REPORT

Centre for Mental Health

Arm in arm

The relationships between statutory and voluntary sector mental health organisations

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Association of Mental Health Providers

Contents

Acknowledgements

We would like to thank the Association of Mental Health Providers for commissioning this project, and the commissioners and VCSE leaders who spoke to us to share their experiences, insights and views.

Foreword from Association of Mental Health Providers

Around 1.5 million people access CCG commissioned mental health support from the voluntary and community sector each year, making it the largest forum of provision. This figure, based on the NHS Benchmarking Network's review of community mental health service provision (2018), shows the extent of the role of the sector in the delivery of services, but is still lower than reality as we do not have data from across all CCGs or meaningful data from local authorities. We believe the scale and contribution of the sector, which is diverse and vast in its complexity, range, and reach, is still not fully understood, but it is essential that the knowledge, expertise, and real strength of the sector is realised and utilised.

As the only national representative body focusing solely on the voluntary and community sector mental health service providers, we are dedicated to supporting the development of the sector and its essential role in effectively meeting the needs of individuals, their mental health and wellbeing. We do this through three key areas of work: ensuring the sustainability and growth of the sector; encouraging coordinated planning to provide joined-up care; and promoting wellness and good mental health with a consideration of the wider determinants to prevent mental ill-health.

We are aware of many excellent commissioning practices, collaborations, and positive relationships between the VCSE sector and statutory bodies that commission them. However, for us, our members, and the wider VCSE mental health sector, there are also several concerns for the sustainability of the sector including reduced access to services people want and need; the impact on the future of health and social care when not giving the true emphasis on the VCSE sector as a planning and delivery partner; commissioning decisions resulting in viability issues leading to a potential decline in the quality of VCSE services; a workforce drain; and the decommissioning of services.

Our members have told us of the real challenges to achieving a whole-system, whole-sector approach to delivering better mental health services at the national, regional and local level, which is why we believe it is so important to understand the experiences of VCSE providers.

This scoping document, which we have commissioned Centre for Mental Health to undertake – focusing on concerns regarding commissioning practices from a VCSE provider and commissioner perspective – builds a picture of the current situation and forms an element of our wider work and campaign on long-term sustainability of the sector. It shows the critical issues that our members and the wider VCSE sector are facing, which, if not dealt with, will only create more risk for the sector and have a catastrophic impact.

Kathy Roberts

Chief Executive
Association of Mental Health Providers

Executive summary

Voluntary, community and social enterprise (VCSE) organisations play a crucial part in supporting people's mental health in communities across the country.

Many VCSE organisations rely on funding from statutory bodies to enable them to work. This small scoping study seeks to understand some of the relationships between VCSE organisations and the statutory bodies that commission services from them.

VCSE organisations can offer support that is distinctive and often complementary to what statutory bodies provide for people's mental health. They are perceived by health and local authority commissioners as taking a holistic view of people's needs, focusing on their strengths and aspirations and being less constrained by clinical thresholds.

However, current commissioning processes and requirements can limit the ability of VCSE organisations to be innovative or work in person-centred ways.

The most widely recognised risks for VCSE organisations and commissioners were financial. These included:

- Reduced funding from local government, which has created greater reliance on NHS commissioning and philanthropic funding
- The practice of 'more for less' contracts, in which commissioners seek the same levels of service but for less money than before
- Short-term or rolling contracts that leave VCSE organisations with very little certainty about the near future
- Framework agreements and contracts, which are experienced as unfair, inefficient, overly complex and insecure
- Unpredictable and delayed decision-making by commissioners
- National policy decisions that can have unexpected effects on local decision-making: for example the Mental Health Investment Standard and the development of Integrated Care Systems.

The commissioners we spoke to had a very strong sense of their role in facilitating the involvement of VCSE organisations in local services.

Good relationships between statutory commissioners and VCSE providers could be supported by collaboration between them, partnership working among providers, inclusive decision-making (including people who use services) and taking a whole system approach. But they could be undermined by changing structures in the statutory sector which can disrupt working relationships, delay contracts and undermine agreed strategies.

Longer term funding was identified by some participants as helpful to reduce the risk to VCSE organisations. But for others, long contracts could exclude them from having the capacity to bid for work, to work flexibly and to respond to changing needs.

Competition between providers was a major concern for all participants. It reduces collaboration between organisations that should be working together; it limits the ability of organisations to share knowledge and expertise; and it can lead to some, mostly smaller, VCSE organisations going out of business altogether.

