NHS LONG TERM PLAN: ABHI ANALYSIS

The NHS Long Term Plan (LTP) was published on Monday 7th January. It is a bold, ambitious plan with an implied 10-year time horizon. It builds on the work that has gone before, notably the Five Year Forward View (5YFV), and is unambiguous about the direction of travel of the NHS being away from competition and towards collaboration. By 2021 it is anticipated that all of England will be covered by a number of Integrated Care Systems (ICSs), spelling the end of the market-based system that has characterised the delivery of health and care in our country since reforms were initiated in the 1990s.

The LTP balances the demands of the here-and-now and the future ambition for the service, and also relies on the publication of other pieces of work, not least the Government Spending Review which will set out details of the NHS capital budget and funding for education and training, as well as the local government settlement to cover public health and adult social care services. Other enabling publications will include a national workforce strategy, a clinical services review and a national implementation framework for the plan. The plan acknowledges the financial pressures on the service and suggests a new financial regime to address the deficits that exist in parts of the system. 2019/20 is seen as a transitional year before the NHS gears up to the more fundamental changes required by the plan.

Delivery of the LTP will be dependent on the ability of the service to be fully digitised and all the digital elements being interoperable. This is anticipated to happen by 2024.

The LTP is also admirably evidence based. There is a strong focus on prevention, but it is not from the line of thinking that existed when the NHS was founded, that making people healthier would reduce spend on healthcare. Rather it is targeted where evidence suggests it is most beneficial, such as smoking cessation. Similarly, a new focus on areas such as cardiovascular diseases, stroke and respiratory disorders, is advocated because they are conditions in which the UK appears do poorly by way of international comparison.

Heartening in the LTP is evidence that many of the messages that ABHI has been delivering over a number of years have been heard. It is the first time that a document of this type has contained so much that has demonstrated the impact we have had as a sector. As well as a strong focus on HealthTech generally, there are several specific items of relevance to ABHI Members. There is a new funding mandate for non-pharmacological technologies that the National Institute for Health and Care Excellence (NICE) finds to be cost saving. A single front door for innovators, with effective signposting provided by the national network of Academic Health Science Networks (AHSNs) is proposed, as is the incorporation of the adoption of proven innovations into the performance metrics of NHS organisations. There is also specific acknowledgement of the fall-off in elective work over recent years, and a commitment

to increasing activity, with cataracts and joint replacements being used as examples. The NHS also commits to playing a leading role in delivering the Sector Deals agreed as part of the Life Sciences Industrial Strategy, and innovations developed by British companies will receive export support from Healthcare UK.

Specific interventions are also highlighted which reflect the successful work of many of our Members over a long period of time. The focus on detection and management of atrial fibrillation, increasing the availability of public access defibrillation, the provision of flash and continuous glucose monitoring and a focus on the management of sepsis and heart failure are all themes advocated as part of the public policy debate by our Members over the last decade. There is a call for a tenfold increase on the number of mechanical thrombectomies and the wider use of molecular diagnostics. To see them explicitly identified in the LTP, is to recognise the important role our sector has in improving the health of the country.

If there is one theme that jumps out of the plan, it is integration. To understand the LTP, the policy that falls from it and the direction of travel of the NHS, one has to consider the flow of patients through our Accident and Emergency (A&E) departments. A&E is the most resource intense part of the health and care system. It is the most expensive part and one that we can only afford for the most appropriate cases. However, there are a large number of inappropriate admissions to A&E, for any number of reasons. But consider just the residential care sector. It is vast, with many more beds than the NHS (c410,000 vs 142,000). These beds are populated, by and large, by the frail elderly. The sector does not have the capability and capacity to adequately manage its residents so, intermittently, people are sent to the NHS, usually via A&E. If these people are subsequently admitted, discharge protocols kick in and it can become very difficult for individuals to be sent home, particularly if the system they have come from has demonstrated that it cannot look after them. Hence there are people who should not have presented at A&E going on to occupy NHS beds because there is nowhere to discharge them to. This results in so called "bed blocking" which, in turn, reduces the capacity of the NHS to do its routine, elective work. Similarly, people with mental health issues may present at A&E as a place of refuge, and a lack of access to primary care, especially out of hours, contributes to more unnecessary visits. The focus on prevention and maternal health are an extension of this, stopping people entering the system when early intervention might have set them on a different path.

