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Sustainability plan:

Infrastructure support for the City and Hackney's placed-based health system after September 2023

Civil Society Consulting

Contents

Executive Summary

The **VCS Enabler**, delivered by **Hackney CVS** since 2021, provides infrastructure support to City & Hackney's voluntary and community sector (VCS) to promote its integration into the City & Hackney Health and Care system.

The Health and Care Act 2022, which came into force in July 2022, contains reforms that make City and Hackney's health and care system now part of the new North East London (NEL) Integrated Care System (ICS). The funding for the VCS Enabler, which now comes from the NEL Integrated Care Board (ICB) rather than the City and Hackney place-based system, is **non-recurrent**. Funding so far agreed permits delivery of the VCS Enabler until the end of March 2025, with no continuation funding beyond this point yet identified. Moreover, there have been two key breakdowns of communications that mean the statutory health system is unclear about whether the VCS Enabler is meeting the needs of City & Hackney placed-based partnership: Hackney CVS has not been made aware of a change in aims; meanwhile, the statutory system has not been aware of many of the positive outcomes that the VCS Enabler has brought about. Therefore, at the request of the ICB, **Hackney CVS** has commissioned **Civil Society Consulting CIC (CSC)** to co-produce this **sustainability plan** with beneficiaries and stakeholders from across City & Hackney's VCS and statutory health system (including those from NHS and local authorities).

There are many factors that have been considered to produce this plan. In a nutshell:

1. **The VCS is needed to tackle the health crisis through delivering holistic and preventative support to those most impacted by health inequalities**, hence the statutory health and care system's legal obligation to support and leverage the VCS as an equal partner in health (stipulated in the Health and Care Act 2022).
2. **Integrating the VCS as an equal partner is hard, and infrastructure support is key for the place-based health and care system to fulfil its legal obligation**: VCS and statutory health sector professionals approach and deliver their work very differently and there is an inherent power dynamic, so an independent intermediary is needed for successful integration of the VCS into the ICS.
3. **The health and care system is financially constrained which means there will likely be a severe reduction in funding for infrastructure support in City and Hackney**, requiring the VCS Enabler delivery structure to be stripped-back and/or funding needs to be sourced from elsewhere.

This sustainability plan presents what CSC found to be the optimum solutions to best meet the multifaceted and complex needs of all stakeholders, whilst recognising financial challenges of the system in City & Hackney.

This plan proposes **three models** through which infrastructure support could be delivered. These three models correspond to three different funding scenarios: a **Gold** Standard VCS Enabler, if the current level of funding is sustained (potentially from funding from outside the borough); a **Silver** Standard, if funding is reduced by 30-40%; and **Bronze**, if funding is severely reduced. All three of these potential models endeavour to be both efficient *and* equitable; in light of the inverse care law, lower investment is likely to put VCS organisations led by and for marginalised communities (which are often smaller) at a disadvantage.

Our approach to sustainability planning has been to strip the VCS Enabler back down to its core purpose (the core functions needed, in terms of infrastructure support, to enable the VCS' integration into the City & Hackney health and care system as equal partners) before building back

in what works, and leaving out what does not work. Three **core functions** emerged from CSC's workshops with stakeholders:

1. **Enable VCS and statutory health partners to locate one another and navigate each other's worlds**
2. **Facilitate the VCS to participate in the statutory health system's decision-making (equitably)**
3. **Enable statutory health funding to flow into City and Hackney's VCS organisations**.

There are a number of catalysts required to deliver the three core functions of the VCS Enabler:

- **Advocacy**: gathering the views of VCS organisations (who are not always in a position to advocate for themselves) and sharing with the statutory health system.
- Ensuring a level playing field by **embedding Equity, Diversity and Inclusion** principles throughout all three functions.
- **Connecting VCS with one another** as well as with statutory professionals.
- **Identifying opportunities and community assets** (e.g. VCS intelligence, complementarity between different partners) so that they can be leveraged.
- **Communications** that keep everyone on the same page.

It was agreed that the VCS Enabler should aim to reduce the need for infrastructure support further down the line by reducing the barriers to VCS integration.

This plan explores the challenges of VCS integration in City and Hackney, and the strengths and weaknesses of the current model before presenting recommendations for improving (1) **clarity and accountability**; (2) **efficiency and impact**; (3) **legacy and sustainability**. Key recommendations incorporated in all three models include the following:

- Establish more clarity by developing a restructured model for delivering infrastructure support that **directly addresses the three core functions** of the VCS Enabler (e.g. by producing tangible maps that will enable VCS and statutory professionals to locate one another and navigate each other's worlds).
- Save resources and capacity whilst creating more alignment between the VCS Enabler and the statutory health system by **reducing the number of networks, forums and working groups** and developing a new structure that is **more closely aligned with the new place-based system** (e.g. networks, forums and working groups could be aligned with statutory health priorities).
- Establish a line of accountability between Hackney CVS and the City & Hackney Health and Care Board by ensuring there is **one focal point managing the VCS Enabler grant**.
- Keep EDI at the heart of the VCS Enabler, by continuing to **support, catalyse and empower grassroots organisations led by and for marginalised communities**.
- Ensure advocacy is heard and the work is valued by channelling advocacy messages through one channel: instead of being integrated into every aspect of the VCS Enabler's work, **advocacy could be isolated as its own workstream**.
- **Support VCS-VCS relationship development through informal get togethers on 'interdisciplinary' topics**: the VCS will be more resilient if there is a supportive and collegiate culture among VCS organisations, and organisations can trust one another to advocate for their needs.
- Allow the VCS Enabler greater focus by **measuring its success in terms of outputs, not outcomes**.

CSC also documents other opportunities identified that may be worth exploring and a number of notable operational constraints, before setting out three recommended models that incorporate all the recommendations outlined:

- **Gold** (if the same level of funding is able to be sustained - probably from other sources), which is characterised as:
    - Refocused, optimised version of the current model
    - Restructured but uncompromising on moral principles
    - Long-termist.
- **Silver** (if the dedicated VCS Enabler budget was cut by around 30-50%), which is characterised as:
    - Slimmed down version of the current model
    - Closely tied to the statutory healthcare system and its priorities
    - Efficient but prosaic.
- **Bronze** (if the level of funding is severely reduced, and only the bare minimum is possible), which is characterised as:
    - The bare minimum
    - Tangible infrastructure but minimal active support.

The key point of difference between the three models is the number of 'core functions' being delivered, and the level of support on offer under each core function area. Gold delivers all three core functions; silver, two; bronze, predominantly just the first (although some contributions to the second core function).

