HEALTHY COMMISSIONING

How the Social Value Act is being used by Clinical Commissioning Groups

Social Enterprise UK

National Voices

ACKNOWLEDGEMENTS

This report was written by James Butler from Social Enterprise UK and Don Redding from National Voices.

Hannah West from National Voices greatly assisted with the research, and Nancy Towers from Social Enterprise UK added hugely to the process. Additional content and copy-editing supplied by Nick Temple from Social Enterprise UK.

We would like to thank the individuals from Clinical Commissioning Groups, Commissioning Support Units and procurement consortiums who responded to the Freedom of Information requests. Overwhelmingly, they went beyond what they were statutorily required to do when providing answers.

We hope that commissioners in the NHS find this report interesting and an accurate reflection of the difficult and important work that they do, in very challenging circumstances.

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FOREWORD

I think I am right in suggesting that this is the first time anyone has put a lens to Clinical Commissioning Groups to see whether, and how, they are applying the Public Services (Social Value) Act 2012.

Whilst far from the only piece of legislation that affects commissioning in the public sector, the Social Value Act is a useful tool to help commissioners get more value for money out of procurement, and encourages commissioners to talk to their local provider market or community to design better services and find new and innovative solutions to difficult problems.

Clinical Commissioning Groups are responsible for around two-thirds of the total NHS England budget, £71.9 billion in 2016/17. Those outside the NHS have a right to demand that this money is spent as effectively as it can be. Those inside the NHS have an obligation to apply the Social Value Act not just because it is a legal duty, but because effective use of the Act should result in better health outcomes.

Social Enterprise UK and National Voices have brought their considerable knowledge of social value and the NHS to bear on the work and the report makes for compelling, if frustrating, reading. The findings will not come as a surprise to anyone familiar with the NHS: use of the Social Value Act in the NHS is limited.

While most commissioners, and their support units, have adopted formal policies, only a small percentage are proactive, creative users of the Act's enabling principle – that commissioners, in exercising their functions, can consider and incentivise their providers to deliver economic, environmental and social benefits to the local area.

What is clear is that we need a stronger Social Value Act, stronger guidance and more best practice examples to inspire commissioners. I welcome the national level work that the NHS Sustainable Development Unit has done to promote the Act, but I retain a healthy scepticism about how much of their excellent work filters down.

CCG Boards and their local partners could, and should, be much bolder in creating a vision of what they want their local healthcare economy to look like. Public bodies have the power to shape the markets in which they operate. Local Authorities like Preston, Croydon and Salford are using the power of procurement to do exactly this – CCGs should follow their lead.

But we in the Voluntary, Community and Social Enterprise movements need to take our fair share of responsibility. Too often we are content to be the optional extra, the nice to have, or the squeaky wheel which requires a bit of attention now and again to shut us up. We have been far too reticent in stating our worth to the system, and we need to work harder to demonstrate that we can, at scale, deliver better services with greater local benefits at, or near, the price that in-house or for-profit providers can.

Those of us who work closely with the NHS know that commissioning is a constantly moving target. Sustainability and Transformation Plans (STPs) were published during the writing of the report and the intention of NHS England's latest plan[1] appears to be to blur the boundaries of the purchaser-provider split, changing the role of commissioners once more. This report briefly touches on mentions of social value in these area plans and finds a remarkably similar picture to that painted by CCGs. There is new work to be done by the NHS both nationally and regionally to understand and demonstrate how Social Value principles can be embedded in this fast evolving system.

Lord Victor Adebowale CBE, Chair, Social Enterprise UK

1 *Next Steps on the NHS Five Year Forward View*, NHS England, March 2017

EXECUTIVE SUMMARY

Social Value refers to wider financial and non-financial impacts of programmes, organisations and interventions, including the wellbeing of individuals and communities, social capital and the environment. The Social Value Act requires those who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commissioners start the procurement process, the Social Value Act requires them to think about how the services they are going to buy, or the procurement process they are going to use to buy them, could secure the most valuable benefits for their area. Consideration of Social Value complements and contributes good commissioning.

Reviews of the Social Value Act have suggested that it is not widely used in the NHS. Social Enterprise UK and National Voices decided to test this assumption by using a Freedom of Information request to gather information on how the 209[2] Clinical Commissioning Groups (and their commissioning support units) are using the Act.

The Five Year Forward View that set the direction for current NHS reforms seeks to safeguard the sustainability of health services in part by establishing new relationships with people and communities. A series of in-depth reviews have recommended much greater use of the Social Value Act as one tool to enable these relationships.

Our assessment of CCGs' state of readiness with regard to the Social Value Act is, therefore, a significant measure of capability for achieving the system's stated vision and goals.

As the key findings below show, we found that, compared to local authorities[3], CCGs' use of the Social Value Act is limited, even though awareness of it is high. Only a small percentage of Clinical Commissioning Groups apply the Act actively and assertively. Good practice does not extend much beyond areas which have historically demonstrated partnership working, or those areas which have benefited from programmes designed to support social value commissioning.

It appears to be the case that the Act is used predominantly at the pre-commissioning stage, in service design. This is a perfectly legitimate use of the Act (indeed, some would say this is its most appropriate use); but it does mean that it is harder to demonstrate cause and effect between the Act and the outcome for the service.

2 At the time of the FOI request. Further merger and reorganisation activity has taken place among CCGs since then.

3 *Procuring for Good*, Social Enterprise UK, 2016

Where there is social value weighting in a procurement, it is typically low. This suggests a certain apprehension about using the Act, or that social value has a low priority compared to other factors.

CCGs' appreciation of what social value can be used to achieve focuses on the 'social' dimension. In common with much of the rest of the public sector, social value tends to be seen as a way that small, local, often BAME or voluntary sector providers can be supported. This is a relatively conservative approach. The Act could be used more fundamentally to shape the nature of local healthcare economies. The NHS could learn much from some of the progressive local authorities in this respect.

Key findings

- 57% of CCGs claim that they have a social value policy, reference social value in one or more of their procurement policies, are developing/reviewing their procurement policies or adhere to the principles of the Act in commissioning (CCGs' ability to demonstrate this was, however, limited).

- The remaining 43% of our respondents either had no policy; were not aware of a policy; or had a policy in some stage of development.

- Just 25 CCGs (13%) demonstrated what we define as 'highly committed, evidenced and active' use of the Act. Of these, the majority weighted (or had pass/fail questions) for social value in their tender evaluations.

- Weighting procurement for social value, even amongst the most highly committed CCGs, is limited and low. A pass/fail question or a weighting of 2% of the total evaluation was common.

- Strikingly, there appear to be few procurement exercises per year in most CCGs. Most reported one or two, while many reported none.

- Use and application of the Social Value Act varies by geography. Some areas seem to have much greater understanding and use of the Act than others.

- We also found that 13% of Sustainability and Transformation Plans mention social value.

Recommendations

1. In line with the *VCSE Review*, the *Realising the Value* recommendations and the *Actions for delivering* Chapter 2 of the *NHS Five Year Forward View*, we recommend that every Clinical Commissioning Group should be mandated to have a social value policy by NHS England and the Department of Health; and that Social Value is further built into the Right Care programme, a value-based offer that assists CCGs with their patient pathway commissioning.

2. Social value has a significant role to play in the joint working needed to allow STPs to succeed: every STP should have a social value strategy, outlining its plans in relation to the Act.

3. The Department of Health, NHS England, NHS Improvement, and Public Health England should disseminate and promote good practice, and champion leading practice in particular areas. They should lead by demonstrating their own commitment as public bodies.

4. The Department of Health, NHS England, NHS Improvement, and Public Health England should work with the Inclusive Economy Unit to draft stronger and clearer guidance for the healthcare system in relation to social value.