There is some reference to social care in the plan, but this remains largely a missing element. The example cited above explains why the integration of health and social care must be the ultimate goal. A long overdue Green Paper on Social Care will now need to be viewed through the lens of the LTP, but in the meantime, the approach is likely to be to muddle through. However, providing the goal of delivering ICSs is achieved, things may look very different with regard to the governance of the NHS. If we do reach a fully integrated, place-based NHS, then it is a much smaller step to structures more akin to local government. At this point, geographies might be able to start thinking about their local "health pound", rather than just the "NHS pound".

Consider the challenges faced by Police Services, around 40% of their workload relates to dealing with mental health issues. A joined up, place-based health economy could decide to divert 20% of the policing budget to mental health services, thus freeing up the police to concentrate on keeping the local population safe. Some areas have moved further than others in integrating health and social care, and models are suggested for future collaboration. Examples of addressing the issue of delayed transfers of care are plentiful, although at the moment the main driver is to free up capacity in the acute sector to deliver more activity and maximise the revenue receipt of hospitals, rather than to consider the sustainability of the system more holistically.

The one area that seems to have landed less well in the service, is the attempt to address workforce issues. Workforce is the single biggest challenge faced by the NHS. Richard Samuel, the Responsible Officer for the Hampshire and the Isle of Wight Sustainability and Transformation Partnership (STP) told ABHI's UK Market Conference in November 2018 that the number of vacancies on his patch was such that every local school leaver would need to join the NHS to fill the gap. There are few answers in the LTP so far, and it is hard to see many more being forthcoming in the new workforce strategy.

Generally, however, there should be much cause for optimism, not least because as is highlighted, there is nothing in the plan that is not already happening in the NHS.

The Chapters

CHAPTER 1: A NEW SERVICE MODEL FOR THE 21ST CENTURY

The Chapter sets out how the service will operate in the future, including the joining-up of care, the networking of GPs, getting closer to community care and new urgent care pathways, including same-day emergency care. There is an ambitious target to reduce outpatient visits by a third. The Chapter describes five practical steps that will be taken:

1. *We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services.*

2. *The NHS will redesign and reduce pressure on emergency hospital services.*

3. *People will get more control over their own health, and more personalised care when they need it.*

4. *Digitally-enabled primary and outpatient care will go mainstream across the NHS.*

5. *Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.*

The plan is clear that there is strong evidence from the Five Year Forward View Vanguard programmes that the joiningup of care has been successful in reducing A&E admissions. There is a clear focus on enhancing community-based services and making better use of pharmacists. The Quality and Outcomes Framework (QOF) will also be used to incentivise targeted prevention measures.

There is an explicit reference to boosting support for those living in care homes. People resident in care homes account for 185,000 emergency admissions each year and 1.46 million emergency bed-days, with 35-40% of emergency admissions potentially avoidable. There will be opportunities for companies who can deliver care and provide targeted screening and monitoring in this sector. Explicitly from p.17

The connecting of home-based and wearable monitoring equipment will increasingly enable the NHS to predict and prevent events that would otherwise have led to a hospital admission.

The plan references a string of initiatives coming out of the 5YFV that are beginning to improve the efficiency of A&E services, and is clear that there are massive efficiency savings to be made by redesigning urgent care pathways. A new, digitally-enabled Clinical Assessment Service will join up GPs, the NHS 111 telephone service and ambulances.

The plan states that, despite a greater focus on collaboration over competition, patient choice will remain, and people will be supported to manage their own long-term conditions, including the further rolling out of personal health budgets. There is also recognition that digital technology should reform the way we receive our healthcare in the same way it has affected other parts of our lives, potentially marking a fundamental difference in the way primary care is delivered.

