

The role of the voluntary, community, faith, and social enterprise (VCFSE) sector within integrated care systems (ICSs) and its contributions to health outcomes – a logic model

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ABSTRACT

The voluntary, community, faith, and social enterprise (VCFSE) sector should be a key partner in the design and delivery of health and care services, alongside statutory partners (e.g., NHS, local authorities) and local communities. However, there has been limited discussion of how the VCFSE sector feature in integrated care models and what outcomes their involvement can contribute to. This study developed a logic model to articulate the potential role of the VCFSE sector within integrated care, by reviewing existing evidence, and engaging with a range of relevant stakeholders. This logic model could be usefully applied as a framework to plan and evaluate future projects and activities which involve the VCFSE sector in integrated care.

INTRODUCTION

Integrated care systems (ICSs) take the form of a partnership of organisations involved in the design and delivery of health and care services of a given geographical area.¹ As of July 2022, after several years of development, 42 ICSs were established across England.² ICSs ultimately aim to support joint working between health and care services, in order to improve the health and wellbeing of their local populations.¹ Within these arrangements, it is expected that the voluntary, community, faith, and social enterprise (VCFSE) sector should be a key partner in the design and delivery of health and care services, alongside statutory partners (e.g., NHS, local authority), and local communities.³

Emerging evidence suggests that models of integrated care have positive outcomes associated with perceived increased patient satisfaction, improved quality of care, and improved access to care.⁴ This international review also found United Kingdom (UK)-specific impacts of integrated care on reduced outpatient appointments and reduced waiting times.⁴ However, the review highlighted the challenges associated with defining models of integrated care, in that many models shared similar elements, but their complex compositions made evaluating their implementation and outcomes difficult. There was limited discussion of how the VCFSE sector featured in integrated care models collated in the review. Given that ICSs are large, complex models of integrated care, there is an opportunity to address this evidence gap and explore the role of the VCFSE sector in integrated care.

Logic models are a tool by which the links between inputs and activities, and the intended outcomes of a programme, intervention, or policy, can be visually represented in a logical way.⁵ They can be used as an aid to plan and/or evaluate a programme, through developing and testing a theory of change about how the programme works.⁶ Logic models are

developed based on underlying evidence and assumptions which are made about the outcomes that can be achieved given the inputs and activities involved.⁶ Previous studies have used logic models to understand the mechanisms involved in an integrated care model for frail older adults,⁷ to assess the evaluability of a community empowerment policy,⁸ to develop ways to collect service user experiences of integrated care,⁹ and to evaluate the scale-up of perioperative medicine for older people undergoing surgery.¹⁰ As part of the evaluation of the national Vanguard programme in 2015, all Vanguards used logic models to describe the model of care, and its intended inputs, outputs, and impacts.¹¹

Applying a theory-driven approach using a logic model can facilitate sense-making of a programme and subsequently provide a framework through which it can be evaluated.¹² In this article, we report on the development of a logic model which aims to visually communicate the inputs, activities, and ultimately the impacts that may be brought about in the planning and delivery of health and care services, as well as the outcomes for local populations, through closer partnership with the VCFSE sector.

METHODS

Logic model development took place across five phases: familiarisation with the logic model concept; review of available evidence; logic model drafting; stakeholder consultation; and model refinement. Implementation science expertise and resources were sought during the initial stage, enabling researchers to familiarise themselves with logic models and their functions. A scoping exercise was undertaken to identify existing literature in this area and develop an understanding of the evidence base for integrated care and the role of the VCFSE sector. Scoping searches were conducted across various websites (e.g., Google, Google Scholar, UK Government, NHS England, National Council for Voluntary Organisations (NCVO)) to identify relevant journal articles, case studies, research reports and briefings, national guidance, and policy documents. A draft logic model was developed by mapping themes from the existing evidence against the basic template outlined in the W.K. Kellogg Foundation Logic Model Development Guide.⁵