5. Clinical Commissioning Groups should enact the principles of the Social Value Act to goods and works that they buy, as well as services being commissioned, and that the Social Value Act is strengthened to that effect.

Future context

The future of commissioning in health is uncertain due to new developments that may either blur or even end the 'purchaser-provider split'.

Thus there is a paradox, that for the first time in its history the NHS has a vision and goals for bringing the contributions of community groups and organisations into the mainstream of care, as an essential component of sustainable healthcare – and yet the responsibility for enabling this has never been more obscure and confused.

As Lord Adebowale notes, new work is needed on how to translate the duty, principles and mechanisms of the Social Value Act into this emerging context.

INTRODUCTION

There has been little research on how extensively the Social Value Act is used in the NHS. Given the local focus of the Act, this research seeks to explore the issue with reference to Clinical Commissioning Groups' activity.

In February 2017 the then Minister for Civil Society announced a review of "the progress of the Social Value Act" [4]. We hope that this research will help to inform any such review under the new administration.

209 Clinical Commissioning Groups (CCGs) are responsible for around two-thirds of the total NHS England budget, or £71.9 billion in 2016/17.[5] Led by an elected governing body formed of GPs, clinicians and lay members they commission mental health services, urgent and emergency care, elective hospital service and community care. How effectively they spend that money is self-evidently important and matters to each and every one of us who relies on the NHS.

CCGs vary enormously in size – research by the HSJ in 2013 indicated a hundred-fold variation in workforce size[6] and so one may assume that commissioning experience within CCGs is equally variable. However, the burden of commissioning healthcare does not fall solely on the shoulders of CCGs. Commissioning Support Units (CSUs), procured through the NHS England Lead Provider Framework, provide support and services – including, notably, procurement support – to those CCGs that choose to use them.

Research is inevitably a snapshot in time. What is true now will have changed in a few years in most of the public sector. This is doubly so in terms of the NHS which has been subject to successive waves of change. For nearly 30 years, the trend has been to introduce diversity, choice and competition in the NHS, including by separating the purchasing of services from their provision so that commissioners can make a market. The CCG commissioning system was introduced in 2013 by the Health and Social Care Act 2012 to give clinicians the power to change services, and to make this happen in every local area.

As this report goes to print there are increasing signals that this form of commissioning may now be on the wane (see page 12 on the emerging context) and the NHS's focus on different structural approaches continues to evolve. However, regardless of the exact shape of the NHS in years to come, it is also clear that the need for integration, prevention, more joined-up working and maximising value from existing spend remains constant. Social value principles will become more, not less important to sustainable healthcare. The question that underlies this research – how to promote and enable greater use of the Act's principles in the redesign of services and support – will remain significant.

4 Announcement at the UK Social Value Summit, reported in Civil Society News, 10th February 2017 https://www.civilsociety.co.uk/news/minister-announces-review-of-social-value-act.html?utm_source=LINX+458+-+16+February&utm_campaign=LINX458&utm_medium=email
5 https://www.nhscc.org/ccgs/
6 https://www.hsj.co.uk/topics/workforce/revealed-the-100-fold-variation-in-ccg-workforce-size/5059624.article

WHAT IS THE SOCIAL VALUE ACT AND WHAT IS THE NHS RESPONSE?

"In the last few months [we have] seen an increased focus on Social Value from CCGs because of greater awareness of the wider financial and social benefits it can bring, and it has now become part of [our] standard questions." – response from a company providing procurement support services to CCGs

'The Social Value Act asks commissioners to think about securing extra benefits for their area when they are buying services. Before they start procurement, commissioners should think about how the services they are going to buy, or the procurement process they are going to use to buy them, could secure the most valuable benefits for their area. '

'The Act asks commissioners to consider social value.'

'To comply with the letter of the Act, commissioners therefore only need to show that they have thought about these issues and have thought about whether they should consult on them. They can show this by documenting the internal process that took place to come to a decision on these issues, or by evidencing that they have spoken to their local provider market, service users, or community about them.'

Social Value Act Review, 2015

The Public Services Social Value Act 2012 emerged from a private member's bill, was accepted by Government, and has been supported by all the main political parties. It has simple provisions. In short, commissioners of local services are given a duty to consider how their actions contribute to social, economic and environmental benefits within their local area.

The Act was a response to the risk of competitive tendering excluding these forms of value; and as a potential route for more providers to be commissioned who were local, smaller, community based, and/or engaged in social enterprise or not-for-profit activities. The Act applies to procurements above the European Union's OJEU threshold, but there is nothing to prevent commissioners weighing the same considerations in smaller procurements.

When Lord Young published a review of the workings of the Act in 2015 it appeared that take-up within healthcare was very low[7]. The review resolved to work with the NHS's Sustainable Development Unit (working to NHS England and Public Health England) to promote it further.

[7] Social Value Act Review, Cabinet Office, 2015

As a result, social value has become an integral element in the NHS Standard Contract, which must be used by CCGs where they wish to contract for NHS-funded healthcare services, regardless of contract or value. Service Condition 18 of the contract, Sustainable Development, stresses that the Provider must give due regard to the impact of its expenditure on the community, over and above the direct purchase of goods and services, as envisaged by the Public Services (Social Value) Act 2012.

The Sustainable Development Unit (SDU) has created a learning module for commissioners, *Creating social value*[8], and a steering group is collecting and disseminating case studies. However, the SDU itself acknowledges that "the social component of sustainable development has not always been considered."

The existing context: why should social value be important to the NHS?

In the last five years, the NHS and its system partners have set new directions of travel for health and care. Common to these is the notion that neighbourhood and community support for people to stay healthy and to manage their health and wellbeing is an essential contributor to effective and sustainable care. The voluntary, community and social enterprise (VCSE) sector should become both a partner and a source of services, support and value. Thus, the Social Value Act has the potential to be an enabling tool to achieve the goals of health service redesign.

A significant new policy drive arose through the Health and Social Care Act to develop 'integrated care' at pace and scale across England. As envisaged in the Shared Commitment of all system leading bodies, this should use person centred care as the organising principle, and bring together services and support – including non-statutory support – around the needs of people and their carers. The government continues to expect every local area to have integrated health and social care by 2020.

The *Five Year Forward View* published by NHS England in 2014, with the support of its system partners, further developed a vision for health and care built on a new relationship with people and communities, mobilising their 'renewable energy' and engagement.

8 Publication gateway ref no: 02651

As implementation of the Forward View has developed, several key reports have mapped the ways in which this vision could be realised, notably:

- An independent review of the VCSE sector in health and care, in collaboration with the Department of Health[9];
- The *Realising the Value* programme, funded by NHS England, that explored the value and effectiveness of person and community centred approaches[10];
- The *Untapped Potential* report funded by the Richmond Group of charities, that outlined the various ways in which VCSE sector groups and organisations can add value[11];
- A refresh of *NICE Guideline 44* on community engagement, which recommends using a 'family of community based interventions' to support better population health[12]; and
- A report to NHS England by its People and Communities Board on actions to deliver better engagement of people and communities[13].

These studies and guidelines have all recommended greater use of the Social Value Act in NHS commissioning as one key means to mobilise community assets for health and wellbeing.

Meanwhile, the NHS' own focus in delivering the *Five Year Forward View* has been on piloting 'new models of care' through its vanguard areas. The two types of vanguard that are focused on scaling up and improving primary and community level care – MCPs and PACS[14]– are required to take a population health approach, to engage with community assets as partners, and to develop community provision. These requirements will be reflected in the standard contracts plus local service specifications that commissioners will be expected to use to procure them.

