funding** – there is a growing availability of a range of social finance products at a national level, hence it makes sense to attract funding from existing sources. Already SW AHSN is taking a proactive role in developing a new regional fund that would help meet the gap for smaller amounts of risk capital which will become part of the supply of funds.
3. **Too many initiatives, not enough focus** – already there is a sense in the region that there are too many new initiatives.

Our thinking, therefore, is to test out the idea to establish a '**Regional Health and Care VCSE Innovation Facility**' designed to build on, connect and leverage funds and initiatives.

The objective of the proposed facility would be to support the prototyping and development of innovation and scale-up of VCSE-led services and models of health and care that support commissioner priorities and that provide personalised, high quality care that deliver better outcomes for individuals and provide good value for money.

The main role of the 'facility' would be to broker and **intermediate both technical support and funding** – connecting the right type of existing support and funding to different VCSE-led models of health and care.

The facility could be available for applications from any VCSE or large local provider/CCG in partnership with a VCSE to respond to an identified market opportunity, for example:

- A group of VCSE organisations want to partner or form a consortium to bid for new Work and Health Programme contracts coming out in 2017 but with a more holistic focus than just focusing on job-readiness and help into employment looking at the underlying causes of worklessness.
- An NHS Foundation Trust wants to pilot a dementia care early discharge mini village that integrates community and acute care on a specific physical site.
- A group of commissioners want to develop new service offers for people living in isolated rural areas using personal budgets.

Additionally, the facility could carry out the following roles which would help overcome market information gaps:

- Support mapping or audits of VCSE health and care providers in local areas so as to help improve market information and intelligence about what local services are available.
- Improve sharing and successful uptake of knowledge, innovation and good practice both within the region and nationally.
- Support outcomes-based commissioning by helping to define outcome metrics and evidence standards that are agreed by commissioners and VCSE organisations and test new Social Investment Bond (SIB) models inspired by local context.
- Explore the value and feasibility of establishing a 'portal' or mechanism that could facilitate the sharing of information about VCSE service offers to NHS and social care users.

Next steps

During the next phase of work we will test out these findings and the facility proposal with stakeholders with a view to developing a strategy to take these ideas from recommendations to action. The aim will be to develop an operational plan for SW AHSN and the commissioners who have supported this study. This must be practical, realistic, acceptable to stakeholders and for them to ultimately take forward and own. In Chapter 5 we set out the questions that need to be answered to take our recommendations forward.

The challenges to our health and care system are significant and growing. But opportunities are opening up, the need for action is clear, and commissioners in the South West region are already leading the way. If existing and new sources of finance can be harnessed to help VCSE organisations and others to overcome the barriers we face through the further development of community-based, person-centred models of health and care, then there is significant potential here to make a real difference and improve the health and wellbeing of people across the South West.

The case for person-centred care: real life examples

The individual experiences described below during the course of this study explain in real life terms what both health and VCSE professionals are seeing on the ground. The themes emerging from these stories are that some reports of physical health problems are in fact related to specific wider issues of wellbeing and that personalised care in the community can make a real difference to people's lives and reduce demands on the NHS.

75 year old John had a history of falls which led to a fractured hip and a spell in hospital. He returned home but continued to fall. Finally, a support worker went to his home and listened to his story. It turned out that John's wife had died the year before and he was drinking heavily which was why he was falling. The support worker got to know John and helped organise social activities to give John something else to focus on. John is now much happier and has not fallen nor had to visit the hospital since.

In another example, a Living Well volunteer in Cornwall describes taking a different approach to achieve a positive health outcome: "I was introduced as a volunteer support worker to a man with severely ulcerated legs – there was a question about whether his foot and toes should be amputated. He had cancelled two operations previously because he couldn't find anyone to look after his dog. He was in trouble for non-payment of council tax. The bailiffs had been around several times but had gone because there was nothing of value. The forms to fill in to claim exemption frightened him as they were 42 pages long. He is worried that his GP will not sign the form as it says 'severe mental impairment' but he doesn't want to say he's severely mentally impaired because he's worried they will put him away somewhere. We're trying to be the catalyst to connect bits of the system around him, to deal with the council and get the operation done. I managed to find someone to look after his dog and took him to hospital for his operation. We've managed to get him a bank account set-up and his bills are being paid on time. The co-ordinator has also arranged for an advocate to deal with his council tax and I've helped him sort through the six years worth of paperwork for his exemption claim. No one was otherwise supporting him in a way that would help deal with all his problems and he couldn't deal with them himself. This gentleman is now doing well. He continues to spend time with his volunteer. He hasn't needed any major hospital treatment so his foot and toes are still intact. He finally feels on top of things."

I.

Introduction

This introductory section sets out the background to this study, its purpose, and describes our research approach.

Background

Our health and social care system is under unprecedented demographic, financial and capacity pressures. Nationally, the NHS is going through the biggest financial squeeze in its history at the same time as we experience growing demand for care. Eight in ten NHS trusts were reportedly in deficit at the end of September 2015. We have an ageing population and an increasing number of people living with long-term health conditions. We have significant inequalities in health and life expectancy between the richest and poorest, often within one place, such as in Plymouth and Exeter¹. At the same time, social care budgets and services are also under enormous pressure.

The crisis in our health services has led to an increasing recognition that greater focus is needed on early intervention, preventing ill-health and delivering integrated person-centred care in the community – both to improve individual health and well-being and to reduce demand and downstream pressures on the NHS. This requires systemic change and a proactive approach to finding and adopting health and care innovations developed outside the NHS².

There is a widely held view in many parts of the care system, among NHS providers, commissioners and policymakers, and in central and local government, that the voluntary, community and social enterprise (VCSE) sector has something more to offer beyond the role it currently plays to help address the challenges faced by the NHS.

VCSE organisations are recognised as being well embedded in their communities and a key source of innovation. Many VCSE organisations are highly trusted and able to connect with people others may find 'hard to reach'. Their services are often praised for taking a holistic, person-centred approach to individual need.

¹ Inequalities in Life Expectancy: Changes over time and implications for policy, David Buck and David Maguire, The Kings Fund, August 2015.

² At the heart of health: Realising the value of people and communities http://www.nesta.org.uk/sites/default/files/at_the_heart_of_health_realising_the_value_of_people_and_communities.pdf



The VCSE sector is very diverse, encompassing a broad universe of organisations from small and informal community groups to well-established charities, public sector spin-outs, new social ventures and arguably even employee-owned mutuals and GP co-operatives. We acknowledge this diversity and the blurred boundaries of this sector and use the abbreviation 'VCSE' as a broad and loose umbrella term.

Purpose of this Study

This study was commissioned by the South West Academic Health Science Network (SW AHSN)³, representing its eighteen NHS and university members; and five local authorities across the region (Cornwall, Plymouth, Devon, Torbay and Somerset).

The purpose of the study was to explore the feasibility of establishing a regional social investment fund to support the scale-up of innovative VCSE-led models of health and social care in the South West region.

We set out to consider what priority needs commissioners believe VCSE providers could best help meet, what VCSE providers could deliver and what financiers might offer. We reviewed the evidence, conducted interviews and held workshops to test our emerging findings.

As the project progressed, we developed a clearer understanding of the three types of demand which may come together to help new models of VCSE-led care to succeed: the needs of health commissioners which create opportunities for sustainable new models, the capacity and demand for finance from emerging VCSE business models, and the interests of investors.

As a result, our findings and recommendations go beyond a focus on finance – the setting up of a 'fund' – to a more holistic analysis of the market opportunity for VCSE organisations, new VCSE-led models of health and care and how to facilitate the flow of investment to support these models.

An experienced team carried out the project led by Sarah Forster of The Good Economy Partnership, and comprising Dan Gregory (Common Capital), Matt Little (Real Ideas Organisation), Simon Mayell (South West Forum), Kirsten van den Hout (independent consultant) and Sue Cooper (independent consultant). The team bring together experience of health and social care policy, social enterprise development and social investment at both the regional and UK level.

Our Approach

Our research approach was evidence-based, participatory, and bottom-up. We set out to triangulate three areas of analysis:

1. **'Customer side' – commissioners.** We started this work with desk research of regional health and social care strategies. Through interviews with local commissioners we identified the health and social care priority needs they believe VCSE could help meet in their locality, as well as the opportunities and challenges of commissioning VCSE organisations. A total of 24 in-depth interviews were carried out with senior professionals in strategic roles within health and social care commissioning and two workshops delivered – one for commissioners only (September 2015) and one bringing together commissioners and VCSE leaders (December 2015). See Appendix 1 for full list of interviewees.
2. **'Demand side' – VCSEs.** We then gathered the perspective of VCSE organisations by interviewing a total of 27 senior professionals from VCSE organisations and support organisations in the South West as well as a handful of pioneering VCSE organisations from across the UK. Our objective was to understand where VCSE organisations see the opportunities and challenges and to understand their capabilities, plans and investment needs to develop sustainable, health and social care models.
3. **'Supply side' – investors and funders.** Lastly, we explored potential sources of grant funding and investment finance. A follow-on phase of work will explore in greater depth how to mobilise sources of funding that match the investment and support needs of the VCSE-led service delivery models identified in this report.

Structure of the Report

The report is organised as follows:

Section 2 describes the policy drivers and regional health priorities and needs where there is a potential opportunity for VCSE organisations to play a greater role.

Section 3 sets out the challenges to realising these opportunities from both a commissioner and VCSE perspective.

Section 4 suggests five strategic areas for the development of VCSE-led care models of health and care.

Section 5 makes recommendations and puts forward a strategy to facilitate the flow of investment to support VCSE innovation that improves the health and wellbeing of people across the South West.

³ The South West AHSN is one of fifteen Academic Health Science Networks established by NHS England to improve patient and population health outcomes by translating research into practice, and developing and implementing integrated health care services. SWAHSN supports knowledge exchange networks to build alliances across internal and external networks and actively share best practice to enable early adoption of new innovations.

II.

Context & Opportunity for VCSEs

This section presents a brief analysis of the national and regional context, the policy drivers that affect VCSE organisations and the priority need areas where we have identified an opportunity for VCSE organisations to play a greater role in delivering better health and care in the South West.

National Context and Policy Drivers

In 2014 NHS England launched 'The Five Year Forward View' in response to the pressures the NHS is facing. This plan articulates why further change is needed, what that change might look like and how it can be achieved. It describes various models of health and care that could be provided in the future and defines the actions required at local and national level to support delivery.

Within this strategy, our conversations with commissioners have led us to identify **three inter-linked national policy drivers**, which are of particular significance in shaping the opportunities for VCSE organisations over the coming years.

First, is the increasing emphasis on integration of services – health and social care, physical and mental health, acute and community health. Integration of services is supported by initiatives like the Better Care Fund⁴ and the Integration Pioneers⁵ programme (two Pioneer sites are based in the South West region).⁶ NHS England's planning guidance for 2016/17 further emphasises the importance of local integration, asking every health and care system to develop ambitious local blueprints for accelerating the Five Year Forward View using place-based planning.

Integration is not a goal in itself. Much of the rationale for further integration comes from the recognition that early intervention and preventative services can save 'downstream' costs. A focus on wellbeing, preventing ill-health and person-centred care in one part of the system can reap benefits and savings elsewhere and help put the whole system on a more sustainable footing.

This increases the need for providers of acute services to strengthen partnerships with early-intervention and preventative services. It may also require systemic change and reform of the health and social care system at the local or regional level to address so-called '**failure demand**'. This exists, for example, where people do not initially receive effective care or treatment and are

passed around the system and consequently require additional services or support at a greater cost later.

We are increasingly seeing not only integration at the commissioning level but the emergence of multi-provider contracts or visions of large Integrated Care Organisations and single Accountable Care Organisations to deliver services that reduce overall demand. Many of these models take a place-based approach, focused on joining up services within a particular geography.⁷

Second, a continuing move towards the idea of personalisation. This may take the form of so-called person-centred care and/or the greater uptake and spread of individual or personal budgets. In financial terms, we are perhaps also starting to see a shift away from block contracts or budgets based on historic settlements towards capitated budgets. Capitated budgets are allocated to a provider(s) based on a sum per patient and may be significant in enabling a shift towards personal budgets. Some care and health services can be purchased privately by individuals while others might be part funded by the taxpayer and bought by commissioners, and in part by individuals, either on a top-up or additional basis.

Person-centred care also recognises the importance of the quality of *relationships* and services that are framed not only in economic terms of costs and savings but in terms of mobilising individual and community resources and capabilities.

Third, an ever-growing emphasis on outcomes-based commissioning. While the idea of public sector budget-holders moving away from a focus on inputs or activity or outputs towards a focus on 'outcomes' has been around for many years, in a tough financial climate, many believe that the taxpayer should be paying only for success and for *what works*. This is increasingly reflected in the rise of the idea of Social Impact Bonds and in other financial arrangements that seek to reward the achievement of outcomes through payment mechanisms. As the NHS has seemingly moved increasingly towards 'marketisation' over several decades (i.e. opening up the NHS to market forces and competition), so the internal market is shifting towards a model where the customer (commissioner) only wants to pay when the provider delivers what they value.

Devolution is also an important trend that brings the potential to give local authorities more freedom to tailor services to local needs and help better integrate interventions across, for example, health, social care, welfare, housing and employment.

Regardless of how devolution evolves, the wider South West region is already pressing ahead with developing models more tailored to local need. There are three vanguard sites developing new

⁴ The Better Care Fund (BCF) aims to provide financial support for councils and NHS organisations to jointly plan and deliver local services – <https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2015-to-2016>

⁵ 14 areas identified as leading the way in delivering better joined up care – <https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2>

⁶ See <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/>

⁷ See, for example, Place-Based Systems of Care: A Way Forward for the NHS in England, Chris Ham and Hugh Alderwick, The King's Fund, November 2015.

integrated care models [for the new care models programme – a step towards delivery of 'The Five Year Forward View']. These include South Somerset Symphony project joining up primary and acute care and South Devon focused on new approaches to emergency services.

Meanwhile, Cornwall is one of the Government's Integration Pioneers with 15 organisations joining together with a commitment to more closely integrate services, overseen by the Health and Wellbeing Board. In Plymouth, the City Council and NEW Devon CCG agreed to form an integrated commissioning function from 1 April 2015 and have developed four integrated commissioning strategies related to Wellbeing, Children and Young People, Community and Enhanced and Specialised Care, all of which create real opportunities for VCSE involvement.

Cornwall is the first area outside Greater Manchester to agree a formal devolution deal which aims to give the area more freedom to tailor services to local needs. Kernow Clinical Commissioning Group and Cornwall Council are aiming to move towards a £2 billion pooled budget combining health, welfare and social care spending with joint commissioning and procurement.

Priority Regional Health and Care Needs

Our desk research and literature review of health and social care priorities within the SW AHSN region of Devon, Cornwall and Somerset enabled us to begin to identify more specific need and demand in the region, as well as public sector priorities and commissioning intentions. This work included reviews of Joint Strategic Needs Assessments, Foundation Trust's strategic plans, and Clinical Commissioning Group and local authority strategies and commissioning plans in different areas [e.g. adult social care, mental health, community services, carers, dementia].

Our analysis was structured by the local authority areas of Cornwall, Plymouth, Devon, Torbay and South Devon, and Somerset. A detailed analysis of our findings can be found in Appendix 2.

