

Evaluation of the new Voluntary, Community and Social Enterprise Health and Wellbeing Programme

Health and Wellbeing Alliance – final report

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1.0 Introduction

In July 2017, Ecorys was commissioned by Department of Health and Social Care (DHSC) to undertake an independent evaluation of the new Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing programme. The evaluation includes both process and impact strands of work relating to both the Health and Wellbeing Alliance and Health and Wellbeing Fund elements of the programme, which are described in more detail in section 1.1.

This report covers the Health and Wellbeing Alliance (the “alliance”) strand, with an additional, separate report covering the Health and Wellbeing Fund (the “fund”) strand.

1.1 The programme

Following recommendations made in the May 2016 Investment Review of the VCSE sector (Department of Health, Public Health England (PHE), NHS England (NHS)) the streamlined VCSE Health and Wellbeing Programme was developed and then launched in 2018. The programme is designed to provide grants to VCSE organisations through 2 co-dependent funded mechanisms: the Health and Wellbeing Alliance to cover partnership working, and the Health and Wellbeing Fund for more targeted health interventions, with social prescribing the initial thematic focus.

According to the terms of reference for this evaluation, the VCSE Health and Wellbeing Programme is intended to:

- encourage co-production in the creation of person-centred, community-based health and care which promotes equality for all
- enable the voice of people with lived experience and those experiencing health inequalities to inform national policy making and shape the delivery of services
- build evidence of sustainable, scalable solutions to mitigate and prevent inequalities impacting on health and wellbeing of communities.

1.1.1 Policy background

The Health and Wellbeing Alliance builds upon a consistent stream of action within the wider health sector emphasising the importance of partnership working and establishing links between policy, the VCSE sector and communities. The Department of Health and Social Care’s shared delivery plan of 2015 to 2020 has emphasised the importance of integrated work and co-production between the VCSE sector and statutory bodies (DHSC, 2016). Moreover, the NHS envisions strengthened relationships with patients and

communities in the [NHS Five Year Forward View](#), including in the further development of the social prescribing model of healthcare, further described below (NHS 2014). This approach was equally emphasised in the NHS Long-Term Plan (NHS 2019). Similarly, PHE's Strategic Plan for 2016 to 2020 included the necessity to 'support local approaches to improve health and reduce health inequalities' (PHE 2017 p14), and PHE's Strategy for 2020 to 2025 notes that "By working ever more closely together in a place, local authorities, the NHS and community organisations can secure better outcomes for the people who live there." (PHE 2019, p11)

The Health and Wellbeing Alliance element of the programme offers a structured approach to utilising co-production to ensure that key stakeholders needs are fully met. The model was developed using the previous [Voluntary Sector Strategic Partner Programme \(SPP\)](#) as a basis. The SPP was launched in April 2009 with the aim "to improve communication and dialogue between the Department and third sector health and social care organisations across England". From an initial partnership of 11 members aiming to establish a robust model for joint working, the SPP programme expanded to 18 members, spanning the breadth and depth of the voluntary sector in relation to health and social care policy. It was estimated that over 300,000 organisations across the VCSE sector could potentially be reached through the Strategic Partner members.

1.1.2 Outline of the programme's model

The Health and Wellbeing Alliance includes 21 VCSE members, around half of which are consortia (thus taking the total number of VCSE organisations involved to 51). Potential members were engaged through a competitive application process, and the final membership has a mixture of participants of the previous SPP as well as 'new' participants. The organisations were selected to have thematic spread and national reach to communities and VCSE organisations.

The work programme for Health and Wellbeing Alliance members is organised into 2 streams – core work and additional work. Core work is undertaken by all Health and Wellbeing Alliance members, as outlined in Appendix 1. This focuses on representing and promoting the Health and Wellbeing Alliance across the health and care system and VCSE sector; sharing and gathering information across the VCSE sector; and providing advice and support to policy leads and groups.

In addition, members are also able to competitively bid for pieces of additional work; standalone projects which are developed to provide VCSE insight on a range of themes within the 3 system partners. In the financial year 2017 to 2018, 10 pieces of additional work were carried out, with tasks including the development of toolkits for health professionals; primary research on diverse subjects including maternal and child health, supporting NHS staff with disabilities, and the marketing of unhealthy foods; and the development of a model to improve commissioning for the VCSE in the health sector.

Sitting alongside the Health and Wellbeing Alliance, the Health and Wellbeing Fund aims to provide grants to bespoke projects which promote equalities and reduce health inequalities. The intention is that the projects will build the evidence base around good practice in social prescribing, sharing lessons and widening the adoption of interventions with a proven track record.

Each year, the Health and Wellbeing Fund has a thematic focus; for the first year of delivery (2017 to 2018) this was social prescribing. The initial focus of the Health and Wellbeing Fund on social prescribing fits with the increasing interest in this approach to meeting patient needs and potentially reducing system demands. Social prescribing is the process of referring primary care social users with social, emotional or practical needs, such as basic care needs or loneliness, to a non-clinical service - in this case, a VCSE organisation. Social prescribing is thought to provide more holistic, preventative, de-centralised care (Baddeley, Sornalingam and Cooper 2016; Whitelaw et al. 2017). However, there is a need to continue to strengthen the evidence-base for this approach, with a recent review of social prescribing noting there was “little good quality evidence to inform the commissioning of a social prescribing programme” (University of York, 2015). The HW programme, and this evaluation, offers the opportunity to further strengthen this evidence base.

1.2 Evaluation aims and methodology

The overall evaluation of the VCSE Health and Wellbeing programme consists of overall programme objectives as well as specific objectives for both the Health and Wellbeing Alliance and Health and Wellbeing Fund elements of the work.

Evaluation objectives of the programme

1. Assess outcomes and impact against the 3 overall Programme objectives
2. Design evaluation metrics to be included into interim report every 6 months and evaluation report
3. Assess programme management, representation, split of work across members and overall experience for members
4. Reflect the programme focus on protecting equalities and reducing inequalities
5. Measures/assess the social value of the programme
6. Incorporate lessons learned into ongoing monitoring
7. Deliver system outcome/impact evaluation that can be adopted going forward

Evaluation objectives of the Health and Wellbeing Fund

1. Design a straightforward sustainable process for evaluating outcome for project grants (including report in spring 2019)
2. Build evaluation measures into monitoring and assessment processes for Health and Wellbeing applications
3. Assess the value for money of the Health and Wellbeing Fund and its project
4. Report on impact of Health and Wellbeing Fund topic (social prescribing)

Evaluation objectives of the Health and Wellbeing Alliance

1. Assess effectiveness of integrated work and co-production between voluntary and statutory sectors

The overall evaluation approach includes several specific strands to provide an overview of the working of the programme as a whole and each individual strand of work. This includes interviews and surveys with Health and Wellbeing Alliance members and organisations they work with as well as similar elements to assess the impact of the work of the Health and Wellbeing Project Fund. The evaluation as a whole is a relatively light-touch evaluation with a limited budget which has aimed to provide feedback across all stakeholders where possible. As a result, the report should be read with consideration of the data limitations noted later in this section.

The findings presented in this report are drawn from several sources, across 2 different waves of activity:

Wave 1 (2017 to 2019)

- Initial interviews with 5 key stakeholders, primarily across system partners
- Light touch data collection from 16 of the 21 Health and Wellbeing Alliance leads
- 54 survey responses from VCSE sector organisations to a light touch (5 minute) questionnaire focusing primarily on awareness of the Health and Wellbeing Alliance, the extent and nature of their contact with the Alliance, and their views on the Health and Wellbeing Alliance aims. Organisations were sampled via a list of relevant contacts (n=68) provided by a small number of members; an internet link sent by members to their existing networks and publicised via other approaches (for example via DHSC newsletter).

Wave 2 (2019 to 2020)

- Case study visits to 3 Health and Wellbeing Alliance members
- Interviews with 10 policy leads. These covered all system partners, from across DHSC, PHE and NHS.