The ways VCSE organisations are held to account by commissioners and measure their outcomes are problematic in many areas. However, some commissioners had found ways of understanding and evaluating the impact of VCSE organisations to create a more level playing field with statutory and private sector providers.

1. Introduction

Voluntary, community and social enterprise (VCSE) organisations play a crucial part in supporting people's mental health in communities across the country. The NHS Long Term Plan (2019) presents an ambition for VCSE organisations to play a significant role in health care provision. Whether participating in 'Integrated Care Systems' (ICSs), working alongside primary care networks, or expanding coverage of alternative forms of crisis support 'arm in arm' with the NHS, VCSE organisations are expected to make an important future contribution to integrating mental health and social care. In this context, Centre for Mental Health set out to explore the dynamics of VCSE commissioning.

The sector represents a diverse range of organisations and groups, ranging from large national organisations and networks to small user- and community-led groups in local areas, providing support ranging from mental health promotion and early intervention to long-term support for people with multiple and complex needs.

The relationships VCSE organisations have with statutory bodies in the areas they work are similarly diverse. Many VCSE organisations rely on funding from statutory bodies to enable them to work. This small scoping study seeks to understand the relationships between VCSE organisations and the statutory bodies that commission services from them.

Centre for Mental Health spoke with a sample of leaders from a range of VCSE organisations and commissioners from the NHS and local government (or both) to understand their experiences of the relationships between them. We also drew on the results of a survey of the Association's members carried out prior to starting this project. We set out to gauge whether and how VCSE organisations add value in local areas, how they are commissioned by local councils and NHS bodies, what the barriers and facilitators are for effective commissioning, and how both parties monitor and assess the impact VCSE organisations make.

This is not an exhaustive survey. It seeks to raise a number of questions and issues about the relationships between VCSE and statutory organisations in supporting people's mental health and wellbeing. Many of these will require investigation in greater depth and further consideration to develop policy and practice changes where these are needed.

2. The value of VCSE organisations

All of the commissioners and providers we spoke to were able to identify numerous ways in which VCSE organisations offer support that is distinctive to what statutory bodies provide for people's mental health. Many described VCSE organisations as being more able to act quickly and try new approaches. They were felt to be more values-led, less rule-bound and more able to take certain types of risk, for example in trying new (predominantly non-clinical) approaches to meeting people's needs. Participants noted that while VCSE services are not necessarily better than those offered by other organisations, they do have a distinctive role in local systems that complements what statutory bodies provide to people directly.

One commissioner said that the VCSE organisations they worked with took "a holistic approach, engaging and supporting people with a wide variety of needs, aspirations and ambitions". A VCSE leader remarked that "we are not there to see someone through a clinical lens; we are there to support them with living their life". Their view was that this coexisted with the role of the NHS in keeping people 'safe and well', rather than conflicting with it.

Respondents commented that VCSE organisations often had a keener sense of gaps in existing services, particularly organisations that emerged from communities and user groups and that had an advocacy as well as service provision role. The sector was seen by both commissioners and leaders as an ally for communities and service users, working 'arm-in-arm' with individuals and offering a more appealing 'front door' than formal services. Commissioners welcomed the way VCSE organisations 'engage people as people', taking a more holistic view of someone's needs, focusing on their strengths rather than problems and not being bound by clinical thresholds. Understanding and responding to the changes that service users want to see in their own lives can be difficult for any provider of mental health support (Crawford *et al.*, 2011). Trusting, open relationships between service users and VCSE organisations can be an asset in overcoming this challenge, offering a complementary style of support alongside the vital work of NHS organisations in providing clinical care and safety.

Participants also felt that VCSE organisations were able to be more flexible in the development of their workforce – for example in recruiting peer support workers – and as a result their workforce could be more diverse and less traditional in the mix of skills on offer.

One commissioner pointed out that mental health was 'contested ground' where a range of different and often conflicting perspectives were present; in their experience, VCSE organisations were more effective in engaging people statutory services regarded as 'hard to reach' or wrote off as 'treatment resistant'. In so doing, VCSE organisations were able gradually to shift the culture in statutory services by demonstrating success in engaging people in such circumstances. This was noted by several participants who saw particular advantages in VCSE organisations employing peer workers, giving them a stronger platform to offer an independent, critical view of services and reducing the risk of being "line managed by someone who has previously restrained you".