This initial desk research indicated a number of consistent, and perhaps unsurprising, priorities across the region. The three primary priorities were:

- smoking cessation
- alcohol misuse
- obesity

These were followed by a number of other issues, highlighted as being of particular importance in three of the five local authority areas but of relevance to all areas:

- independent living for those with long term conditions
- emotional wellbeing and depression
- support for carers
- dementia



Westbank arts project, client drawing

Our interviews with commissioners steered us away from focusing on single health conditions in isolation and towards a focus on 'population outcomes'.

Two key priority areas emerged where the opportunity for VCSE involvement was seen to be the greatest.

The first priority area identified is **Care for the Elderly and Ageing Better**. This emerges as a clear response to demographic changes, which are particularly strong in the South West region. Over the coming years, the region will continue to see increases in the numbers of patients with a combination of multiple, long-term conditions, who are frail and vulnerable, with dementia, and who are isolated and lonely, often in rural areas.

Commissioners are
interested in services
and interventions which
offer care in the community
and closer to home,
enabling people to live
more independently.

Health and care system leaders are interested in services and interventions which offer care in the community and closer to home, enabling people to live more independently and in their own homes for longer while reducing their isolation. This includes models which reduce falls and prevent unplanned admissions, support reablement and recovery and either reduce the severity of conditions or detect and prevent the onset of long term conditions. Commissioners and policymakers are keen to see the development of services and models of care which offer greater choice and control to patients including extra-care housing, domiciliary [home] care, telecare and self-care, responding both to need and which are either cost-saving or cost-neutral to the NHS.



[Westbank volunteer befriending a client](#)

The second priority area is around **Healthy Lifestyles**. There was clear recognition that the underlying determinants of health are related to poverty and inequality and that housing conditions and worklessness, have a significant influence on behaviours, such as alcohol misuse, smoking, physical inactivity and unhealthy diets. These, in turn, cause the majority of conditions and diseases which lead to most health problems and deaths. The focus here is on tackling the underlying socio-economic determinants of health problems, particularly among low-income families, children and young people, as well as keeping the 'pre-frail' group from becoming frail and the mostly well group from becoming 'pre-frail'.

Health and care system
leaders would like to see
better joining up of services
and interventions which
address the underlying
causes of health problems.

Health and care system leaders would like to see better joining up of services and interventions which address these underlying causes of health problems through improvements to affordable housing, job opportunities, community transport, and economic circumstances.

Commissioners are also interested in models which may include advice, information, advocacy and promotion, and community-led action which encourage people to take greater control over and responsibility for their own health and wellbeing and make it easier for people to make more positive lifestyle choices.

This includes an increasing interest in 'social prescribing' where healthcare providers direct their patients to non-medical services, such as exercise classes, reskilling and employment programmes, or community activities. This helps the individuals feel less socially isolated and better in themselves which in turn can result in reductions in GP and A&E visits.

III.

Realising the Opportunity – Challenges for the South West

This section sets out the challenges to realising the opportunity for VCSEs from both a commissioner and VCSE perspective.

Commissioner Perspective

The commissioners interviewed all had experience of working with VCSE organisations typically in the form of tendered contracts or provision of grants for specific services including day care and supported living for the elderly, support for those with learning difficulties, accommodation and support for young people at risk, sexual health advice services, and tackling substance misuse.

There was a strong interest in building on VCSE strengths, particularly the provision of community-based care that is person-centred, focused on preventative services and tailored to individual needs.

However, this was tempered by a common perception that, *“VCSE capability to respond to market opportunities is limited”*. Many interviewees expressed the view that, *“the market is composed of many very small organisations, plus a few national providers”* (these are perceived to be easier to deal with from a contract management perspective). Few VCSEs were seen as having clear business and operating models and most were viewed as neither scalable nor replicable.

There was no clear understanding about the ‘social enterprise’ component of the VCSE sector, namely an organisation focused on delivering a social mission using a trading business model. One notable exception, however, is awareness of Livewell South West, formerly known as Plymouth Community Healthcare (PCH), a well-known NHS *‘spin-out’* that delivers a wide range of community-based health and social care services and is widely regarded as “crucial to the city”.

However, when the social enterprise model was explained, commissioner attitudes were very positive, be they support for spin-outs or scaling up existing or new locally-grown social enterprises.

The social enterprise model that combines a business-like approach, public service ethos, focus on achieving long-term financial sustainability and reinvestment of the majority of profits was seen as a good half-way house between public and pure commercial business models.

The social enterprise model that combines a business-like approach, public service ethos, focus on achieving long-term financial sustainability and reinvestment of the majority of profits was seen as a good half-way house between public and pure commercial business models.

As one interviewee put it, *“There is not much fat in the system for big business to make megabucks so social enterprise models are more appropriate and better able to be stomached by health professionals and the public.”*

Commissioners suggested that a number of changes may be necessary if VCSEs are going to play a much more significant role in service delivery. These changes include:

- **Greater collaboration and partnership** – both within the VCSE sector, in forming consortia, partnerships and commercial joint ventures, and with other providers from the statutory and private sectors, both inside and outside the health system, for example, with housing associations and the justice system. Commissioners admitted that it is *“hard for VCSE organisations to engage in commissioning. The bigger organisations and private providers want to come in at lead provider level and this makes it a challenge to join everything up and work with smaller organisations. Unless the smaller ones create a JV or consortium it is hard to know how to engage them”*.
- **New and better approaches to evidencing outcomes** in which commissioners are interested. While there was some recognition of a bias in favour of (often statutory) incumbent providers who may not have to match the same standards of evidence in order to maintain their preferred provider status, there were calls for VCSE organisations to *“better demonstrate appropriate outcomes and a stronger evidence base that is of relevance to commissioners”* in order to earn a greater

share of resources. It was recognised that linking actions through to outcomes might be somewhat speculative, but the process of attempting to relate and create a value chain was seen as very important, with acknowledgement of risks and the need to use surrogate measures of impact if necessary.

- **Overcoming perceptions, accurate or otherwise, of a need for the sector to develop more professional, business-like capabilities.** Charities are operating in a wider context of criticism that some have an over-reliance on charismatic leaders that hinder good governance, the scale of executive salaries and inflated overhead costs while private providers of public services (perceived as professional and business-like) have suffered scandals, including the tragic Winterbourne View case, for example. Many VCSE organisations would themselves admit that they would like to enhance the professionalism of their operations and develop more commercial business skills.
- **Improvements in quality assurance** in terms of the legal and regulatory frameworks around non-statutory providers and the capacity of VCSE organisations to meet regulatory requirements (CQC, Ofsted, Monitor etc.). As above, this may be exacerbated by unfair perceptions and some confusion around non-statutory providers being unregulated when this is not the case but these are nevertheless significant perceptions which need to be overcome. A particular challenge in this regard was raised in relation to organisations with *“a lot of volunteers”*.

However, commissioners themselves recognised that they will also need to change their way of working if they are to successfully leverage the potential opportunity of working with VCSE organisations. Commissioners interviewed expressed a need for:

- **Improved market intelligence** to provide commissioners with a more informed and segmented view of the VCSE sector, existing capability and innovation to inform provider market development and identify ‘capable’ providers.
 - **Continued development of commissioning processes and incentives** to support working with VCSE providers (and service users) to co-design and co-produce new service models in a joined-up, participatory way.
 - **Better contracting arrangements** for commissioners to engage with smaller, potentially riskier providers but where innovation is to be found and new ways to commission lead contractor models and consortia models.
- It was recognised that better use could be made of the Social Value Act provisions to encourage greater VCSE commissioning. However, no mention was made of the new EU procurement rules which introduce an Innovation Partnerships model and the so-called ‘Mutuals Reservation’ which allow commissioners to reserve some contracts to some social enterprises in certain circumstances. There is a need for procurement and legal teams to better understand these recent changes to EU legislation which could aid greater VCSE commissioning.

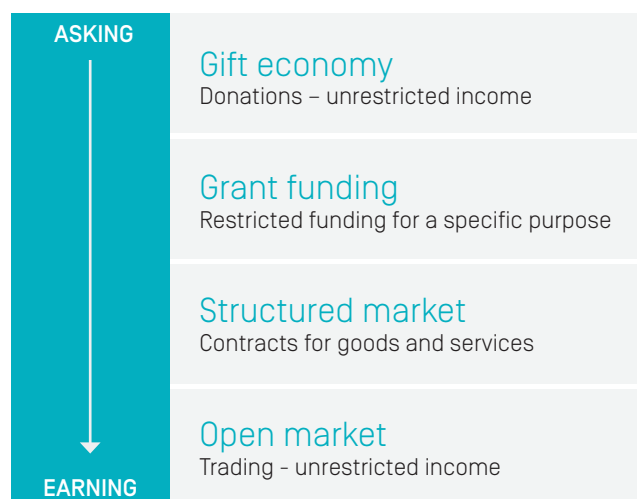
- **Deepening their own understanding of the opportunity offered by social investment** and how different external funding models could work in practice, including Social Impact Bonds (SIBs).

Despite the appetite for innovation in some quarters, many interviewees didn’t feel able to innovate within the current system given the pressures of austerity to save money and not to spend on innovation (despite the fact that some innovations are specifically designed to deliver cost savings), combined with the reality of having to deal with urgent day-to-day priorities.

However, overall, there was a clear sense among interviewees that health and care systems absolutely need to transform and innovation is essential. Hence the attractiveness of mobilising external funding and finance, facilitated by organisations such as the SW AHSN, that would provide the time, space and investment to foster innovation and VCSE development in practical ways in the region.

VCSE Perspective

VCSE organisations are often ambitious about playing a greater role in service delivery and believe that VCSE-led models can deliver both better outcomes for individuals and cost savings. The interviews with the VCSE representatives underlined how these are times of change for many organisations. The pressures in the health and care system present particular opportunities but also challenges for the sector. The *high degree of instability in the public sector landscape and funding cuts* are having a very real impact with many VCSE organisations finding it much harder to generate income or raise finance to support their operations. Traditionally there has been a high proportion of national and local government grants and donations to fund services that are of public benefit. However, as operating conditions, markets and public service reform have evolved, such funding is harder to find which has placed an imperative on some VCSE organisations to consider operating more as businesses, i.e. as social enterprises. This means moving from a dependency on donations and grants towards winning contracts – a shift from *‘asking to earning’* (see diagram).





VCSE representatives during this research expressed the following opinions on opportunities and challenges:

- The focus on prevention, tackling health inequalities and more individualised care offers potential opportunities for VCSE providers. However, some VCSE leaders expressed the view that the *“rhetoric is not always matched by reality.”* – *There are real difficulties in shifting money from busy services to services focused on prevention.* The shift to preferred provider frameworks is seen as favouring large organisations – not smaller VCSE organisations.
- Having good relationships with commissioners is critical to success. Here there is mixed experience – some VCSE organisations have very good relationships with commissioners and procurement teams, others struggle with building these relationships. Contract readiness support has been funded by central government and been tried by VCSE organisations but there are mixed feelings about its success.
- Commissioners need to recognise that immediate solutions at scale are often not achievable and need a willingness and route to *commission at small-scale* to prove concepts and work out viable business models.
- It would help to build ways for commissioners and VCSEs to connect outside the procurement process. Commissioners need to *“get out of the office”* and see what’s really happening in communities and how VCSE organisations are making an impact. *“Some commissioners get it – those that are more forward thinking and involved in the SW Commissioning Academy – but there are too many conversations with commissioners that demonstrate ignorance, misunderstanding and distrust”* of VCSE organisations.
- Commissioners are *“not used to working with people who operate in an enterprising way”* – this requires a culture shift and greater knowledge for them to see the potential role and benefits of social enterprise models.
- VCSEs themselves also need a better understanding of what commissioners are looking for, developments in the marketplace and what they can offer in response. For example, *“there is a clear role for VCSE organisations to work in the personal budget space. Could personal budgets be pooled to help invest in an innovative range of support for a specific cohort/client group?”* *“How do we scale-up social prescribing through GPs?”*
- Partnerships and consortia relationships are going to be critical to success in the future. There are already good examples of partnerships that are working e.g. Cornwall Works with Families, Exeter CVS Engagement Hub and more. However, transitioning to consortia and alliance models demands new skills and requires investment.
- VCSE organisations need to get better at branding and marketing to gain traction in the marketplace.
- There are opportunities for bio-tech and medical technologies to be developed as social enterprises. The *“tech for good agenda needs more focus in the South West”*, for example, the use of technology in the home.
- The leadership skills and confidence and ambition of VCSE managers can act as a barrier to VCSE development. Creating leadership groups and providing mentoring could help build capacity

Leadership is required on both sides to engage in a more committed and strategic way if we are to see deep systemic change and new VCSE-led service models develop.

These findings echo similar analysis undertaken at a national level by representatives of the VCSE sector, the Department of Health, NHS England, and Public Health England, published in March 2015:

- A case for a much deeper collaboration, one in which risks, rewards, and resources are shared in pursuit of co-designed goals.
- Smaller organisations are particularly challenged by current approaches.
- Commissioners do not always – or cannot – recognise the multiple outcomes and wider value that VCSE organisations deliver.
- The need for greater flexibility and collaborative working.
- A future system which has co-design and collaboration as its core values: a system which looks for and values all of the resources available to it, not just money and the staff, kit, and buildings it can buy, but also community resources, social action, peer leadership, and volunteering.

While much of our analysis is not necessarily new, it is important. Despite the challenges our interviews suggested an increasingly shared view and sense of common purpose among commissioners and VCSE organisations about the system-wide problems and what's needed to address them. Additionally, the responses from both sides show that this is a highly pressurised environment – both in terms of time and money.

Leadership is required on both sides to engage in a more committed and strategic way if we are to see deep systemic change and new VCSE-led service models develop. Recognition is needed of the complexity of the task and therefore the time it will take, the risks associated with change and how these risks might be mitigated.

Now is the time for a long-term, strategic approach to making change happen. Organisations within the VCSE sector itself needs to be making a clear offer of what they can do to respond to commissioner priorities, help commissioners understand their service offer and the impact of their work. Commissioners need to find a way to break through bureaucracy and develop collaborative co-design commissioning approaches rather than the *'sterile commissioner – specification – procurement – contract process'*. Alliance commissioning approach in Plymouth and elsewhere in the region are showing real promise in finding co-designed solutions to service needs. Such approaches need to be built upon and supported.

In the next chapter we examine five specific areas which have emerged from the research as realistic areas of strategic opportunity for the development of VCSE-led care models.

IV.

A Way Forward: Five Routes to VCSE Innovation and Scale-up

We have identified five areas where we consider there is a real opportunity for VCSE development in health and care in the South West:

- > Developing community-based micro-providers
- > Scaling up existing VCSE organisations
- > Outcomes-based commissioning models
- > New forms of consortia and partnerships
- > Co-creating new asset-backed social enterprises

For each of these we set out the opportunity, the challenges and ways in which social investment might help develop these care models.

The integrated, personalised care (IPC) and personalisation agendas within social care are opening up opportunities for the development of micro enterprises.