9 *Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector*, Department of Health, 2016

10 *Realising the Value: ten actions to put people and communities at the heart of health and wellbeing*, Nesta, 2016

11 *Untapped Potential: bringing the voluntary sector's strengths to health and care transformation,* New Philanthropy Capital for the Richmond Group, 2016

12 *Community engagement: improving health and wellbeing and reducing health inequalities*, NICE Guideline 44, NICE, 2016

13 *A new relationship with people and communities: Actions for delivering Chapter 2 of the NHS Five Year Forward View*, People and Communities Board, National Voices, 2017

14 'MCP' means multispecialty community provider. MCPs scale up primary and community care and integrate it across the health, social care and VCSE sectors. 'PACS' means primary and acute care system. See https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/community-sites/ PACS have a similar mandate to MCPs but they also include (and are usually led by) the local NHS acute trust.

With these directions for the transformation of services now set, it is, therefore, important that NHS commissioners have the skills, knowledge and confidence to be able to 'commission for wellbeing', as the VCSE Review put it.

Our assessment of CCGs' state of readiness with regard to the Social Value Act is, therefore, a significant measure of capability for achieving the system's stated vision and goals.

The emerging context and the future of commissioning

Clinical Commissioning Groups remain – unless and until there is new legislation – the statutory organisations through which the NHS budget is devolved for the procurement, contracting and performance management of most local NHS services. Although they do not formally commission GP services, they have increasingly been involved in 'co-commissioning' these with NHS England's regional offices. Whether CCGs continue to be seen within the NHS as the engine for service redesign, however, is a moot point. Recent signals suggest that this form of commissioning may be waning in influence.

First, the drive for more integrated care has led to increasing interest in creating future providers that are similar to the Accountable Care Organisations that have been piloted in the United States. In these models, commissioners wrap large budgets together and commission a lead organisation (in the English context, this would usually be an NHS trust) to organise a whole system of care for a large population. Contracts tend to be outcome-based, so that responsibility for actually redesigning care, including organising other partners and providers, devolves to the ACO. Taken to its fullest extent, this effectively means that the CCG becomes a monitoring panel that judges the achievement of outcomes, rather than an active commissioner, making markets.

Second, the need to 'transform' systems of care across wide geographies has led to frustration for many stakeholders with the small size of CCGs, and their often poor fit with other geographies (such as local authority boundaries, metropolitan areas and/or acute trust catchment areas). Recently some CCGs have come forward with merger proposals that appear to be a migration back towards the preceding system of primary care trust commissioning.

Third, both integration and the Forward View have shifted the emphasis towards 'place-based' and 'whole system' approaches to reform. This requires 'shared leadership' across local systems and a collaborative approach to pooling budgets around a place. In turn, it tends to blur the formal separation of commissioners and providers as they become mutual partners in deciding how to proceed across the locality.

Finally, and perhaps most significantly, the NHS leadership (in NHS England and NHS Improvement), in pursuit of shared leadership and stronger planning, have created 44 new geographies where system leaders were required to come together to produce Sustainability and Transformation Plans (STPs) on 'footprints' that are much larger than the CCGs.

Although these plans are only voluntary mutual agreements between NHS and social care organisations, the NHS is now signalling they will become formalised through organisations with appointed leaders, staff teams, and authority to drive change. The chief executive of NHS England has said that in their most developed form, these will 'end the purchaser-provider split'.

Whose job is it to mobilise local community provision?

There is now a paradox, that for the first time in its history the NHS has a vision and goals for bringing the contributions of community groups and organisations into the mainstream of care, as an essential component of sustainable healthcare – and yet the responsibility for enabling this has never been more obscure and confused.

CCGs will continue to have a role and will remain the recognised statutory bodies for deploying the majority of the NHS' local budget. Some, however, may merge into new forms. MCPs and PACS, working on 10-15 year contracts, will be required to engage their communities and partner with community bodies and organisations for provision. Other types of accountable care organisations may be in place in various single localities, organising 'alliances' for provision. STP areas will be leaned on to be the engine of reform, but without any statutory basis and with uncertainty over their governance, accountability and ultimately, their legitimacy.

All that can be said with certainty is that social value, and the principles and mechanisms to help achieve it, will be important to any and all of these transformation methods.

METHODOLOGY

Social Enterprise UK and National Voices issued requests under the Freedom of Information Act to the 209[15] Clinical Commissioning Groups in the summer of 2016. We received 192 responses of sufficient quality to interpret, a 91% response rate.

The Social Value Act applies to the pre-commissioning stage, where commissioners are considering how to go about a redesign and procurement of services. They can then use various mechanisms within the procurement in order to evidence social value. For this reason, our questions were targeted at CCGs' procurement policies and activities.

What we asked:

1. To supply a copy of, or link to, the CCG's social value policy, strategy, framework or similar document if there is one.

2. How has the CCG applied the Public Services (Social Value) Act 2012 in its commissioning, tendering and grant making?

3. Has the CCG applied the concept of social value below the OJEU threshold for services, or for contracts other than for services?

4. The percentage and number of tenders over the past 12 months where the Public Services (Social Value) Act 2012 has been applied and social value considered (that is to say, how much use does the CCG make of the Act).

5. Where social value has been considered and is weighted in assessing tenders, what is the typical weighting for social value in the CCG's scoring across those contracts?

How we assessed:

Based on the responses we examined CCGs' commitment to considering social value, whether their responses were evidenced, and characterised their approach. We looked at whether CCGs had a standalone "social value policy, strategy, framework or similar document" and examined how embedded social value appeared to be. We then rated the CCG by commitment to social value. We asked CCGs whether they had applied the Social Value Act in their commissioning, tendering or grant making; and, whether they had applied the concept of social value below the threshold or for contracts other than services. These responses were adjudged to be evidenced or not evidenced. Finally, we asked how much use the CCG made of the Social Value Act; and, whether weighting was used in tender evaluations. We categorised CCGs as having an Active, Limited or Passive approach to considering social value.

15 There are now 207 Clinical Commissioning Groups

Using these three categories, it was possible to characterise CCGs based on their approach to social value:

Commitment	Evidenced	Approach
Highly committed	Evidenced	Active
Apparently committed	Not evidenced	Limited
Committed		Passive
Uncommitted		
Unaware		

We then looked at how the resulting groups mapped against population, running cost allowance, STP footprint, historic PCT Cluster and Commissioning Areas, and NHS England new care model vanguards.

Limitations

FOI requests

Freedom of Information requests are a blunt instrument and analysis of their responses is only ever as good as the responses received. It is somewhat likely that our findings at least partly reflect how good CCGs and CSUs are at responding to FOIs, rather than how effectively they apply the Social Value Act.

Social Value

There is limited guidance on applying social value, and great variation in how a "duty to consider" is interpreted. Our survey relies on proxy indicators for social value use and is based on interpreting responses and as such is probably an 'informed estimate' as to what is going on rather than research which can be absolutely relied upon.

'Procurement' versus 'commissioning'

One of the striking features (to us) of the responses was how little 'procurement' appeared to be being carried out by Clinical Commissioning Groups. In follow-up interviews, interviewees were much less surprised, noting that management of existing contracts with NHS services occupies much of commissioners' time.

CCGs and CSUs

Although CCGs are the statutory organisations for local healthcare commissioning and are therefore responsible for the application of relevant legislation and guidance – and for answering Freedom of Information requests – many of our respondents referred, for their answers, to the work of their support bodies, the Commissioning Support Units (CSUs).

The Health and Social Care Act 2012 established CCGS and CSUs. The CSUs' role is to support CCGS (and NHS England) in transformational commissioning functions such as service redesign, healthcare procurement, contract negotiation and monitoring.

CSUs are not limited geographically in theory, though in practice there appears to be little competition between them and they operate largely within discrete areas.

In practice, many CCGs chose not to use the service of CSUs in order to keep control of commissioning in their own hands. There were a number of mergers and closures of CSUs who did not gain enough initial business.