1.2.1 Data limitations

This section outlines limitations with the data provided in this report to avoid misinterpretation of any key findings. This is particularly important given the small-scale nature of the project evaluation, with the following being particularly relevant:

- the deliberate approach taken to sampling for the VCSE survey focused on those were potentially engaged with the Health and Wellbeing Alliance and hence does not provide a representative sample of all VCSE organisations
- the policy lead interviews reflect the views of 10 individuals in total. This provides a relatively comprehensive overview of the considerations of this group and helps contextualise other findings. These are used to highlight the range of views expressed, rather than necessarily to suggest the prevalence with which views are held
- as with the above policy lead interviews, the 3 case study visits allowed a depth of understanding among specific Health and Wellbeing Alliance members and the views of their staff and other stakeholders but are not intended as means of establishing prevalence of views.

1.3 Theory of change

A provisional theory of change was developed by Ecorys in November 2017 to shape ongoing evaluation activities. This was based on official programme documentation and input both from Health and Wellbeing Alliance members and the wider programme steering group. This has been subsequently developed during the evaluation on the basis of additional feedback.

1.4 Report structure

Chapter 2 of this report examines in depth the structure of the Health and Wellbeing Alliance and reviews the range and focus of activities undertaken by the member organisations. Chapter 3 explores opportunities and threats for sustainability and future development, with chapter 4 presenting a set of recommendations.

2.0 Health and Wellbeing Alliance activities

This section of the report provides an overview of Health and Wellbeing Alliance activities and outputs drawing on the follow up interviews, case studies and surveys. This includes views on Health and Wellbeing Alliance membership and partnership working, as well as views of and outputs from the core and additional workstreams.

2.1 Initial set-up and remit

The first wave of research investigated the reasons participants had for becoming involved in the Health and Wellbeing Alliance, as well as their views on the application process. This is covered in the following sub-section, along with initial perceptions of the Health and Wellbeing Alliance remit and membership.

2.1.1 Reasons for involvement

Health and Wellbeing Alliance members who had been strategic partners saw their involvement in the Health and Wellbeing Alliance as a beneficial, natural extension of this work. The Health and Wellbeing Alliance facilitated work that they saw as particularly important either for their organisation or for the VCSE sector as a whole, for example in being able to develop a platform and greater awareness around certain issues, being able to develop direct links with policy and influence the policy agenda. It also allowed them to continue working in partnerships that they felt were successful in the past:

One key stakeholder said:

“We found that we worked together effectively in the strategic partner programme and we wanted to carry on.”

2.1.2 The application process

Respondents were generally happy with the application process to join the Health and Wellbeing Alliance. The requirements were felt to be in line with expectations and not overly burdensome. The system partners were seen as responsive during the process, with 1 view specifically relating to the quick replies provided to any queries.

2.1.3 Aims and rationale

An important element of the overall model for the Health and Wellbeing Alliance was that it moved towards being more directly led and driven by the expressed views and needs of policy leads rather than those of members and/or the VCSE sector:

One key stakeholder said:

"Previously the strategic partners partnership worked by everyone getting the same amount of money and essentially set[ting] their own work programmes... Instead of Health and Wellbeing Alliance members drafting their own work programme, the idea is that policy people will go to them and commission them to do particular work and they'll stay interested as they're asking for them."

As a different stakeholder suggested, this model was designed to allow both for strategic work to be undertaken but also for more reactive and responsive work

"so that if things come up, [such as] policy intentions from government, that the Health and Wellbeing Alliance is there as a standing sounding board that can be accessed by government."

For stakeholders this was a vital element of the overall Health and Wellbeing Programme model:

"[The] most important thing, thinking about the Health and Wellbeing Alliance, is being able to match-make with policy leads and strategically influence the travel of policy development and different programmes."

Overall, Health and Wellbeing Alliance members were positive about the overall aims and objectives of the Health and Wellbeing Alliance. They envisaged the Health and Wellbeing Alliance as a route towards meeting a distinct need for the wider VCSE sector as a whole, allowing the voice of the VCSE sector and people with lived experience to be accessed and amplified.

One key stakeholder said:

"I just think it is such a good idea, such a brilliant idea of bringing people together, particularly in view of how the landscape of health and social care is changing."

Policy leads generally had a positive first impression of the Health and Wellbeing Alliance's remit, seeing it as providing a "good opportunity to engage with the [VCSE] sector". The overall model and aims were felt to be appropriate and they welcomed the

opportunity to engage with the VCSE sector and people with lived experience in a structured way. The chance to engage on a national basis through a set structure was particularly appealing.

One key stakeholder said:

“My first thoughts were: ‘This is ideal, I think it is very easy for statutory partners’.”

While the specific remit was seen as appropriate, an additional theme was that Health and Wellbeing Alliance funding was primarily a means of giving needed money to VCSE sector organisations at a time of cuts.

One key stakeholder said:

“And I think the other word I would use [to describe initial thoughts on the Health and Wellbeing Alliance] would be ‘relief’ that there are some organisations that, changing resources were cutting in, meaning that some were about to go bust.”

One key stakeholder said:

“The cold thing is [it is] an opportunity to leverage money out of the state system into the voluntary system.”

A different perspective was that the Health and Wellbeing Alliance remit was beneficial as it gave an “important signal” to the sector around the value of working with the VCSE sector in a strategic way, rather than a more piecemeal approach. This was seen as a “declaration of intent” from system partners and laying a “really good foundation” for later working.

Staff from other VCSE organisations tended not to be aware of the Health and Wellbeing Alliance (see section 2.3), but where they were they too saw the basic role and remit as appropriate.

One key stakeholder said:

“During this time of public sector cost savings, it is absolutely essential that the voluntary sector be closely aligned with public health, and vice-versa. With the advent of low-cost community solutions and the increase of social prescribing, such partnerships continue to be needed more than ever.”

2.1.4 Health and Wellbeing Alliance membership

Interviewees felt that the membership of the Health and Wellbeing Alliance offered a good mix of types of organisation, and that they could meet the expectations of providing:

One key stakeholder said:

“Depth and breadth of links to wider organisations, health sector and [be] inclusive of equalities groups and those with protective characteristics.”

Members and policy leads felt the Health and Wellbeing Alliance succeeded in this aim, having a good mixture of groups covering protected characteristics, health inequalities and infrastructure groups. One view was that the membership included groups that might otherwise be overlooked in policy-making, and that the diversity of the membership was greater than that of the strategic partner programme.

One key stakeholder said:

“The mix of organisations that are more local and can access people with lived experience and those that are more national umbrella organisations makes sense.”

One key stakeholder said:

“If this [the Health and Wellbeing Alliance] wasn't happening, I don't have confidence that anyone in the system is interested in [our theme and] work. It would be left on the shelf. Is a big difference to 2 years ago - has been really positive being in the Health and Wellbeing Alliance.”

Policy leads recognised that their needs were so wide-ranging that they could not necessarily be met by a limited number of groups, but felt that the Health and Wellbeing Alliance provided a very good level of coverage across themes (albeit that the rationale for selection was not necessarily transparent).

One key stakeholder said:

“I think the idea of having a number of consortia that cover the protected characteristics and many of the stakeholder groups, and in principle, has some type of resource, seems sensible.”

One more minor theme was the membership of the Health and Wellbeing Alliance was suitably varied, particularly in ensuring that both condition-specific and more thematic VCSEs were included, with the latter positioning the Health and Wellbeing Alliance well with regards to the increasing move away from a more medical model of health and

towards one focused on prevention, sustainability and supporting people within their local settings.

Few additional areas of expertise were suggested by members or policy leads, with those that were mentioned being community foundations, women's health, volunteering, social enterprise and the sex worker industry. There were no suggestions of existing thematic areas that were considered less relevant or potential areas that could be removed.

2.2 Health and Wellbeing Alliance work

The following section provides specific detail on the processes and work undertaken by the Health and Wellbeing Alliance.