Having developed this sustainability plan, the Civil Society Consulting team was also in a position to produce recommendations on the planning process itself. When deciding how to use this plan, CSC recommends that decision-makers:

- **Use this sustainability plan** as an opportunity for **an honest conversation** about what is needed and/or wanted from infrastructure support.
- **Face the need to prioritise head on**. The VCS Enabler has been hindered by a lack of prioritisation in the past. Looking ahead, failure to prioritise will lead to the VCS Enabler continuing to be spread too thin.
- **Strike a balance between change and continuity**: Gold, Silver and Bronze all strike a balance between being different enough to inspire faith in the new model, but not so drastic that it leads to more (rather than less) confusion.
- **Anticipate the need for transition planning**: the activities the VCS Enabler carries out over the next two years should be spent laying the groundwork for whichever model the funder chooses on being presented with this sustainability plan (i.e. Gold, Silver or Bronze).
- **Make a record of the priorities and concerns already identified** through so that the good work done in the past does not get lost.
- **Be mindful of the "ikea effect"**: although many key decision-makers and stakeholders have helped to co-produce this plan, this plan has ultimately been produced by independent consultants. Key decision-makers need to develop buy-in to this plan to ensure the learnings and co-produced solutions are not wasted.

1. Context

This section explains the context for this analysis/report and sustainability plan, starting off with the wider context. This section has been condensed, and a longer version, containing more detail and justification on the abbreviated subsections, can be found in **Annex 1**.

a. The new health and care system

In the UK, the statutory health system is *"not a 'national health service but a national illness service"* (to borrow the words of one of the stakeholders that contributed to this plan and The Hewitt Review). The biomedical approach to health, though capable of miracles, focuses mainly on eradicating illness, and not enough on promoting good health and wellbeing (CSC, 2023).

In light of this, the UK is moving towards new approaches to health embodied in a new model of care: the Integrated Care System (ICS). The new system acknowledges each individual as a whole person whose health is affected by their socio-cultural and physical environment (rather than isolating specific aspects of their development or conditions as is characteristic of biomedicine). In so doing, the new system seeks to treat individuals **holistically** by providing joined-up care and puts greater emphasis on **prevention** of health issues, rather than curing ill health after it has materialised. Ultimately, the ICS, brought into force by the the Health and Care Act 2022, acknowledges that *"there's a place for health service, but there's so much preventative work that needs to be done around the clinical work [if we are to tackle health inequality]"*.

b. Why the VCS are equal partners in the new system

The VCS has a well-evidenced track record in delivering cost-effective preventive support. Its effectiveness is attributed to certain superpowers or *"USPs"*. Stakeholders in City & Hackney recognised that VCS organisations - particularly those that are grassroots - are **agile**, **trusted** by their communities, extremely **knowledgeable** of them and sincerely and deeply **motivated** to drive outcomes and change (see **Figure 1**). This corroborates with Civil Society Consulting's findings previously (CSC, 2023). Thanks to these core attributes, VCS organisations have impressive **reach** and already live by **holistic** and **preventative** approaches that the statutory health system is moving towards.

Charities led by and for marginalised communities are a particular asset for reaching those most affected by the social determinants of health and underserved by the statutory system. The VCS also have insights that are valuable for commissioners to be able to do their jobs effectively and access to useful data on key intersections of the population.

In acknowledgement of VCS organisations' USPs, the new ICS health system states that the VCS must be 'equal partners' in the new system.

Figure 1: word cloud of City and Hackney's "USPs", according to those that contributed to this plan

c. Why place-based infrastructure support

Across the country, ICSs are attempting to better **integrate the VCS as an *equal* partner in health**, but the transition is proving challenging. As it stands, VCS organisations are, for the most part, not appropriately supported, respected, recognised for their expertise or - let alone leveraged as serious partners in delivering support to prevent and tackle health issues. Certainly, this is what has been reported to us in City & Hackney from those that contributed to this plan - as well as what has been reported directly to Hackney CVS and to the independent evaluator of the VCS Enabler in spring of this year (2023).

Generally, challenges include the following:

1. **The relationship between statutory services and VCS is not equal, because statutory services have ultimate decision-making power.**
2. **The two sectors see and do things differently and often struggle to understand each other.**
3. **There are widespread funding shortages.**
4. **Both sectors are "vast" and difficult for the other to infiltrate.**

We, the authors, encourage you to read **Annex 1a** for an evidence-based explanation of each challenge.

These challenges are widely reported and can be regarded as the '**root causes**' of many practical barriers; the NHS has recently produced a framework/report which sets out these practical barriers to integration (NHS, 2023). Later in this plan, we will report how these challenges transpire as practical barriers to VCS integration in City & Hackney specifically.

Infrastructure support, often provided by an independent intermediary such as a CVS, offers a solution. Infrastructure support like City and Hackney's VCS Enabler — delivered by Hackney CVS — can help to overcome some of the immediate practical barriers to VCS-statutory service partnership working, as well as work to address some of the root causes for said barriers.

There are three key reasons infrastructure support is needed if VCS are going to be equal partners in the new system:

- **VCS and statutory health partners need help locating one another and navigating each other's worlds.**
- **VCS professionals need support, encouragement and advocacy when interacting with the statutory system in order to mitigate power dynamics.**
- **Statutory partners need support to help understand the VCS and how to work with them**

We noted that infrastructure support is of *particular* value now and in the initial years of the new system, because:

- **Getting systems and relationships in place now while the system still has flexibility will ensure VCS is embedded into the new system.**
- **Funding mechanisms need to be set up in order to create the foundations for partnership in the longer term.**
- **An independent intermediary is required to overcome the initial barriers presented by local politics and pave the way for an equal partnership (and equitable access to that partnership).**

Again, we invite you to read **Annex 1a** for a longer explanation of these factors.

City and Hackney is ahead of other localities, having had (since 2021) infrastructure support dedicated to promoting collaboration, understanding and integration between those working (from both sectors) to address health inequalities in City and Hackney. The infrastructure support is delivered through the '**VCS Enabler**'.

d. Infrastructure support in City and Hackney currently: the VCS Enabler

City and Hackney's VCS Enabler was established (and funded) by City & Hackney's Health and Care Board in 2021 prior to the NEL ICB coming into formation, at a time when City & Hackney – a local borough-based partnership – had independent decision-making powers.

Back when it was set up, the VCS Enabler aimed to support the VCS in City & Hackney so that VCS organisations can 'engage better' and 'co-produce more' with the statutory sector, with a focus on providing the mechanism for VCS to develop 'ready-to-fund' solutions to local health issues. See **Annex 1b** for a longer explanation and the aims of the VCS Enabler according to the original (and current) grant agreement.