One participant also noted that VCSE organisations may have a particular role with groups and communities that have negative experiences of statutory services and don't trust 'the authorities'.

3. Barriers and limitations

Participants were able to give clear examples of the difference VCSE providers could make to a wide range of services from their experience. But there were important nuances and qualifications too. One commissioner, for example, told us that they found VCSE organisations were most likely to be innovative before they had been commissioned – that once they became a part of their local system, their capacity to innovate further was more limited.

The commissioners we spoke to emphasised that spending public money by necessity required caution and some level of assurance that it would be spent wisely in a well governed organisation. This can reduce the scope for innovation and make it particularly difficult to commission smaller organisations that lack the internal governance systems, quality assurance, training and supervision infrastructure that larger charities often possess. This can disadvantage the most marginalised and poorly served communities that smaller organisations engage most effectively.

The extent to which VCSE organisations can influence mainstream practice can also be affected by the context they are working in. One VCSE leader described a community rehabilitation service which they led and which included an NHS provider bringing in clinical expertise. The service was managed by the VCSE partner, with the clinical lead (a psychologist) embedded in the service, and it had a strong recovery focus. They observed that this gave it a very different feel to other services and that this was beginning to influence the wider system around it. By contrast, when the same organisation seconded its staff into the NHS, they had much less influence as a much smaller part of a large service.

Another VCSE leader noted that working with NHS bodies made it difficult "not to become 'NHS-lite'", especially when they recruit clinical staff and have to work through formal reporting and monitoring systems. This can lead to a loss of the distinctive identity that created the VCSE organisation in the first place and made it so valuable a part of its local system. And it was also noted that statutory mental health services are working under such pressure, managing very high levels of risk with limited resources, that it was difficult to carve out spaces for innovative practice together.

Several participants noted that when VCSE organisations are included within a partnership, their ability to influence its direction, culture and practice was variable. Simply being involved in a contract isn't enough unless they are also involved in decision-making. One described decisions being made at levels where they were not present, both within provider partnerships and commissioning organisations.

4. Risks and vulnerabilities

Despite having clear strengths and distinctive roles, VCSE organisations also face a number of significant risks and vulnerabilities in their interactions with statutory bodies. As with the strengths noted above, there was broad agreement between commissioners and sector leaders in their understanding of these risks.

Financial risk was noted to be a major risk to the sustainability of VCSE organisations. The ways in which statutory funding is made available can have serious implications for smaller VCSE organisations in particular. Concerns raised in this regard included:

Reduced funding from local government has created greater reliance on NHS commissioning for VCSE organisations: Some had previously been commissioned predominantly from local authority housing, social care or Supporting People budgets and had been forced to seek alternative funding sources in the last few years to overcome major cuts in those areas. This included a growing reliance on voluntary and philanthropic funding, including from the National Lottery and charitable foundations, in order to fill gaps and seek capital funding. Their ability to bring in such funds was seen by commissioners as a significant strength of the sector – reaching funders that statutory bodies are unable to access.

The practice of 'more for less' contracts, in which commissioners seek the same levels of service but for less money than before: This creates dilemmas for organisations concerned about their ability to deliver safely and pay their staff fairly for their work, raising the question of when they need to withdraw from a contract. This can be particularly difficult if it happens year after year.

One survey respondent pointed out that seven out of nine retendered contracts that they received in 2017/18 were with reduced funding. Another VCSE leader noted: "There have been no uplifts to our contracts for a number of years, despite growing costs for providers such as issues with [higher wages for staff working] 'sleep in' [shifts], pension auto-enrolment and living wage increases. All of this makes it increasingly difficult to continue to invest in new and improved support and deliver our contracts to the high standards we expect for people we support."

When this practice is sustained, existing providers reach the point where they feel they can no longer safely run the services and withdraw when the contract is retendered. Such situations create risks for new providers that take on contracts at lower prices and only realise once they have started work that they cannot meet the level of need within the available resources.

Short-term or rolling contracts that leave VCSE organisations with very little certainty about the near future: This can leave staff under threat of redundancy and means organisations lose skilled, experienced staff. It also limits the extent to which they can build capacity, train and develop staff and develop necessary infrastructure. And providers mentioned that on occasions decisions about rolling contracts would be left very late, creating even more uncertainty and attrition of staff.

Framework agreements and contracts were a major concern for VCSE organisations: They are regarded as unfair, inefficient, overly complex and insecure. They created an enormous amount of work to get into, but once accepted left providers with uncertainty about

how much work they would actually get as a result with no minimum income guaranteed. Spot purchasing was also a concern for providers for similar reasons.