2.2.1 Core work

Members were generally positive around the overall aims of the core work of the Health and Wellbeing Alliance and saw it as a key and appropriate part of their role. Interviews indicated that member organisations had developed a better understanding over time as to what the core work should entail. For example, one organisation which was not specifically health-focused noted that in the first year they had tried to retro-fit their input to align with core requirements, but now were better-placed to manage their input and contributions on a more pro-active basis. However, another interviewee expressed that they had struggled to define core work from the outset of the programme, and how to distinguish the role from their day job.

Members saw clear value in their core work, albeit that this could be constrained by resource availability. One interviewee noted how their organisation had used this funding to facilitate engagement activities in their local branches to consult with the public. More commonly, organisations had developed newsletters to ensure that dissemination took place in a consistent and streamlined manner across organisations with whom they were in contact. The newsletters were also used as a mechanism to promote webinars and events, and as information-gathering exercises. One interviewee noted that the core work has provided them with the resource and impetus to carry out work they had aspired to do but had previously been unable to.

This generally allowed members to input on a broad spectrum of issues of interest to the groups the members represent. Multiple interviewees referred to their work in the inclusion subgroup of the Health and Wellbeing Alliance, feeling this was valuable and productive, enabling them to target very specific policy areas.

Some members felt that it was not straightforward to provide clear evidence of the impact of any core work. Measuring outcomes from communication and dissemination work was

seen as inherently difficult, particularly when they were undertaking similar work regularly anyway.

Policy leads did not tend to have strong views on the extent to which core work was carried out, although there was a minor theme that more could be done to represent strategic developments to the wider sector:

One key stakeholder said:

“The membership of the Health and Wellbeing Alliance gives them some privileged access to national policy-making discussions, and I think they could share that more proactively and make it more relevant for their members.”

2.2.1.1 Resourcing core work

One recurring theme was that members felt there was a lack of resource and capacity to undertake core work to the required standard. They wanted to play as active a role as possible, but struggled to resource this, noting that “we do more days than ever proposed”.

Many of those involved felt there was less funding than in the strategic partners programme, limiting the potential for undertaking core work for some members. One interviewee, who had previously been a strategic partner, felt that they now had less resource to run regional consultation events than in the past. A common view was that time was disproportionately occupied with attending webinars and reporting / monitoring, distracting attention from “doing work of value”.

There were also concerns about the delays and uncertainty relating to payment for core work. A number of those involved in the research had not received confirmation of the funding for the next year of the core work when expected. One interviewee felt that continuity and stability was more important than the level of funding, and that they would be happier if funding could be put in place over the longer-term. Another interviewee noted:

One key stakeholder said:

“It’s challenging to manage the late notice of the funding for a project which is meant to be continuing. There is no clarity that core funding will continue but there is the expectation to start planning work for next year.”

2.2.2 Additional work

Additional work provided by Health and Wellbeing Alliance members covered a broad range of issues (from inequalities in end of life care to racial disparities in mental health) and outputs. The latter included seminars and several reports, some of which have been referenced in government strategies.

Health and Wellbeing Alliance members involved in the research appreciated the opportunity to feed into the planning process for the additional work programme, noting that members had been able to comment on outline plans at an early stage. The process of bidding for additional work had largely been straightforward for the organisations involved, although one described it as labour-intensive.

A strong theme was that there were delays in getting approval for the work to begin, and this resulted in timescales for delivery being constrained. In one case, Health and Wellbeing Alliance members had begun work prior to final approval and first payments in order to ensure additional work could be finalised in the remaining timeframe. Another Health and Wellbeing Alliance member noted that their organisation would no longer be bidding for additional work in the year because of payment delays, combined with short time scales for delivering work and what they believed to be tight budgets for the requirements.

One key stakeholder said:

“There are always huge time pressures. You get something like 8 weeks to complete a project, which is ridiculous.”

Furthermore, interviewees flagged that without the 1-year commissioning cycle they would have been able to produce a more useful output.

One key stakeholder said:

“A year isn’t really long enough to get all the issues out on the table – if we had been commissioned over a longer period of time that would have been much more helpful, and we’d have a more concrete output at the end, rather than trying to get it all flushed through in 8 months.”

Health and Wellbeing Alliance members often felt that the more generalist organisations in the Health and Wellbeing Alliance were less well-placed to contribute to additional work than organisations with a more specific audience, focus or specialism. This resulted in the more generalist organisations not being able to contribute to (or indeed benefit from) participation in as much additional work as they might have liked.

Working with the system partners through the additional work process had generally been a positive experience from the perspective of Health and Wellbeing Alliance members, and relationships with system partners were described as working well throughout the process. A more secondary theme was some interviewees feeling that the level of scrutiny and reporting to system partners was disproportionate to the size of the projects in question. Where work had been delivered in consortia of Health and Wellbeing Alliance members, the process had also been positive, with good links made between organisations.

Interviewees appreciated the opportunity to highlight the lived experience of their target groups and felt that they had been able to give people a voice through the additional work process that would otherwise have not been heard. Indeed, one interviewee described the output of their additional work as being “really powerful.” In more than one case, interviewees noted that the work they had produced in consultation with people with lived experience would lead to longer-term, sustainable pieces of work beyond the lifetime of the Health and Wellbeing Alliance, for example by shaping the priorities of relevant organisations and consortia. Another noted that their work will also have implications for the policies of other government departments such as the Department for Work and Pensions, by flagging issues that are relevant across sectors.

Example: Health and Wellbeing Alliance input into the NHS Long-Term Plan

The NHS consulted the Health and Wellbeing Alliance around the development of the Long-Term Plan during the autumn 2018. Health and Wellbeing Alliance members were asked to contribute their views, and their users’ views, on the following areas, in which the NHS believed there was the greatest potential to improve the way it provides care:

- Life stage programmes: early life, staying healthy, ageing well;
- Clinical priorities: cancer, cardiovascular and respiratory, learning disability and autism; mental health;
- Enablers of improvement: workforce, primary Care, digital innovation and technology, research and innovation, engagement.

One Health and Wellbeing Alliance member took on the key role of coordinating a joint Health and Wellbeing Alliance response to the Long-Term Plan consultation. Members worked in groups based on to the topics they chose to respond to; they agreed shared strategic objectives and fed them back to the Health and Wellbeing Alliance. The approach led to close joint working on occasions across members and policymakers to ensure focused input on certain topics.

Some of the Health and Wellbeing Alliance organisations expressed frustration that after investing time and resources in responding to the consultation on the Long-Term Plan on a very tight timeline, they did not receive feedback as to whether or how their input was

used. Equally, a challenge was the time required for this work, which some respondents felt was difficult within the funding provided for undertaking core work.

However, many of the Health and Wellbeing Alliance members felt that contributing to shaping and implementing the NHS Long-Term Plan was 1 of the key achievements of the Health and Wellbeing Alliance. Members really engaged with the process and saw some of their recommendations incorporated in the Plan. One of the members said:

“As an Alliance, I felt we did really grown up, sensible, brilliant stuff about coming up with an offer, and a suggested plan [to work together], and costing it, and did really collaborative stuff... really great collaboration. We understood what the potential was for us as an Health and Wellbeing Alliance. The VCSE members did a nice job – might not have been the most perfect plan but 20-odd members came up with something in the space of weeks; it was great.”

Another member reported that they valued the opportunity to involve their VCSE partners and service users in informing the Long-Term Plan. Throughout the process, service users had the chance to express their views at the most senior levels of policy, by having representatives on the Equality and Diversity Council and in meetings with senior NHS staff. One organisation reported seeing recommendations from their users on a wide range of policy areas in the Long-Term Plan, which they felt was a major achievement. Equally, senior staff within the NHS emphasised the importance of consulting service users directly during the process.

2.3 Working with the VCSE sector

An important aim of the overall model for the Health and Wellbeing Alliance was that it would be more visible, not just to policy leads but also to the wider VCSE sector. As a participant in the first round of interviews pointed out:

One key stakeholder said:

“[It] would be good to think about how it has regional presence, ties into other networks, so that people in local VCSE organisations can see that it works and come to them.”

2.3.1 Awareness and contact with the Health and Wellbeing Alliance

All respondents to the VCSE Survey (see Evaluation aims and methodology section for details of approach taken) were asked whether they had heard of the Health and Wellbeing Alliance.