In 2015 NHS England created a framework for support services for CCGs. There are currently 9 organisations which are accredited to support CCGs in end-to-end commissioning: Capita Support Services; eMBED Health Consortium; NHS Arden-GEM Partnership (AGP); NHS Central Southern CSU; NHS Midlands and Lancashire CSU; NHS North East London CSU; NHS North of England CSU (NECS); NHS South and West Commissioning Support Alliance (SaWCS); NHS South East CSU; Optum.

It is possible that the quality of the responses was affected by CCGs relying on their CSUs for answers to the questions.

Judgements

Although we were led by the responses provided, we accept that our grouping of respondents according to the matrix above includes some element of subjectivity.

FINDINGS

"The CCG is currently in the process of tendering…. This service and other procured services use patient experience to influence the service redesign through significant engagement. The new model will… aim to maximise opportunities for engagement with voluntary sector, faith groups, etc., in developing wrap around services for vulnerable adults in maintaining them in their local community." – CCG response

1. Results from CCGs

Broadly, the pattern which emerges from the data is that there are 3 groups of CCGs:

The 'active, evidenced and highly committed group'

- 21% were classified as 'active' in applying social value.

The classification was applied where CCGs not only included social value in their procurement policies (or had a separate social value policy), but also provided evidence that they had considered social value in their procurement exercises.

Among these, a sub-group of 25 CCGs (13%) provided detailed and convincing evidence of their positive use of the Act. Nevertheless, even this 13% of CCGs had what might be seen to be a narrow interpretation of what social value is. This sub-group was exclusively outside London, and there appeared to be some regional clustering.

The 'limited' group

- 36% of respondents were classified as active but 'limited' in their approach.

These are CCGs whose responses indicate that they may have a policy or similar document and may be tentatively using the Social Value Act.

The 'passive and unevidenced ' group

- 43% of respondents had a passive approach to social value.

While some of them might have a written policy, these CCGs did not or could not produce evidence of using the Act, and did not seem to be actively engaged in procurement exercises.

2. CCGs and commissioning

"No. of Procurements = 0; No. where SV considered = 0; % of all procurements = 0%" – CCG response

We asked: *The percentage and number of tenders over the past 12 months where the Public Services (Social Value) Act 2012 has been applied and social value considered (that is to say, how much use does the CCG make of the Act).*

What was striking was just how little procurement was actually being done. Not only did those CCGs we classified as passive display little enthusiasm for engaging with social value, they apparently had little or no commissioning activity in the last 12 months. Of the 100 CCGs we classified as having either a limited or active approach to social value, very few had undertaken more than 10 procurement exercises in the previous 12 months.

Looking at the 'active' and 'limited' CCGs, we find that social value was considered in both Any Qualified Provider (AQP) and competitive tendering processes. In follow-up interviews, it became clear that in healthcare (unlike some other areas of public services), commissioning is not closely identified with procurement.

Unlike commissioning in local authorities, for social care or housing, for instance, in healthcare, commissioners have not seen their role as 'making a market' for provision, except in some relatively small and discrete areas of service such as those that fall within the Any Qualified Provider categories[16].

The majority of CCG activity is based around managing large, recurrent contracts with single NHS providers. Contract management is here seen as the route to service improvement, rather than service redesign and re-commissioning.

Although these standard contracts, as discussed above, include a condition on sustainable development that references social value, it is unlikely that social value considerations play a significant role in this year to year contract management. It may be the case that what we are seeing is a reflection of low commissioning activity: where it is clear a major service needs to be reconfigured, the social value manual is dusted off the shelf and used but is not part of the day-to-day CCG toolkit.

16 The Any Qualified Provider (AQP) policy was introduced in 2011 with the aim of extending choice for patients in which provider to use for certain services. It means that commissioners should bring into the market any provider that can demonstrate that it meets NHS quality standards, so that patients can choose where to go. AQP typically covers services found outside acute hospitals such as musculo-skeletal services for back and neck pain, adult hearing services in the community, continence services, diagnostic tests closer to home, wheelchair services for children, podiatry services, venous leg ulcer and wound healing and primary care psychological therapies for adults.

That Clinical Commissioning Groups relatively infrequently commission clinical services will not come as a surprise to many in the NHS. The procurement of healthcare (clinical) services is far from simple, and far from uncontroversial. It has high transactional costs, is subject to legal challenge and therefore risky, and is a very time intensive process.

Various factors will influence whether a CCG takes the decision to fully redesign a service by putting it out to competitive tender. These include:

- The confidence of the CCG (and/or its CSU) in its own capacity to conduct the redesign and to manage a procurement process;
- The objective capacity of the CCG to handle more than one or two procurements concurrently;
- The attitude of the CCG members to competitive tendering for a given service (such as whether they are willing to risk the transfer of a service to an alternative provider);
- The advice given by system leading bodies and legal opinion on whether a competitive tender is required by law.

We noted a very strong correlation between those CCGs we classified as active in procurement and those that are committed to use the Social Value Act. This in part is a limitation of our questions (or how they were understood): it is easier to demonstrate that you are using the Social Value Act if you are issuing and evaluating tenders than if you are not. But it may also reflect that there are certain CCGs – a relatively small minority – who have the confidence and determination actively to reshape services in pursuit of particular values and principles.

It could also be that a large procurement exercise encourages CCGs and CSUs to dust off their procurement manuals to explore how best to achieve the outcomes they want. 'Passive CCGs' may only be passive because they have not yet had the opportunity or need to reshape a service. We cannot know whether, given such an opportunity, they would seize upon the Social Value Act.

3. Weighting for social value; and procurement thresholds

"The CCG regards social value as a strategic consideration at the early stages of all its commissioning, and reflects this in determining its overall approach to procurement of providers for any services. It typically does not include social value within the evaluation criteria which are applied in the qualification or selection of specific providers." CCG response

"The CCG has not applied the concept of social value to below threshold contracts." CCG response

Broadly we see two approaches to considering social value in public sector commissioning.

The first explicitly attaches a weighting for social value when a tender is evaluated, alongside price and aspects of quality. This can be done by using pass/fail, within quality; or as a standalone measure, where each element is scored 1-5 and 5 will be only given where social value is demonstrated.

The second involves considering social value at the commissioning stage and constructing the tender to take into account social value; social value here is taken into account in the design of the service or perhaps the service specifications.

An intriguing picture emerges within CCGs.

CCGs we classified as **passive** tended to have very little commissioning activity and no separate social value policy. They almost exclusively said that social value was a strategic consideration at the early stage of commissioning and service design. However, for the most part, this group were unable to evidence this activity. There seemed to be a slightly theoretical air to their replies.

The passive CCGs are a problematic group for the survey. We suspect in practice that having a looming procurement exercise on the horizon may act as a driver for updating policies and considering use of the Social Value Act. They may then be 'passive' in regards to social value, but only because they have not had reason to explore its possibilities. More generally, they may be 'passive' in respect of radical service transformation, and have a less interventionist approach to improving services, preferring to improve services incrementally.

CCGs we classified as having an active or limited use of social value tended to weight, if only at a low level. Given the variety of ways that social value can be weighted, it is difficult to generalise, but a 2% of total weighting was commonly cited by CCGs.

A minority, the 13% of highly committed, evidenced and active CCGs, were significantly bolder in their weighting, citing up to 10% of the total weighting. Previous work[17] suggests that a weighting above 5% appears to make a difference to the quality of bids, and ultimately the quality of services delivered to patients.

The Social Value Act is tied to EU thresholds. However, guidance from Government has encouraged public sector commissioners to be bold and ignore these thresholds.[18]We asked CCGs about the thresholds and we see a mixed picture from those that use the Act.