We convened an advisory group, through the National Institute for Health and Care Research (NIHR) Applied Research Collaboration North West Coast (ARC NWC), comprised of individuals with interest, experience, and/or expertise of embedding the VCFSE sector in integrated care (e.g., VCFSE and NHS colleagues, local community members). We held a workshop in July 2021 with the advisory group (n=16), which focused on facilitating a discussion to refine and validate the logic model. Attendees were asked to consider what outcomes

could be associated with VCFSE involvement in integrated care, what resources and activities are needed, and whether they could suggest any existing examples of VCFSE involvement in integrated care. The themes that emerged from the workshop and additional literature highlighted by the group were used to refine the draft logic model. The advisory group were sent an updated version of the logic model via email and invited to contribute any further input in amending the model. Two further meetings were held with a subgroup of the advisory group (n=6) to present the model and collate any additional insights to refine the model. Ethical approval was not required for this study.

The logic model

The final logic model developed through the process described above is presented in Figure 1. The logic model includes the following key components as per the W.K. Kellogg Foundation Logic Model template:⁵ inputs (resources); outputs (activities and participants); and outcomes (changes that occur as a result). The model maps short, medium, and long-term outcomes and groups these into three levels (outcomes for patients/public, for services/organisations, and for systems). Contextual factors and assumptions underpinning the model are also depicted. In the sections below, each component of the logic model is discussed, with reference to the available evidence.

Outcomes

Long-term outcomes

Developing an understanding of the intended outcomes required reviewing the policy aspirations for ICSs as outlined by policy documents and reports,^{1, 3, 13-20} and the academic research on integrated health and care more generally.^{4, 21-29} Improving health and wellbeing outcomes and reducing health inequalities is frequently cited as a longer-term aspiration for integrated care.^{1, 3, 13} A systematic review examining the effectiveness of integrated care however, found no indication of impact related to population level health outcomes or inequalities.^{4, 21} In part this may be because it is too soon to measure these outcomes or measures of health have not been included in studies.

Baxter et al.²¹ identified evidence that integrated care can contribute to improvements in perceived quality of care, patient satisfaction, and access to care. However, the extent that VCFSE organisations were involved in the design and delivery of approaches where these outcomes were reported in studies was not clear.

Another systematic review concluded integrated care to be associated with lower costs in different country contexts,²⁹ although study findings were not always statistically significant. Baxter et al.²¹ did not identify any clear evidence on the cost-effectiveness of integrated care in their review of models in the UK and internationally. Guidance on working with VCFSE organisations as part of ICSs suggests partnership approaches can improve productivity and cost efficiencies, for example, through early discharge, and freeing up hospital staff and beds, citing a virtual wards project for COVID-19 patients as an example of this.³

Short and intermediate outcomes

Goodwin²⁶ suggested that engaging and empowering communities should be a central component to any integrated care strategy; and that there should also be a shift to the promotion of health and wellbeing. The author argued “both these ideas see the integration element as a way of bringing community assets together to promote health and wellbeing to populations ...”.²⁶ Hughes et al.²⁷ similarly suggested that in the context of supporting chronically ill patients by linking the health system with “wider community resources”, this can contribute to promoting good health and better meet their needs.

Where VCFSE organisations are partners in co-design and delivery of integrated health and care services,^{13, 28} an improved “culture of cooperation and coordination between health, social care, public health, other local services and the third sector” could potentially avoid crises in people’s care that result in avoidable hospital admissions.²⁷ In the shorter term though, this necessitates increased awareness, understanding and recognition of the VCFSE sector’s offer among statutory partners,^{13, 28, 30} the capacity of VCFSE organisations to inform design and delivery of services,^{13, 30} and the establishment of effective partnerships and opportunities for joint working.^{15, 31, 32} Several case studies have demonstrated the ways in which VCFSE organisations can help to identify need and if commissioned appropriately can support an improved response to need.^{3, 13} More recently, national studies^{33, 34} and local research have collated examples of the VCFSE sector’s response during the pandemic. At a local level these have included, for example, the development of a community hub network connecting city wide structures,³⁵ the coordination and support of community volunteering,³⁶⁻³⁸ adapting and delivering extra services in response to local unmet needs,³⁹ sharing of information and intelligence,³⁵ as well as the development and extension of partnership models to avoid service duplication.³⁹