Table 1: Whether heard of the Health and Wellbeing Alliance

Response	Total
Yes	79%
No	21%
Base (total sample)	(54)

QB1: Have you heard of the Health and Wellbeing Alliance?

In total, about four-fifths (79%) had heard of the Health and Wellbeing Alliance, with the remaining fifth (21%) not having done so. This level of awareness was likely to be inflated by the data collection approach deliberately used for the survey, namely relying in part on Health and Wellbeing Alliance members to provide contact details and/or distribute the questionnaire.

Table 2: Whether had contact or undertaken work with the Health and Wellbeing Alliance

Response	Total
Yes- a lot of work/contact	5%
Yes- some	22%
Yes - a little work/contact	43%
No	20%
Don't know	9%
Base (total sample)	(54)

QB2: Have you had any contact or done any relevant work with the Health and Wellbeing Alliance in the last 18 months or with an Health and Wellbeing Alliance member (see list here <https://www.england.nhs.uk/hwAlliance/>) that may have been Health and Wellbeing Alliance work? This could have been sharing information with you or getting information and insight from you on a particular issue.

In total, just over a quarter of respondents (27%) had done at least some work with the Health and Wellbeing Alliance, although a large proportion (43%) had undertaken a little and a fifth none at all. Again, this is likely to have been influenced by the data collection approach taken. Those with less contact or work with the Health and Wellbeing Alliance tended to be positive about what they had heard:

One key stakeholder said:

“Not really sure I know enough about it – but like the idea of it!”

One key stakeholder said:

“I don’t really know enough about the Health and Wellbeing Alliance and what it does as I wasn’t really aware I worked with them while working with [Health and Wellbeing Alliance member].”

However, the follow up interviews and VCSE survey suggest that the Health and Wellbeing Alliance as a ‘brand’ does not have a particularly strong identity beyond the organisations directly involved. As one interviewee noted, Health and Wellbeing Alliance members are constantly communicating with other organisations through newsletters, webinars and events, and by asking the wider VCSE sector for information to contribute to core work, but organisations don’t always know that it’s the Health and Wellbeing Alliance brand sitting behind that.

One key stakeholder said:

“They [VCSE organisations] are really pleased with the opportunity to get their views to government, but they don’t know what the Health and Wellbeing Alliance does. It’s not important to them to know what the Health and Wellbeing Alliance’s aims and activities are because they deal with us”

Where VCSE organisations were broadly aware of the Health and Wellbeing Alliance they had a positive initial impression of the Health and Wellbeing Alliance and wanted to know more about their work:

One key stakeholder said:

“[The] Health and Wellbeing Alliance is good. I’d like to see more published accounts of its work on the ground.”

One key stakeholder said:

“We do not really have insight into the work; although we have heard good things about the Health and Wellbeing Alliance re. raising the profile and voice of people with lived experience”

One key stakeholder said:

“Very useful partnerships, not widely known so should be publicised more.”

Where strong links with the VCSE sector were made and work was clearly visible as for the Health and Wellbeing Alliance it had helped to encourage further participation in relevant activities:

One key stakeholder said:

“I have received feedback on how my information was used and how the wider Health and Wellbeing Alliance work has been progressing. This is encouraging and makes me believe that our projects and concerns about services and particularly gaps in service are being heard. It also encourages me to continue to assist with these types of feedback/information gathering as I hope that my contributions will lead to a change in local service provision.”

While Health and Wellbeing Alliance members would like the Health and Wellbeing Alliance brand to be stronger in the VCSE sector, a number noted that current resources don't allow for members to take on this responsibility. One view was that it was more important to generate visibility amongst the system partners than the wider sector:

One key stakeholder said:

“Brand recognition is important for system partners but not in the voluntary sector. It's important for Health and Wellbeing Alliance members to be able to say to system partners that they are part of it because it legitimises their views.”

Interviewees noted that work was being done amongst Health and Wellbeing Alliance members to improve visibility of the group and the brand, with stands being hosted at relevant conferences and events. This was seen as a positive move by those interviewees.

Those who had been involved with the Health and Wellbeing Alliance had done so in a variety of ways. VCSE staff had jointly worked with Health and Wellbeing Alliance members in presenting at conferences; organising seminars; taking part in regular cross-VCSE groups; running focus groups; helping with workshops; as well as providing case studies, research, consultation feedback and other information provision activities. Almost all of those involved welcomed the opportunity and felt Health and Wellbeing Alliance involvement was beneficial:

One key stakeholder said:

“The Health and Wellbeing Alliance was very supportive in raising awareness of the project [they were running].”

Feedback to VCSE organisations involved in the work of the Health and Wellbeing Alliance tended to be relatively patchy. Where VCSE's worked closely with Health and Wellbeing Alliance members there was little need for additional feedback as those involved tended to know organically what was happening. Where there was more of a need for direct feedback (for example where VCSE organisations responded to calls for evidence or helping access people with lived experience for bespoke purposes) there were fewer signs that this was provided beyond relatively isolated incidents of VCSE organisations being sent an e-mail showing how their input had been used. Where this did happen it was viewed positively and where it did not happen it was felt to be potentially beneficial:

One key stakeholder said:

“I think it's good to have consultations but frustrating when you don't hear if it has influenced policy and practice. Would be good to have an ongoing dialogue rather than one off sessions.”

As noted earlier, Health and Wellbeing Alliance members themselves felt that they did not always receive information from policy leads as to the result of their work, thereby making it difficult for them to provide any meaningful feedback to other organisations.

2.3.2 Perceived benefits of working with the Health and Wellbeing Alliance

Two core benefits were noted by VCSE organisations to being involved in the work of the Health and Wellbeing Alliance. Firstly, their key role in amplifying the voices of people with lived experience to policy was important:

One key stakeholder said:

“I think it is really important that policy-makers and practitioners hear the voices of young people from first-hand. Closing the gap between policy and the public is a job that still needs to be done in a better way.”

Where organisations had worked with Health and Wellbeing Alliance members to do this, they were very positive about how it had worked in practice:

One key stakeholder said:

“I was pleased to be given the opportunity to share my views on the difficulties my clients were experiencing accessing community mental health services. I believe some of the info I provided was used to inform national research and that the practical problems are now recognised in the new pathway guidance.”

One key stakeholder said:

“I think the aspiration to ‘make sure the voices of people with lived experience are heard across VCSE organisations’ is very important and will have a positive impact on policy and practice. Continue to do this.”

Secondly, taking part in this work was not only beneficial from the viewpoint of policy development and ensuring that the voices of people with lived experience were heard, but in capacity building:

One key stakeholder said:

“I felt it was a genuine opportunity for our clients to have dialogue with decision makers and input into a significant policy change... It was a good opportunity for me to develop stronger relationships with service users that I could then invite back to take part in other opportunities to have their views heard. So, from this perspective it was helpful in helping people's voices being heard across the organisation.”

Overall, where they had been involved in the work of the Health and Wellbeing Alliance, survey respondents from across the wider VCSE sector were very positive about what it achieved, feeling it was “working well”, that “the Health and Wellbeing Alliance objectives are just and will hopefully improve the overall experience for users” and asking that it “keep up the good work”.

2.4 Policy and member links

The following section examines the links between policy and Health and Wellbeing Alliance members, focusing on:

- overall relationships and joint working
- experience working with communities and people with lived experience
- outputs and quality of work

This is then followed by a final sub-section examining key enabling factors and barriers.

2.4.1 Overall relationships

2.4.1.1 Health and Wellbeing Alliance and policy relationships

Health and Wellbeing Alliance members and policy leads both felt that relationships were vital and a key factor in whether outcomes were achieved or not. Relationships across members and policy leads tended to be positive, with clear examples of where constructive relationships existed and members had added value through their involvement:

One key stakeholder said:

“It’s been very helpful for us to have them [members] providing that input. So, a positive experience. Their experience and that relationship, it’s always been ‘What do you think of doing x, adding y?’ I found it a very easy relationship to be honest, it’s been good.”