Three types of response were noted: those that applied social value proportionately across all non-framework contracts; those who said their contracts were invariably above threshold (as one CCG pointedly replied "We are not a local authority you know"); and, those that said that it applied above threshold only.

It should be noted that the procurement environment in England is becoming increasingly permissive in relation to EU regulations and thresholds. This is likely to continue in the run-up to the UK's withdrawal from the European Union.

17 Feedback from the Health and Social Value Programme http://www.socialenterprise.org.uk/uploads/editor/files/HSVP_National_Event_Report_Feb2016final.pdf

18 Revised statutory Best Value Guidance.

A comparison between how some Local Authorities and the active Clinical Commissioning Groups tend to use the Social Value Act

The Social Value Act enables consideration by commissioners of three dimensions of value, in addition to value for money: economic, environmental and social benefits to the local area.

The 13% of CCGs within our 'active, evidenced and highly committed' group tend to use the Social Value Act to focus mainly on the 'social' dimension, with some additional attention to the environmental.

Their answers demonstrated concern with: engagement with the VCSE sector; equality; inclusion; smaller organisations; local providers; sustainability; and the environment. These are the elements mentioned in the Standard Condition 18, Sustainable Development, of the NHS Standard Contract.

This shows a smaller scale of ambition than in some Authorities' use of the Act[19] where there is a broad notion of what social value is, and a bold approach to using the Act.

Preston Council, for instance, drawing heavily on the 'Cleveland regeneration model', has used the Social Value Act to double its procurement spend with local companies from 14% in 2012-13 to 28% in 2014-15.

Likewise, Durham Council has recently adopted a Sustainable Procurement and Social Value Policy aimed at supporting local businesses through its procurement spend.

What Preston and Durham – and countless other councils to a lesser extent – have realised is that the money they spend gives them power to shape what their local economy looks like.

The NHS operates under a different commissioning and procurement regime to Local Authorities. Yet the point that money is power holds true; what the local healthcare economy looks like in any given area is largely a product of the operation of CCG policy over time.

With greater market-building, more thought at the pre-commissioning stage, and weighting for social value there is no reason that large 'for private profit companies' necessarily would dominate local healthcare contract-letting. To commission is to choose.

19 *Procuring for Good,* Social Enterprise UK, 2016

What does 'good' look like?

With relatively little in the way of guidance and a weak "duty to consider", the application of the Social Value Act in the NHS is extremely varied (and certainly less ambitious than in some other parts of the public sector).

However, this research provides useful information on the indicators that distinguish the more active and engaged commissioners.

First, there is clear evidence of use – it's not enough just to have a policy. Commissioners should be able to point to specific instances where they have considered social value. Where the service is tendered, CCGs can give a number or percentage of contracts where they have actively considered social value.

Second, where a service is tendered, there is evidence of weighting in the tender evaluation. Typically, this is either a pass/fail where AQP is used. Where it is not, we see a weighting of typically 1-5% of the total score, but in a few cases significantly higher (up to 30% in one case).

One might assume that Social Value is applied more where the CCG uses the AQP process. This does not seem to be the case; it appears at this stage to be impossible to generalise about where CCGs have tended to apply social value.

Not all respondents to the FOI quoted services where they had applied social value but those that did specified:

- Adult community services
- Child and Adolescent Mental Health Services
- Children's community services
- Dermatology
- Enhanced Diabetes & Specialist Podiatry
- GP Interpreting
- IAPT Data System
- Integrated Community Equipment and Wheelchairs
- Integrated Urgent Care Service
- Peer Health Champion
- Personal Health Budgets

4. Commissioning and geography

"The CCG commissions the…CSU to manage OJEU Procurements. The following question is included in Invitation to Tender documents:
"Please provide details of your sustainability and social values that will ensure that the following benefits are delivered for the population of the relevant areas:
- Social Benefits
- Economic Benefits; and
- Environmental Benefits" CCG response

Of the 25 Clinical Commissioning Groups who appear to have the most extensive use of the Social Value Act **(highly committed, evidence and active)**, there is some interesting clustering.

Using NHS Commissioning Area definitions, 13 are from the North, 7 from the Midlands and East and 5 from the South. The absence of CCGs from London on the list of active users of social value is somewhat of a puzzle given we understand that there is some good practice in the Capital, but given the limitations of the survey, it is possible to read too much into this apparent lacuna.

There is no demonstrable link between areas where NHS England's 'new models of care' are being trialled and those CCGs which seem to use the Social Value Act effectively.

When we look at who supports the active and committed CCGs we see that just 3 of the 9 organisations accredited to support CCGs crop up repeatedly: eMBED Health Consortium, NHS Arden and Greater Manchester Commissioning Support Unit and NHS South, Central and West Commissioning Support Unit. It is likely that some CSUs are more clued up than others on how to apply to Social Value Act and/or provided better or more complete initial FOI answers to their CCG.

Intriguingly, there seems to be a correlation between best practice CCGs and former PCT Clusters[20]. Of the 25 best CCGs, 15 come from just 6 former PCT Clusters. It seems unlikely that PCT Clusters, which were essentially a short-term fix to staffing crises caused by the Health and Social Care Act, really had such a long-term effect. We suspect that (if the pattern is anything more than random noise) what we are seeing is that in some areas of the country there is a history of long-term healthcare collaboration and innovation (which are the bedrocks upon which social value rests) and that this geography is reflected somewhat in the geography of former PCT

[20] https://www.england.nhs.uk/resources/ccg-directory/

Clusters. We suggest that the importance of informal relationships and trust between professionals in different organisations operating in local healthcare economies are underestimated.

5. STPs and Social Value

The 44 STPs were published whilst we were researching the way that CCGs applied the Social Value Act. We briefly reviewed the plans to see whether social value was referenced in the draft final plans. Given that STPs should rely on joint working across agencies and be actively bringing in partners from the social sector in order to ensure that they maximise what they get from spend, the Social Value Act should be one of the first things that they look at, and firmly at the centre of what they do.

Of the 44 STPs, just 6 mention social value, or 13%.

This is aesthetically pleasing given that we calculate 13% of CCGs stand out as demonstrating best practice on social value but, sadly, there seems to be no golden thread linking **active and evidenced** CCGs and the STPs which mention social value. Of course, it is possible for STPs to describe a strong and effective partnership with the VCSE sector without explicitly mentioning the Public Services (Social Value) Act 2012 and several STPs go into considerable depth about the importance of the Third Sector and how the plan is to build on already fruitful relationships.

We can draw some tentative conclusions. That only 6/44 STPs mention social value seems to suggest that innovative commissioning is not at the top of STP authors' priorities – which is a surprise. It also suggests that the Act has some cheerleaders for it within the NHS, and given how little push there has been from the centre (and understandable clinical and budget pressures) it may be realistic to expect this limited degree of traction. Whilst we should not get too fixated by the repeated figure of 13% given the limitations of a FOI survey and a brief review of STPs, it is suggestive of how far social value has come in the NHS. And how far there is to go.

CONCLUSIONS AND RECOMMENDATIONS

The NHS has appeared slow to embrace the Social Value Act. Our survey was an attempt to gather more information about the extent to which the Act has penetrated local healthcare commissioning. The Act's provisions have been written into procurement policies in many CCGs and CSUs, and into the NHS Standard Contract.

However, the evidence from our responses and from our analysis of STPs shows that only a small minority of commissioners – 13% – are highly committed and active in using the Act in the design and procurement of services. Reasons may include the lack of 'push' from the centre; the limited capacity of many smaller CCGs to undertake active procurement (and the limited confidence of others). There may also be some cultural and institutional reluctance to engage with market-based solutions, and the lack of commercial expertise in the NHS has also been widely acknowledged[21].