Where systems work in partnership, this may lead to improved capacity to share and learn from each other. The NHS England and NHS Improvement (NHSE/I) ICS maturity matrix states that for systems to be considered “mature” or “thriving”, they must be able to demonstrate “strong collaborative and inclusive system leadership, including local government and the voluntary sector, with a track record of delivery”.¹ At a system level, VCFSE have a role to play in governance and system transformation as well as strategic planning and implementation.^{3, 13} However, Baxter et al.⁴ found little evidence related to governance and accountability or processes of organisational change in their review, with the exception of one study that suggested governance was most strengthened when partnerships involved health and care services, local authorities, and voluntary organisations.

Outputs

National level briefings and guidance provide several examples of the ways in which engagement with the VCFSE can develop in practice,^{3, 13} with case studies and research providing local examples of how that has been achieved.^{30-31, 40-46} At a systems level, activities often include: the creation of a VCFSE leadership group or alliances; VCFSE representatives on different partnership structures; communication mechanisms;

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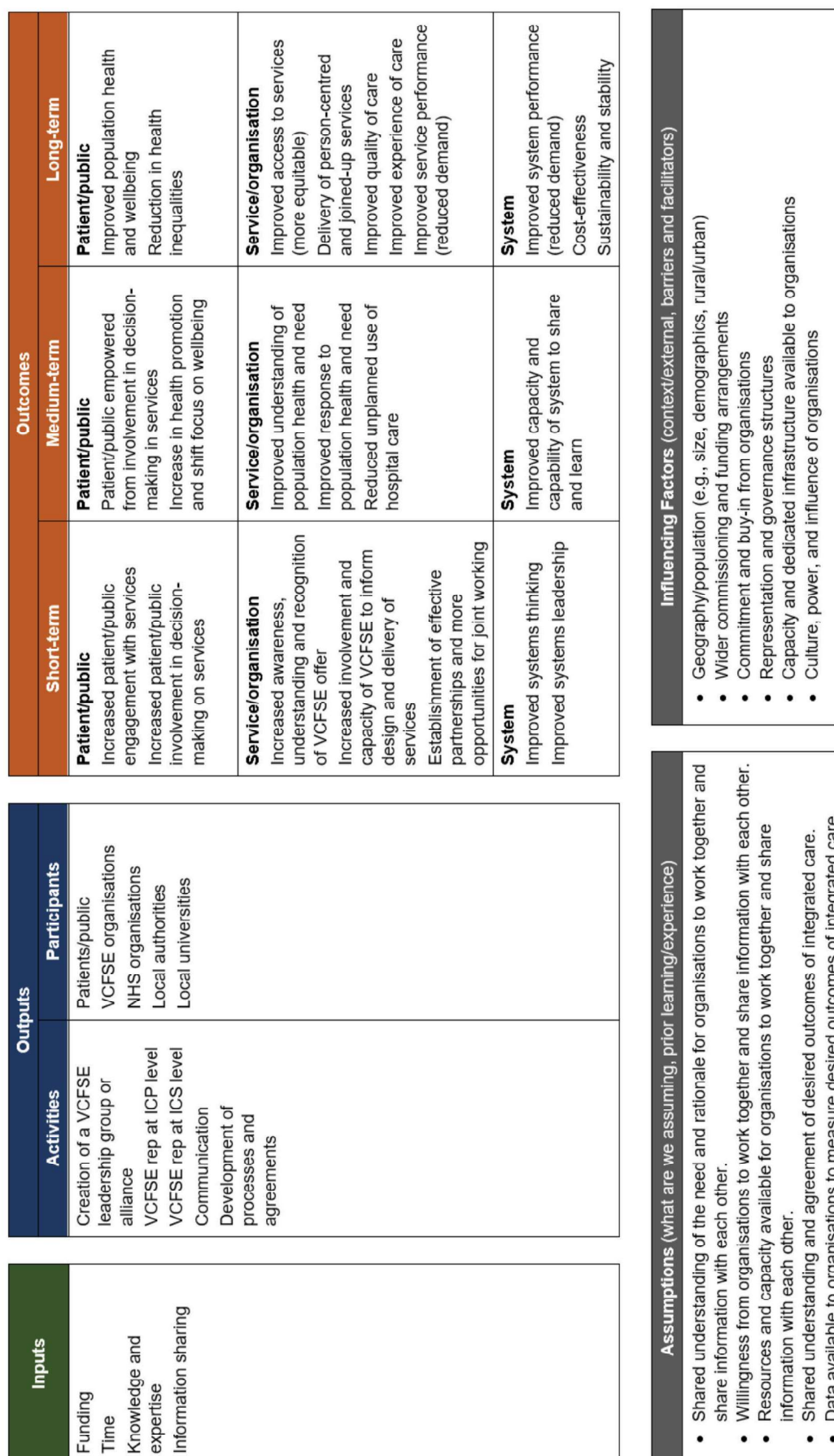