These positive relationships were sometimes sustained throughout certain difficulties in delivery. The policy lead on one project reflected on how the attitude of the member they worked with had ensured positivity despite needing to negotiate a project extension, reflecting on their approach being one of flexibility, responsiveness, openness and honesty.

A less common theme was that relationships were negative or had broken down, with this tending to be linked to projects that did not deliver. On 1 occasion, Health and Wellbeing Alliance members were seen as “borderline unprofessional”.

2.4.1.2 Intra-Health and Wellbeing Alliance relationships

A main theme of interviews with Health and Wellbeing Alliance members was that there were strong relationships across members that helped facilitate joint working. Members often understandably found it easiest to build on relationships that already existed, for example those established during the strategic partners programme. A secondary theme was that establishing new relationships could be particularly valuable, exposing members to new organisations and thematic areas of work. These relationships took longer to establish:

One key stakeholder said:

“It feels like it’s just getting to the point where people know each other and have relationships, but it took 3 years to get here. It means collaboration is more likely to happen.”

While these co-operative relationships were noted by some members, an alternative view was that members could be overly competitive. Members sometimes had their own agendas, which could negatively affect joint working or meant that organisations avoided collaboration altogether.

One key stakeholder said:

“I can't remember last time a Health and Wellbeing Alliance member involved us proactively. They often work with those that are easy to work with or have similar approaches.”

One key stakeholder said:

“There is quite a lot of hostility and groups within the Health and Wellbeing Alliance which is really not helpful – people who always get together and sometimes exclude other people and it's always the same people. We have Health and Wellbeing Alliance working days which are a real challenge, it's just so busy, it is the same people saying the same thing.”

When this occurred, it was felt to be primarily the result of competition for funding, with the limited amount of finance available to the sector as a whole making it a “challenge” to “look beyond your own needs”. The competition among members was seen by policy leads as a particularly negative factor impacting on the quality of Health and Wellbeing Alliance work, with leads reflecting on members “push[ing] specific interests”, “fighting for their own thing” or having to “scramble for resources”.

2.5 Working with communities and people with lived experience

2.5.1 Overall approach and model

Health and Wellbeing Alliance members had different views as to how well the views of people with lived experience and engaged communities were accessed, with this largely being dependent on the size and set-up of each member:

- More “grassroots” and often smaller organisations were in regular, direct connection with people with lived experience and could react quickly to the tight timelines often required by policy leads
- Larger, umbrella organisations could often provide evidence and voices from existing secondary research due to existing resources but were less nimble in directly accessing people with lived experience

Certain Health and Wellbeing Alliance members were acting as a proxy for those with lived experience, with it being “taken on trust” that they were representing these views fairly and appropriately (as appeared to be the case, with these organisations often having a detailed level of insight and experience that was potentially very valuable). As a result, a relatively small number of members accounted for most of the instances where people with lived experience provided direct input, meaning that the voices of certain groups could potentially be accessed quicker than others.

2.5.2 Engaging people with lived experience

Members that did engage people with lived experience used a variety of different approaches. These depended on the nature of policy requirements and the communities themselves, including developing bespoke workshops for members to meet NHS staff; arranging for young people to attend meetings; consultations with service users on health pathways; and other forms of direct contact. Feedback on these activities both from Health and Wellbeing Alliance members and VCSE organisations involved was very positive, for example that “just meeting people made the issues very clear very quickly” to policy leads. Policy leads welcomed and saw the benefits to direct engagement with people with lived experience via the Health and Wellbeing Alliance:

One key stakeholder said:

“As a result of the Health and Wellbeing Alliance we were able to get in touch with more people with protected characteristics. The group was there, and the numbers were greater, the discussion was more lively and engaged than it would have been [otherwise].”

One key stakeholder said:

“Events and workshops went really well; I couldn't fault them. It's clear that the individual Health and Wellbeing Alliance members have good rapport and connections with people in the room... What was great was being able to have that indirect conversation and discussions that we don't get to gather often because of capacity.”

This ability to run these events effectively was a key strength dovetailed with the experience members had built up over time via regular contact with people with lived experience and could bring to their work in the Health and Wellbeing Alliance. Members were able to bring additional value and challenge, providing a different perspective and develop thinking constructively:

One key stakeholder said:

“The value is that whilst they [members] have the real depth of experience on the ground, they [also] know that things aren't going right. The Health and Wellbeing Alliance could point out specific detail that might not make sense. They are able to unblock [a problem] because they can see it from a real, living experience.”

More than one policy lead felt that while the information they received was useful, in an ideal situation the Health and Wellbeing Alliance would allow them to engage more frequently with those whose voices were particularly excluded:

One key stakeholder said:

“I suspect on the face-to-face side you might be more likely to hear from people who have benefitted [from programmes or approaches] as you draw people in from project groups. They [these people] are absolutely excluded and marginalised, but really have the vocabulary.”

One theme was that policy required a level of understanding that the Health and Wellbeing Alliance did not always provide and, as a result, they were not getting any genuinely new information, particularly feedback that might lead them to change their approach:

One key stakeholder said:

“Whether it gave us any more insight into things we already knew, I'm not sure of... They did do the access, but whether it asked deep enough questions I'm not sure. For that, you need things that run for a longer life or are absolutely targeted at local organisations... We miss the opportunity to predict change, what's coming our way that we haven't seen yet.”

This represents a challenge to the Health and Wellbeing Alliance around the relative value of primary research as opposed to direct input from people with lived experience; the breadth of organisations that are able to provide this within tight timescales; and the extent that “new” voices can be accessed given the inherent challenges of engagement.

One key stakeholder said:

“I do think there needs to be greater emphasis on the people who we support/represent rather than promoting the VCSE more widely... We are in the Health and Wellbeing Alliance to ensure that policy and projects take into account the needs of people with complex needs, not to necessarily push the VCSE as a sector.”

The need to genuinely access the views of people with lived experience was also a theme from policy leads. Rather than presenting a full view of experiences there was a feeling that members often tended to represent their own personal or organisational viewpoints:

One key stakeholder said:

“As a charity you have to be objective. A lot of people were talking about their own experiences. It is difficult to interact [with them]. With some charities it was difficult to gauge if it was their views [as a charity] or the official’s opinion.”

2.5.3 Overall delivery

Health and Wellbeing Alliance members were generally positive about the quality of work that they provided, with certain examples being particularly highlighted, such as the work on the Long-Term Plan noted previously. Although interviewees were not always clear about the impact of their work within the Health and Wellbeing Alliance (unless specific feedback had been given by system partners), others perceived that the Health and Wellbeing Alliance had allowed them to do significant work. For example, one member explained that they had been able to take a policy lead to meet members of the community they represent, which had had a significant impact in terms of highlighting need. They noted that “just meeting people made the issues very clear, very quickly”.

As another interviewee noted, the Health and Wellbeing Alliance allowed them as a member organisation to do “really important work on all 3 core aims” (2-way communication, co-production and giving VCSEs influence over policy), while others felt that the Health and Wellbeing Alliance had enabled them to represent specific groups in policy-making in a way which wouldn’t be possible without it.

One key stakeholder said:

“We’ve had lots of achievements along the way in terms of having a direct voice to policy-makers on [specific groups’] particular experience on a huge range of policy areas.”

Policy leads had a range of views about the overall delivery of Health and Wellbeing Alliance projects. On one end of the spectrum, there were those that were very successful and had led to the creation of important outputs across a variety of different elements of work. In these circumstances, leads valued the specific input and expertise of Health and Wellbeing Alliance members and felt this made a substantial difference to their work as a whole. As a result, they were able to clearly reflect on the positive difference the Health and Wellbeing Alliance had made to their policy work.

One key stakeholder said:

“The Health and Wellbeing Alliance was extremely helpful in developing [a particular high-profile policy area]. Some were in there [generally], others got into detail and implementation. It was very positive from our perspective.”

On the other end of the spectrum were projects where the quality of work was felt to have been mixed or not met expectations.