1. Developing community-based, micro-providers

The Opportunity

The integrated, personalised care (IPC) and personalisation agendas within social care are opening up opportunities for the development of micro enterprises providing support or care to people in their community paid for by personal budgets. People may need support or care at home because they are older, disabled, have ill health or are particularly vulnerable. They don't want to go into residential care and are able to live at home with the right support from people with whom they have good relationships. Examples of support they might need could include:

- Support to socialise, get out and engage in local activities and remain independent
- Help at home including with shopping, cooking, and personal care (bathing and dressing)
- Support taking medication and at-home care during ill-health
- Support taking short breaks and holidays

Micro-enterprises can offer a middle way between large care providers and individual carers, which some people may not want to employ directly. Organisations are classed as micro if they have five or fewer paid or unpaid workers and are independent of a larger organisation. This includes self-employed individuals, limited companies, community interest companies (CICs), and community groups. Many micro-enterprises operate over a small geographic area, and are set up by people with experience of using care services themselves, of caring for family members or of working in larger care providers. Micro-enterprises delivering personal care and residential care must be registered with the Care Quality Commission (CQC).

The increased uptake of personal budgets cannot be achieved without developing a greater supply and range of local services that provide real choice and therefore make the option of a direct payment an attractive one. There is also a large market of older people who have resources to pay for their own care services, so called 'self-funders', who are a significant potential market opportunity for micro-providers.



Westbank volunteer patient transport driver with client

Personal budgets

A personal health budget is an amount of money allocated to an individual, often with long term conditions or disabilities, based on their care needs which gives them control over purchasing care services. Personal budgets are driven by the aim of giving patients greater choice and control, empowering them. Personal budgets have been used in social care for some time and are slowly spreading into a health context.

Personal budgets can be used for perhaps a wider range of goods and services than conventional NHS budgets are understood to be for, such as therapies, personal care and equipment. People using mental health services have used personal budgets to get help with cooking, shopping and cleaning, have a short break, undertake leisure activities and more. Personal budgets are behind some provocative newspaper headlines we have seen in the South West, such as *"NHS blows a fortune on pedalo rides!"*

The uptake of personal budgets within adult social care is greater than in healthcare, largely driven by the introduction of personal budgets as a legal entitlement in the 2014 Care Act. Local NHS organisations are free to offer personal health budgets to patients if they think an individual will benefit. The Coalition Government introduced a right to a personal health budget for people who would benefit from it and adults eligible for NHS Continuing Healthcare and children in receipt of continuing care have had a right to have a personal health budget since October 2014.

Care is planned and agreed between the individual, or their representative, and the local clinical commissioning group, GP, social care provider, or other care provider who holds the budget on behalf of the patient.

There are already ongoing efforts in the South West to develop integrated personal commissioning that links to VCSE and micro-enterprise service provider development. The **South West Integrated Personal Commissioning Programme (IPC)**, for example, is one of nine demonstration projects nationally that brings together local government, VCSE organisations and the NHS to work differently to support people with complex care needs [see Appendix 3: Regional and local initiatives]. IPC aims to use person-led approaches, with the option of a personal budget to provide integrated support.

A number of VCSE providers have been involved in the design, development and roll out of the South West IPC Programme. These include Compass Disability, Enham Housing, Age UK Cornwall, Totnes Caring and Community Catalysts.

Somerset County Council is an example of a local authority seeking to lead the way in supporting the development of community micro-enterprises. It has created a two-year partnership with Community Catalysts CIC to support the development of small, community based care and support services that:

- provide personal, flexible and responsive support and care
- give local people more choice and control over the support they get
- offer an alternative to more traditional services

This initiative [see box] is driven by a recognition that currently commissioned 'block' services are not financially viable, nor do they offer the outcomes people want. Somerset Council wants to shake up the provider market and offer a greater choice alongside promoting an increase in the uptake of personal budgets. The aim is to increase the proportion of people with care needs using personal budgets from 15 per cent to 70 per cent.

Community Catalysts CIC

www.communitycatalysts.co.uk

Community Catalysts is a Community Interest Company launched by Shared Lives Plus to support the development of sustainable local enterprises delivering a range of services for people who need care and support. In Somerset, Community Catalysts has focused on services and support which can help older people stay independent at home.

Community Catalysts uses a tried and tested five step process:

1. Mapping what is already happening in a community or area
2. Identifying and connecting people with existing advice-givers, community groups, organisations and community micro-providers
3. Identifying local catalysts for change
4. Identifying and overcoming barriers
5. Designing and delivering dynamic events and workshops

Since it started working in Somerset, Community Catalysts has supported the start up of 42 new micro enterprises; compiled a directory of 68 local care options for older people in Somerset and created a peer network of 210 providers. These providers are supported to register on Somerset's E-marketplace and Community Catalysts website www.smallgoodstuff.co.uk.

Two examples of micro enterprises supported by Community Catalysts include:

Girl Friday Somerset Ltd is a community micro-enterprise operating in the small coastal town of Watchet, Somerset. Pearl set up Girl Friday out of her florist shop to offer a matching and introduction service between local people (working on a self-employed basis) able to offer 'home help' services (gardener, cleaner or home help) to older people needing support to live their lives independently at home. Pearl is now working in partnership with 24 new and fledgling micro-providers in Watchet.

John set up '**Helping to Remember**' to offer flexible, highly personalised support to people living with a memory impairment or the early onset of dementia following 14 years of being a full time carer for a relative living with dementia. Support can mean anything from going on walks, playing scrabble to shopping trips, medical appointments and visiting the barbers for a haircut or shave. John explains "*Actively assisting people to get back into doing things together that other people take for granted brings great reward.*"

Community Catalyst's experience in Somerset and elsewhere as well as independent research has evidenced the potential **benefits** of micro-providers over large providers⁸. These include:

- Operating at a very small-scale means that micro-enterprises can offer a **more personalised** service than larger care providers and better continuity of care with carers forming long-term relationships with their clients.
- Micro-enterprises can be more innovative, particularly in terms of **how** services are delivered – for example taking the time to sit down and have a meal with someone rather than making the food and leaving.
- Micro-enterprises can offer **better value for money**, offering more personalised and valued care without a high price tag. With larger providers there is a trade-off between price and quality: the cheapest prices are offered by those providers that conform to the 15 minute care visit model, and are associated with high rates of turnover among care staff. At the more expensive end of the market, larger providers are able to match the micro-enterprise offer more closely, providing longer care visits and better staff continuity.

The challenges

There are a range of challenges in developing micro-providers:

- **The uptake of direct payments** remains at low levels in many local areas.
- **Low levels of local authority referrals.** Simply listing providers in a directory of services on a website is not going to generate sufficient business. It can be difficult for micro-providers to become known and they find it hard to market their services and receive referrals, either directly from people wanting to use the service or from health and care professionals.
- **Micro-providers can find it difficult to navigate local government systems, bureaucracy, procurement requirements and CQC standards.**
- **Commissioner concerns about risk and safeguarding.** Evidence suggests that people using services and their carers do not perceive a risk in contracting with smaller, less-known services in the way commissioners do, rather they care about the quality of the personal relationship with their care worker and the care provided. The goal is to get the balance right, moving away from being risk averse towards a shared responsibility for risk with the service user, while still having appropriate regard for quality assurance and safeguarding issues.⁹
- There is an inherent tension between encouraging community-based services, such as those offered by micro-providers, and the move to consolidating

⁸ See Microenterprises: care and support on a scale that is 'just right'?, University of Birmingham (2015) <http://www.birmingham.ac.uk/research/activity/micro-enterprises/index.aspx>

⁹ Social Care Institute for Excellence (2010) Enabling risk, ensuring safety: Self-directed support and personal budgets.



Westbank allotment – volunteers working on the allotment – providing fresh grown produce for a Seedlings Community Cafe

and minimising procurement activity by offering larger contracts to a decreasing number of traditional providers. There is a frustration among providers at the *rhetoric of individualised commissioning/ market diversity and the reality of preferred provider frameworks/managed personal budgets*. These conflicts need to be recognised and managed if micro-providers are not to be squeezed out.

- **Micro-providers can be very isolated if unsupported and be financially fragile.** Personalised budgets, by definition, lead to unpredictable 'peaks and troughs' of spot-purchasing. The unpredictability of income therefore makes micro- enterprises very vulnerable in periods of low demand. Larger providers, that have other contracts / sources of income / other areas of operation are better insulated.
- **Accessing small amounts of funding for basic set-up costs**, such as getting CQC registration (if needed), buying equipment, personal development and marketing materials can be a barrier to starting-up, and then accessing working capital finance to both scale-out and scale-up can be challenging.

How we might overcome these challenges?

There are specific actions that commissioners could take to support the development of the micro-provider market:

- Explicitly recognise micro-enterprise development as an important part of local government strategies to develop more personalised community-based services, particularly in the context of personal budgets. Recognising that micro-providers are part of the ecosystem of care provision would mean these organisations are better valued and supported and are no longer under the radar. This would include:
 - » Enabling micro-enterprises to join preferred provider lists and ensuring procurement guidelines are micro-provider friendly
 - » Ensuring social care teams promote flexible payment options for people wanting to use micro-enterprises, including direct payments
 - » Ensuring social workers and other care professionals are informed about micro- enterprises operating close-by so that they can refer people to them
- Replicate a microenterprise development support programme, such as the one Somerset Council has

created, in other parts of the South West to provide dedicated start-up support, with care sector experience, as well as ongoing support and peer networks for micro-providers. This would help micro-providers to:

- » understand what care services are needed in their area
 - » create a vision and shape their enterprise idea
 - » provide coaching and expert advice around complex care and health systems and regulatory requirements to help people ensure their micro-enterprise is legal and sustainable and able to offer strong outcomes to people using its service
 - » provide a liaison mechanism with commissioners and social care workers
- **Create a means to share lessons and experience** about the use of personal budgets and range of community micro-providers across the region. The IPC programme plans to do this through action learning sets and network events.
 - Set up and market **e-portals** with information to advertise all local services to help people know what is available and choose the right care and support. Somerset is doing this through a dedicated website: <https://www.somersetchoices.org.uk>.

Potential demand and supply of social investment

According to Community Catalysts and the microenterprises interviewed, there is some demand for funding and finance among micro-providers, particularly from those who want to provide CQC-registered care. These providers may need access to grants or low cost, unsecured loans to cover start-up costs, including the cost of CQC registration (currently £750 but due to increase to over £2,000), insurance costs, training and marketing. The amounts needed in the early stage of development are relatively small – in the range of £500 to £10,000.

As micro-providers develop a client base and revenue stream, they may need access to larger working capital loans to develop their service. However, it should also be recognised that many micro-providers by their very nature may decide to stay small – remaining a micro-enterprise providing services to a small number of residents in their local area – and will have no interest in or need to take on loan finance. Rather what is important to them is getting enough referrals and clients to put them on a stable financial footing.

Currently, the main sources of potential funding for micro-providers – beyond self-funding, friends and family – are grants from organisations such as UnLtd or micro-loans from the Fredericks Foundation. In Somerset, the County Council's economic regeneration programme has small grants for people who face barriers to employment that can be used to set-up a micro-provider. The Council has also established a Social Enterprise Loan Fund in partnership with the Somerset Community Foundation (see Appendix 4). Charitable trusts and foundations, such as the Esmée Fairbairn Foundation, also provide grants for local organisations sometimes through local community foundations.

Potentially, micro-providers could also look at crowd funding from the community through platforms such as Crowdfunder. Plymouth County Council has launched a partnership with Crowdfunder to encourage local projects and businesses to engage with crowdfunding by offering match funding from Plymouth City Council up to 50 per cent of a project, to a total of £5,000.

This is an area where there is room for further development of tailored support and finance in the South West region.

Many businesses start as micro-providers – some make a decision from the out-set to stay small and local. However, others plan to scale-up which brings us to the next opportunity area.

2. Scaling up existing VCSE organisations

The opportunity

This study has revealed that there are a number of existing VCSE organisations in the South West region that are providing high quality services and have the appetite and capacity to scale-up. These organisations are providing services that fit with the commissioner priorities identified in this study (Ageing Better and Healthy Lifestyles) as well as the NHS Five Year Forward View.

Perhaps the best-known social enterprise in this category is the public sector spin-out Livewell South West (formerly known as Plymouth Community Healthcare, PCH) which provides integrated health and social care services for people in Plymouth, South Hams and West Devon. PCH was set up in 2011 as a CIC Ltd by Guarantee with an aim to keep mental health, children's services and community health services operating together in a joined up way and through a single organisation. When first established, PCH had 2400 staff and an annual turnover of circa £90m. It now has approximately 2800 staff and a turnover of circa £110m. Expansion has primarily come from taking on adult social care in Plymouth and community hospitals in Tavistock and Kingsbridge. Livewell South West sees opportunities to grow from providing more preventative services.

There are a number of existing VCSE organisations in the South West region that are providing high quality services and have the appetite and capacity to scale-up.

Many VCSE organisations are less well-known to commissioners, in part because they are locally grown and have to establish their relationship and credentials with commissioners. Examples of VCSE organisations identified during this research that are seeking to scale-up include:

- **Plymouth Active Plus** is looking to develop a service in which disabled veterans provide support to isolated elderly people providing benefits to both the veterans and the elderly.
- **Kernow Health CIC**, which is owned by GPs, is interested in developing new pathways and models of care, and creating new partnerships to deliver a range of community based services, including social prescription models and integrated care for the elderly. Kernow Health is seeking investment for R&D and system redesign to develop new services that can be scaled-up.
- **Cornwall Health** is a limited company providing out of hours GP services for the whole of Cornwall. It is half owned by Devon Doctors CIC and half owned by Kernow Health CIC. The service started in June 2015 and relies on the vested interests of primary care to make the model work. "GPs need good out-of-hours services to make their practices run smoothly, out-of-hours needs good in-hours GP practices so if everyone pulls together it works well." The service is commissioned by Kernow CCG. Cornwall Health sees opportunities for growth coming from the provision of 'urgent primary care services' that includes 111 telephone service and community health services.
- **Westbank** is a company limited by guarantee with charitable status based in Devon that has been in existence for 30 years. Westbank started out providing day care services for the elderly and now offers care and healthy living services for the entire community both at its centre and through outreach services. Westbank is seeking to develop its services by linking into outcomes based commissioning in the area of diabetes prevention (see next section). It is also seeking to scale-up through franchising its model elsewhere in the region.
- **Sandwell Community Caring Trust (SCCT)** was set-up to provide care services for the elderly and those with physical and learning disabilities in the Black Country in the West Midlands, but has since expanded to Torbay. SCCT has developed expertise in taking over and turning around local authority residential home and care services and developing specialist care units, e.g. for dementia. SCCT delivers cost savings as well as high quality care by reducing staff turnover and sick leave and streamlining back-office costs. SCCT is seeking to scale-up both by offering specialist property development and management services to smaller local charities and through the acquisition and turn around of more care homes into social enterprise models.
- **Carers Break** is a Community Interest Company that provides one-to-one palliative and end of life care at home in Cornwall and West Devon. Carers Break piloted a successful out of hours, rapid response service available to GPs and paramedics to reduce unnecessary emergency hospital admissions. The pilot saved approximately 100 patients from being admitted to hospital which Carers Break estimates provided the equivalent cost savings of circa £30k a month on average. Carers Break is seeking to scale-up this service across the South West



Social Investment and Health Care event

The challenges

The main challenge for many existing VCSE organisations wanting to scale up is simply getting their services commissioned and winning contracts. Interviewees cited how organisational boundaries and budget silos in health and social care create vested interests which make commissioning integrated services difficult. The movement towards greater integration is positive and should mean that a greater value is placed on VCSE models of health and care, however, there is a frustration that the talk by public service bodies about integration is not yet matched by genuine commissioning opportunities.