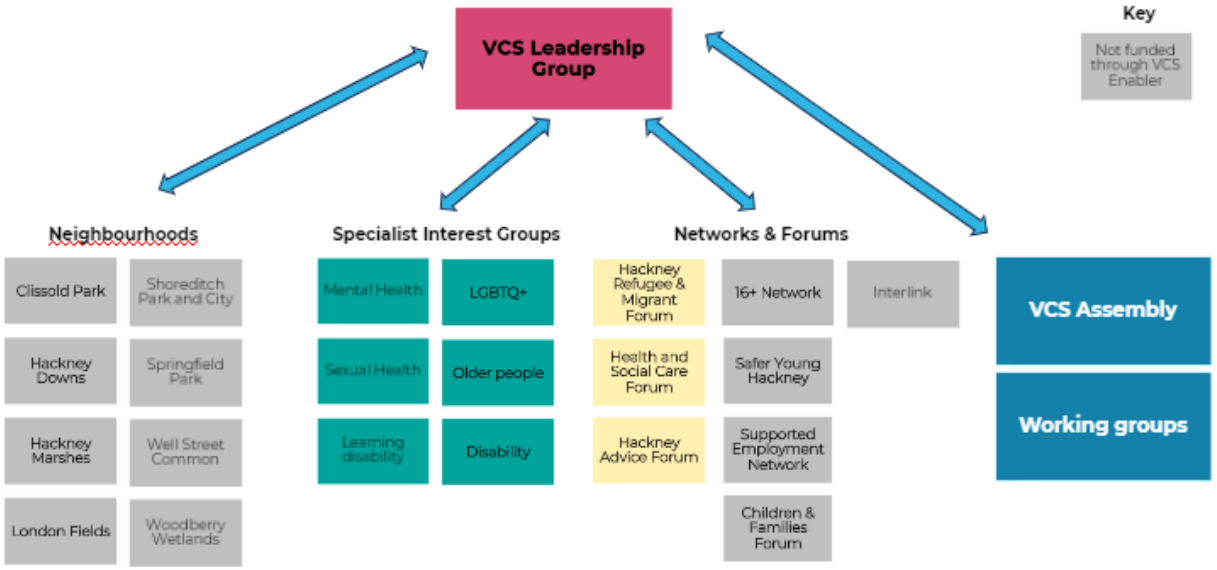
Since its inception in 2021, the VCS Enabler has been acting as a 'system convenor': the Enabler brings together the skills, expertise and passion of those working (from both sectors) to address health inequalities in City and Hackney. The key activities carried out by the VCS Enabler include:

- Convening networks, forums and working groups (including Special Interest Groups; SIGs), shown in **Figure 2** to connect professionals from both sectors, to support collaboration and co-produce solutions.
- Recruiting and actively supporting VCS representatives to participate in statutory health meetings.
- Advocating for the VCS' needs, concerns and priorities.
- Facilitating consortia and supporting them to apply for joint funding.

Hackney CVS are also, via a separate pot of funding, commissioned to deliver the City and Hackney Neighbourhood Forums, which are integrated into the VCS Enabler.

The VCS Enabler has successfully produced outcomes under all four of the aims in the original grant agreement. **Annex 1b** contains a more detailed overview of the current VCS Enabler, including key outcomes (highlights) from the last 12 months.

Figure 2: how is the VCS Enabler structured?



e. Why this sustainability plan?

As much as the current model for providing infrastructure support has produced some fantastic outcomes, **key players in the statutory sector are not currently convinced the VCS Enabler is delivering on its *desired* outcomes, serving the needs of the system**. It became evident that there are three main reasons for this:

- The aims of the Enabler have shifted since the grant agreement back in 2021 in light of the new integrated system without having been communicated to Hackney CVS); see **Annex 1b** for the original aims.
- Statutory sector professionals do not have a strong understanding of the needs of the VCS and have not been made aware of many of the positive outcomes.
- It is difficult to capture and measure the outcomes (as opposed to outputs) of infrastructure support.

What is more, **funding for the VCS Enabler is non-recurrent**. There are two reasons for this:

- Statutory sector budgets mean there will not be enough funding to sustain City and Hackney's VCS Enabler operating at the current level past 2025 (unless funding is secured from another source). In the words of one stakeholder: *"the current level of cash is unsustainable given the wider context… we did always know this before the one-off chunk of money that came in."*
- When it comes to improving VCS-statutory sector partnership working, the ICB is now looking to ensure equal levels of funding across the North East London boroughs. Having established the VCS Enabler prior to the new ICB coming into formation (when City &

Hackney had independent decision-making powers), City and Hackney are ahead of other boroughs in terms of funding and resources for place-based infrastructure. The ICB may decide to take a 'levelling down' approach (as opposed to a 'levelling up' approach), which would see City and Hackney funding restricted whilst other place level partnerships catch up.

In light of these pressures, the City & Hackney Health and Care Board, which represents the NEL ICB at place level, has requested a 'sustainability plan' before further funding is released.

This is the sustainability plan: the rest of this report presents the optimum way forward, proposing three possible new operating models for the Enabler, based on what is most needed to facilitate the VCS to become an equal partner within the City & Hackney health and care system - based on three possible funding scenarios.

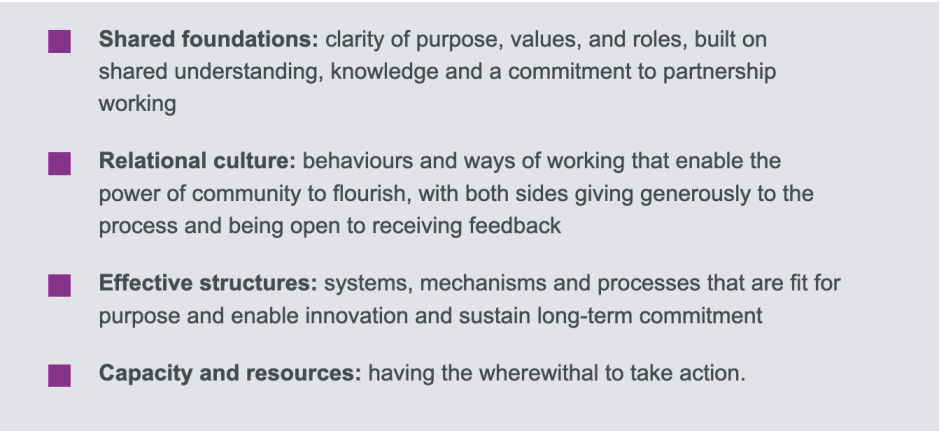
f. Civil Society Consulting's approach to sustainability planning

Our approach to sustainability planning has been to strip the VCS Enabler back down to its core purpose (the core functions needed, in terms of infrastructure support, to enable the VCS' integration into the City & Hackney health and care system as equal partners) before building back in what works, and leaving out what does not work.