Unpredictable and delayed decision-making: VCSE leaders spoke of being forced to make bids for work or retendering for existing contracts at very short notice but then being kept waiting for many months for a decision.

National policy decisions can have unexpected effects on local decision-making: One commissioner told us that the Mental Health Investment Standard, which seeks to ensure clinical commissioning groups (CCGs) provide real terms increases in mental health service funding, meant in practice that their main statutory service provider was getting a larger proportion of the CCG's spending on mental health. As a result the CCG had ended some of its contracts with VCSE organisations in order to meet its obligations towards the Trust.

Some participants also discussed a lack of trust on the part of NHS organisations, and a perception that VCSE organisations were amateurish compared with clinical services. This can be a major issue when VCSE organisations are working alongside statutory bodies as part of a single contract or when they rely on referrals from statutory services. On a similar theme, one NHS commissioner spoke of the limited options NICE guidelines gave them: placing a narrow, clinical interpretation of what it was possible to purchase and thereby reducing the scope to bring in providers with more holistic approaches compared with the offer from large statutory providers.

A recent trend mentioned by some participants (commissioners and providers alike) was the emergence of Sustainability and Transformation Partnerships (STP) and Integrated Care Systems (ICS). This was regarded as a threat, particularly to smaller organisations that do not have the infrastructure to compete for tenders on a larger scale than most local authority or CCG geographies. This risks taking all but the largest organisations out of the market if more contracts are made at STP or ICS level. One VCSE leader also noted that their (national) organisation had yet to be brought into discussions with any of the STPs its services worked in, creating a further barrier to their involvement in strategic planning.

A similar difficulty emerges for some VCSE organisations when contracts are made for a longer period: in one case, for ten years. Smaller organisations in particular may struggle to meet due diligence requirements, for example to demonstrate they are a going concern, to be eligible for contracts lasting many years at a time. While longer contracts are often welcomed because they bring greater security and more opportunities to bring about system change at scale, there is clearly a risk that these contracts exclude the very organisations they are intended to help.

As contracts for mental health support become longer and larger, the number of opportunities for VCSE organisations to be commissioned may reduce. This could have an impact on their relationships with statutory bodies and with one another, as well as their ability to adapt to changing needs and to innovate.

5. Effective commissioning relationships

Participants shared a range of examples of good relationships between statutory commissioners and VCSE providers and discussed what had made them effective. Unsurprisingly, key elements of effective ways of working (for both parties) included collaboration between commissioners and providers, partnership working among providers, inclusive decision-making (including service users) and approaches that took a whole system approach.

Two participants (a provider and a commissioner) separately cited the Lambeth Living Well Alliance as an example of positive practice. The Alliance was commissioned jointly by the CCG and local authority, and it is a single contract which covers all adult mental health spend in Lambeth. It is an 'outcomes-based contract' with five partners, including the local NHS mental health care provider, which is due to last for at least seven years. The vision and outcomes framework for the Alliance was co-produced with members of the local community. Crucially, the way the Alliance was developed encouraged a sense of shared responsibility across the partnership, for example with a pooled budget which gave each partner clarity about their 'share', and an equal voice for different perspectives in the decision-making process.

This approach was tested for three years with a focus on rehabilitation services for people with complex mental health needs in the borough. This pilot programme reduced the number of people in restrictive settings and out of area by increasing the amount of community support and options for people outside hospital. As a result the local system was able to reduce the level of inpatient provision, leading to significant savings and opportunities to reinvest in other services. The practice of piloting new models in this way to test out whether they will work first, and changing it if it doesn't, was thought to be helpful in this regard.

Collaboration was also the hallmark of Bradford Metropolitan District Council's dementia strategy which was cited by one respondent as an example of an 'absolutely perfect' piece of work in which the local branch of a national charity worked hand in hand with the local authority from the beginning of the process. Together they ensured the strategy enjoyed consistent political support, it was developed in partnership and its implementation was led jointly (Bell, 2016).

Establishing and maintaining these relationships has its challenges, however. One VCSE leader noted that they experienced regular turnover among commissioning staff which results in delays to contracts, disrupted relationships and a succession of new strategies and approaches whenever things change. Another cited tensions between the NHS and local government commissioners which could create a 'disjointed' or even 'adversarial' approach between health and social care. Two of the commissioners we spoke to held posts that spanned the two sectors which may have helped to manage or resolve such difficulties. Other participants mentioned that even when a good relationship is formed with a commissioning officer, decisions could still be made by others (for example working in finance or procurement).