One key stakeholder said:

“A charity bid for a project [for the Health and Wellbeing Alliance] when it did not have the relevant expertise. It went ahead and it was a disaster. It was shambolic.”

One key stakeholder said:

“Different organisations have different levels of capacity to deliver high quality of work and different track records in delivering high quality work. You can have the ambition of the Health and Wellbeing Alliance but then you have expectations about how they will deliver. Some have delivered very well and had a strategic impact and others have not.”

2.5.4 Facilitators and barriers

Members and policy leads felt that the quality of projects was impacted by a range of key facilitators and barriers.

2.5.4.1 Application process and timescales

In the first wave of interviews, members noted that the overall application process for additional work was “very complex” and that they felt they needed to “elbow in to be involved”. This was echoed by an interviewee in the final round of research who stated that they felt they had to “be proactive to get involved.” Another said that the bidding process “feels like the most painful process” with unrealistic timescales often at play, while another felt that the bidding model itself was problematic:

One key stakeholder said:

“Bidding for additional work creates lots of bureaucracy, red tape and unwelcome competition between members.”

Members recognised the same issues, feeling that constrained timelines placed too many demands upon them and impacted on the quality of the work they could deliver. They felt the Health and Wellbeing Alliance was often being approached “late in the day, meaning that true consultation, involvement and co-production is compromised”, risking services not meeting needs. This was felt to have impacted upon the Health and Wellbeing Alliance’s relationship with policy:

One key stakeholder said:

“The deadlines have been incredibly tight... Have been some quite tense situations, some quite tricky conversations, some challenges asking about why the work is going ahead...The concern I’d put forward is that the goalposts get changed at the partners end for their needs but can’t be changed at their end... You can’t put a deadline out there and then change it – we’re small organisation with not many people.”

Resolving these conflicts was not always straightforward. One policy lead found it difficult to get clear advice from Strategic Partners as to the best approach to take, having assumed that there would have been similar learning from other projects. They felt there needed to be clarity around roles and governance and that they were left to make decisions without sufficient support.

While some policy leads felt that timescales were not an issue, this tended to be where they were involved in relatively small-scale projects. Those who were involved in more substantial piece of work often felt timings were problematic. The annual nature of funding meant timescales were limited from the start, with delays to official sign-off leading to further constraints and meaning that work that was planned for twelve months often had to be delivered over a far shorter period. Policy leads found the process in general to be “convoluted”:

One key stakeholder said:

“I found the process of working with the Health and Wellbeing Alliance great, I found the administrative elements not great. These had a knock-on with relationships... You'd be stalled, in one case for about 2, 3 months, not being able to say what would happen next, when you've got people working late until 2 in the morning.”

A further factor noted on occasion was that the administrative processes had changed over the course of the Health and Wellbeing Alliance. In general, it was recognised that changes had made things easier than in the past, but the processes were still a concern for some:

One key stakeholder said:

“The problem is every year DH have changed the system and so they haven't found the right system. The bidding process was crazy 1 year, filling in loads of forms, it is bureaucratic. I haven't been part of it, thank God, for the last year.”

Some projects used subcontractors to ensure that projects were delivered when timescales were short, although this was only used when required due to delays. This raised questions among policy leads as to the relevance of using the Health and Wellbeing Alliance in these circumstances given that the Health and Wellbeing Alliance was no longer directly carrying out the work and it could have been commissioned directly from sub-contractors.

2.5.4.2 Health and Wellbeing Alliance membership and organisations

The spread and nature of Health and Wellbeing Alliance membership was a key contributing factor to joint working and effective delivery of projects. Leads often felt that certain aspects of the remit were better suited to certain types of organisation than others. Smaller organisations were felt to be better linked to events on the ground and, hence, able to provide the views of people with lived experience. Larger organisations were more likely to have the required skillsets to deliver effectively in other aspects, particularly in delivering the required outputs and working efficiently.

One key stakeholder said:

“The central challenge is how to engage such a big, diverse sector. How do you make sure that you hear from the voices that you need to hear from? There is a bit of a tendency when you have less structure that, what tends to happen is you get a conversation between policy members and the big charities that you know best. They are not necessarily representative of the sector.”

One key stakeholder said:

“Large organisations give you stability, whether it is about managing finances and competence around that or resilience around everything... Smaller organisations often generally, whether because they set out with 1 very clear objective [or not]... they are really focused so you can get a depth of people and get their voice heard.”

A different lead agreed with these strengths, feeling that their experience in the Health and Wellbeing Alliance showed that “small charities... don't have the expertise or the skillset” to deliver to the required standard, in particular being able to deliver outputs that met the

stated needs of system partners. When this did not happen, policy leads had to spend substantial time working with members on issues. Organisational efficiency was a key factor in delivering to a required standard. When there were issues in delivery, this was exacerbated in some occasions by an absence of regular contact, which affected the quality of work being delivered and the confidence of the policy lead in the quality of the partnership.

One key stakeholder said:

“A bit more operational efficiency from [Health and Wellbeing Alliance member] partners would be welcomed. Sometimes I think the [Health and Wellbeing Alliance] staff don't have the level of knowledge they should have and [the] understanding, and sometimes I think they are spread quite thin so there's a question of time.”

Others felt that the size of organisation was less important than their approach and attitude to the Health and Wellbeing Alliance as a whole and their links to the wider VCSE sector.

One policy lead commented:

One key stakeholder said:

“Organisations that are committed to the Health and Wellbeing Alliance are better than those that aren't. It is very important for them to be networked and have access to a broader constituency.”

Some members felt that while the organisations making up the Health and Wellbeing Alliance were appropriate, that they did not always have appropriately senior staff participating in Health and Wellbeing Alliance activities. One theme was that a declining number of organisations had CEO-level staff representing them at meetings, largely for resource reasons. Some members were concerned that there could be a vicious cycle, with declining CEO involvement rapidly leading senior staff from other organisations feeling it was not sufficiently advantageous for them to attend. On occasion, staff from some organisations had not turned up at all:

One key stakeholder said:

“When we've had meetings, some people haven't turned up as they're busy. It is a shame as they've been given X amount of money to get involved. If they can't do it then someone else can.”

2.5.4.3 Agenda setting

A commonly view among members was that the overall value they provided would be maximised if they had an increased role in setting the agenda, working to co-produce priorities and actions with policy:

One key stakeholder said:

“We need to make a noise, flag it as an issue that is overlooked.... We only really got attention from ministers when our work... was on the front page of the Daily Mail – then we had everyone clamouring for a response.”

Members suggested that they could be more closely integrated in designing policy specifications, primarily for additional work. Members felt that existing specifications developed by policy leads were not always sufficiently clear and would have benefitted from being co-produced with them. Where specifications were substandard, it resulted in wasted time and effort, creating bad feeling among members with regards to that area of work.

A further theme was a request by members for more input to the process of defining what themes or projects were explored through the additional work stream. There was a feeling that calls for additional work sometimes focused on issues where there was a good existing evidence base, or that it would be useful to have access to funding to carry out self-directed additional work.

One key stakeholder said:

“There are occasions when we can see interesting small pieces of research that could be done to inform emerging policy questions, but unless they are identified by system partners there won't be funding for additional work.”

2.5.4.4 Awareness of the Health and Wellbeing Alliance

Interviewees suggested that opportunities to set the agenda could be increased via system partners, ensuring wider visibility for the Health and Wellbeing Alliance both among those who were engaged and those who were not. Policy leads often reflected that they would benefit from more regular proactive communication:

One key stakeholder said:

“There was time to time a quarterly e-mail. I don't think we ever seemed to be in time to put something through. I don't think I've seen anything go

round to say ‘we are now accepting bids, is there anything we want to do with it?’”

One key stakeholder said:

“It’s fine for us to tell the sector, to make it clear that they can influence policy through this channel so please give us information. But it’s not right that we should be selling it to policy leads... I wonder whether the core partners are able to influence their own policy colleagues and departments widely enough.”

One key stakeholder said:

“I’m struggling to think of anything that is an actual output of the Health and Wellbeing Alliance... I can’t remember seeing anything that has been circulated.”