Figure 1: Logic model for the role of the VCFSE sector in integrated care systems.

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and the development of processes and agreements between sectors. This may include engagement with a range of organisations and stakeholders including patients and the public, NHS organisations, local authorities, universities as well as VCFSE organisations. ICS guidance cites examples of projects where working in partnership with the VCFSE sector is perceived to have led to benefits for local services and populations.³ Although it is unclear if these projects have been formally evaluated, perceived benefits are stated to include more joined up mental healthcare, better prevention and treatment of eyecare, improved vaccination uptake among homeless populations, and improved employment prospects for carers.³ Various case studies as part of the Institute for Voluntary Action Research (IVAR) Building Health Partnerships Programme, also allude to examples of partnership working with VCFSE organisations and the potential positive impacts that have been realised through implementing leadership groups,³¹ community action networks⁴⁴ and community health events.⁴⁵

Inputs

Four key inputs were frequently cited as essential for developing partnerships with VCFSE organisations in the context of models of integrated care: the role of funding,^{4, 22, 28, 41, 47} time,^{28, 31, 40, 47} knowledge and expertise,^{41-44, 47} and information sharing within and between all sectors involved.^{4, 22, 28, 41, 42, 47} In interviews conducted in one ICS,³⁰ participants identified the related components of influence, funding, and capacity (both in terms of time and expertise), as being critical for building partnerships between VCFSE and statutory organisations within integrated care.

Assumptions and context

Prior examples of VCFSE involvement in integrated care and wider literature around healthcare partnerships suggest a number of assumptions that influence intended outcomes. A shared understanding and willingness, and shared resources and capacity (including data), from all organisations to work together to achieve the desired outcomes of integrated care, were frequently noted here.^{4, 23, 31, 45, 47} Contextual factors were identified through collating information from a range of sources, which describe the environment in which the partnership working was being undertaken, and the factors that interact and influence the development and sustainment of partnerships. Evidence frequently cited the geographical context of the area, organisational cultures, wider commissioning and funding structures, and organisational capacity and infrastructure, as factors that may influence partnership working in integrated care.^{4, 22, 23, 25, 28, 46} Many of these factors also emerged from previous research reported in this journal, involving interviews with VCFSE and statutory representatives from Lancashire and South Cumbria.³⁰ This research highlighted how those factors influenced building relationships across organisations.

Advisory group

A key element of developing this logic model involved the contribution of stakeholders to refine and validate the draft model. The knowledge and experience of the advisory group provided additional sources of evidence to consider,

and insights into the context in which the VCFSE sector and statutory partners are working. The group corroborated many of the components already identified, particularly highlighting funding and resources as key inputs that would enable the VCFSE sector to contribute to outputs and outcomes. The advisory group had a shared view that the focus of integration offers an opportunity to achieve different outcomes, beyond improving services and treating people, and instead improving population health and wellbeing, and addressing inequalities.