The process has been **co-productive** and **iterative**. We discussed the core functions of the VCS Enabler with beneficiaries of the VCS Enabler (i.e. VCS organisations) and professionals from the statutory sector and local authority to learn that there are three core functions (21 stakeholders in total). The Local Government Association has identified four building blocks required for successful statutory-VCS partnerships (see **Figure 3**), which we used as a prompt in workshops to stimulate deeper/bigger-picture discussions about the challenges and opportunities for VCS integration. In a second round of workshops, we discussed the activities needed for (and most effective at delivering on) each of the three core functions.

Our approach is also characterised as **future-facing** - looking ahead to what's going to work going forward. By building on the independent impact evaluation carried out in the spring, we were able to focus on implementing lessons learned, rather than dwelling on them.

Figure 3: the four building blocks for successful statutory-VCS partnerships (LGA, 2023)



We have also been **action-oriented** (aiming to produce tangible suggestions of new ways to deliver the desired outcomes). It is well understood why we need VCS integration (e.g. Adebowale, 2022; New Local, 2022). And there was a consensus among stakeholders that City and Hackney

needs, and will need for the foreseeable, VCS infrastructure support to enable VCS integration - *"that's clear, everyone knows that"*. Therefore, this plan does not focus on *why* VCS need infrastructure support to integrate into the statutory health system, but *how* infrastructure support should look.

Even more specifically, this plan keeps a laser focus on *how* infrastructure support can be **optimised** under conditions of ever tightening resources. Whilst it is understood that infrastructure support for the VCS is needed, it seems very likely there will be a reduction in funding from the NEL ICB, which now controls the purse strings (as of July 2022).

The end-product is this plan, which:

1. Establishes the core purpose of the VCS Enabler.
2. Ascertains strengths and weaknesses of the current model, in order to be able take an 'amplification strategy' (i.e. taking what's good and growing it).
3. Explores challenges and avenues for optimisation.
4. Ascertains/proposes how and what to prioritise (and advocates for prioritisation, because under conditions of finite/tight resources, it's necessary to stay focused on those priorities).
5. Presents three possible options for 'VCS Enabler 2.0' - Gold, Silver and Bronze, which decision-makers can choose from. All of which are all realistic, however have differing levels of investment and therefore varying opportunities for achieving outcomes - emphasising the need to prioritise and work around constraints.

2. What is the core purpose of the VCS Enabler - now and going forward?

Our approach to sustainability planning has been to first of all strip the VCS Enabler back down to its core purpose. We asked VCS and statutory sector professionals to identify the core functions of place-based infrastructure support to promote VCS integration into the new system. **Three core purposes** came through. Interestingly, these are misaligned to the current aims as stipulated in the original grant agreement (see **Figure 7** in **Annex 1b**; these core functions don't fundamentally clash with the original aims, but their emphasis does slightly differ).

The core functions of the VCS Enabler, according to beneficiaries and stakeholders in City and Hackney, should be to:

1. Enable VCS and statutory health partners to locate one another and navigate each other's worlds

The *"vast and sometimes inaccessible"* statutory health system needs to know who is where, and who is doing what among the *"diverse and dynamic"* VCS. And vice versa. Statutory health professionals told us they need a map of the VCS (who's working on what, where, with which other organisations, at what scale, and how to contact them) including and especially smaller organisations led by and for marginalised communities. Meanwhile, the VCS need a means for navigating and approaching those in the statutory sector.

At its most basic, the first core function could be to provide two maps of each sector. A more developed function could offer active support to stakeholders to use the map (e.g. helping key statutory professionals to identify organisations with potential to contribute to the health goals

they're working towards, particularly those led and by and for marginalised communities). Further still, active support to then build understanding and relationships between the relevant individuals.

2. Facilitate the VCS to participate in the statutory health system's decision-making (equitably)

As equal partners, VCS need to be involved in the design of services. VCS organisations know about the issues in the real world and can advocate for their communities to maximise the effectiveness of services. They also know what's achievable for VCS organisations to deliver; and without their voices to set expectations, VCS organisations awarded commissions/funding could be set up to fail. However, because of the power imbalance vis-a-vis the statutory sector, the nature of who works in each of the organisation types and a history of not feeling recognised or valued, the VCS require active support to participate in statutory meetings (e.g. encouragement, coaching and confidence building, support translating system jargon).

At its most basic, the second core function could be to recruit and support VCS representatives to participate in statutory health sector meetings. However, this works best if VCS are also connected to each other - so able to represent the interests of the whole sector. Better still, to build a positive culture that will reduce the need for infrastructure support in years to come: some decision-making should take place on 'VCS turf' - in VCS-led spaces where VCS are comfortable and have space to contribute. At its more developed, the second core function could entail identifying which areas/health priorities VCS organisations can contribute to/lead on.

3. Enable statutory health funding to flow into City and Hackney's VCS organisations

Throughout the development of this plan, stakeholders firmly asserted that the ultimate aim of the VCS Enabler was to ensure funds to flow to VCS organisations from the statutory health system - whether that through service development, commissioning and delivery or grant funding. *"The only way to get, and maintain, a vibrant and sustainable VCS [that is an equal partner] is for there to be a significant, and recurring budget for prevention (which is mostly, but not exclusively, what the VCS does), which is given to the VCS as a sector…."*

The facilitation of funding was regarded as the ultimate indicator of a successful VCS Enabler. Functions 1 and 2 pave the way for funding to flow into the VCS, but a third function of the VCS Enabler could be to 'convert' relationships formed into funded partnerships.

As with the first core functions, the third core function could be more basic or more developed.

There are a number of **catalysts** required to deliver the three core functions of the VCS Enabler:

- **Advocacy**: gathering the views of VCS organisations (who are not always in a position to advocate for themselves) and sharing with the statutory health system.
- Ensuring a level playing field by embedding **Equity, Diversity and Inclusion** principles throughout all three functions.
- **Connecting VCS with one another** as well as with statutory professionals.
- **Identifying opportunities and community assets** (e.g. VCS intelligence, complementarity between different partners) so that they can be leveraged.
- **Communications** that keep everyone on the same page.

As well as answering to the immediate needs of the place-based partnerships, which are the foundation of Integrated Care Systems (NHS England, 2021), ultimately, the VCS Enabler should aim to reduce the need for infrastructure support further down the line by addressing the root causes outlined in the subsection above - e.g. supporting the statutory sector to develop commissioning processes that are more equitable and inclusive.