There is a clear appetite for more mergers of provider organisations, indeed this is seen as inevitable as we move towards an ICS system.

CHAPTER 2: MORE NHS ACTION ON PREVENTION AND HEALTH INEQUALITIES

This Chapter sets out how health inequalities will be reduced by preventative measures and targeted intervention. The plan acknowledges that there are a number of reasons why demand for NHS services continues to rise. An ageing population, areas of unmet medical need and the expanding possibilities of medical science are all seen as legitimate. However, once again the plan emphasises the need to ensure that care is delivered in the most optimal setting and that a focus on upstream prevention will ultimately result in avoidable presentations. There is even a hint that some public health services might be better if they were integrated back into the NHS.

The Chapter identifies the evidence base for targeted prevention in areas such as smoking, alcohol misuse and obesity. A continued focus on antimicrobial resistance

has the potential to provide opportunities for companies with appropriate technologies in the diagnostic space.

Clinical Commissioning Groups (CCGs) are explicitly tasked with reducing health inequalities in their populations and the methods for resource allocation are being reviewed to support deprived areas better.

CHAPTER 3: FURTHER PROGRESS ON CARE QUALITY AND OUTCOMES

This Chapter reinforces earlier work on the parity of esteem of mental and physical health, and also identifies areas where progress needs to be improved.

There is an extensive list of actions to reduce variability in the outcomes in maternal and neonatal health. Identifying that children and young people account for 25% of all A&E admissions and are the most likely group to attend unnecessarily, the plan talks about moving to a 0 – 25 service.

Clinical priorities are identified, with targets to significantly increase the early detection of cancer presenting more opportunities for companies in that space. A report on how current screening programmes can be upgraded and participation increased is due at Easter. New Rapid Diagnostic Centres also present the possibility of significant investment in diagnostic hardware, and increasing the use of molecular diagnostics is also called out.

There is a renewed focus on cardiovascular disease, with evidence that this is the area where most lives could be saved by targeted intervention. Atrial fibrillation and heart failure are areas, specifically highlighted in the plan, where there are significant opportunities for wearables and other diagnostic technology, whilst a focus on out-of-hospital cardiac arrest should support the roll-out of public-access defibrillation.

Given the changing demography of the UK, stroke is seen as a condition likely to increase in prevalence. Specialised stroke units will be expanded and there is a target for a tenfold increase in the number of mechanical thrombectomies. The greater use of advanced imaging is also seen as central to improvements in outcomes.

Opportunities for flash and continuous glucose monitoring are identified in improvements in diabetes care, whilst smart inhalers are called out in a new focus on respiratory disorders.

There is a significant commitment to improve mental health services and funding will grow faster in this sector versus the NHS as a whole. Sanctuaries, safe havens and crisis cafes are all listed as alternative settings for individuals with mental health issues, again preventing unnecessary presentations to A&E. The South West Ambulance service, for example, reports that 10-15% of its calls relate to mental health.

There is a specific aim to increase the number of elective procedures, specifically on p.74

Under the Long Term Plan, the local NHS is being allocated sufficient funds over the next five years to grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list.

There is also an indication that the NHS will look to expand the use of 'cold' elective sites for routine surgery.

There is a welcome section on the role of research and innovation in improving outcomes, explicitly acknowledging the role of the NHS in delivering the Sector Deals from the Life Sciences Industrial Strategy. Genomics is also seen as a very significant factor in improving care.

A more simplified system for innovators to access the NHS will be identified alongside the AHSNs, and the development of real-world evidence will be expanded via an increase in the number of "Test Beds" across England. There is now a funding mandate for non-pharmacological interventions identified as cost saving by NICE and the number of assessments of HealthTech products will increase. Adopting proven innovations will be part of the performance metrics for NHS organisations, and there will be increased support for UK innovators to export from Healthcare UK.