Nonetheless, the commissioners we spoke to had a very strong sense of their role in facilitating the involvement of VCSE organisations in local services. This included being able to 'unblock' systems that got in the way, to support joint leadership between different organisations and to reach out to other sectors, for example physical health. One felt that commissioning was increasingly about creating the conditions for collaboration to take place, which included "knowing when to butt in and when to butt out". Taking this approach was often made more difficult, however, by prescriptive national policies and specifications that limited their ability to work creatively with local partners.

6. Supportive commissioning mechanics

Participants spoke about the specific ways in which commissioning processes and structures could support VCSE organisations more effectively. There was a more mixed picture here about what participants valued. Longer term funding was cited by some participants to be helpful for a number of reasons. It gave security to organisations on both sides of the relationship and allowed for learning to take place in a safer context than the alternative of a succession of short-term contracts. Block contracts – often vilified in national policies for their lack of accountability and flexibility – were also valued by VCSE organisations for giving them more security and space to innovate or adjust their offer according to changing needs.

Commissioners also gave examples of shorter term and smaller scale approaches to supporting VCSE organisations, especially locally-based groups. These included a small grants programme developed by a local authority public health department which included the option of longer term funding for projects that were successfully able to demonstrate impact. This helped to overcome the limits of short-term funding while also enabling smaller organisations to try out new approaches without taking on too much risk. It may also help to mitigate the commissioning risk of exploring new approaches which don't follow an established model of practice (Davidson Knight *et al.*, 2019).

7. Competition

Commissioners and providers alike spoke of the effect of competition within the market on their ability to build effective relationships. Both said they wanted to see different service providers (in all sectors) working more collaboratively, sharing responsibility and learning from each other. And some commissioners had taken steps to facilitate this. But all acknowledged that as soon as competitive procurement exercises began, organisations that might otherwise be collaborating and sharing knowledge retreated away from one another:

"The barriers go up when the money comes in."

Commissioners and providers acknowledged that competition for bids created 'winners and losers' and that sometimes losing a contract meant smaller organisations went out of business entirely. With such high stakes, procurement exercises can be like a 'battle' and VCSE organisations are reluctant to collaborate with each other for fear of losing competitive advantage.

"We talk about partnership a lot but retreat back to our offices to win the bid."

Competition was noted by one commissioner to impel VCSE organisations to "over-promise and under-deliver" in order to get contracts. This can lead to organisations becoming too thinly spread and losing their ability to offer a distinctive approach and work according to their values.

Another commissioner said that smaller VCSE organisations in particular were often "willing to be paid not very much" with ad hoc funding, which undervalued their contribution. They observed a tension between local and national VCSE organisations which meant they did not work together well in the way commissioners hoped.

Other participants spoke about the difficulty competition for contracts can create for organisations that also have an advocacy role. Many VCSE organisations have an important role in speaking out about gaps in support or campaigning for neglected issues in their communities. They then face a risk that doing this could compromise their position with regard to contracts with the bodies they are criticising or be seen as special pleading for their organisation to maintain its place in the market. Ensuring that VCSE bodies continue to have the space to speak on behalf of their members and beneficiaries requires effective leadership on the part of commissioners and providers alike.

8. Monitoring and measuring impact

The way VCSE organisations are assessed, monitored and held accountable is highly contested territory. Evidencing impact is the subject of wide debate. There is evidence suggesting that adherence to strict outcome metrics and performance management can make it harder to produce real outcomes in the lives of service users (Lowe and Wilson, 2017). The limitations of clinical outcome measures in articulating the broader issues contributing to ill health are the topic of frequent discussion, and alternative 'recovery'-based measurement frameworks, designed to provide a holistic view centred on individual service users, are often disputed (Collins, 2019).

Most participants spoke about the need to measure 'outcomes' rather than 'outputs' but there was little agreement about how these should be distinguished in practice and, if so, how the former can be measured effectively. And there was a tension about how 'outcomes' are defined, and how far the use of quantitative outcome measures in the public sector really reflects or supports the 'impact' of a service.