VCSE organisations also cited a risk aversion on the part of commissioners particularly if they don't yet have the track record or asset size to win contracts.

Once contracts are won, the main concern is pricing and ensuring that margins are sufficient to run a sustainable service that also allows VCSE organisations to work according to their values, such as paying their staff a proper living wage.

The main challenge for existing VCSE organisations wanting to scale up is getting their services commissioned and winning contracts.

How might we overcome these challenges?

Systemic and cultural changes are needed on both commissioner and VCSE sides to overcome these challenges, including:

- **Greater collaboration and partnership** by commissioners with VCSE organisations to understand and assess new service models, to decide where there is a case for more widespread adoption and to co-create appropriate ways to commission such services either directly or through personal budgets.
- **Identifying and bringing VCSE leaders into governance arrangements** and the commissioning process to help build knowledge, understanding and engagement of the sector.
- **Greater market intelligence.** VCSE organisations need to articulate their service offer, the outcomes it delivers, the evidence base and why the service is of value to commissioners i.e. make both the business and social case.
- **New commissioning arrangements** that enable commissioners to engage with VCSE organisations that are potentially riskier but where innovation is to be found.

Potential demand and supply of social investment

There is some demand from VCSE organisations for social investment to support scale-up. Those that can demonstrate the following characteristics can typically access finance either from mainstream banks, particularly if they have physical assets or long-term secure contracts or guarantee, or from the growing number of specialist social investment finance intermediaries:

- A strong management team with proven capability to deliver
- Good governance
- A high-quality service offering
- Committed staff – some social enterprises are employee-owned which can support staff engagement and retention
- Entrepreneurial culture that is open to innovation and risk-taking
- A history of good financial management and positive cash generation or clear near-term path to cash and surplus generation from trading revenue
- A viable business model which is either scaleable or replicable
- Management and Board with the ambition to grow the business and its impact and a willingness to take on the cost of repayable finance

Specialist social investment providers, including Big Issue Invest, Bridges Ventures, Charity Bank, Unity Trust Bank, Community and Cooperative Finance, Key Fund, Resonance, Social Investment Business/Social and Sustainable Capital (SASC), Triodos, Venturesome and more, are able to provide a range of finance options from £25,000 to £10m plus. This is typically in the form of loans with interest rates ranging from 6–12 per cent depending on risk and terms ranging from three to ten years [see Appendix 4 for more information about these finance providers].

VCSE organisations typically borrow for property acquisition or renovation and for working capital to fund business development or building up the staff capacity to deliver on contracts.

Equity and quasi-equity (typically structured as revenue-participating debt as most VCSEs are not legally structured to take equity investment) is also available and can be attractive to social entrepreneurs seeking risk capital to finance growth. However, given risk capital tends to be more expensive, most social entrepreneurs prefer a loan unless there are clear benefits to these other forms of finance.

Bonds are another form of finance option open to VCSEs, particularly those with fixed assets and a regular revenue stream. This is another form of debt when the bond issuer owes the bond holder a debt and, depending on the terms of the bond, is obliged to pay them **interest** (the **coupon**) and repay the principal at a later date, termed the '**maturity date**'. Triodos has helped VCSE organisations issue private placement bonds and the Retail Charity Bond Platform exists to help charities issue listed bonds. Golden Lane Housing, for example, has used both types of bonds to finance the expansion of specialist housing for those with disabilities. The advantage of bonds is that the cost of finance can be lower than straight loans with coupons in the range of 2–5 per cent.

Social investors are continually seeking out good investment prospects and there is now healthy competition to find 'good deals'. At the same time, VCSE organisations are increasing their knowledge and understanding of the potential role of borrowing or investment, what it takes to be 'investment-ready' and an increasing number are successfully accessing social investment as well as more conventional bank finance, where possible.

One example from outside the region is Highland Home Carers, a provider of home care in remote communities in the highlands and islands of Scotland [Note: this may be of interest given the business model is potentially replicable to help scale-up care for the elderly in rural areas of the South West]. This care model also creates jobs in remote areas where jobs are scarce (see box).

Highland Homes Carers

www.highland-home-carers.co.uk

Highland Home Carers (HHC) is the largest provider of at-home care services for vulnerable people living in the Highlands of Scotland. HHC provides at-home care for approximately 500 elderly individuals and those with learning difficulties and has a turnover of nearly £6m.

The company was set-up as a private micro-enterprise in 1994 by Nick Boyle and his wife who both had a social work background. They wanted to provide flexible, personalised care as an alternative to traditional local authority service provision. The culture set out to be holistic and person-centred from the outset. *"Private sector firms – driven by profit – are not interested in serving these remote communities."*

In 2004, the company was bought out by its employees and is today operated as a mutually-owned social enterprise. Employee ownership is an important part of HHC's ethos. HHC believes the right for staff to share in profits and staff involvement in governance is a key driver of service quality. *"The quality of care is only as good as the commitment of the people providing the care."*

HHC is growing and profitable and sees exponential demand for its services. Many communities in the Highlands and Islands have no adequate provision of home care and people's only alternative is to end up in a residential home. The majority of income is from commissioned contracts from NHS Scotland for independent living services. However, increasingly HHC is seeing growth opportunity in brokerage services for personal budgets. HHC is working in remote communities where they pool personal budgets and manage them and work with local community groups to recruit and identify local residents to work as care workers.

Social investment has played an important role in HHC's growth. HHC received equity finance to assist fund the original employee buy-out. However, the finance terms became so costly that they ending up inadvertently penalising growth and discouraging management from bidding for high value/low margin contracts. In 2012, Big Issue Invest and Cooperative and Community Finance agreed to refinance the original investment on more favourable terms. HHC has now borrowed a total of nearly £0.5m which it has used to provide working capital to help win contracts and to refurbish a new head office. *"Our experience of social investment has been very positive. If we had stuck with more conventional finance we would not be in the position we are today."*

Social investors are continually seeking out good investment prospects and there is now healthy competition to find ‘good deals’.

However, our research found that for most VCSE organisations the focus is on winning contracts with a sufficient margin to cover costs and generate a surplus to reinvest in improving services rather than seeking to take on debt or other forms of repayable finance.

In some cases VCSE leaders and Boards have an ideological opposition to the notion of investment in which private investors make financial returns from services paid for by the public. Livewell Southwest, for example, has adopted a promise of not making more than 1 per cent margin on contracts as from an ethical standpoint they do not believe in making money from public service delivery. Livewell Southwest has had interest from a range of investors given their size and profile, but have yet to find an investor that can accept their return limitations as most investors themselves can not operate at such low margins.

However, there were two areas identified in this research and reinforced by national evidence where existing VCSE organisations looking to develop their services identified gaps in current finance provision:

First, is the **lack of availability of patient, low-cost, risk capital** to support VCSEs transition from grant dependency to income generation and develop new service offers. This is where the bulk of demand is and the lack of such finance from social investors has led to some frustration that they are not responding to market need (see box). Social investors are well aware of this gap, however, it is a finance gap which is seen as too risky and economically unviable for investors. Social investment organisations themselves have to cover costs, including losses, from interest and fee revenue earned on their lending and investment activity and so typically cannot afford to lend at rates of less than 6 per cent.

This finance gap has now been recognised by Government and in response, Access, The Foundation for Social Investment, was established in 2015 with backing from the UK Cabinet Office, Big Society Capital and Big Lottery Fund. **“Access will be a champion for those charities and social enterprises who are at early stages of developing new ways of creating income to bring real change to more people’s lives.”** Access works through intermediary organisations and enables them to offer finance up to £150,000 which blends grants with loans to offset some of the perceived or actual risk in lending to early stage organisations and grants for capacity building for specific business needs (which also reduces the risk to the lender). The SW AHSN is actively engaged in helping ensure these funds are available to support VCSE organisations in the South West.

Second, is the **demand for larger scale amounts of capital for property purchase to develop VCSE business models of supported living and residential care**. For example, Sandwell Community Care Trust is looking to raise a multi-million pound finance facility to finance the purchase and development of specialist care accommodation based on its proven care model which successfully delivers both very positive outcomes and cost savings to local authorities. There are two specialist social property funds – Cheyne Capital Social Property Impact Fund and Salamanca’s Funding Affordable Homes – that could potentially help meet this gap. Both provide capital to buy or build affordable housing, including for the elderly and people with disabilities, in partnership with housing and care providers.

An observation on social finance from one VCSE organisation

“Towards the end of 2015 we decided to take on social finance for a project involving developing property for rent. We could see that if / when we got to April 2016, the rental revenues would make us sustainable, but the cashflow challenge in sustaining our organisation as well as meeting the scale and ambition of the capital project was not do-able within existing resources. It was a crunch moment for us, and as early advocates of social finance within our sector, we turned to the social finance market for support.

We spoke to a social finance provider that we already had a very good relationship with. However, having presented them with all the necessary financial information, it became clear that the level of ‘risk’ they could tolerate was low. We were asked to provide a written guarantee from our own landlord (the City Council) that in the event of going bust in the lifetime of the loan the social investor would then be repaid the full outstanding investment sum, plus the relevant interest. This guarantee effectively made the investment 100% risk-free to the investor, yet the quoted interest rate was still 6% (having been originally negotiated down from 9%!)

Once we approached the Council to ask whether they would be willing to underwrite in this way, their assessment was that – if they were fully liable for the investment – the far cheaper option was for them to “cut out the middleman” and lend directly to us – which they are now doing, on far more generous terms: less than half the interest rate we were quoted, repayment and interest-free first year, and then longer repayment period.

While this is obviously a satisfactory outcome for us it did lead us to think that social investment as “risk capital” still has some way to go before it truly does what it says on the tin!”

3. Outcomes-based commissioning models

The opportunity

Systems leaders and commissioners in the South West region are already relatively well advanced with exploring new, outcome-based commissioning models, and ones which seek to involve the VCSE sector at their heart. Some are already well underway and others are in the early stages of exploration.

The three most advanced outcomes-based commissioning projects are summarised here (see Appendix 3 for more detail):

1. Devon County Council is exploring the development of outcomes-based commissioning funded through a Social Impact Bond (SIB) with NEW Devon CCG, Bridges Ventures and Westbank, a community-based organisation providing healthy living and care services. This SIB would seek to influence better weight management and the reduction of Type 2 diabetes, linked to Westbank's Living Well, Taking Control model.
2. NEW Devon CCG, Devon County Council and Plymouth City Council are exploring the development of an 'outcomes-based commissioning demonstrator' project focused on preventative and pro-active management of alcohol dependent, high-frequency users of the health and care system.
3. Kernow CCG and Cornwall Council are exploring the use of outcomes-based commissioning in partnership with social investors to scale-up the Living Well programme across the county.

Systems leaders and commissioners in the South West region are already relatively well advanced with exploring new, outcome-based commissioning models.

Furthermore, in Somerset, the CCG is planning to appoint a Most Qualified Provider within the next 18 months to manage a vast contract for integrated services across the county for up to ten years. An element of this commission is expected to be paid on an outcomes basis. Even a small percentage of the contract modelled on this basis would be worth many millions of pounds in success payments. The commissioners in Somerset are keen to see the VCSE sector play a role in the delivery and looking for ways to identify and partner with suitable providers.

Two key models of outcomes-based commissioning seem to be emerging within this regional work and the broader development of outcome-based commissioning with VCSEs:

- **Investor-led outcomes-based commissioning with VCSEs:** where a social investor or group of investors work in partnership with a commissioner to develop a new intervention model commissioned using an outcome-based contract. The investor or group of investors may create a special purpose vehicle (SPV) at the heart of the financial and contractual relationships. An example of particular relevance to the priority needs identified in the South West is The Ways to Wellness programme in Newcastle which is using an investor-led SIB to finance a service to provide patients with a Link Worker to meet one-to-one with them to identify and work to overcome the barriers to managing their long-term conditions.
- **Provider-led outcomes-based commissioning with VCSEs:** where a VCSE provider is commissioned to deliver an outcomes-based contract and then, if necessary, turns to an investor to finance the working capital required to deliver the contract until payments materialise. The 'It's All About Me (IAAM) Adoption Bond' is an example of the provider-led model.

The challenges

There are a number of challenges in developing new and often innovative, outcomes-based commissioning models. These can include:

- **The cost and complexity** of establishing an appropriate outcomes-based contract above and beyond more conventional models without creating significant perverse incentives, unintended consequences, or metrics prone to *gaming* (i.e. so-called 'creaming and parking').
- **Access to necessary data**, which is sufficiently robust and accurate. In one instance, the difficulty faced by GP practices in managing and interrogating patient data was problematic. The development or success of some SIBs have been hampered by the unwillingness of public agencies to release certain datasets that would evidence the nature and scale of outcomes being achieved.
- **Identifying the most appropriate provider partner** and doing so within the procurement law.
- **Attracting the necessary investment capital**, especially with VCSE providers, to cover both the delay in the timing of payments and the risk of outcomes not being met, but on terms which do not incur such a significantly high risk premium / cost of capital to outweigh the potential benefits of an outcomes-based model. In other words, does the investor demand such returns to ultimately render the cost to the taxpayer higher than that of a more conventional contractual arrangement?
- **Cultural aversion** or lack of familiarity with such a rigorous focus on measurable outcomes and /or cashable savings in the VCSE sector, as opposed to a more trust based approach in which the focus is on qualitative information, such as the quality of care relationships and patient satisfaction.



Westbank Table Tennis Session

How might we overcome the challenges?

Some of these challenges cannot always be overcome, or can only be overcome at disproportionate cost. Outcomes-based models will only be the most appropriate model in certain, specific circumstances. Advocates for SIBs and other outcome based models themselves admit that SIBs can only work in circumstances where:

- There is an objective mechanism for assessing and agreeing measurable outcomes;
- The target groups are identifiable and large enough to justify the development of an outcome based approach;
- The benefits accrue in cash to just one or a few budget-holders and within a reasonable timescale; *and*
- There is a model of intervention that works and which generates greater savings than it costs.

If all these circumstances are not met, other contractual and payment mechanisms, such as fee-for-service or grants are likely to be more appropriate.

Sometimes an outcomes-based approach may, however, be appropriate, and ways can be found to overcome the implementation challenges. Westbank, for instance, has worked with GP practice staff to improve data management systems and support. While other barriers may be overcome through greater collaboration on both the commissioning and provider side (see below).

Potential demand and supply of social investment

There are already significant resources being directed towards SIBs and related outcomes-based payment models. The three outcomes-based commissioning projects in the South West referred to above, have attracted financial support from the multi-million pound Big Lottery *Commissioning Better Outcomes* fund. Other social investors have done so or are keen to invest further in Social Impact Bonds. The 2015 Autumn Statement recently committed the Government to over £100m towards the development of SIBs.

At the moment, there are funds available from central government to pay both for the development of SIBs and sufficient supply of risk capital from social investors to provide the capital. It seems, therefore, there is little *need* to develop local pools of capital.