3. What are the challenges of VCS integration in City and Hackney?

The time for VCS integration is now. There is an incredible amount of **goodwill** on both sides and change is in the air as professionals from both sectors believe the new system is moving in the right direction. Good progress has been made already. City and Hackney's Public Health team evidently value the VCS and already have a good sense of how they need to change their systems/approach to work with them successfully (some of which has already been started). Those working in the NHS are moving in the right direction too (e.g. there has been relaxing the requirements of competitive tendering to complement the new ICS).

What's more, we learnt that the ICB has an **incoming budget that is ring-fenced for funding VCS organisations to tackle health inequalities**, so the statutory system means to develop relationships with VCS and put some of the new approaches/ideas into action.

Ultimately, there is a **window of opportunity** to develop a new system of working together.

However, there are numerous challenges to VCS integration, which present barriers to the VCS taking up its rightful place as equal partners in City and Hackney. These are factors that make infrastructure support necessary, others are factors that 'VCS Enabler 2.0' needs to work around/circumvent.

With professionals from City and Hackney's VCS and statutory health system, we discussed and mapped the current **challenges** to VCS integration/partnership (and, later, the **opportunities** for overcoming these through infrastructure support). As part of the plan development process, we have thematically analysed these findings; they are summarised below and the analysis is documented in more detail in **Annex 2**.

1. There is a **lack of mutual understanding between the statutory health system and VCS professionals**; stakeholders expressed that it is difficult to navigate one another's 'worlds' and the VCS often does not feel respected/valued by the statutory health system.
    - In many cases, the VCS has some mistrust of the statutory sector.
    - Those working in the NHS have an inconsistent and often weak understanding of how the VCS works, including: (1) underestimating just how little infrastructure the VCS has and (2) underestimating the VCS' level of expertise. It's also difficult for the statutory system to (3) get a full picture of the VCS: there are over 1,950 independent organisations in City and Hackney; they are all different because they have all sprung up organically according to need. The voices of those from larger, more established

organisations are more easily heard, so the statutory sector can struggle to get a full picture of the VCS (unless individuals have worked in the VCS before). There are also (4) misunderstandings of how much VCS organisations and projects cost to run leading to constant requests from statutory partners to deliver more for less.

2. Resulting from a weak understanding of the VCS, **the statutory sector's expectations of VCS organisations are misaligned with reality**:
    - **VCS are expected to operate like businesses** in order to participate in competitive tendering. However, they operate very differently to the statutory/private sector, and these differences should be recognised and respected.
    - **Many VCS organisations are not set up to work in the statutory sector framework** and are coming from a low-base in terms of their understanding of how the statutory health system works, yet the expectation is that VCS organisations will *"come to us"* rather than statutory health partners having the responsibility to *"go to them"*. What's more, the VCS have **internalised feelings of inferiority** in relation to the statutory sector that can be difficult for statutory health professionals to appreciate. VCS organisations require support and encouragement to be able to participate in statutory meetings, including help translating acronyms and "jargon", as well as general words of encouragement. They require coaching in order to have the confidence to participate in meetings.
    - **Impact measurement looks different for different VCS organisations**: (1) for those working on prevention, outcomes are notoriously hard to measure, (2) positive health outcomes are long-term and take time to materialise and it is hard to identify causality and (3) working with intersectional communities tends to be associated with depth of impact (profound change in a smaller number of individuals).
3. **Capacity on both sides is extremely limited:**
    - **The VCS lacks resources due to lack of long-term and core funding**, including a lack of funding from the statutory health and care system (which occurs due to a combination of ingrained culture, internal processes and regulation, and limited resources in the first place; explained in greater detail in **5b**). The health system's current funding practices do not enable VCS to work in a long-termist way and encourages VCS to compete with each other for funding and influence, which perpetuates the already imbalanced playing field. With limited capacity/resources to dedicate to monitoring and evaluation, **VCS organisations can find it difficult to communicate their impact** - especially in light of the misaligned expectations mentioned above.
4. **Inherent power dynamics are omnipresent:**
    - As a funder or potential funder, **the statutory sector controls resources**, so has centralised **power** over the VCS.
    - There is also **inequity within the VCS**: smaller organisations led by and for disadvantaged parts of the community face barriers to funding (CSC, 2023) and therefore achieving growth and influence. Many smaller organisations successfully reaching priority/underserved communities lack capacity and struggle to 'speak the language' of the system, which means their ideas and solutions aren't being accessed (e.g. they might know what needs to happen in terms of systems change because of their cultural knowledge and panoramic vantage point, but not have the confidence, language skills or opportunity to get these perspectives heard).

5. **The statutory health and care system partners are still *"finding its feet"* in terms of the new way of working**: the statutory health and care system is identifying how it would like to approach prevention, including allocation of place-based resources, which they are keen to spend and measure to work out to determine what has the biggest impacts. The system is still in the process of moving away from siloed working, whilst working with tightening financial resources. Under these conditions, it has been difficult to develop the **shared foundations** between statutory and VCS needed for an effective partnership, and the complexities of working collaboratively across organisations with different cultures.
6. **Both sectors' workforces are burnt-out**, due to perpetual crises (ie. the pandemic and Cost-of-Living crisis) that have led to increased demand and urgency of services, paired with prolonged periods of underfunding. In times of stress, we resort back to our 'default settings' (i.e. siloed working and non-preventative) and find it difficult to open our mind to new ideas/approaches and create new behaviours, which the new way of working requires. According to stakeholders, this regression back to default settings has happened post-pandemic. In the context of underfunding, low capacity leading to high levels of burnout, the task of addressing the determinants of health, whilst addressing the immediate effects of health inequalities is **overwhelming**.
7. **There are some 'weak links' in terms of relationship development:**
    - **There has been a loss of connections/relationships** between the VCS and the statutory sector due to the many changes that the NHS has been through, as well as the Covid-19 pandemic. Staff turnover has also been relatively high in recent years; turnover is expected to remain a challenge.
    - **Local politics is conspicuous across City and Hackney's health and social sector** (politics with a lower-case "p"). Individuals within both the VCS and statutory sectors have worked with each other in different contexts over many years and some relationships have been damaged and trust broken. There were numerous examples given where multi-stakeholder cooperation has been inhibited as a result of internal politics creating tension and confusion between key individuals.
8. **Unless/until the ICS funds the VCS sufficiently, it is not possible/appropriate to stipulate what the VCS should do**. For example, It is not possible to request/expect that the VCS delivers on the health priorities without funding them, especially if the priorities don't reflect what the VCS recognise as a priority.

4. Strengths and weaknesses of the current model

We identified and analysed strengths and weaknesses of the current model, according to City & Hackney stakeholders. The columns below set out the strengths and weaknesses of the current model relevant to sustainability planning.