One policy lead felt awareness raising should start within system partner organisations before moving to focus on external agencies or organisations. Another commented that there was an issue in their organisation in people both knowing about the Health and Wellbeing Alliance and using it to its full potential, with this being largely due to their internal knowledge management processes.

Members generally reported that they did not standardly get feedback from policy leads providing detail on how their input and work had helped shape policy. This lack of feedback meant it was not always clear what the result had been and how their involvement had helped or not. As well as making it difficult for members to learn from practice, it also meant they could not feed back on results to any VCSE organisations with whom they had worked.

2.6 Value for money and additionality

As noted previously, Health and Wellbeing Alliance members tended to be positive about the work they had undertaken while feeling that longer timescales, increased funding and other aspects of best practice would improve delivery and overall effectiveness. From a policy perspective, feedback was more mixed with several examples of very positive delivery but also certain projects that were seen not to have delivered and to have created internal difficulties.

Policy leads were asked in detail around the additional value that they felt the Health and Wellbeing Alliance brought compared to alternative approaches of funding or commissioning projects, with 3 different viewpoints being expressed.

Firstly, some leads felt that the Health and Wellbeing Alliance had provided definite added value as opposed to other potential approaches. The main theme among those who felt this way was that the Health and Wellbeing Alliance provided straightforward access to a wide spread of organisations, particularly in terms of having a solid link to people with lived experience. This meant that they did not need to organise workshops or events themselves but would have confidence that these could be run sensibly and provide useful insight.

One key stakeholder said:

“[The] Health and Wellbeing Alliance adds value as brings together groups. It's that co-ordination, they know the partners that would be able to add value... the Health and Wellbeing Alliance have that experience of bringing it together and working with the voluntary sector and tapping into their experience and connection..”

One key stakeholder said:

“The Health and Wellbeing Alliance was extremely helpful in developing [a particular high-profile policy area]. Some were in there [generally], others got into detail and implementation. It was very positive from our perspective.”

Another policy lead spoke about the Health and Wellbeing Alliance providing an “entry point into what is a complex situation”, that the VCSE sector was large and diverse and hence that commissioners did not always know how best to navigate through the system. The Health and Wellbeing Alliance was seen as a more effective and efficient way of ensuring high-quality commissioning through being an established group with a set process for engagement and commissioning work.

A lesser theme was that the Health and Wellbeing Alliance provided added value through ensuring that there extra funding available for the voluntary sector at a time when they felt it was struggling. It potentially sustained organisations, although money was spread across what was felt to be a small number of organisations.

Secondly, some leads were unsure about the added value of the Health and Wellbeing Alliance, with 2 slightly different views being expressed. One view was that projects had gone at least acceptably well but they were genuinely unsure as to whether it provided value for money compared to other potential approaches. An alternative view was that the Health and Wellbeing Alliance provided finance that allowed them to commission work that they would have otherwise not been able to commission, and hence provided at least some kind of added value.

One key stakeholder said:

“We could commission it ourselves but we'd have to go through all the tendering stuff and we'd have the 28 days, the really strict criteria, tendering framework... Whereas one of the benefits of some of the current arrangements is once you've an idea and a partner you can refine it to what you wanted. It freed up that bureaucracy but then you're caught up with delays in announcements. Which would I prefer? It's too tough to call.”

One key stakeholder said:

“If I were told I have to commission from an external organisation I would probably go back to those [Health and Wellbeing Alliance] organisations because of their reach My preference would be not to be limited to the 20 Health and Wellbeing Alliance partners - there might be others that provide a cheaper service. Definitely, their reach, geography, reach across different BAME communities [is a benefit for Health and Wellbeing Alliance members]. They've built that across 2 decades.”

One view was that the VCSE sector generally was often relatively willing and ready to assist with policy questions and this goodwill meant that they could often access information without needing to work through the Health and Wellbeing Alliance processes for little benefit. This was exacerbated by the relative lack of Health and Wellbeing Alliance branding, meaning that there was no perceived benefit in being able to state that your policy had been developed in conjunction with the Health and Wellbeing Alliance.

One key stakeholder said:

“When we have a particularly tricky question we could have accessed... [the views of the VCSE sector] anyway. We'd probably be able to tap up a few leading charity areas and asked what they think.”

Finally, there was a view for some that the Health and Wellbeing Alliance did not provide added value or, for some projects, any real value at all from a policy perspective. This was either as they felt that projects had not delivered to any meaningful extent in terms of direct policy impact or that they did but that this could have been achieved without using the Health and Wellbeing Alliance.

One key stakeholder said:

“I probably would have said [if someone asked about working with the Health and Wellbeing Alliance, that] it took a lot of time and not worth energy.”

One key stakeholder said:

“[If it stopped] it would be a relief. It is not value for money. It is not well thought out... Fundamentally it is a bad idea... £2 million is a lot of money that could be used on the NHS in other ways.”

3.0 Sustainability and future development

Several Health and Wellbeing Alliance members involved in the research noted the changing health context as particularly important in potentially enabling or constraining the ability of the Health and Wellbeing Alliance to deliver positive impact, highlighting key strategic possibilities. As noted (see section 2.1.4), a minor theme in policy lead feedback was that the Health and Wellbeing Alliance membership had resulted in a spread of organisations that could meet the on-going emphasis on a more preventative as opposed to medical condition health focus.

The development of sustainable transformation partnerships (STPs) and subsequent integrated care systems (ICSs) provides opportunities for the Health and Wellbeing Alliance to leverage its voice within broader regional plans, with the rise of primary care networks (PCNs) potentially offering similar possibilities at a place-based level embedded within ICSs. The development of these systems has already led to the involvement of collaborative working across health professionals, patients and communities, potentially changing how the wider VCSE sector and patients engage with the health system.

Health and Wellbeing Alliance members felt that these new structures provided a significant opportunity to help shape the system, with considerable willingness to develop approaches and thinking in this area. For many members the key question was how this could be approached, particularly given that Health and Wellbeing Alliance members are unlikely to be able to devote considerable time to granular work at regional or sub-regional levels.

One key stakeholder said:

“There are some concerns for me, that if the Health and Wellbeing Alliance is not engaged in the design and development of the above [STPs and ICSs], then we are not targeting our resource at the parts of the system that will most affect the people we represent, but also that these new structures/approaches will suffer as a result also because they won't have really engaged in data or insights that look beyond the natural limitations of the systems knowledge and therefore as a result the system doesn't actually improve.”

This is a genuine and real question for the Health and Wellbeing Alliance itself, but also reflects, in part, the reality of the current health system. Other large-scale VCSE organisations are in a similar position, namely that they have the advantages (and disadvantages) of considerable scale but not the connections, detailed local knowledge or staffing to provide very localised input, particularly into PCNs. However, where the Health

and Wellbeing Alliance can work is to provide genuine strategic insight to help guide and develop the work of STPs and other structures across areas.

Health and Wellbeing Alliance members have spoken positively about the opportunities that this provides, while recognising that there is no clear direction for the Health and Wellbeing Alliance to take at present and no significant action underway at the time of writing. This is partly as support to STPs and ICSs is largely organised via NHS England's System Transformation Group, which does not currently have a clear link to the Health and Wellbeing Alliance. For the Health and Wellbeing Alliance, consideration must be given not just to how to potentially link to the System Transformation Group, and/or STPs and ICSs, but how best to position themselves strategically in the longer-term.

The latter raises the question of the tension between the Health and Wellbeing Alliance as an overall group and individual members of the Health and Wellbeing Alliance, and how this facilitates or obstructs input at a strategic level. In a similar situation, Health and Wellbeing Alliance members are encouraged to be involved in the work of the NHS Assembly (a collaborative approach to help deliver the Long-Term Plan, including a role for VCSE organisations) as individuals, reporting back to the Health and Wellbeing Alliance on progress.