However, it may still make sense for local investment to be channelled towards supporting outcomes-based commissioning models for any of the following reasons:

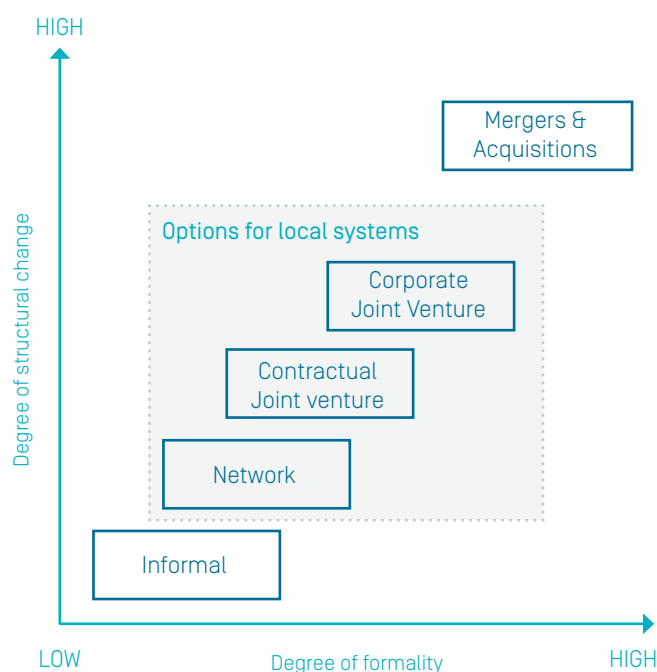
- To help local VCSE organisations build the organisational capacity to engage in the development of an outcomes-based commissioning model as a precursor to applying for national funds.
- As the market develops, if SIBs struggle to repay investors, the supply of finance from social investors may reduce so local investment will become more important.
- Central Government funding for SIB development may dwindle, although this currently seems unlikely.
- If SIBs succeed and local social investors see the potential to earn a financial return from such opportunities and would prefer returns to be recycled into the local health economy.
- In order to help develop new and different outcomes-based models with a particularly local flavour, evolving from the first wave of SIBs. The Private Finance Initiative has evolved into PF2 and one Scottish SIB is very different from other SIBs south of the border, based around a model which attracts a large number of local, more connected investors than the usual SIB model. Some SIB observers are keen to develop outcomes-type models where individual patients are at the heart of the payment trigger mechanism, rather than metrics developed by investors and commissioners. Perhaps a South West variation of the SIB model could emerge, addressing some of the criticisms of existing SIB models?
- If the appetite for risk from national social investors is not sufficiently generous to finance some local outcomes-based commissioning models, such as in Somerset, local alternatives may be required. With the Ministry of Justice Transforming Rehabilitation programme, social investors did not feel able to invest on the terms on offer, while other commercial companies, such as Sodexo and Interserve, were happy to take that level of risk.

4. New forms of consortia and partnerships

The opportunity

As integration continues, potentially new and bigger integrated care organisations emerge, and contracts are aggregated, individual VCSE organisations will increasingly miss out on opportunities to play a role in this new market place unless they find ways to work together to seize opportunities at scale.

Organisational options along the spectrum of collaboration



Source: Adapted from *Future Organisational Models for the NHS: Perspectives for the Dalton Review*, The King's Fund, July 2014.
Adapted from original source Pearson (2011).

VCSE organisations will increasingly miss out on opportunities to play a role in this new market place unless they find ways to work together.

One example of a partnership that we believe will be of interest in the South West region has recently been created in the North of England. The social enterprise Social adVentures has formed a consortium of local VCSE organisations that have come together to capture the opportunities presented by devolution in Manchester. Nine VCSE organisations have created a social enterprise partnership called The Health and Wellbeing Partnership. Comprising public service spin-outs and local charities, the Health and Wellbeing Partnership has been forged to meet the ever increasing move towards 'macro-commissioning'. Together, members have a combined turnover of over £30m, making them more able to compete in the new commissioning landscape. The partners contend that The Health and Wellbeing Partnership provides a new model for delivering integrated public health and social care interventions, innovation and tendering, offering "a platform where all partners have security in giving their best ideas to stimulate innovation; it removes perverse incentives from the service user pathways and shares surpluses/risk equally, collectively contributing to the creation of a resilient local health economy".

In the South West, Simon Bowkett of Exeter CVS believes the traditional local voluntary sector infrastructure model is outdated and will not survive. Instead, he is re-positioning Exeter CVS to support commissioners and broker partnership work with the VCSE sector. In this context, Exeter CVS is developing an engagement hub in partnership with Exeter City Council and Working Links. The hub is a large physical centre that brings together public, private and VCSE enterprises together into one delivery space to devise and provide recovery and wellbeing services to people at risk of social exclusion; and has four key "pathways" for recovery, wellbeing and inclusion:

- Promoting wellbeing and recovery (including addiction and mental health)
- Preventing (re)offending
- Tackling homelessness and promoting sustainable, affordable homes
- Personal development, skills and employment

The hub is a community-led response to a range of social challenges in the city, which – despite resources and with a range of providers commissioned to address the challenges – were not seeing improvements. Some of the organisations recognized that their services are disjointed, and fragmented, overlapping and sometimes competing. At the heart of this partnership model is a building which is managed by the CVS as "system architects", and hosts probation and related services, including Addaction, the Clocktower GP practice, the mental health crisis outreach team, the assertive homelessness outreach team, and the Eddystone

Trust – a leading HIV & sexual health service. The vision is for many services to be accessible under one roof creating an integrated collaborative community of service providers working closely together to support service users with a full range of services from understanding the benefits system through to organisations that provide skills and employment opportunities so helping individuals into work and living independently. By the time the hub fully opens in April 2016, over 26 projects and services will be hosted and collaborating within the hub.

These partnership models are increasingly common. ACEVO, a UK-wide network for charity and social enterprise leaders, has described how the 'third sector' (another term meaning VCSE) is a pioneer in collaborative working and that the number of third sector consortia has increased rapidly in the last two decades. ACEVO suggests that, *"Alliance contracting may be a large part of the answer. It is, in short, a contractual arrangement that relies on all parties having an equal decision-making role in the delivery of services. It is a mechanism for delivering joined up care. Alliance contracting can enable the NHS to work better with the third sector and get better at providing care in the community."* Pooling resources and expertise in this way can help organisations deliver greater impact, spread risk, share knowledge and improve joined-up service provision for beneficiaries.

Alliance contracting may be a large part of the answer. It is, in short, a contractual arrangement that relies on all parties having an equal decision-making role in the delivery of services. It is a mechanism for delivering joined up care.

The challenges

There are a number of challenges for greater collaboration across the VCSE sector, as well as between public, private and social sector partners more widely. These can include:

- 'Cultural fiefdoms' which discourage partnership working across conventional institutional boundaries and hinder the development of effective trust-based relationships.
- Formal, legal and governance impediments to such collaborations, such as narrowly defined charitable objects or geographical limitations of statutory providers.
- Tendency for many public bodies and social sector organisations to focus on existing and short-term organisational priorities rather than potential future opportunities, especially in a tough financial environment.
- Practical difficulties in resourcing and agreeing legal, financial, contract management or other partnership arrangements.
- Technical challenges, for example, inflexibility in the NHS standard contract or pensions regulations which discriminate against sub-contractors or make partnership arrangement more difficult. There is work underway by the NHS to produce a 'standard contract *lite*' which aims to make it easier for smaller organisations to contract with NHS.
- There is often not the margin in the contracts and commissions to support the additional costs incurred when working in partnership (even if this brings additional value).

How might we overcome the challenges?

While some of these challenges cannot be overcome, at least in the short-term, such as legal or technical impediments, others can be mitigated. Steps to overcome barriers include:

- Commissioning practices that encourage partnership. As one commissioner put it *"the problem of fiefdoms within the VCSE sector is encouraged by commissioning practices. Very few procurement or contracting discussions are collaborative and about co-design. If more commissioners spent more time nurturing partnerships and collaboration and focused on shared outcomes and shared risk there would be fewer fiefdoms."*
- Concerted, strategic efforts at both senior and operational level among prospective partners to understand where common purpose and mutual benefit lies, supported by maintaining a focus on beneficiary need above institutional self-interest.
- Physical co-location can support the development of partnership models (see example from Exeter CVS above).
- Time! Trust cannot be developed overnight and it is to be expected that partnership models require time to develop. Longer-term contracts may help create more fertile conditions for partnerships to flourish. Currently commissioning and procurement processes tend to offer short deadlines and insufficient time for partnerships to form in response to opportunities. Hence this aspect of commissioning also needs attention.
- New contractual and budget arrangements which are designed to overcome institutional silos can speed up partnership working, such as capitated and personal budgets as well as integrated commissioning models.
- External support, funding and resources to spread learning, bring partners together and highlight the potential benefits of successful partnerships.



Westbank Living Well, Taking Control project – programme for people with pre-diabetes or newly diagnosed. Christmas party food preparation, Volunteer and project participant.

Potential demand and supply of social investment

All too often, partnership models are driven by short-term revenue opportunities and long-term investment in genuine partnerships are far less common. Funding for the development of partnerships and alliances is not easy to find. The Cabinet Office's Transforming Local Infrastructure Fund in 2012 made available £30m to 74 organisations across England to work together but was focused on so-called *infrastructure* organisations.

Meanwhile, one interviewee commented, *"If just a fraction of the central government resources which have been directed at the development of Social Impact Bonds had been directed at exploring the benefits of Alliance contracting or other forms of partnership among frontline VCSE organisations, we would be much better placed to learn lessons on how to effectively fund these arrangements."*

It seems then that there could be some demand for investment in consortia and partnership building, learning from the likes of the Health and Wellbeing Partnership in Manchester and other models. However, for the reasons explored above, this demand may be constrained by cultural, legal, technical and other issues. There is perhaps a chicken and egg problem here (a.k.a. 'build it and they will come'). If funds were available for these types of consortia building, then *perhaps* more demand would emerge. However, it is unlikely that this demand could be predicated on straight forward debt finance, with existing VCSE organisations borrowing money to work more closely with others and repaying the debt from costs savings of collaboration or extra income generated.

We believe what is needed is *cornerstone risk capital or a blend of grant and loan* for the creation of new bidding consortia. This idea is not dissimilar to the creation of 3SC several years ago, when 10 large charities each invested £10k towards the creation of a new special purpose vehicle (SPV), which subsequently picked up millions of pounds of contractual income from DWP and elsewhere, feeding back to the membership. Similarly, Big Society Capital has recently indicated its support for a partnership between Interserve, Catch 22 and Clubfinance to create an independent vehicle that combines the qualities of the private and VCSE sectors to deliver public services at scale recognising that many excellent VCSE organisations find it difficult to access finance and do not necessarily have the skills to bid for large public sector contracts.

There may be scope here for investors to provide genuine risk capital or a mix of grant and loan towards the creation of a new SPV and associated costs, and in return retain the right to a percentage of the revenue earned by the consortia, for example. This is a relatively high-risk model and success and repayments would depend on winning one or two large tenders.

As well as consortia and partnerships within the VCSE sector there is also scope for developing multi-outcome partnerships across sectors: for example, across housing and health, or employment and health. The VCSE consortia that emerge within a silo are often delivering a range of diverse outcomes in communities, and could therefore do so for a range of public bodies and commissioners – which creates more scale and potentially more efficiency.

5. Co-creating new asset-backed social enterprises

The opportunity

Within the VCSE sector, social enterprises combine their social mission with a business model in order to trade and avoid a reliance on grant funding to deliver services. They are often understood to emerge in one of these ways:

- As charities increasingly trade and operate in market conditions, either consumer facing or in public service markets
- As small, start-up social entrepreneurs grow and develop in a community
- As parts of the state 'spin-out' to become independent, trading enterprises, such as leisure trusts, housing associations or health and care spin-outs

Through this work, however, we have been reminded of another model for social enterprise creation, which may have particular significance in the health and care context in the South West. On occasions, the strategic foresight of public sector system leaders, entrepreneurs and/or local people can lead to the creation of entirely new, relatively large social enterprises, established to meet a specifically targeted market opportunity, backed by investment and/or assets (either properly or contracts).

One of the most commonly known examples of this type of model is the Evergreen Cooperative in the US, which emerged when the Cleveland Foundation, the City of Cleveland Government and others looked for a vehicle to ensure spending by local 'anchor institutions' (the university and hospitals) was retained in the local economy. The Evergreen Co-operative attempts to harness that spending power by creating quasi-autonomous businesses, each owned and controlled by workers but part of a larger mutual association.

There is an opportunity to create creation of entirely new, relatively large social enterprises, established to meet a specifically targeted market opportunity, backed by investment and/or assets.

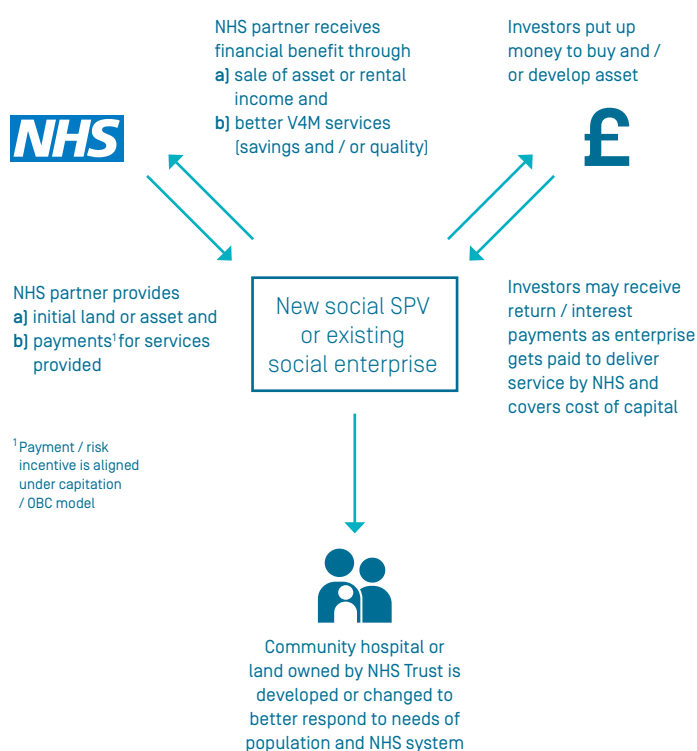
There is also a long history and increasing interest in public bodies creating entrepreneurial trading arms to meet a market opportunity. In Bristol, for example, Bristol Energy has been created to be a "new type of electricity and gas supplier that intends to address social inequality and fuel poverty, support locally generated renewables and provide more resilient energy". But in this case, the company is owned and controlled by the City Council and is not an independent VCSE as such.

There is interest in exploring these kinds of models in the South West (see diagram). A senior professional at the Royal Devon and Exeter (RDE) NHS Foundation Trust describes a number of significant market opportunities where the creation of a new social enterprise, supported by a public body could reduce costs to the system and generate financial returns, helping take it towards the kind of reforms the system desperately needs. These opportunities include both service reconfigurations, such as non-invasive pre-natal testing for Down Syndrome offered free to high risk NHS clients while charging private clients, or telecare models for cystic fibrosis patients, as well as new partnership models which move services closer to communities.

There is, for example, an opportunity for NHS providers to transfer community hospital assets to local communities and enable the development of Health and Wellbeing 'hubs'. These facilities could retain some beds for re-enablement acting as a step down service from an acute setting (e.g. for elderly patients with dementia under circumstances where home care isn't immediately possible) but also including other health and wellbeing related services such as a restaurant, dementia garden, local allotments or Community Land Trust-style housing elements. This could create a new type of care village for people with extra care needs possibly including dementia care. Use of the social enterprise model could allow an incumbent NHS provider to partner with local communities (under 'Place Based' principles) to transform local community assets into facilities that deliver greater community benefit, exploit the opportunities of integration and for newly created social enterprises to earn money from the savings generated by acute providers.