Strengths	Weaknesses
As a partially council-funded and -affiliated entity, Hackney CVS has **convening power** and brings	**The current aims of the VCS Enabler are not aligned with what the statutory**

continuity, which makes it possible for the VCS Enabler to take a long-termist approach to providing infrastructure support. Plus the rest of its **infrastructure work (not all specific to health)** complements the outcomes of the VCS Enabler: Hackney CVS delivers the City and Hackney Neighbourhood Forums model, which ensures key insights and expertise are shared across the programmes to ensure the design and delivery of activities that have maximum impact and organisational development support.

The VCS Enabler is **successfully engaging smaller, grassroots organisations led by and for marginalised communities**, which have a particularly crucial role to play in tackling health inequalities in City and Hackney. Moreover, the current VCS Enabler understands the need to provide **active support, encouragement and coaching** to these invaluable partners in health, and prioritises this work.

Relationships and networks have successfully been developed through the Enabler:

- **VCS-VCS relationships are becoming more collaborative and less competitive**: as well as co-producing solutions, SIGs and assemblies bring VCS professionals together as collaborators (not competitors) and gradually build consensus and trust among them.
- **Consortia** have been established and successful in joint funding applications. For example a group of organisations from Learning Disability and Autism SIG won a LBH tender to deliver a project developing accessible communications.
- **VCS feel more connected to the statutory sector**: The VCS reported feeling much more connected to and enabled to be *"in the conversation"* with the statutory sector, more able to air issues, share insights and understanding, more

health system wants to get from it, because of a failure to recognise and communicate a change in aims. As a result, much capacity has been going into developing SIGs and assemblies. Although they produce impressive outcomes, SIGs and assemblies cannot solely f deliver on the three core functions of the VCS Enabler (ie. what's needed).

The VCS Enabler's structure is not sufficiently aligned with the statutory health and care system. The VCS Enabler has been delivered via numerous entities (i.e. networks, forums and working groups/SIGs), rather than built off statutory structures and frameworks. The health and care system perceives that *"the VCS Enabler has created a whole new separate structure"* rather than supporting the VCS to map onto each other's existing structures. Additionally, SIGs and assemblies do not entirely correspond to local health priorities nor align well with the new Neighbourhood lens the health system is moving towards.

There is not one focal point in the health system managing the VCS Enabler contract, which generates more work, confusion/ambiguity and, ultimately, more margin for misunderstanding and messages being lost. Instead of having one line of accountability, as it stands, Hackney CVS liaises with multiple decision-makers in the health and care system, and has to piece together different instructions to establish its own brief; there is no clear line of reporting either.

The VCS Enabler is 'spread too thin'. As a result it **lacks clarity** of purpose and people are confused about what it does, as well as how to interact/engage with it. According to evaluation findings: having too many functions and doing too many things means that depth of impact is being sacrificed. The VCS Enabler is trying to answer all immediate needs of the system, whilst also building a system/culture for the future - *"that's a lot!"* In *"trying to do everything"*, the structures created for the VCS Enabler are confusing and convoluted, which presents a barrier to VCS organisations'

listened to and heard, more validated and appreciated.

A constructive and collaborative culture has been cultivated within the VCS Leadership Group and other VCS Enabler networks, forums and working groups. There are two particularly enthusiastic and productive SIGs: Refugee and Migrant and LGBTQIA+.

The VCS Enabler has a bank of solutions and a good grasp of VCS priorities and concerns, which can lead/guide the VCS Enabler going forward. VCS Enabler networks, forums, working groups and assemblies, which typically have 20-30% attendance from statutory partners, have produced some good outcomes. Both VCS and statutory partners that participated in assemblies and SIGs were impressed with the solution development and outcomes that came from these co-productive sessions. VCS organisations reported making use of the insights they gained in the assembly meetings (e.g. a representative from Mind reported that assemblies have provided insights that are influencing their work).

All the good work that's been done on anti-racist commissioning, has led to the creation of resources, thought leadership, to support the statutory sector to implement new good practices.

effective involvement because they do not understand how the VCS Enabler works.

Low levels of participation from key players in the statutory health system and from large VCS organisations undermine the VCS Enabler. VCS professionals are co-producing valuable solutions via SIGs and Assemblies, but because it's on *"VCS turf"* when there is low-levels of participation from senior statutory health professionals. From the perspective of the VCS, there is no buy-in, faith in, or deep understanding of the outputs by the statutory sector.

Additionally, greater participation from the statutory sector, as well as from larger VCS organisations (who are also underrepresented in meetings) would strengthen the credibility of solutions co-produced in SIGs and assemblies, as well as drive them forward.

Assemblies and SIGs are producing more solutions than they have time/capacity to follow through on, which risks creating a sense of disillusionment and inhibits the Enabler's focus. Some contributors were also concerned that SIGs and assemblies are achieving similar results, so is there duplication.

The current model has not created effective structures (systems, mechanisms and processes) or communications channels. As a result, there remains a **lack of tangible infrastructure**, so no legacy to all the institutional knowledge developed among the team. Also, the VCS Enabler has not successfully communicated what it does and what the outcomes are. Given the *"confusing"* structure, it would have been beneficial to develop **constitutional documents** that could be easily shared, but this has not happened. Clear communications and reporting channels have also not been established with the system.

Infrastructure outcomes are not well-understood by statutory health system professionals, which appears to lead to

statutory health professionals undervaluing the work of the VCS Enabler, and being influenced by the opinions of larger organisations who they have more contact with.

- **VCS infrastructure is coming from a low base**: statutory health do not appreciate how little infrastructure there is besides the VCS Enabler, and therefore do not have a good understanding of the value being added by the VCS Enabler.
- **The value of connecting the VCS with one another is not understood**: there is little understanding of/appreciation for the value of stimulating the creation of strong VCS-VCS relationships among statutory health professionals.
- Many VCS Enabler outcomes are **ad-hoc.**
- **Infrastructure outcomes are difficult to track and measure**.
- **Shooting the messenger:** the statutory system doesn't appreciate the value of the Enabler's advocacy work because oftentimes they're telling the statutory health system *"things they don't want to hear"*. Multiple advocacy messages shared through different channels are not heard by key decision-makers; there is no line of accountability and the messages get lost.

5. How should VCS Enabler 2.0 look?

This section paints a picture of how the new model of infrastructure support could look, providing our recommendations on delivering it successfully, whilst noting known constraints, which decision-makers should be mindful of. These recommendations and constraints are incorporated in the Gold, Silver and Bronze models presented in the following section.

a. Our recommendations: opportunities to deliver more impactful and efficient infrastructure support

Following two rounds of workshops, we had iterative discussions to identify opportunities to: (1) overcome the challenges presented by the current system, (2) amplify the strengths of the current

model, and (3) mitigate its weaknesses. From these opportunities, we have developed the following recommendations.