One key stakeholder said:

“If it is going to inform national policy it must inform the national policies which are the People Plan and the Long-Term Plan. In order to represent the Health and Wellbeing Alliance it needs to have views and it needs to come together to develop views. I know individual members can deliver views, I don't know if the Health and Wellbeing Alliance is intended to represent views, has a mechanism to do so or could do.”

Finally, members expressed that they would be keen to see continuity between the end of the Health and Wellbeing Alliance programme and any successor, particularly in terms of timing; they believed that any breaks in activity could lead to established relationships being lost.

4.0 Conclusions and recommendations

Health and Wellbeing Alliance members were positive around the overall aims of the Health and Wellbeing Alliance and felt it had delivered important work, albeit recognising that it would need to continue to evolve to provide maximum value from a potentially limited budget. Members felt that the model provided considerable opportunities:

One key stakeholder said:

“[The Health and Wellbeing Alliance] is a fantastic platform for engagement and the department should be applauded for continuing with this at a time of funding cuts, when other departments have cut these platforms. It should be nurtured and developed.”

Meaningful networks have been established, the views of people with lived experience have been accessed in certain (but not all) pieces of work and fed into policy development via primary and/or secondary research and there are some examples of policy being shaped as a result. There are signs that awareness of the Health and Wellbeing Alliance could be improved among both policy leads and the wider VCSE sector.

The views of policy leads on the Health and Wellbeing Alliance was considerably more mixed than that of members. Leads generally felt the remit was sensible, welcoming the aim to improve the links between the wider sector and policy. However, there were questions as to the extent that the remit is achieved in practice. The quality of projects was felt to be mixed, being most positive where the views of people with lived experience were directly accessed and where outputs were delivered to a high standard. In the number of occasions where this was not the case, policy leads were considerably more negative, with some projects being felt to have substantially underdelivered and caused difficulties for the leads. Often this was felt to be due to constricted timelines, although there were other concerns around the ability of members to deliver to requirements, particularly for certain types of organisation in terms of scale and experience.

This represents an overall challenge to the Health and Wellbeing Alliance, with 4 particular questions being highlighted throughout the evaluation. Whether:

- a clear remit can be developed that clarifies expectations and is achievable, avoiding the Health and Wellbeing Alliance trying to be ‘all things to all people’
- an approach to timescales and funding (for example roll-over funding) can be developed which can either avoid constricted timescales or limit the extent they impact on delivery

- a clear case can be developed to show the value for money of the Health and Wellbeing Alliance as opposed to alternative funding approaches (potentially linked to ease of commissioning or providing a quality guarantee)
- the Health and Wellbeing Alliance has a distinct role in the Long-Term Plan and other NHS developments

4.1 Cross-cutting themes

A number of important themes cut across these 4 issues, as noted below:

4.1.1 Collaboration or competition

Many Health and Wellbeing Alliance members questioned the competitive approach inherent in the Health and Wellbeing Alliance, particularly in bidding for additional work. While for most members this was not necessarily problematic on an individual organisational level, it made it difficult for some to contribute and had potentially led to them (and, hence, the voice of those they were representing) being potentially side-lined. As a result, there was a general feeling that systems needed to help ensure collaborative work via a different, most collegiate approach.

Should a more co-operative approach be adopted, particularly in terms of the additional work processes, this would require consideration of how to establish a system that provided value for money without adding to overall burden among system partners. One possibility suggested was to leverage their strengths collectively via focused elements of work; for example, working collectively across the Long-Term Plan rather than potentially on different elements. This is already an aim of the Health and Wellbeing Alliance but not all members felt it was sufficient at present.

4.1.2 Primary and/or secondary research

As noted in the report, some members were relatively well set-up to access the views of people with lived experience directly, with these tending to be smaller organisations, often focusing on relatively specific thematic areas. Other organisations, often larger, were not necessarily as nimble in this way, but had the advantages of working at scale and having access to secondary research, often in-depth.

In many ways, this represents a strength of the Health and Wellbeing Alliance - that it has different members that can provide specific input in a variety of ways. Occasionally, there has been a feeling that policy leads and/or members place most emphasis on primary research, perceiving that this will clearly involve the voice of people with lived experience.

However, it is possible that this is not required and that secondary research may provide better quality in a more efficient manner than poorly designed primary research or data that simply “reinvents the wheel”.

Ensuring that both primary and secondary research is used effectively is likely to require both the original specification to make clear what is/may be required and for members themselves to justify approaches that they take. There should be an onus on proving why primary research is required, particularly given the ethical need to avoid wasting the time of people with lived experience in restating existing evidence. As secondary research is likely to be quicker and cheaper than detailed primary research, this may help in terms of timelines and free up resource for additional research or work.

4.1.3 Proactive or reactive input into policy agenda

Health and Wellbeing Alliance members generally felt that they would welcome the opportunity to have more of a proactive input into the policy agenda. This could be operationalised in 2 different ways:

Firstly, there is a potential role in setting the agenda around any particular Health and Wellbeing Alliance piece of work, providing guidance or advice to policy leads to ensure that additional work can be facilitated easily, for example on taking into account the views of people with lived experience. Secondly, there is a potential role in setting the policy agenda more widely, either informally (through ensuring a clear, consistent Health and Wellbeing Alliance viewpoint on issues) or more formally through an earlier involvement in the policy cycle. This may require consideration of where strategically to use resources, for example whether on official bodies, such as NHS Trusts, the best approach is:

- Having formal representation as Health and Wellbeing Alliance members, with set mechanisms developed so that members present can officially speak on behalf of the Health and Wellbeing Alliance (or not) as required
- Informal representation, where members are present in an informal capacity, potentially reporting back to the Health and Wellbeing Alliance on progress

While the former has benefits in terms of allowing a strong Health and Wellbeing Alliance view to be expressed, it is likely to raise questions in terms of the extent that members can provide their own views and how this can be resourced both financially and in terms of time.

4.2 Secondary learning points

In addition, there are several individual learning points that may help develop the work of the Health and Wellbeing Alliance further, should developments be required. These include the need to:

- ensure any thematic gaps are covered either via potential new members (albeit that this would need to be carefully managed) or, potentially temporarily, via larger, umbrella Health and Wellbeing Alliance members
- ensure clear processes and systems in place to minimise the learning curve faced by any new members
- establish clear feedback loops, led by clear feedback from policy leads that can be cascaded to Health and Wellbeing Alliance members and VCSE organisations as required
- streamline internal monitoring and reporting systems as much as possible to ensure proportionate with overall resources for elements of work

5.0 Appendix 1: core work

The following provides an outline of the Health and Wellbeing Alliance core work requirements:

Supporting the Health and Wellbeing Alliance

- Representing and promoting the Health and Wellbeing Alliance across the health and care system and VCSE sector
- Acting as a focal point for VCSE sector organisations (relevant to the community/communities that the member represents) to raise awareness of issues and feed information into system partners
- Participate in quarterly Health and Wellbeing Alliance working days, sub-groups on key thematic issues (for example inclusion) and online discussions as required.
- Representing the Health and Wellbeing Alliance at events, meetings and conferences – travel and subsistence costs are part of your core work funding.
- Supporting the system to maximise the transfer of learning from the projects delivered through the Health and Wellbeing Fund
- Input into the evaluation of the programme (which is externally led)

Sharing information across the VCSE sector/communities

- Cascading health and public health announcements and information to key networks and communities
- Ensuring the VCSE sector are aware of key developments within health and care, and are able to respond appropriately

Gathering information and insight from the VCSE sector

- Facilitating input from the VCSE sector on different aspects of policy, such as asking for their feedback on general or specific questions
- Gathering intelligence from the sector or specific communities, sharing emerging evidence, for instance on:
 - areas of good practice and effective interventions to prevent or improve health inequalities

- trends or areas of concern from the VCSE sector to ensure that these are escalated as appropriate.

Providing advice and support to policy leads and groups

- Engaging directly with policy teams, supporting the development of new policies by providing insight and advice on behalf of the wider networks
- Providing VCSE Health and Wellbeing Alliance representation on relevant committees and working groups for example, the Equality and Diversity Council, Empowering People and Communities Taskforce and so on.

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