Commissioners and providers agreed that the NHS was "data and performance management hungry" and that this put a major burden on VCSE organisations. One noted that NHS trusts and many private providers had whole departments dedicated to producing data, which the vast majority of VCSE organisations cannot match. Another (a commissioner) felt that VCSE organisations were naïve in their understanding of what public bodies needed by way of information about how they were spending public money and the extent to which they needed to be held to account for this.

Other participants (on both sides) observed that the public and voluntary sectors "speak two different languages" on this issue, and that the narrowly defined outcome measures preferred by public sector commissioners could inhibit creativity and learning in VCSE organisations.

There were also significant differences among VCSE organisations in their approach to this issue. One of the larger charities we spoke to had its own quality assurance function that sought to assess all of its services using an agreed framework. Others described a struggle to demonstrate the impact of their services and preferred to use personal testimonies to show the benefits of their services, acknowledging that in a competitive market providing feedback when things do not work well can be difficult.

In practice, this means compromises were needed to ensure that public bodies were able to assess what they were getting for their money without placing impossible burdens on providers.

Several participants had sought ways of bringing together these very divergent perspectives. Statutory bodies were seeking to better understand the way smaller organisations in particular worked and to develop ways of measuring impact that better reflected how they added value. Some were moving towards 'whole system' monitoring rather than seeking data from separate organisations within a joint contract: this helped to reduce the burden on individual organisations but could also obscure the extra value of the VCSE partner in a contract dominated by an NHS organisation. Other commissioners had worked with providers and service users to agree outcome measures from the outset, included evaluation in contracts in order to get a broader understanding of their impact, or sought qualitative feedback from service users in place of numerical data.

Openness and trust were essential to embedding these very different approaches to assessing the impact of VCSE organisations: for example to make it safe to share negative feedback and develop an understanding of what doesn't work as well as what does. This echoes a recent study on 'complex' commissioning which concluded that trusting, reflective relationships between commissioners and providers underpin the ability of any system to function effectively and make improvements (Davidson Knight *et al.*, 2019).

9. Implications for policy and commissioning

This initial scoping report has identified issues and opportunities for both national policy and local commissioning of VCSE organisations across the spectrum of mental health support in England. While many of our findings are tentative due to the nature of the exercise, they have potentially significant implications for the ways in which VCSE organisations are valued and the relationships they have with statutory bodies and each other.

Learning from experience

There is an opportunity for commissioners and policymakers across the country to learn from service models which achieve high levels of cross-sector satisfaction. Understanding and sharing insights from promising examples could help other areas adopt or replicate positive practice. At the same time, we need to learn from the challenges experienced by VCSE organisations and those who commission them, for example in assessing how longer and larger contracts at ICS level may affect the sustainability and diversity of the VCSE sector and particularly the smaller organisations and user-led groups within it.

Collaborative commissioning

The knowledge and expertise of VCSE organisations should be recognised in commissioning and service development processes. Commissioners should work collaboratively with VCSE providers at the earliest stage of the commissioning cycle to deliver better, more holistic and more inclusive support, particularly for those who have historically been poorly served by mainstream services.

Evaluation and monitoring

Finally, there is an opportunity for statutory commissioners and VCSE providers to achieve a shared understanding of impact. Where outcome-based contracts are already in place, there may be opportunities to review and better understand how impact can be measured in a multi-agency partnership. Research has highlighted a 'severe lack of evidence' for commissioners to draw on when developing outcome-based contracts (Tomkinson, 2016). Robust evaluation can help address this gap and support commissioners and providers to find meaningful, measurable and affordable ways of assessing and understanding the value VCSE organisations bring to people and communities, while maintaining necessary accountability for the use of public money.

10. Future research priorities

This short report has sought to review the current relationship between VCSE organisations and those who commission them at a local level. Further research could provide a more in-depth look at some the issues we have identified in the context of a rapidly changing landscape. Key areas for further investigation may include:

- Looking in more detail at different models and approaches to VCSE commissioning and their impacts
- Investigating the best ways of monitoring impact and outcomes of VCSE organisations and partnerships with statutory providers
- Understanding the perspectives of users of VCSE services and exploring inequalities and intersectionalities in experience
- Exploring the impact of policy change, e.g. the arrival of STPs, ICSs and primary care networks and their interactions with VCSE organisations
- Understanding the role and impact of philanthropic funding, how it intersects with statutory funding, and how it affects the sustainability of the VCSE sector in mental health
- Exploring the experiences and perspectives of smaller, 'grassroots' and user-led organisations about their relationships with commissioning bodies and other charitable organisations.

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