Yet as our introductory discussions of the context and direction of health and care demonstrate, the imperatives to understand and actively apply social value principles have grown considerably since the Act was established. There is an increasing clamour from VCSE sector organisations and other stakeholders for the Act and its principles to be given a much higher priority and emphasis in the pursuit of the Five Year Forward View.

Social Enterprise UK and National Voices offer the following recommendations for additional actions to bring this about.

1. In line with the *VCSE Review*, the *Realising the Value* recommendations and the *Actions for delivering Chapter 2 of the NHS Five Year Forward View*, we recommend that **every Clinical Commissioning Group should be mandated to have a social value policy** by NHS England and the Department of Health and that Social Value is further built into the **Right Care** programme, a value-based offer that assists CCGs with their patient pathway commissioning.

2. Social value has a significant role to play in the joint working needed to allow STPs to succeed: **every STP should have a social value strategy**, outlining its plans in relation to the Act.

21 Public Accounts Committee, 25th Report: *UnitingCare Partnership contract inquiry*, 2016

3. The Department of Health, NHS England, NHS Improvement, and Public Health England should disseminate and promote good practice, and champion leading practice in particular areas. They should lead by **demonstrating their own commitment as public bodies.**

4. The Department of Health, NHS England, NHS Improvement, and Public Health England should work with the Inclusive Economy Unit to draft **stronger and clearer guidance** for the healthcare system in relation to social value.

5. Clinical Commissioning Groups should enact the principles of the Social Value Act to **goods and works** that they buy, as well as services being commissioned, and that the Social Value Act is strengthened to that effect.

APPENDIX 1: A Brief history of NHS Commissioning

Until the publication of the NHS *Five Year Forward View* in 2014, the overarching narrative of NHS reform since at least the 1990s is one of successive attempts by politicians from both main political parties to inject competition (in various forms and for arguably different reasons) into the NHS, institutional resistance to those initiatives, followed by yet further top-down changes.

The idea of commissioning as a discrete function within the NHS dates from 1991. Before this, local health authorities organised both the planning and the delivery of services for their patients. In 1991 the Conservative government split this function by creating 'purchasers' and 'providers' in the local health system (NHS and Community Care Act 1990). It created two models of commissioning – one based on general practice (GP fundholding) and the other based on health authorities (through primary care trusts or PCTs). Both of these were brought to an end with the advent of Clinical Commissioning Groups (CCGs) in 2012-13.

GP fundholders

Under GP fundholding, GPs held real – albeit small – budgets with which they purchased primarily non-urgent elective and community care for patients. They had the right to keep any savings and the freedom to deliver new services. The aim was to give GPs a financial incentive to manage costs and to apply some competitive pressure to hospital providers. Some GP practices came together in consortia, creating larger organisations to pool financial risk and share resources. This version of fundholding was abolished in 1997 by the Labour government.

For the next seven years PCTs, were the only commissioners of healthcare. In 2004, however, the government brought back an element of GP commissioning called practice-based commissioning (PBC). PBC was not compulsory: practices that chose to participate were given an indicative budget by their PCT along with data on the volume of services their patients were using, in, for example, accident and emergency departments or as hospital inpatients. Where GPs made efficiency savings through PBC they were allowed to plough back an agreed share into developing new services.

PCTs

The health authority model meant that from 2001-13 Primary Care Trusts were responsible for commissioning primary, community and secondary health services from providers. Collectively PCTs were responsible for spending around 80% of the total NHS budget. 300 or so PCTs were created, themselves a rationalisation of the 481 Primary Care Groups which replaced GP fundholding (which was created 1991 and introduced a quasi-market for healthcare services).

As part of the NHS Plan 2000, PCGs were converted into Trusts, working under a framework set by the Department of Health and Strategic Health Authorities.

In 2005, the number of PCTs was reduced to 152, with the majority being coterminous with the local authority tier that had responsibilities for delivering social care.

The 2010 White Paper *Equity and Excellence: Liberating the NHS* ushered in significant further change, including the abolition of PCTs. In recognition that it would "not be possible to retain effective management capacity in all PCTs until their abolition… current PCTs will be retained as statutory organisations, in order not to add further to disruption from reorganisation, but there will be consolidation of management capacity, with single executive teams each managing a cluster of PCTs…. These new clusters are not statutory bodies, nor are they permanent features of the landscape, but they are necessary to sustain PCT capability and enable the creation of the new system."

PCT Clusters would "provide a mechanism to enable high quality NHS staff to move to new roles in consortia, commissioning support arrangements and the NHS Commissioning Board…" . PCTs were abolished on 31 March 2013 as part of the *Health and Social Care Act 2012.*

CCGs

The Coalition Government passed the Health and Social Care Act 2012 which abolished PCTs and created Clinical Commissioning Groups (which replaced some of the functions of PCTs) and Commissioning Support Units (which support CCGs in their commissioning and procurement function). There was substantial movement of staff from PCTs to CCGs and from PCT Clusters to Clinical Support Units (CSUs).

The 209[22] Clinical Commissioning Groups are groups of GP practices that come together to commission health services for their population. A large proportion of the NHS budget is given to NHS England and passed on to CCGs for this purpose. NHS England monitors their performance and accountabilities.

CSUs' role is to support CCGs (and NHS England) in transformational commissioning functions such as service redesign, healthcare procurement, contract negotiation and monitoring. CSUs are not limited geographically in theory, though in practice there appears to be little competition between them and they operate largely within discrete areas.

22 In April 2017, the Manchester CCGs merged, leaving 207 CCGs.

In 2015 NHS England created a framework for support services for CCGs. There are currently 9 organisations which are accredited to support CCGs in end-to-end commissioning: Capita Support Services; eMBED Health Consortium; NHS Arden-GEM Partnership (AGP); NHS Central Southern CSU; NHS Midlands and Lancashire CSU; NHS North East London CSU; NHS North of England CSU (NECS); NHS South and West Commissioning Support Alliance (SaWCS); NHS South East CSU; Optum.

STPs

The NHS *Five Year Forward View* (5YFV) 2014 perhaps represents an epistemological break with what had gone before. Written by Sir Simon Stevens, Chief Executive of NHS England, it is, in theory the only radical change to the NHS which has been authored and owned by the system itself. Relevant to this study are the Sustainability and Transformation Plans (STPs), a central plank of the 5YFV. STPs are place-based, multi-year plans built around the needs of local populations and their aim is that investment in the NHS will drive genuine and sustainable transformation. The 44 STP 'footprints' are in effect clusters of CCGs (many of STP footprints are based on county borders) and their members have been charged with the task of planning local healthcare within their geographical boundaries.

APPENDIX 2: CCG by STP footprint area

CCG	STP footprint area
NHS Airedale, Wharfedale and Craven CCG	West Yorkshire STP
NHS Ashford CCG	Kent and Medway STP
NHS Aylesbury Vale CCG	Buckinghamshire, Oxfordshire. Berkshire West STP
NHS Barking and Dagenham CCG	North East London STP
NHS Barnet CCG	North Central STP
NHS Barnsley CCG	South Yorkshire and Bassetlaw STP
NHS Basildon and Brentwood CCG	Mid and South Essex STP
NHS Bassetlaw CCG	South Yorkshire and Bassetlaw STP
NHS Bath and North East Somerset CCG	Bath, Swindon and Wiltshire STP
NHS Bedfordshire CCG	Milton Keyes, Bedfordshire and Luton STP
NHS Bexley CCG	South East London STP
NHS Birmingham Crosscity CCG	Birmingham and Solihull STP
NHS Birmingham South and Central CCG	Birmingham and Solihull STP
NHS Blackburn with Darwen CCG	Lancashire & South Cumbria STP
NHS Blackpool CCG	Lancashire & South Cumbria STP
NHS Bolton CCG	Greater Manchester STP
NHS Bracknell and Ascot CCG	Frimley Health STP
NHS Bradford City CCG	West Yorkshire STP
NHS Bradford Districts CCG	West Yorkshire STP
NHS Brent CCG	North West London STP
NHS Brighton and Hove CCG	Sussex and East Surrey STP
NHS Bristol CCG	Bristol, North Somerset and South Gloucestershire STP
NHS Bromley CCG	South East London STP
NHS Bury CCG	Greater Manchester STP
NHS Calderdale CCG	West Yorkshire STP
NHS Cambridgeshire and Peterborough CCG	Cambridgeshire and Peterborough STP
NHS Camden CCG	North Central STP
NHS Cannock Chase CCG	Staffordshire STP
NHS Canterbury and Coastal CCG	Kent and Medway STP
NHS Castle Point and Rochford CCG	Mid and South Essex STP
NHS Central London (Westminster) CCG	North West London STP
NHS Central Manchester CCG	Greater Manchester STP