Clarity and accountability

- Establish more clarity by developing a restructured model for delivering infrastructure support that **directly addresses the three core functions** of the VCS Enabler. In other words, organise activities according to the core functions they're contributing to - for example, by producing tangible maps that will enable VCS and statutory professionals to locate one another and navigate each other's worlds. This clearer structure will benefit VCS and statutory professionals that, currently, aren't clear on what the VCS Enabler does, as well as for the team at Hackney CVS delivering it/overseeing the communications and reporting.
- Create more alignment between the VCS Enabler and the statutory health system by developing a new structure that is **more closely aligned with the new place-based system** (e.g. networks, forums and working groups could be aligned with statutory health priorities).
- Support the VCS Enabler to focus on its role and better report on what it's doing, by developing a **more structured theory of change**, to support a model that focuses on outputs rather than the outcomes that we hope these outputs will lead to. Health outcomes take time to materialise and are often multi-causal, and therefore notoriously hard to measure. It is more appropriate to measure the success of health infrastructure support in terms of outputs, rather than outcomes.
    - A more output-oriented model - i.e. a model that's structured according to the three core functions - will likely help to establish clarity for/around the VCS Enabler, as the Enabler would be accountable for delivering the outputs and more able to focus on those.
    - A more structured theory of change (e.g. an itemised flow diagram) would help ensure it is possible to meaningfully monitor and evaluate this more output-oriented model, because it could be used to identify KPIs that correspond to desired outcomes.
- Ensure advocacy is heard and the work is valued by channelling advocacy messages through one channel: instead of being integrated into every aspect of the VCS Enabler's work, **advocacy could be isolated as its own workstream**. 'De-integrating' the Enabler's advocacy work may be a better way of getting through to key people in the statutory health system, whilst also ensuring that advocacy is counted and valued as a deliverable (whereas currently, the effort put into advocacy goes somewhat unnoticed by the funder). Instead of advocating on key messages in a general way in various contexts informally, the messages could be delivered in a dedicated space and through a formal channel (such as a dedicated quarterly meeting, at which minutes are taken); having a more formal communications channel will also improve accountability as there will be a clear record of which advocacy messages have been shared/heard.
- Establish a line of accountability between Hackney CVS and the City & Hackney Health and Care Board by ensuring there is **one focal point managing the VCS Enabler grant**. Hackney CVS can report back to this one person on KPIs and annually reflect on the core functions of the Enabler. As it stands, Hackney CVS liaises with multiple decision-makers in the health system, integrates the different messages and, in effect, establishes its own brief;

this generates more work, confusion/ambiguity and, ultimately, more margin for misunderstanding.

Efficiency and impact

- Establish clearer focus still by **identifying areas of work (e.g. health priorities) on which VCS is best-placed to lead**, as well the areas on which VCS is more suited to contributing. The clearer sense of roles and focus will improve efficiency, as well as paving the way for an equal partnership to reduce the need for infrastructure support in the future.
- Save resources and capacity by making good use of all the outputs that the VCS Enabler has already produced. Assemblies and SIGs have co-produced more ideas for solutions than there has been time to pursue or implement, any future version of the VCS Enabler should **continue to be guided by this bank of solutions**, and led by everything the VCS Enabler already knows about VCS priorities and concerns.
- Save resources and capacity whilst improving clarity by **reducing the number of networks, forums and working groups**, prioritising instead better integration with the existing Neighbourhood Forums (funded from another pot), in favour of the development of one quarterly intersectional VCS Health and Social Care Forum. The VCS Health and Social Care Forum could amalgamate the forums, networks and working groups (SIGs) that will be lost. In addition and more specifically, we recommend:
    - **Discontinuing assemblies all together**: Assemblies are an effective, positive space that contribute to the original aims of the VCS Enabler: “what’s good about assemblies is getting a whole bunch of people in a room together that all really care and… gets everyone working towards the same goals”. However, assemblies do not contribute directly to the core functions of the VCS Enabler. What’s more, they are incredibly time-consuming to organise. At the current cadence, assemblies produce more content/ideas than there is time/capacity to pursue/implement.
    - **Replace SIGs with intersectional working groups that are working towards health outcomes**: Grassroots organisations appreciate SIGs, but larger organisations less so and the statutory health system hardly at all. According to the statutory health system, SIGs do not drive commissioning activity. Another challenge for SIGs in their current form is that the health system wants to use the Neighbourhood lens. It seems we need to end up with a small number of impactful strategic groups. One contributor strongly suggested the SIGs should be used for more specific discussions on topics areas defined by health (specific to ensure good attendance and meaningful discussion; defined by health to ensure the conversations are useful to health and driving towards some definite action).
    - **Continue and strengthen more informal/unstructured networking opportunities**, such as coffee mornings - instead. Informal networking could produce similar results in terms of building relationships, whilst being less capacity-intensive to facilitate.
    - To optimise resources and increase alignment with the statutory system, we recommend **making greater use of the statutory meetings** - the organisation and facilitation of which does not need to be covered by the VCS Enabler. Any resources saved coordinating fewer networks, forums and working groups could be spent on or reserved for providing active support to VCS representatives to encourage and coach them to participate in the statutory meetings. However, it is

important for partners to recognise the possible limitations of the VCS contribution to these meetings and then the reduced depth of 'insight' and input. Focusing on VCS participation in statutory meetings will only work if concerted effort goes into making the meetings actively inclusive to all VCS representatives, as the VCS Enabler has been able to achieve. Moreover, we strongly recommend more than one VCS representative at each meeting (though we are mindful that VCS representatives need to be remunerated so there are budgeting implications).
        - Also of note, the ICS is changing the current rhythm of Health and Care Board and Neighbourhood Health and Care Board meetings. The plan is to reduce the frequency of formal board meetings, and add into the mix regular 'development meetings' in between board meetings. If VCS could contribute to them, these development meetings could provide a further (and ideal) opportunity to integrate the VCS into ICS decision-making.
- Keep EDI at the heart of the VCS Enabler, by continuing to **support, catalyse and empower grassroots organisations led by and for marginalised communities**. Marginalised communities were the only clear priority that came through when discussing demographics, organisation type and health priorities: people could not prioritise one health priority (see Annex 2) over another or identify any specific demographics that should be prioritised by the VCS Enabler; however, prioritisation of the 'furthest behind first' was unanimous.
  There is an inference here that the VCS Enabler should prioritise smaller/grassroots organisations, as they are most likely to be addressing the needs of the 'furthest behind'. This said, contributors were slow to point to one organisational size/type that should be prioritised over others because the success of the VCS Enabler hinges on high levels of participation from all VCS organisations.