Public Social Partnership / Asset-backed SPV

Joint venture with external investment



The challenges

There are a number of challenges in developing these models:

- **Risk aversion in public bodies** to more strategic and entrepreneurial, asset management approaches.
- **A lack of clarity and experience about the most appropriate ways to balance risks, create the right incentives, share rewards, and create legal and governance frameworks** which are fit-for-purpose in these type of arrangements. Sometimes a joint venture with the private sector may be the most appropriate model. On other occasions, a wholly-owned but arms-length public trading organisation may be most appropriate. When is it most useful to pursue a social enterprise model? How does a public body best reflect its ongoing interest in the enterprise? How should the local community be involved, if at all? There is significant experience across the UK of public-private partnerships, of public trading bodies, of spin-outs from the public to the social sector and VCSE organisations delivering services on behalf of public bodies but very little in terms of public-social asset-backed partnerships.
- **Complexity and issues with the sale and disposal of publicly owned land.** Some of the NHS estate is managed and controlled centrally by NHS Property Services and assets can only be disposed of, if the secretary of state approves the sale and this tends to be if they are lying dormant. Other land and assets are owned and controlled by acute trusts.
- **Public and media sensitivity** to perceived 'selling off NHS assets'. This underlines how the public debate very much focuses on 'privatisation of the NHS'. There is very little public awareness or understanding of the potential role of VCSE in health and care delivery to create new models of health and care that maintain a public service ethos and models which principally reinvest profits. Commissioners and local government officials could help create a more informed public and political debate about the role of social enterprise models in care delivery.

How might we overcome the challenges?

Some of these challenges cannot be overcome, at least in the short-term without changes to national policy with regard to the NHS estate, for instance. Since the 2015 Autumn Statement, local authorities have greater flexibility and incentives to dispose of assets but may now also be tempted to pursue short-term financial returns rather than longer-term value and the wider community interest.

Others can be overcome with the right system leaders, supportive and engaged investors and sufficient resources available to get a project past feasibility or piloting stage.

Potential demand and supply of social investment

Given the need for change within the NHS over the coming years and the imperative to reduce demand on acute trusts, move services closer to communities and to focus on prevention and early intervention, there is clearly significant demand for social investment to help VCSEs address these priorities, at least in principle.

The first question is whether commissioners and acute trusts across the regions can identify the type of projects that can deliver cost savings and returns as identified above. Secondly, once identified, are system leaders likely to adopt a more comfortable position in turning to what they know – public-private partnerships or wholly owned public trading arms – and miss the opportunities presented through the social enterprise model? The latter can offer community engagement, a greater proportion of profits recycled in the local care system and the potential for attracting social investment, perhaps on relatively generous terms.

NHS providers and local authorities can already borrow money through the NHS finance facility or the Public Works Loans Board, respectively. Social investment, then, only makes sense in this context if it comes in the form of genuine equity-like risk capital, with an appetite for risk beyond that of public lending facilities. However, it may be the case that land, assets or contracts are involved against which investment could be secured and / or acute trusts or local authorities may be able to provide guarantees. The capital required may be at a significant scale, with the cost of a new care village, for example, running into many millions of pounds.

There may also be a case for feasibility funding for these type of projects, where the ambition and capital sums are large and significant work is required in the early stages to undertake business planning, set-up, forecasting, and surveying, etc.

Initial discussions suggest that social and commercial investors could have an interest in such models, particularly if the Social Investment Tax Relief could be used to improve the risk and return profile.

Summary of Opportunity Area and Financing Gap

Opportunity area	Demand for finance/ support	Existing supply of finance/ support	Financing Gap
1. Developing community-based micro-providers	Demand for small amounts of funding from £1-10k in form of grants or affordable, unsecured loans + business support	Limited	Yes – some demand for small, unsecured loans (< £10K)
2. Scaling-up existing VCSE organisations	Some VCSE organisations seek external finance for property acquisition or working capital for new business development and to scale operations. Typically from £50k to £10m +	Good supply of finance options (£100k+) from banks and social investment organisations Lack of availability of risk capital finance for early stage trading VCSEs (social enterprises) and for business development/ service innovation	Sufficient supply of finance for VCSE with proven business models and clear pathway to positive cash generation Yes – R&D funding, risk capital finance for early stage trading VCSEs (social enterprises) and new business development from £50k to multi-million
3. Outcomes-based commissioning models	Funding required for both development of outcomes-based commissioning models/ SIBs and risk capital for providers	Good supply of finance for both the development of SIBs and risk capital with strong central government backing	Good supply of funding available including government subsidy for development
4. New forms of consortia and partnerships	Risk capital for creation of new partnerships/ SPV	Limited	Yes – risk capital and technical support required to underpin new partnerships/ alliance contracting
5. Co-creating new social enterprises	Asset transfer + risk capital	Limited	Yes – risk capital + facilitating asset transfer

V.

Conclusions and Recommendations

This section outlines the conclusions from our research and our recommendations for all stakeholders – including commissioners, VCSE organisations, funders and investors as well as the SW AHSN itself – to support the scale-up and development of innovative VCSE-led health models of health and care.

Our research has demonstrated that there is a shared will and clear opportunities for commissioners and VCSE organisations to work together to develop services that take a more preventative, person-centred approach in the South West.

It is also clear that any development of VCSE models at scale will require leadership, commitment and engagement from both commissioners and VCSEs and the development of new processes and commissioning policies that enable co-designed service models.

How do we realise the potential and provide support for the development and scale-up of existing and new VCSE-led services? Can social investment – investment that seeks both a social and financial return – help support such market development?

The original thinking behind this research was to set-up a single fund to support VCSE innovation in health and social care in the South West. Our research has led us to believe that a single regional 'fund' is not the best approach for three main reasons:

1. **Diversity of financing needs.** The diversity of health and care models and financing needs identified – ranging from micro-loans to community-based sole traders through to large-scale, risk capital investment for a new community hospital – would be very hard to meet within a single fund given the very different financial products needed.
2. **Leverage existing funding.** The existing availability of social investment both nationally and regionally means it makes sense to attract funding from existing sources with an aim of matching the right sources of funds to the right financing needs. Already SW AHSN is taking a proactive role in developing a new regional fund that would help meet the gap for smaller amounts of risk capital and will become part of the supply of funds.
3. **Too many initiatives, not enough focus.** It seems best to develop an operational strategy that mobilises existing capacity and builds on what is already happening in the region. Several interviewees complained that there are already too many initiatives within the NHS with

management time stretched to deal with them all and a risk they will not deliver on their promises.

Our thinking therefore is to test out the idea to establish a **Regional VCSE Health and Care Innovation Facility** designed to build on, connect and leverage existing funds and business development support initiatives. The objective of the proposed facility would be to **support the prototyping and development of innovation and scale-up in VCSE-led services and models of health and care**. The facility would focus on developing the service models outlined in Section 4 that provide personalised, high quality care that deliver better outcomes for individuals as well as provide good value for money with a focus on the two identified regional priority areas:

1. Care for the elderly that enables people to live well independently
2. Tackling the underlying determinants of health inequalities

The main role of the 'facility' would be to broker technical support and finance – connecting the right type of support and funding to new service and care model development. A list of existing sources of funding and finance, including bank, social investment, EU and other sources is provided in Appendix 4. The aim would be to create a mechanism (some form of syndicate) that enables VCSE health and care models to raise funds for projects from these different investors.

Potentially, the facility could be assigned its own 'pot of capital' to provide funding and/or finance for unmet needs that leverages other funding, but only where it is demonstrated there are no existing alternative sources available.

The facility could be available for applications from any VCSE or large local provider/CCG in partnership with the VCSE to respond to an identified market opportunity seeking health and wellbeing outcomes and using an innovative solution, for example:

- A group of VCSE organisations want to partner or form a consortium to bid for new Work and Health Programme contracts coming out in 2017 but with a more holistic focus than just focusing on job-readiness and help into employment looking at the underlying causes of worklessness, including mental health issues, lack of confidence, and debt problems.
- An NHS Foundation Trust wants to pilot a dementia care early discharge mini village that integrates community and acute care on a specific physical site, including beds and VCSE-led care services.
- A big provider trust wants to bid for a social care tender along with a group of VCSE delivery organisations.

- A rural Community Land Trust wants to work with an acute provider to take over a cottage hospital and turn it into a mixed-use facility with beds but also homes and a community hub.
- A group of commissioners want to develop new service offers for people living in isolated rural areas using personal budgets by learning from experience elsewhere and finding ways to support community-based micro-providers or models that can reach individuals living in isolated, rural areas.
- A commissioner or large NHS provider wants to see the development of new person-centred services financed through an outcomes-based approach to contracting which is funded from cost savings by relieving pressure on other parts of the health and care system, such as reducing admissions, faster discharge or reduced falls among elderly rural citizens.

Additionally, the facility could carry out the following roles:

- Support mapping or audits of VCSE health and care providers in local areas so as to help improve market information and intelligence about what local services are available.
- Improve sharing and successful uptake of knowledge, innovation and good practice within the region, linking-up VCSE leaders with exemplars and national and regional expertise to help develop new care models, including understanding of the business and financial models and approach to evidencing outcomes.
- Support development and understanding of outcomes-based commissioning, including helping to define outcome metrics and evidence standards that are agreed by commissioners and VCSE organisations and testing new SIB models inspired by local context (such as the strength of community shares, crowdfunding, Quakers, etc).
- Explore the value and feasibility of establishing a 'portal' or mechanism that could facilitate the sharing of information about VCSE service offers to social care and NHS commissioners and service users.

Next steps

During the next phase of work we will test out these findings and the 'facility' proposal with stakeholders with a view to developing a strategy to take these ideas from recommendations to action. Specifically, we will be focusing on the following stakeholders and questions:

- > **Commissioners** – how do the proposed opportunity areas for VCSE link back to commissioning opportunities? Are there specific opportunities you would like to focus on and commit to making happen? What role would commissioners like SW AHSN to play in supporting VCSE development?
- > **Providers** – what is their view of the facility proposal? What functions would providers like it to play and how do they envisage engagement?
- > **Funders** – are funders interested in meeting demand for finance in any of the opportunity areas identified? On what terms and conditions? Would investors be interested in having some form of partnership arrangement in which specific deals are referred where there is a fit with their financial product offer. Would investors be willing to pay an introducer's fee or consider other revenue share arrangements?
- > **Infrastructure organisations** – what role could existing infrastructure organisations play to help deliver the roles/ services of the facility? What resources are required for them to fulfil these roles?
- > **Universities** – are there specific roles for the regional universities within the proposed facility?
- > **SW AHSN** – is it set-up to connect these needs to potential solutions? What continuing role can the SW AHSN play to further innovation and market development of VCSE-led care models? What are the business strategy and resource implications for SW AHSN?

The aim will be to develop an operational plan for SW AHSN and the commissioners who have supported this study. This must be practical, realistic, acceptable to stakeholders and for them to ultimately take forward and own.

The challenges to our health and care system are significant and growing. However, opportunities are opening up, the need for action is clear, and commissioners in the South West region are already leading the way. If existing and new sources of finance can be harnessed to help VCSE organisations and others to overcome the barriers we face, then there is significant potential to make a real difference and improve the health and wellbeing of people across the South West.

APPENDIX 1:

List of interviewees

Commissioners

Organisation	Name	Role
Cornwall Council	Cindy Marsh	Consultant in Public Health
Cornwall Council	Denis Cronin	Consultant in Public Health
Cornwall Council	Kim Hager	Joint Commissioning Manager DAAT
Cornwall Council	Angela Andrews	Senior Commissioning Manager
Cornwall Council	Liz Nichols	Senior Manager
Cornwall Council	Helen Riley Humfrey	Commissioning Manager (Healthy Lifestyles)
Cornwall Council	Charlotte Hill	Senior Manager Partnerships & Improvement
Cornwall Council	Rachael Bice	Strategic Environment Manager, Economy, Enterprise and Environment Directorate
Cornwall Council	Penni Pollard	Senior Manager
Devon County Council	Steve Brown	Assistant Director of Public Health
Kernow CCG	Tracey Roose	Programme Director for Integration
Kernow CCG	Simon Bolitho	Deputy Chief Finance Officer
NEW Devon CCG	Tim Burke	Chair
NHS England	Frances Tippet	SW IPC Programme Director
NHS England	Ray Heal	Joint Long Term Conditions lead SW IPC
Plymouth City Council	Katie Shorten	Strategic Commissioning Manager
Plymouth City Council	Sarah Lees	Consultant in Public Health
Plymouth City Council	Craig McArdle	Head of Co-operative Commissioning
Somerset CCG	Ann Anderson	Director of Clinical and Collaborative Commissioning
Somerset CCG	Alison Henly	Interim Chief Finance Officer and Director of Performance and Acute Commissioning
Somerset County Council	Trudi Grant	Director of Public Health
Somerset County Council	Orla Dunn	Consultant in Public Health
Somerset County Council	Louise Woolway	Consultant in Public Health
Somerset County Council	Alison Bell	Consultant in Public Health
Torbay & SD CCG	Paul Hurrell	Head of Innovation and Quality Improvement
Torbay Council	Mike Roberts	Consultant in Public Health
Torbay Council	Bruce Bell	Head of Public Health Commissioning
Torbay Council	Fran Mason	Senior Manager Pioneer and Joined Up
University of Exeter	Ken Stein	Professor of Public Health

VCSE organisations, infrastructure bodies and others

Organisation	Name	Role
Care Plus Group	Lance Gardner	Chief Executive
Carers Break	Reuben Jenkins	Director
CASA	Guy Turnball	Chief Executive
Community Catalysts	Rhys Davies	Micro-Enterprise Co-ordinator
Cornwall Health	Kate Lock	Chief Operating Officer
Cornwall Voluntary Sector Forum	Ian Smith	Interim Chief Executive
DERiC	Geetha Rabindrakumar	Non-exec Director
Devon Partnership Trust	Tobit Emmens	Managing Partner for Research and Innovation
Exeter CVS	Simon Bowkett	Chief Executive
Exhale Foundation	Niky Dix	Director
Heart of the South West LEP	Lindsey Hall	Chair, Social Enterprise Sub Group
Highland Home Carers	Stephen Pennington	Managing Director
Kernow Health	Peter Stokes	Chief Operating Officer
Peninsula Dental Social Enterprise	Robert Witton	Director
Peninsula Enterprise	Pam Cole	Social Enterprise Focus Programme Manager
Plymouth Community Healthcare	Dan O'Toole	Director of Finance and Deputy Chief Executive
Plymouth Community Homes	Clive Turner	Chief Executive
Plymouth Social Enterprise Network	Gareth Hart	Director
POP Zebra	Jacky Clift	Project Lead
Royal Devon & Exeter NHS Foundation Trust	Dave Tarbet	Business Development Director
Sandwell Community Caring Trust	Geoff Walker	Chief Executive
Social Enterprise Mark	Lucy Findlay	Managing Director
SSE Dartington	Sheena Leaf	Programme Development Associate
Upstream Health Living Centre	Justin Smallwood	Director
Virgin Care	Jayne Carol	Head of Devon Integrated Children's Services
Westbank	Jaine Keable	Head of Health and Wellbeing
You First Support Services	Andy Robinson	Chief Executive

APPENDIX 2:

Regional context

Cornwall

Cornwall is a sparsely populated county with a relatively high level of population growth. The county has a growing ageing population with significant inequalities in life expectancy between the richest and poorest and a growing number of people who are carers.