CHAPTER 4: NHS STAFF WILL GET THE BACKING THEY NEED

This Chapter focusses on plans to bolster the workforce of the NHS. Initiatives include working with universities to enable more people to start nurse training and a renewed focus on international recruitment. The new National Implementation Programme will be published in the Autumn. Technology is seen as a way to free up expensive staff time and provide safety prompts that will improve the quality of care. Professor Eric Topol is currently leading work to consider what education and training changes may be needed to maximise the opportunities of technology, artificial intelligence and genomics in the NHS. His conclusions will inform the Implementation Programme.

CHAPTER 5: DIGITALLY-ENABLED CARE WILL GO MAINSTREAM ACROSS THE NHS

The entire LTP is predicated on the full digitalisation of the NHS. A series of practical steps are identified to achieve this, specifically:

- *Create straightforward digital access to NHS services, and help patients and their carers manage their health.*
- *Ensure that clinicians can access and interact with patient records and care plans wherever they are.*

- *Use decision support and artificial intelligence (AI) to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition.*
- *Use predictive techniques to support local health systems to plan care for populations.*
- *Use intuitive tools to capture data as a by-product of care in ways that empower clinicians and reduce the administrative burden.*
- *Protect patients' privacy and give them control over their medical record.*
- *Link clinical, genomic and other data to support the development of new treatments to improve the NHS, making data captured for care available for clinical research, and publish, as open data, aggregate metrics about NHS performance and services.*
- *Ensure NHS systems and NHS data are secure through implementation of security, monitoring systems and staff education.*
- *Mandate and rigorously enforce technology standards (as described in The Future of Healthcare) to ensure data is interoperable and accessible.*
- *Encourage a world leading health IT industry in England with a supportive environment for software developers and innovators.*

All NHS organisations will be expected to have a core level of digitisation by 2024. Pathology (2021) and digital imaging (2023) networks will be developed and will again offer opportunities for companies with the appropriate technology.

CHAPTER 6: TAXPAYERS' INVESTMENT WILL BE USED TO MAXIMUM EFFECT

This Chapter sets out the balance between the current financial pressures on the service and the longer-term investments that will be needed to realise the ambitions of the LTP. Five "tests" are set out:

- *The NHS (including providers) will return to financial balance.*
- *The NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care.*
- *The NHS will reduce the growth in demand for care through better integration and prevention.*
- *The NHS will reduce variation across the health system, improving providers' financial and operational performance.*
- *The NHS will make better use of capital investment and its existing assets to drive transformation.*

The Chapter quite clearly signals the end of the internal market with less funding being related to activity and more population-based. A new Financial Recover Fund will replace the Provider Sustainability Fund and will control the total regime by 2021. The number of Trusts reporting a deficit in 2019/20 will be expected to decrease by more than half, with no Trusts reporting deficits by 2023/24. This will be a significant challenge and next year will be extremely tight as the service strives to achieve

financial sustainability. Whilst long-term sustainability plans will be designed and delivered locally, it is expected that all systems and trusts will implement proven initiatives, including the Model Hospital, Rightcare and GIRFT and the major opportunities identified within the Long Term Plan, such as redesigning outpatients over time to be able to avoid up to a third of face-to-face outpatient visits.

The ambitions of the new NHS Supply Chain Operating Model are embedded within the LTP, with the target of procuring 80% of all products via this route by 2022. £700 million of savings have been identified from back-office consolidation by 2023/4.

The Chapter suggests that there is some appetite to decommission services regarded as having limited clinical value, whilst there is a belief that improving patient safety will reduce patient harm and the substantial costs associated with it through a new ten-year national strategy, to be published in 2019. Part of this will be the delivery of the National Wound Care Strategy which featured as part of a Sector Deal brokered by our Health Technology Partnership.

CHAPTER 7: NEXT STEPS

To support local planning, local health systems will receive five-year indicative financial allocations for 2019/20 to 2023/24 and will be asked to produce local plans for implementing the commitments set out in the Long Term Plan in 2019. Oversight of the system will be provided by the new regional teams of the integrated NHS England / Improvement.