CONCLUSIONS

In this article, we have outlined a logic model to articulate the role of the VCFSE sector within ICSs. We have developed this through synthesising evidence from various sources, not limited to academic literature, and engaging with a range of relevant stakeholders. The logic model produced could be usefully applied as a generic framework to plan and evaluate projects and activities which involve the VCFSE sector in integrated care. It could also be applied to support the VCFSE sector to articulate the ways in which they can contribute to longer term health outcomes (e.g., improving population health, reducing health inequalities).

Logic models effectively provide a reference point for all involved in a project or programme,^{5, 6} and as such enable a range of organisations, sectors, or groups, that need to be involved in the planning and delivery of integrated care to agree on shared inputs, outputs, and outcomes.⁴⁸ The logic model discussed here can serve as a high-level framework, which can be adapted and updated by individual ICSs at any stage of their implementation to meet the national guidance in building partnerships with the VCFSE sector.^{1, 3} Wang and Groene⁴⁸ suggest that previous examples of integrated care have often been limited by a lack of communication and understanding on the proposed activities and desired outcomes, and logic models can be applied to address this limitation. This is particularly the case here, as we identified a potential gap in the evidence base with very few examples of the role of the VCFSE sector and the intended outcomes.

Despite its usefulness, there are some limitations to applying this logic model. It is not representative of reality and presents a linear depiction of systems that are invariably much more complex than in practice. The model presents a generic framework of the broad inputs, outputs, and outcomes, associated with the role of the VCFSE sector in integrated care. If applying the model, it may need to be adapted and used flexibly to detail more specific inputs, outputs, and outcomes associated with a particular project or programme. Also, we do not suggest causal attribution in the logic model, only causal connections between factors, mostly due to the limited evidence on the impact of VCFSE involvement in integrated care. Finally, the model does not report unintended consequences or disbenefits that may arise from partnership arrangements between the VCFSE sector and statutory organisations. However, it has been suggested that when developing and evaluating complex policies or programmes, such as integrated care, engaging with stakeholders and agreeing an adaptive theory of change, similarly to that presented in our logic model, adverse effects can be mitigated against.⁴⁹

We propose the following avenues for future research

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activity to address the gaps in this evidence base. Whilst evidence on the impacts of models of integrated care associated with health outcomes and reducing health inequalities is limited, existing UK and international evidence highlight contributions to outcomes for local services and systems.^{4, 21} Where studies of integrated care reported such impacts, it was largely unclear whether VCFSE organisations were involved and if so, knowledge of their role. Future studies should more clearly articulate and measure the contribution of VCFSE organisations to these outcomes alongside statutory partners. A growing body of evidence appears to be available on the processes of VCFSE organisations working within the evolving ICSs in England, demonstrating the development and delivery of partnerships. However, studies reporting outcomes for local populations were more difficult to locate. Where available, the reported benefits of projects or services delivered in partnership with the VCFSE sector tended to be located in descriptive case studies, suggesting a need for more robust studies measuring impact. Finally, it is plausible that integrated care approaches involving the VCFSE sector could result in greater efficiencies for commissioning and funding services however, the evidence base on cost effectiveness is insufficient.^{21, 29} The stakeholders involved in this project highlighted the need for evidence on the cost and value of integrated care approaches to support commissioning decisions. In turn, we propose that future research should also consider the economic implications of partnership working with VCFSE organisations, particularly given the financial pressures that the sector is facing in the current climate.

ACKNOWLEDGEMENTS

We would like to thank the advisory group members for their time and contribution to the development and refinement of the logic model.

FUNDING STATEMENT AND DISCLAIMER

This research was funded by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration North West Coast (ARC NWC). The views expressed in this publication are those of the authors and not necessarily those of the NIHR or the Department for Health and Social Care.

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(a full list available on request)