Public Health England's 2014 profile of Cornwall suggests that alcohol related and self-harm hospital stays and smoking were higher than in other parts of England.

NHS Kernow is the Clinical Commissioning Group for Cornwall and the Isles of Scilly. Cornwall Council's 2015/16 to 2018/2019 strategy identifies a number of priorities, which include reducing costs through greater integration; reducing health inequalities; early years support, early intervention and effective mental health services.

The county's **Joint Health and Wellbeing Strategy** for 2013-15 encourages a shift from dealing with problems to preventing them and reducing health inequalities by bringing communities together. Cornwall's **Health Inequalities Strategy** 2011-2016 sets out five priorities for reducing health inequality – stopping smoking, active lifestyles, the best start in life for children, a focus on older people and reducing worklessness.

Cornwall is one of the Government's Integration Pioneers with 15 organisations joining together with a commitment to more closely integrate services, overseen by the **Health and Wellbeing Board**.

In 2015, a Cornwall **devolution** deal was agreed which aims to give the area more freedom to tailor services to local needs; this is likely to see particular emphasis on preventative models and the integration of health and social care.

Devon

Devon is the third largest county in England and one of the most sparsely populated, with a higher proportion of older people than average.

Alcohol-specific hospital stays, incidence of malignant melanoma, hospital stays for self-harm, recorded diabetes, and suicide rate are higher than the national average.

The Devon County Council area is served by **North, East and West (NEW) Devon CCG**, the largest in the country, which also serves the Plymouth unitary authority area while the remainder is covered by **South Devon and Torbay CCG** (see below).

Devon County Council's strategic plan ***Better Together 2014-20*** states the authority's commitment to: help communities help themselves; promote early action for better health and wellbeing; and protect and support the most vulnerable.

Devon's **Public Health Annual Report** (2014-15) is themed around health inequalities. Devon Council's **Adult Social Care Annual Report** (2014) highlights the challenge of an ageing population and increases in the numbers of people with long-term conditions.

In 2014, Devon County Council and the two CCG's produced 'The I-Plan' setting out aims and objectives for the integration of health, wellbeing and care in the county. There are a number of partnership commissioning strategies in place or in development in the county.

Devon County Council and NEW Devon CCG have initiated the **Delivering Integrated Care Exeter (ICE) Programme** looking at collaborative ways towards integrated care. In June 2015, Devon was announced as one of three areas in England where local health and care organisations would be part of the **Department of Health's new Success Regime**, which provides increased support to the most challenged health and care economies.

Plymouth

Plymouth City Council is a unitary authority that falls within the Western Locality of the North, East & West (NEW) Devon CCG. Levels of deprivation in the city are higher than national and regional averages and the city is significantly worse than the national average on a range of indicators, including children in poverty, smoking prevalence, life expectancy and unemployment.

Plymouth City Council's corporate plan puts significant emphasis on health and social inequality. Plymouth City Council and NEW Devon CCG formed an integrated commissioning function from 1 April 2015. The **Health and Wellbeing Strategy** [2013] for Plymouth identifies a number of priorities for the city.

Thrive Plymouth is the city's 10 year plan to improve health based on the idea that four behaviours (smoking, drinking, inactivity and diet) cause the four diseases (respiratory disease, heart disease, cancer and stroke) that are responsible for 54 per cent of deaths.

The integration agenda is well developed in the city. Plymouth City Council and NEW Devon CCG formed an integrated commissioning function on 1 April 2015, bringing together over £630m of Plymouth City Council and NEW Devon CCG funding. This is fulfilling the vision of the Health and Wellbeing Board of integrated health and wellbeing. The aims of the integrated commissioning system are:

- To improve health and wellbeing outcomes for the local population
- To reduce inequalities in health and wellbeing of the local population
- To improve people's experience of care
- To improve the sustainability of our health and wellbeing system

Commissioning will take place in line with four integrated commissioning strategies related to Wellbeing, Children and Young People, Community and Enhanced and Specialised Care and creates real opportunities for co-commissioning with VCSE organisations.

In October 2013, Plymouth was announced as a 'Social Enterprise City' – one of the first in a scheme run by Social Enterprise UK that recognises the growth and success of the sector in a particular geographic location.

Somerset

The population of Somerset is spread relatively sparsely throughout the county, is growing faster than the national average and more people are economically active than for the country as a whole. The Joint Strategic Needs Assessment 2014/15 highlights the need to reduce emergency admission rates for people over the age of 75 in rural areas.

Somerset County Council and Somerset CCG are coterminous. The **Health and Wellbeing Board's Strategy for Somerset 2013 – 2018** identifies priorities which include community-led action to encourage healthier lifestyles; giving health and wellbeing due consideration in planning and other policy decisions; prevention and support for carers. The CCG's five year strategy proposes that people receive more care in the community and asserts a need to focus on key health risks such as obesity, smoking and alcohol use.

The Council's **County Plan for 2013-2017** sets out very broad priorities, which include helping vulnerable and elderly people stay in their own homes for longer; fewer children in local authority care; more people approved to foster and adopt; helping residents stay healthy; and encouraging children to be active.

The **Adult Social Care Market Position Statement for 2014** identifies priorities as prevention and early intervention; independence, choice and control; and long-term specialist care and support.

Somerset Together is an emerging strategy for the CCG and the County Council to pursue an 'outcomes-based commissioning' approach through pooled budgets. Meanwhile, South Somerset was in the second wave of the DH's integrated care pioneers. The **South Somerset Symphony** Vanguard programme has been working to bring together primary, secondary and other sorts of care in one place.

Torbay

Torbay Council is a unitary authority area that includes the principal towns of Torquay, Paignton and Brixham. It is served by the **Torbay and South Devon Clinical Commissioning Group**.

A high proportion of Torbay and South Devon's population is aged 65 or over and Torbay has more children in poverty, long term unemployment, alcohol specific hospital stays, hospital stays for alcohol related harm, and recorded diabetes than average. The numbers of children on protection plans or in looked after care in Torbay are among the highest in the country.

South Devon Healthcare NHS Foundation Trust which runs Torbay Hospital and Torbay and Southern Devon Health and Care Trust which runs community services, community hospitals and adult social care have merged to become one **new Integrated Care Organisation – Torbay and South Devon NHS Foundation Trust** (TSDFT).

The **Health and Wellbeing Strategy** for Torbay focuses on children having the best start in life; reduced gaps in life expectancy and mental health and wellbeing.

The **Integrated Prevention Strategy for Torbay** identifies five **determinants of health** (poverty; housing and living environment; working environment, education, community environment and resilience); five **behaviours** (smoking, excess alcohol, lack of physical activity, poor diet and lack of social connection); four **conditions** (dementia, diabetes, obesity, hypertension) and five **diseases** (cancer, cardiovascular disease, mental health problems, liver disease, respiratory disease) responsible for **75 per cent of premature mortalities** across South Devon and Torbay. Torbay is one of the 14 integration pioneer sites.

APPENDIX 3:

Regional and local initiatives

Living Well

Region	Cornwall (Delivery: Newquay, Penwith and East Cornwall)
Partners	Age UK (lead) Kernow CCG Cornwall Council Volunteer Cornwall
Url	http://www.livingwellcornwall.com
Summary	<p>A programme of bespoke wrap around support for older people with a focus on wellbeing outcomes for the individual before applying health interventions.</p> <p>The aim is to focus on what is perceived by the recipient to be most important to them, this might be support with shopping, filling in forms or simple companionship. This helps individuals to build confidence and reduces isolation.</p> <p>This new way of integrated working (combining social services, VCSE, voluntary support and medical care only if and when needed) enables everyone, especially those who are frail or vulnerable, to live the lives they want to the best of their abilities.</p> <p>The estimated costs (administrative) attributed to one recipient is £250, whereas the estimated saving to public services is £1,500 per annum per person.</p>
Funding	This initiative is supported by Nesta and the Cabinet Office, through the Centre for Social Action Innovation Fund, and by a legacy left to Age UK for the benefit of people in Penwith. The Commissioning Better Outcomes Fund paid for the development of a business case.
Future Plans	There are plans for expansion across Cornwall, subject to funding. The challenge is how to scale up and find the right operational model to do so. Currently, there is a reliance on community volunteers, however the team wants to explore possibilities of engaging corporate and public service volunteering schemes. There may be future opportunities to link to personal budgets, but it is unknown how at this time. Currently developing a business case for an outcomes-based contract financed by social investors.

Living Well, Taking Control

Region	Devon (A pilot has also been rolled out in Birmingham, Newcastle and Durham to examine potential cultural, ethnic and religious barriers to health improvements)
Partners	Westbank Community Health and Care CIC Devon County Council Exeter Medical School (guidance with NICE compliance)
url	https://www.westbank.org.uk/diabetes-support
Summary	<p>Living Well, Taking Control is a lifestyle education programme designed to support individuals diagnosed with type 2 diabetes & pre diabetes.</p> <p>It's a community-based prevention programme designed and delivered locally by Westbank, a Devon based social enterprise and by voluntary sector organisations in other pilot locations. Westbank's strategy was to target health inequalities deemed a local priority and work in partnership to secure funding and contracts.</p> <p>The programme aims to:</p> <ul style="list-style-type: none">• Help people with type 2 diabetes improve their lives and manage the condition• Reduce longer term complications linked to diabetes• Help prevent the onset of diabetes in people at high risk <p>Participants are matched with a trained health 'buddy' for one-to-one sessions to discuss their health and how to improve it as well as signposting to other local activities and services.</p> <p>Included in the programme are six free group sessions providing useful tips on eating well, feeling good, stress and relaxation, reaching and maintaining the right weight. These small group sessions provide support, encouragement and reassurance.</p>
Funding	Big Lottery grant for initial start up; Bridges Ventures for development of Social Impact Bond
Future Plans	<p>Initial evidence has been extremely positive, with over 90% course retention rates, over 70% of participants reducing BHAIC and over 40% being able to reverse their condition.</p> <p>Westbank is now looking to develop a social impact bond and has successfully achieved a first stage bid for Big Lottery and Cabinet Office.</p> <p>Scaling up the programme remains a challenge, in particular retaining the sense of local ownership and delivery of the service. Westbank is currently appraising the options for using service level agreements, franchise agreements or licenses to roll the programme into other communities across England.</p>

I Love Life Campaign, run by Livewell Southwest

Region	Plymouth
Partners	Plymouth City Council Livewell South West Plymouth Community Homes Plymouth Herald newspaper University of St Mark and St John
url	http://livewellsouthwest.co.uk/livewell/livewell-home-page/

Summary

The I Love Life Campaign was launched in 2014 as part of Plymouth City Council's strategy to improve the health and wellbeing of local people. The campaign focuses on the health issues most affecting Plymouth, what services and facilities there are available, and what people can do to improve their lives.

The campaign is run by the wellbeing team at Livewell Southwest in partnership with Plymouth Community Homes, a local social housing provider. They offer a series of exercise classes and seminars from health professionals in a bid to help people change their lifestyles and become healthier.

The campaign includes a focus on tackling obesity – for example ways people can improve their diet and exercise, providing advice and information on how to cut down on alcohol and smoking, and talking about the things people can do to improve their mental health and wellbeing.

The Plymouth Herald is a key partner and runs regular features on the campaign including stories from 'Love Lifers' who talk about their experience of living in Plymouth and what they are doing to make their lives better. They have also had specific features on issues such as men's health, children's health and wellbeing, and the range of activities available locally to suit local residents' interests.

There have been real successes. A taxi driver, nicknamed the 'salad dodger', lost an amazing 11 stone over ten months on the I Love Life programme.

Read more:

<http://www.plymouthherald.co.uk/Plymouth-taxi-driver-lost-amazing-11-half-stone/story-28874441-detail/story.html#ixzz43Z0Fr7wR>

Funding	Plymouth City Council
----------------	-----------------------

Future Plans

The I Love Life campaign was initially planned as a 12 month campaign but has been so successful it is now in its third year.

Outcomes-based Commissioning Demonstrator

Region	Devon
Partners	NEW Devon CCG (lead) SW AHSN Devon County Council Plymouth City Council
url	n/a

Summary

The four partners are keen to explore the development of an outcome-based commissioning model focused on preventative and pro-active management of alcohol dependent, high-frequency users of the health and care system.

NEW Devon CCG recently secured funding to develop this project including carrying out a thorough analysis of the opportunity and to explore the development of a Social Impact Bond.

It is intended that learning and insight from the OBCD project will also be used by the CCG to inform their engagement in the 'Living Well Taking Control' project led by WestBank and Devon County Council.

Funding

Big Lottery Commissioning Better Outcomes Fund
Social investors

Future Plans

Development of a Social Impact Bond or other outcomes based commissioning model

Integrated Care Exeter (ICE)

Region Devon
(Delivery: Exeter)

Partners

Devon County Council; Age UK Exeter; Devon and Cornwall Constabulary; Devon and Somerset Fire and Rescue Service; Devon Partnership NHS Trust; Dorset, Devon and Cornwall Probation Trust; Exeter City Council; Exeter Primary Care Ltd; New Devon Clinical Commissioning Group; Northern Devon Healthcare Trust; Royal Devon & Exeter NHS Foundation Trust; Westbank Community Health and Care

url n/a

Summary

ICE is a strategic alliance of public, voluntary and community sector organisations, working together to provide the infrastructure and architecture for designing and delivering new and better ways of working.

In April 2014 twelve local government, public and community sector organisations joined forces to promote independence for adults with complex needs in the city, by working together to deliver high quality, cost effective, sustainable health and social care services.

The ICE vision aims to shift the focus from 'patients' to 'people', and from "What is the matter with you?" to "What matters to you?"

The ICE Board has an ambitious vision with a focus on population health, wellbeing, preventative care and support shifting the emphasis from crisis intervention to helping people help themselves to stay well at home.

The creation of a cross-organisational team provides coordinated support within communities, and key frontline posts have moved to single common roles. The result is that services are delivered through a single point of access so local residents have one place to access information that enables them to make the best decision about their care.

New voluntary sector roles are being developed to facilitate a more integrated response to those at most risk, drawing on more of the skill and resource of the voluntary and community sector.

Others will benefit from support through community based wellbeing networks to deliver alternative and early intervention services designed to promote healthy lifestyles and prevent declining health. These roles will provide co-ordinated support within communities and will include packages of support for safe early discharge; links into community based services and will strengthen social action.

Funding

£1.5m provided by the Department for Communities and Local Government

Future Plans

By 2017/18 the plan is to roll out learning from Exeter across Eastern Devon ensuring sustainability of the model is achieved through mainstream commissioning

South Somerset Together

Region South Somerset

Partners

Avon & Somerset Police; Devon & Somerset Fire & Rescue, Somerset County Council; South Somerset District Council (principal funder and host); SSVCA; Yarlinton Housing Group; Yeovil Chamber of Trade & Commerce; Yeovil College; Yeovil District Hospital NHS Foundation Trust

url <http://www.southsomersettogether.org.uk>

Summary

South Somerset Together is the Local Strategic Partnership in South Somerset. It consists of public, private and voluntary organisations committed to improving the quality of life in South Somerset. Together, these partners act as an initiator and facilitate multiagency projects which bring organisations and people together to communicate about difficult issues facing the community.