CCG	STP footprint area
NHS Chiltern CCG	Buckinghamshire, Oxfordshire. Berkshire West STP
NHS Chorley and South Ribble CCG	Lancashire & South Cumbria STP
NHS City and Hackney CCG	North East London STP
NHS Coastal West Sussex CCG	Sussex and East Surrey STP
NHS Corby CCG	Northamptonshire STP
NHS Coventry and Rugby CCG	Coventry and Warwickshire STP
NHS Crawley CCG	Sussex and East Surrey STP
NHS Croydon CCG	South West London STP
NHS Cumbria CCG	West, North and East Cumbria / South Lancashire & South Cumbria STP
NHS Darlington CCG	Durham, Darlington, Tees, Hambleton, Richmondshire, Whitby STP
NHS Dartford, Gravesham and Swanley CCG	Kent and Medway STP
NHS Doncaster CCG	South Yorkshire and Bassetlaw STP
NHS Dorset CCG	Dorset STP
NHS Dudley CCG	Black Country STP
NHS Durham Dales, Easington and Sedgefield CCG	Durham, Darlington, Tees, Hambleton, Richmondshire, Whitby STP
NHS Ealing CCG	North West London STP
NHS East and North Hertfordshire CCG	Hertfordshire and West Essex STP
NHS East Lancashire CCG	Lancashire & South Cumbria STP
NHS East Leicestershire and Rutland CCG	Leicester, Leicestershire and Rutland STP
NHS East Riding Of Yorkshire CCG	Humber, Coast and Vale STP
NHS East Staffordshire CCG	Staffordshire STP
NHS East Surrey CCG	Sussex and East Surrey STP
NHS Eastbourne, Hailsham and Seaford CCG	Sussex and East Surrey STP
NHS Eastern Cheshire CCG	Cheshire & Merseyside STP
NHS Enfield CCG	North Central STP
NHS Erewash CCG	Derbyshire STP
NHS Fareham and Gosport CCG	Hampshire and Isle of Wight STP
NHS Fylde & Wyre CCG	Lancashire & South Cumbria STP
NHS Gloucestershire CCG	Gloucestershire STP
NHS Great Yarmouth and Waveney CCG	Norfolk and Waveney STP
NHS Greater Huddersfield CCG	West Yorkshire STP
NHS Greater Preston CCG	Lancashire & South Cumbria STP

CCG	STP footprint area
NHS Greenwich CCG	South East London STP
NHS Guildford and Waverley CCG	Surrey Heartlands STP
NHS Halton CCG	Cheshire & Merseyside STP
NHS Hambleton, Richmondshire and Whitby CCG	Durham, Darlington, Tees, Hambleton, Richmondshire, Whitby STP
NHS Hammersmith and Fulham CCG	North West London STP
NHS Hardwick CCG	Derbyshire STP
NHS Haringey CCG	North Central STP
NHS Harrogate and Rural District CCG	West Yorkshire STP
NHS Harrow CCG	North West London STP
NHS Hartlepool and Stockton-On-Tees CCG	Durham, Darlington, Tees, Hambleton, Richmondshire, Whitby STP
NHS Hastings and Rother CCG	Sussex and East Surrey STP
NHS Havering CCG	North East London STP
NHS Herefordshire CCG	Herefordshire and Worcestershire STP
NHS Herts Valleys CCG	Hertfordshire and West Essex STP
NHS Heywood, Middleton and Rochdale CCG	Greater Manchester STP
NHS High Weald Lewes Havens CCG	Sussex and East Surrey STP
NHS Hillingdon CCG	North West London STP
NHS Horsham and Mid Sussex CCG	Sussex and East Surrey STP
NHS Hounslow CCG	North West London STP
NHS Hull CCG	Humber, Coast and Vale STP
NHS Ipswich and East Suffolk CCG	Suffolk and North East Essex STP
NHS Isle Of Wight CCG	Hampshire and the Isle of Wight STP
NHS Islington CCG	North Central STP
NHS Kernow CCG	Cornwall and Isles of Scilly STP
NHS Kingston CCG	South West London STP
NHS Knowsley CCG	Cheshire & Merseyside STP
NHS Lambeth CCG	South East London STP
NHS Lancashire North CCG	Lancashire & South Cumbria STP
NHS Leeds North CCG	West Yorkshire STP
NHS Leeds South and East CCG	West Yorkshire STP
NHS Leeds West CCG	West Yorkshire STP
NHS Leicester City CCG	Leicester, Leicestershire and Rutland STP
NHS Lewisham CCG	South East London STP
NHS Lincolnshire East CCG	Lincolnshire STP
NHS Lincolnshire West CCG	Lincolnshire STP

CCG	STP footprint area
NHS Liverpool CCG	Cheshire & Merseyside STP
NHS Luton CCG	Milton Keyes, Bedfordshire and Luton STP
NHS Mansfield and Ashfield CCG	Nottinghamshire STP
NHS Medway CCG	Kent and Medway STP
NHS Merton CCG	South West London STP
NHS Mid Essex CCG	Mid and South Essex STP
NHS Milton Keynes CCG	Milton Keyes, Bedfordshire and Luton STP
NHS Nene CCG	Northamptonshire STP
NHS Newark & Sherwood CCG	Nottinghamshire STP
NHS Newbury and District CCG	Buckinghamshire, Oxfordshire. Berkshire West STP
NHS Newcastle Gateshead CCG	Northumberland, Tyne and Wear STP
NHS Newham CCG	North East London STP
NHS North & West Reading CCG	Buckinghamshire, Oxfordshire. Berkshire West STP
NHS North Derbyshire CCG	Derbyshire STP
NHS North Durham CCG	Durham, Darlington, Tees, Hambleton, Richmondshire, Whitby STP
NHS North East Essex CCG	Suffolk and North East Essex STP
NHS North East Hampshire and Farnham CCG	Frimley Health STP / Hampshire and Isle of Wight STP
NHS North East Lincolnshire CCG	Humber, Coast and Vale STP
NHS North Hampshire CCG	Hampshire and Isle of Wight STP
NHS North Kirklees CCG	West Yorkshire STP
NHS North Lincolnshire CCG	Humber, Coast and Vale STP
NHS North Manchester CCG	Greater Manchester STP
NHS North Norfolk CCG	Norfolk and Waveney STP
NHS North Somerset CCG	Bristol, North Somerset and South Gloucestershire STP
NHS North Staffordshire CCG	Staffordshire STP
NHS North Tyneside CCG	Northumberland, Tyne and Wear STP
NHS North West Surrey CCG	Surrey Heartlands STP
NHS Northern, Eastern and Western Devon CCG	Devon STP
NHS Northumberland CCG	Northumberland, Tyne and Wear STP
NHS Norwich CCG	Norfolk and Waveney STP
NHS Nottingham City CCG	Nottinghamshire STP
NHS Nottingham North and East CCG	Nottinghamshire STP