The Chapter recognises that legislation may be necessary to support the delivery of the LTP. Eight potential areas are identified:

- *Give CCGs and NHS providers shared new duties to promote the 'triple aim' of better health for everyone, better care for all patients, and sustainability, both for their local NHS system and for the wider NHS.*
- *Remove specific impediments to 'place-based' NHS commissioning.*
- *Support the more effective running of ICSs.*
- *Support the creation of NHS integrated care trusts.*
- *Remove the counterproductive effect that general competition rules and powers can have on the integration of NHS care.*
- *Cut delays and costs of the NHS automatically having to go through procurement processes.*
- *Increase flexibility in the NHS pricing regime.*
- *Make it easier for NHS England and NHS Improvement to work more closely together.*

The delivery of the LTP will be supported by the creation of an NHS Assembly in 2019. Its members will be drawn from, among others, national clinical, patient and staff organisations; the Voluntary, Community and Social Enterprise (VCSE) sector; the NHS Arm's Length Bodies (ALBs); and frontline leaders from ICSs, STPs, trusts, CCGs and local authorities.

An Appendix links the LTP to the attainment of wider social goals in six areas:

- *Health and employment.*
- *Health and the justice system.*
- *Veterans and the Armed Forces.*
- *Care leavers.*
- *Health and the environment.*
- *The NHS as an 'anchor institution'.*

Appendix – Selected Milestones and Markers

Milestones for urgent and emergency care

- *In 2019 England will be covered by a 24/7 Integrated Urgent Care Service, accessible via NHS 111 or online.*
- *All hospitals with a major A&E department will:*
  - *Provide SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20.*
  - *Provide an acute frailty service for at least 70 hours a week. They will work towards achieving clinical frailty assessment within 30 minutes of arrival.*
  - *Aim to record 100% of patient activity in A&E, UTCs and SDEC via ECDS by March 2020.*
  - *Test and begin implementing the new emergency and urgent care standards arising from the Clinical Standards Review, by October 2019 - Further reduce DTOC, in partnership with local authorities.*
- *By 2023, CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.*

Every ICS will have:

- *A partnership board, drawn from and representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate - local authorities, the voluntary and community sector and other partners.*
- *A non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/ governing bodies.*
- *Sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes.*

- *Full engagement with primary care, including through a named accountable Clinical Director of each primary care network.*
- *A greater emphasis by the Care Quality Commission (CQC) on partnership working and system-wide quality in its regulatory activity, so that providers are held to account for what they are doing to improve quality across their local area.*
- *All providers within an ICS will be required to contribute to ICS goals and performance, backed up by a) potential new licence conditions (subject to consultation) supporting NHS providers to take responsibility, with system partners, for wider objectives in relation to use of NHS resources and population health; and b) longer-term NHS contracts with all providers, that include clear requirements to collaborate in support of system objectives.*
- *Clinical leadership aligned around ICSs to create clear accountability to the ICS. Cancer Alliances will be made coterminous with one or more ICS, as will Clinical Senates and other clinical advisory bodies. ICSs and Health and Wellbeing Boards will also work closely together.*

Milestones for cancer

- *From 2019 we will start to roll out new Rapid Diagnostic Centres across the country.*
- *In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days.*
- *By 2020 HPV primary screening for cervical cancer will be in place across England.*
- *By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.*
- *By 2022 the lung health check model will be extended.*
- *By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers*
- *By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.*

Milestones for cardiovascular disease

- *The NHS will help prevent up to 150,000 heart attacks, strokes and dementia cases over the next 10 years.*
- *We will work with our partners to improve community first response and build defibrillator networks to improve survival from out of hospital cardiac arrest.*
- *By 2028 the proportion of patients accessing cardiac rehabilitation will be amongst the best in Europe, with up to 85% of those eligible accessing care.*