South Somerset Together aims to achieve more and better outcomes for less resources and independent effort through collaboration. It does this by:

- Directly commissioning, delivering or sponsoring activities/programmes that act as a catalyst for change;
- Focusing on issues that have consistently proved resistant to earlier actions;
- Being willing to take calculated risks by trialling new ways of working together;
- Helping partners identify better, more cost effective ways to deliver local services;
- Engaging communities in discussions with partners about what the issues are, what support they need to do things for themselves and practical examples of what has worked/not worked elsewhere;
- Accessing external funding and negotiating the pooling of local budgets/resources to make things happen;
- Disseminating information about what has been learnt/achieved;
- Lobbying at a local and national level on the issues that are important to the communities of South Somerset;
- Championing living and working in a sustainable way that will benefit people in the District, nationally and globally, today and for future generations.

The partnership has an independent Chair and dedicated Coordinator

Funding

The principal funder is South Somerset District Council

Additional funding partners include: Bournemouth Churches HA; Knightstone HA; Raglan HA; Somerset County Council; Yarlinton Housing Group; Yeovil Chamber; Yeovil College and Yeovil District Hospital

Future Plans

Housing and welfare reform are currently key topics being examined by the South Somerset Together partnership

Ageing Well Torbay

Region	Torbay
Partners	Torbay Community Development Trust (lead) Age UK, British Red Cross, Brixham Does Care, Crossroads Care, and Mencap
url	http://www.torbaycdt.org.uk/index.php/projects/ageing-better

Summary

Ageing Well Torbay, has been created to support older people and to tackle the high levels of social isolation within Torbay, where half of the population are over the age of 50.

Funded by Big Lottery the programme aims to reconnect communities and give everyone the opportunity to feel valued and lead more enriched, fulfilling lives.

Torbay Community Development Trust was awarded funding for the 6 year project in April 2015, following an extensive shortlisting process, involving 100 areas across the UK, of which 14, including Torbay were successful.

Ageing Well aims to reconnect communities across Brixham, Paignton and Torquay, so everyone no matter what their age can:

- Celebrate the skills stories and knowledge of people over the age of 50
- Enable themselves and others to feel their lives have value and purpose
- Involve everyone, (themselves, neighbours, friends and family) to make Torbay a positive place where everyone can feel included
- Reconnect people with their friends and communities
- Strengthen the voice of older people

Funding

£6m grant awarded by the Big Lottery (Fulfilling Lives: Ageing Better programme)

Future Plans

The programme is running for six years (2015-21) during which time there will be project evaluation and cross programme knowledge sharing

Transformation Challenge Award [TCA] Cornwall

Region	Cornwall
Partners	Cornwall Council (lead); Cornwall Rural Community Charity; Cornwall Voluntary Sector Forum; Penwith Community Development Trust; Volunteer Cornwall; ECCABI; CAB Cornwall; and NHS Kernow

url <http://www.cornwall.gov.uk/cornwalltca>

Summary

Cornwall TCA aims to improve the commissioning of services and strengthen the voluntary, community and social enterprise (VCSE) sector.

Partners in Cornwall have successfully bid for £936k from the government's Transformation Challenge Award (TCA), which will be used to improve the commissioning of services and strengthen the VCSE sector's ability to meet demand for services that are commissioned differently in future.

Cornwall is one of over 70 local authorities that successfully bid for a share of £320m TCA funding from the Department for Communities and Local Government over the next two years. The aim is to support initiatives that improve the way that public services are commissioned, managed and delivered.

The project has three objectives: – improving outcomes for people; improving commissioning and value for money; and strengthening the VCSE sector.

To help achieve this, representatives from the VCSE sector are involved in the steering group which is overseeing the project, and three task and finish groups which will deliver it. They will be supported by a TCA team, which includes people seconded from VCSE organisations.

TCA Cornwall will also explore the links with the devolution agenda – giving towns, parishes and community groups more control over local services and assets – and the opportunities arising from the new programme of European funding.

An important part of its work is to look in detail at the existing contracts the Council (and NHS Kernow) have with the VCSE sector, and the existing provision of information, advice and guidance.

As well as getting a deeper understanding of what is currently commissioned, this work is helping us to test TCA Cornwall's understanding about the wider role of the sector.

Funding

Department for Communities and Local Government

Future Plans

TCA Cornwall team aims to regularly review the needs of the VCSE in Cornwall

Following the announcement of the Council's 'Devolution Deal', TCA Cornwall has made links with the health and social care integration leads to explore how it can get involved. It is also looking at the role of the Better Care Fund, a £50m pooled budget between the NHS and the Council

South West Consortium

– Integrated Personal Commissioning Programme (IPC)

Region Cornwall and Devon

Partners

NHS England, Local Government Association (LGA), Think Local Act Personal (TLAP) and the Association of Directors of Adult Social Services (ADASS)

url <http://www.ipcprogramme.org.uk>

Summary

In July 2014 NHS England, the Local Government Association (LGA), Think Local Act Personal (TLAP) and the Association of Directors of Adult Social Services (ADASS) formally invited health and social care leaders to help build a new integrated and personalised commissioning approach through an Integrated Personal Commissioning (IPC) programme which will, for the first time, blend comprehensive health and social care funding for individuals, and allow them to direct how it is used.

IPC is a delivery vehicle for personalisation. It is both a care model, i.e. person-led integrated care planning, combined with an optional personal health and social care budget; and a financial model: an integrated, 'year of care' capitated payment model.

The South West Consortium programme is one of nine demonstrator sites nationally. It brings together local government, the VCSE sector and the NHS to work differently to support people with complex care needs.

IPC aims to use person led approaches, with the option of a personal budget to integrate support for people. The result is that an individual will have one care plan focused on what matters to them.

51 potential local implementation sites have been identified in the South West and 11 sites are already operational, including:

- Cornwall: 11 people with mental health needs who are frequent admitters to acute hospital
- B&NES: 12 children with complex needs and their families
- NEW Devon: 5 young people with learning disabilities in transition
- Torbay and South Devon: 34 people with multiple long term conditions in Totnes

Funding

This programme is supported by the four founding partners

Future Plans

Three priorities:

- Reviewing opportunities and / or gaps in the market
- Developing a funding resource that up to date information about available funds for capacity building capacity
- Preparation of practical toolkits – costed case studies, resources to help applying for funds, quality, monitoring, outcomes

APPENDIX 4:

Funder/support provider list

Grants and low cost finance

Regional

Dartington Seedbed

<http://seedbedenterprise.co.uk>

A new type of social accelerator programme offering intensive support and investment for early-stage social ventures in the South West. The programme is able to provide a £600,000 worth of loan investment and a support package of £8,500 per venture

The Engine Room

<https://www.theengineroom.org.uk>

A business support and development programme for social enterprises and small and medium sized enterprises in Cornwall and the Isles of Scilly. The service is based across four hubs and is delivered by CN4C, Cornwall College, Cornwall SSE, and RIO

School for Social Entrepreneurs [SSE]

<https://www.the-sse.org>

Supports individuals to set up new charities, social enterprises and social businesses across the UK through start-up training programmes and grants (£4,000). There are two Schools in the South West operating across various locations: SSE Cornwall and SSE Dartington

National

Access Foundation [Big Society Capital]

<http://access-socialinvestment.org.uk>

A new charitable foundation developed in partnership with the UK Cabinet Office, Big Society Capital and Big Lottery Fund. It will be a champion for charities and social enterprises at early stages of developing new ways of creating income

Big Potential [Big Lottery]

<http://www.bigpotential.org.uk>

A BIG Lottery Fund grant fund that will deliver approximately £20m of grant funding over three years to eligible VCSE organisations with the aim of improving the sustainability, capacity and scale of VCSE organisations in order that they may deliver greater social impact

Centre for Ageing Better [Big Lottery]

<http://www.ageing-better.org.uk>

An independent charitable foundation working to help everybody enjoy a good later life. Its approach is based on evidence – it aims to develop, share and apply evidence to help people age better

Power to Change [Big Lottery]

<http://www.thepowertochange.org.uk>

An independent charitable Trust set up in 2015 to support, develop and grow community business across England. Over a 10-year period funding of £150m will be used to deliver grants and practical support for at the start up and growth stages

UnLtd

<https://unltd.org.uk>

UnLtd is the Foundation for Social Entrepreneurs providing grant finance and support to social entrepreneurs at varying levels of development: at the ideas stage, building a social venture, and scaling a social venture

Specialist social investment finance providers

Regional

Resonance

<http://www.resonance.ltd.uk>

Resonance is a south-west based organisation assisting social enterprises with development strategies, investment readiness and securing finance. It aims to match find investors who share the values of the social enterprises. It also operates and manages several impact funds

Social Enterprise Fund – Somerset

<http://www.somersetcf.org.uk/apply-for-a-grant/Somerset-Social-Enterprise-Fund>

This fund has been established with initial funding from Somerset County Council to provide loan finance to support new and established social enterprises. Whilst the SSEF is primarily a loan fund, there is scope for an element of grant funding. Loans from £10,000-£100,000

Social Enterprise Investment Fund – Plymouth

<http://www.plymouth.gov.uk/homepage/business/economicdevelopment/strategicgrowth/socialenterprises>

Provides a mixture of loans and grants for social enterprises to create jobs and bring redundant buildings back into use in the city. The fund will be a mixture of grant and loan (revenue grants – £5,000-10,000 and capital grants / loans £15,000-80,000)

National

Big Issue Invest

<http://bigissueinvest.com>

The social investment arm of The Big Issue, providing finance to social enterprises and the trading arms of charities from £50,000 to £2 m including early stage risk capital (through a Corporate Social Venturing programme), affordable loans and equity-like growth capital investment

Bridges Ventures

www.bridgesventures.com

Bridges Ventures funds focus on achieving a positive social and/or environmental impact. It manages a variety of venture funds including the Social Entrepreneurs Fund, the Social Impact Bond Fund as well as sustainable growth and property funds

CAF Venturesome

<https://www.cafonline.org/charity-finance--fundraising/borrowing/social-investment>

Provides affordable finance to charities and social enterprises in the form of unsecured repayable loans of £25,000 – £250,000. It offers: unsecured loans; a standby facility (like an overdraft); Social Impact Bonds and revenue participation debt

Charity Bank

<http://charitybank.org>

A specialist bank that raises deposits and only lends to charities and social enterprises. Offers loans to small and large organisations from £50,000 to £2.5m, up to £3.25m to social housing providers and more in partnership with other lenders. Typically seeks security and only lends to organisations that are assessed to be creditworthy from a banking perspective

Cheyne Capital

<http://cheynecapital.com>

Cheyne Capital is a commercial investment firm that has launched a Social Property Impact Fund which works with social sector organisations that are delivering services in the UK including social housing, elderly extra care, housing for the homeless, adult social care and supported living for people with physical and / or learning disabilities. Cheyne's Social Property Impact team will acquire or build properties and lease these properties to social service providers at affordable rates

Community and Cooperative Finance

<https://www.coopfinance.co.uk>

Set up in 1973, Community and Cooperative Finance (originally Industrial Common Ownership Finance Ltd) provides loan finance to the cooperative and social enterprise sector. Offers loans from £10,000 to £150,000 at competitive rates of interest

ClearlySo

<https://www.clearlyso.com>

ClearlySo helps social entrepreneurs raise capital and introduces investors to investment opportunities. For businesses and charities raising between £150k and £20m, ClearlySo provides advisory, capital raising services, and introductions to investors

Crowdfunder

<http://www.crowdfunder.co.uk>

Crowdfunder is a platform that enables VCSEs, community groups, businesses, sports clubs, or individuals to setup crowdfunding projects, to 'create' a crowd and to collect payments from backers. Projects can be funded through rewards-based, community shares or equity-based schemes

Esmée Fairbairn Foundation

<http://esmeefairbairn.org.uk>

Alongside grants Esmée Fairbairn provides social investment with the aim of creating social impact. It can commit up to £35m in a diverse range of organisations including charities, social enterprises, community benefit societies and other social investment funds

Fredericks Foundation

<http://www.fredericksfoundation.org>

A Responsible Finance Provider (RFP) and a charity that provides loans to people who want to set up a new business or maintain or expand an existing business. Fredericks is open to anyone who has a viable business proposition but cannot obtain mainstream finance

Funding Affordable Homes

<http://salamanca-group.com/our-media/funding-affordable-homes-founded-by-salamanca-group-announces-15million-investment-by-big-society-capital/>

Funding Affordable Homes is a specialist fund providing capital for affordable housing, including housing for the homeless, supported living and specialist housing for people with disabilities. The fund works in partnership with housing providers and buys or builds properties that are rented back to the service provider to manage and use to meet the social need for housing

ImpactVentures

<http://www.impactventuresuk.com>

Impact Ventures is an impact first growth capital fund focused on accelerating the growth of innovative businesses and expanding their social benefit

Local Partnerships – Technology Spin Outs Fund

<http://localpartnerships.org.uk/our-work/investment-reform/tsf>

Enable existing public sector spin-outs to access loans from £250,000 to £1m for investment in technology to improve services in health and social care. The fund can only support organisations that would be unable to access loans on the commercial market

Social Finance

<http://www.socialfinance.org.uk>

Partners with the government, the social sector and the financial community to find better ways of tackling social problems. Since 2007, it has mobilised over £100m of investment. Social Finance also supports the development of social impact bonds

Social Investment Business

<http://www.sibgroup.org.uk>

Helping social enterprises, charities and community organisations prosper by providing innovative financial solutions and business support. Funds include: First Steps Enterprise Fund; Big Potential (see above); Impact Readiness Fund and Local Impact Funds

Social and Sustainable Capital (SASC)

<http://socialandsustainable.com>

Manages loan funds for charities and social enterprises across the UK, of note: the Community Investment Fund and Third Sector Loan Fund (investing between £250,000 and £3m with a focus on improving the economic and social well-being of individuals)

Triodos Bank

<https://www.triodos.co.uk>

Loans for charities and social enterprises of over £25k and assistance to raise capital from £250k to £10m+. Currently lending over £100m to a hugely diverse range of clients – from local to major regional, national and international businesses and organisations

Unity Trust Bank

<https://www.unity.co.uk>

Offering specialist banking and finance to organisations that have a positive impact on their communities. Provides secured loans of over £250,000. It puts social good and financial sustainability equal first and uses customer deposits to fund lending where there are clear social impacts

EU Funding

European Structural and Investment Funds Strategy

<http://www.heartofswlep.co.uk/news/european-structural-and-investment-funds-strategy>

The Heart of the South West LEP has recently published ERDF calls for proposals that the VCSE sector can respond to. The Cornwall SME Support call in January 2016 attracted a bid with a core social enterprise component and is currently in negotiation. A further social enterprise support call for proposals for the areas of Devon, Plymouth and Torbay as well as Somerset will be published in April 2016. Match funding is required for all of these three-year programmes

This report was commissioned by the
South West Academic Health Science Network (SW AHSN),
Devon County Council, Cornwall Council,
Somerset County Council, Plymouth City Council and
Torbay Council