CCG	STP footprint area
NHS Nottingham West CCG	Nottinghamshire STP
NHS Oldham CCG	Greater Manchester STP
NHS Oxfordshire CCG	Buckinghamshire, Oxfordshire. Berkshire West STP
NHS Portsmouth CCG	Hampshire and Isle of Wight STP
NHS Redbridge CCG	North East London STP
NHS Redditch and Bromsgrove CCG	Herefordshire and Worcestershire STP
NHS Richmond CCG	South West London STP
NHS Rotherham CCG	South Yorkshire and Bassetlaw STP
NHS Rushcliffe CCG	Nottinghamshire STP
NHS Salford CCG	Greater Manchester STP
NHS Sandwell and West Birmingham CCG	Black Country STP
NHS Scarborough and Ryedale CCG	Humber, Coast and Vale STP
NHS Sheffield CCG	South Yorkshire and Bassetlaw STP
NHS Shropshire CCG	Shropshire Telford Wrekin STP
NHS Slough CCG	Frimley Health STP
NHS Solihull CCG	Birmingham and Solihull STP
NHS Somerset CCG	Somerset STP
NHS South Cheshire CCG	Cheshire & Merseyside STP
NHS South Devon and Torbay CCG	Devon STP
NHS South East Staffordshire and Seisdon Peninsula CCG	Staffordshire STP
NHS South Eastern Hampshire CCG	Hampshire and Isle of Wight STP
NHS South Gloucestershire CCG	Bristol, North Somerset and South Gloucestershire STP
NHS South Kent Coast CCG	Kent and Medway STP
NHS South Lincolnshire CCG	Lincolnshire STP
NHS South Manchester CCG	Greater Manchester STP
NHS South Norfolk CCG	Norfolk and Waveney STP
NHS South Reading CCG	Buckinghamshire, Oxfordshire. Berkshire West STP
NHS South Sefton CCG	Cheshire & Merseyside STP
NHS South Tees CCG	Durham, Darlington, Tees, Hambleton, Richmondshire, Whitby STP
NHS South Tyneside CCG	Northumberland, Tyne and Wear STP
NHS South Warwickshire CCG	Coventry and Warwickshire STP
NHS South West Lincolnshire CCG	Lincolnshire STP
NHS South Worcestershire CCG	Herefordshire and Worcestershire STP
NHS Southampton CCG	Hampshire and Isle of Wight STP

CCG	STP footprint area
NHS Southend CCG	Mid and South Essex STP
NHS Southern Derbyshire CCG	Derbyshire STP
NHS Southport and Formby CCG	Cheshire & Merseyside STP
NHS Southwark CCG	South East London STP
NHS St Helens CCG	Cheshire & Merseyside STP
NHS Stafford and Surrounds CCG	Staffordshire STP
NHS Stockport CCG	Greater Manchester STP
NHS Stoke On Trent CCG	Staffordshire STP
NHS Sunderland CCG	Northumberland, Tyne and Wear STP
NHS Surrey Downs CCG	Surrey Heartlands STP
NHS Surrey Heath CCG	Frimley Health STP
NHS Sutton CCG	South West London STP
NHS Swale CCG	Kent and Medway STP
NHS Swindon CCG	Bath, Swindon and Wiltshire STP
NHS Tameside and Glossop CCG	Greater Manchester STP
NHS Telford and Wrekin CCG	Shropshire Telford Wrekin STP
NHS Thanet CCG	Kent and Medway STP
NHS Thurrock CCG	Mid and South Essex STP
NHS Tower Hamlets CCG	North East London STP
NHS Trafford CCG	Greater Manchester STP
NHS Vale Of York CCG	Humber, Coast and Vale STP
NHS Vale Royal CCG	Cheshire & Merseyside STP
NHS Wakefield CCG	West Yorkshire STP
NHS Walsall CCG	Black Country STP
NHS Waltham Forest CCG	North East London STP
NHS Wandsworth CCG	South West London STP
NHS Warrington CCG	Cheshire & Merseyside STP
NHS Warwickshire North CCG	Coventry and Warwickshire STP
NHS West Cheshire CCG	Cheshire & Merseyside STP
NHS West Essex CCG	Hertfordshire and West Essex STP
NHS West Hampshire CCG	Hampshire and Isle of Wight STP
NHS West Kent CCG	Kent and Medway STP
NHS West Lancashire CCG	Lancashire & South Cumbria STP
NHS West Leicestershire CCG	Leicester, Leicestershire and Rutland STP
NHS West London (K&C & Qpp) CCG	North West London STP
NHS West Norfolk CCG	Norfolk and Waveney STP
NHS West Suffolk CCG	Suffolk and North East Essex STP
NHS Wigan Borough CCG	Greater Manchester STP

CCG	STP footprint area
NHS Wiltshire CCG	Bath, Swindon and Wiltshire STP
NHS Windsor, Ascot and Maidenhead CCG	Frimley Health STP
NHS Wirral CCG	Cheshire & Merseyside STP
NHS Wokingham CCG	Buckinghamshire, Oxfordshire. Berkshire West STP
NHS Wolverhampton CCG	Black Country STP
NHS Wyre Forest CCG	Herefordshire and Worcestershire STP

APPENDIX 3: STPs and social value

North

Footprint area	mentions social value
Cheshire and Merseyside	no
Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby	no
Greater Manchester	yes
Humber, Coast and Vale	yes
Lancashire and South Cumbria	no
Northumberland, Tyne and Wear and North Durham	no
South Yorkshire and Bassetlaw	no
West, North and East Cumbria	no
West Yorkshire and Harrogate	no

Midlands and East

Footprint area	mentions social value
Bedfordshire, Luton and Milton Keynes	no
Birmingham and Solihull	no
Cambridgeshire and Peterborough	no
Coventry and Warwickshire	no
Derbyshire	no
Herefordshire and Worcestershire	no
Hertfordshire and West Essex	no
Leicester, Leicestershire and Rutland	no
Lincolnshire	no
Mid and South Essex	no
Norfolk and Waveney	no
Northamptonshire	yes
Nottinghamshire	yes
Shropshire and Telford & Wrekin	no
Staffordshire and Stoke on Trent	no
Suffolk and North East Essex	no
The Black Country	no

London

Footprint area	mentions social value
North Central London	yes
North East London	no
North West London	yes
South East London	no
South West London	no

South

Footprint area	mentions social value
Bath and North East Somerset, Swindon and Wiltshire	no
Bristol, North Somerset and South Gloucestershire	no
Buckinghamshire, Oxfordshire and Berkshire West	no
Cornwall and the Isles of Scilly	no
Devon	no
Dorset	no
Frimley Health	no
Gloucestershire	no
Hampshire and the Isle of Wight	no
Kent & Medway	no
Somerset	no
Surrey Heartlands	no
Sussex and East Surrey	no

Social Enterprise UK

We are the national body for social enterprise. We are a membership organisation. We offer business support, do research, develop policy, campaign, build networks, share knowledge and understanding, and raise awareness of social enterprise and what it can achieve.

We also provide training and consultancy for clients of all kinds, including local authorities. Our members come from across the social enterprise movement – from local grassroots organisations to multi-million pound businesses, as well as the private and public sectors. Together with our members we are the voice for social enterprise.

We believe that social enterprise is our best chance of creating a fairer world and protecting the planet.

www.socialenterprise.org.uk
@SocialEnt_UK

National Voices

National Voices is the coalition of charities that stands for people being in control of their health and care. We work for a strong patient and citizen voice and services built around people. We stand up for voluntary organisations and their vital work for people's health and care.

We have more than 140 charity members and 20 professional and associate members. Our membership covers a diverse range of conditions and communities and connects with the experiences of millions of people.

www.nationalvoices.org.uk

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