Milestones for stroke care

- *In 2019 we will, working with the Royal Colleges, pilot a new credentialing programme for hospital consultants to be trained to offer mechanical thrombectomy.*
- *By 2020 we will begin improved post-hospital stroke rehabilitation models, with full roll-out over the period of this Long Term Plan.*
- *By 2022 we will deliver a ten-fold increase in the proportion of patients who receive a thrombectomy after a stroke so that each year 1,600 more people will be independent after their stroke.*
- *By 2025 we will have amongst the best performance in Europe for delivering thrombolysis to all patients who could benefit.*

Milestones for mental health services for adults

- *New and integrated models of primary and community mental health care will give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023/24.*
- *By 2023/24 an additional 380,000 people per year will be able to access NICE-approved IAPT services.*
- *By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis. We will also increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways. Families and staff who are bereaved by suicide will also have access to post-crisis support. By 2023/24, we will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis.*
- *Mental health liaison services will be available in all acute hospital A&E departments and 70% will be at 'core 24' standards in 2023/24, expanding to 100% thereafter.*

Examples of specific requirements in the Workforce Implementation Plan

For cancer, we need to recruit an additional 1,500 new clinical and diagnostic staff across seven priority specialisms between 2018 and 2021. Since 2017, there has been a net increase of 833 FTE staff across the seven priority specialisms.

The mental health sector is already delivering innovative workforce solutions to meet the needs of patients. As well as an increase in the recruitment and retention in mental health medical training, new roles, such as physician associates, nursing associates, AHP associates and Advanced Clinical Practitioners are an important part of meeting current and future workforce demands. The evidence for these approaches is strong –

introducing Peer Support Workers to acute settings has been shown to reduce readmissions.

We will work with HEE to modernise the stroke workforce with a focus on cross-specialty and in some cases cross-profession accreditation of particular competencies. This will include work with the medical Royal Colleges and specialty societies to introduce a new credentialing programme for hospital consultants from a variety of relevant disciplines who will be trained to offer mechanical thrombectomy.

Milestones for digital technology

- *During 2019 we will introduce controls to ensure new systems purchased by the NHS comply with agreed standards, including those set out in The Future of Healthcare.*
- *By 2020, five geographies will deliver a longitudinal health and care record platform linking NHS and local authority organisations, three additional areas will follow in 2021.*
- *In 2020/21, people will have access to their care plan and communications from their care professionals via the NHS App; the care plan will move to the individual's LHCR across the country over the next five years.*
- *By summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system.*
- *In 2021/22, we will have systems that support population health management in every Integrated Care System across England, with a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation.*
- *By 2022/23, the Child Protection Information system will be extended to cover all health care settings, including general practices.*
- *By 2023/24 every patient in England will be able to access a digital first primary care offer (see 1.44).*
- *By 2024, secondary care providers in England, including acute, community and mental health care settings, will be fully digitised, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored and transmitted electronically, supported by robust IT infrastructure and cyber security, and LHCRs will cover the whole country.*

Glossary

5YFV: Five Year Forward View
A&E: Accident and Emergency
AHSN: Academic Health Science Network
AI: Artificial Intelligence
ALB: Arms Length Body
CAS: Clinical Assessment Service
CCG: Clinical Commissioning Group
CQC: Care Quality Commission
DTOC: Delayed Transfer Of Care
ECDS: Emergency Care Data Set
GIRFT: Getting It Right First Time
GP: General Practitioner
HEE: Health Education England
FTE: Full-Time Equivalent
HPV: Human Papilloma Virus
IAPT: Improving Access to Psychological Therapies
ICS: Integrated Care Systems
LHCR: Local Health Care Records
LTP: Long Term Plan
NHS: National Health Service
NICE: National Institute for Health and Care Excellence
QOF: Quality and Outcomes Framework
SDEC: Same Day Emergency Care
STP: Sustainability and Transformation Partnerships
UTC: Urgent Treatment Centre
VCSE: Voluntary, Community and Social Enterprise