Legacy and sustainability

In a general way, we recommend balancing the infrastructure needs of today whilst promoting cultures and systems that will reduce the need for infrastructure support in the future:

- Build the statutory sector's understanding of the VCS by continuing **advocacy** work, positioning Hackney CVS as a "critical friend".
- Developing a **self-assured VCS that is confident in its USPs and comfortable communicating with the statutory health system** will help to reduce the dependency on infrastructure support further down the line. As above, the VCS Enabler should support, catalyse and empower grassroots organisations by continuing its good work coaching grassroots leaders to participate in both sectors. The VCS Enabler could also consider covering the costs of low-bono consulting as the most effective (and cost-efficient) way to capacity-develop their organisations into flourishing and resilient partners in health (e.g. through Civil Society Consulting's highly impactful Steps to Sustainability programme).
- **Support VCS-VCS relationship development through informal get togethers on 'interdisciplinary' topics**: the VCS will be more resilient if there is a supportive and collegiate culture among VCS organisations, and organisations can trust one another to advocate for their needs. However, it is unlikely that health will fund VCS-VCS relationship development work: statutory health professionals were honest and upfront in admitting that they could not see, from where they stood, the value of connecting VCS orgs with one another. Therefore, we recommend that future models need to provide opportunities for

VCS-VCS relationship development that need minimum capacity and resources to organise (unlike the current networks, forums and working groups, which are capacity-consuming).
    - With sustainability and legacy in mind, we particularly recommend leveraging the complementarity between larger and smaller organisations: there is interdependency between large and small organisations. Larger and smaller organisations could work together to share infrastructure, resources, skills and expertise.
- All four of the building blocks for successful statutory-VCS partnerships (**Figure 3**) were reported to be lacking in City and Hackney. Establishing shared foundations and a relational culture, whilst getting effective structures in place (which build on rather than rival existing ones) will, theoretically, eventually reduce the dependency on high levels of infrastructure support in years to come. We recommend keeping these building blocks in mind. In particular, we recommend focusing on developing resources and tangible infrastructure (e.g. mappings). One VCS professional highlighted that once *"things like a website and mapping are created [the VCS Enabler] only needs to allocate a small amount of capacity to keep them regularly updated"* - potentially as little as two or three days a month.

Other opportunities worth exploring:

There are further opportunities to deliver more impactful and efficient infrastructure support to City and Hackney's VCS, which we identified but did not have the opportunity to explore further. We recommend exploring:

- How to **outsource capacity development work for organisations led by and for marginalised communities** that have been identified as key health partners, e.g. by subsidising low-bono consulting).
- How to **harmonise better with Hackney CVS' generic infrastructure support** (i.e. the support that's not funded by health).
- How to **make the VCS Enabler more symbiotic with the Neighbourhood Forums**: the Neighbourhood lens is highly valued the statutory health partners. The models we've put forward propose to swap SIGs for working groups that are more closely aligned to statutory health frameworks (as recommended above). However, we note that another way to achieve better alignment with the statutory health system could be for the VCS Enabler to be oriented to the Neighbourhood Forums. A possibility so-far unexplored could be to keep the current SIGs (which are reported to serve the VCS well) but change their focus to implementing solutions at neighbourhood-level, thereby integrating themselves with Neighbourhood Forums.
- **Harmonising with other infrastructure support**: other infrastructure support structures are being set up in Neighbourhoods and at North East London level, harmonising with these could boost the VCS Enabler's outcomes and reduce capacity.
- The development of **Social Return on Investment (SROI) tools could help decision-makers justify investing in VCS**. Individual decision-makers in the statutory sector struggle to pull the trigger on funding the VCS to run preventative initiatives because: (1) the positive outcomes of preventative work are slow to reveal themselves and difficult to measure and (2) decision-makers are dis-incentivised as decision-makers to take risks. SROI enables decision-makers to justify their spend on preventative work by providing evidence (if a bit pseudo-scientific). (This was identified in workshops that informed this plan, having also been made known to us by statutory professionals in other neighbouring boroughs.)

Therefore, empowering VCS organisations to communicate their impact in terms of SROI to the health system could facilitate funding to start flowing to the VCS.

SROI is inaccessible for many VCS organisations (being expensive and a little complex). It could be worth exploring how SROI tools (i.e. Social Return on Investment 'Calculators' for particular types of organisation, say, social prescribing providers) can give the VCS access to the benefits of SROI, without the costs/risks.

- **Explore how grants can help get funding flowing to the VCS**: we heard about how, under the current system, it's near impossible to have VCS participating pre-commissioning and also being eligible for bidding for the commission. In the words of a statutory professional from Hackney Council: *"with competitive tendering being a legal requirement, if you're involved in helping us design a contract, you can't compete for it."* Therefore, a number of key players indicated that commissioning might not be the best way to get funding from the statutory health system flowing to the VCS. Grants for core funding would be the most effective way for the statutory system to build the VCS' trust and would likely kickstart a strong and equal partnership.
- The VCS Enabler needs to engage VCS organisations of all sizes. One contributor suggested there is a strong case for **making medium-sized organisations the top priority** among these, since they occupy a 'sweet spot', having agility and reach in marginalised communities but also financial sustainability and a good level of capacity. Currently, it was felt that medium-sized charities are forgotten and larger and smaller organisations are at the greatest advantage.
- Preliminary findings in this report have already been shared with the statutory health system. Through these conversations, we learnt (contrary to what came through in the workshops) of concerns that developing a community mapping or 'compendium' could drink a lot of capacity. A solution to this could be to **develop and build on existing mappings/tools** - e.g. Hackney Council's community mapping - or leverage the numerous free online platforms that have been developed in recent years with the express designed of enabling infrastructure organisations to produce community mappings with ease. Examples include a.doddle and Time to Spare. The onus would be on VCS organisations to register themselves, which was felt to be appropriate by the VCS professionals we consulted, which would mitigate the drain on capacity.

b. Threats: operational constraints for the new model

Whatever shape or form it takes, the VCS Enabler 2.0 needs to work within a number of known constraints - set out here.

- **There is a fundamental and urgent need to prioritise due to resource constraints, but limited 'entry points' for prioritising**. Energy cannot be spent twice. Therefore, limited resources for infrastructure support (and indeed VCS/health partnership development generally) means tradeoffs need to be made. For example, it is fundamentally not possible to meaningfully reach over 2500 VCS organisations - and it never will be. Therefore it will be necessary for the VCS Enabler, or its equivalent, to prioritise in one way or another, between:
    - The core functions or the different types of activities it runs
    - The different types of VCS organisation

    - City and Hackney's five health priorities
    - Demographic groups or sections of the community (e.g. geographic areas within City and Hackney
    - The different lenses or frameworks through which VCS networks can be structured (e.g. Neighbourhoods vs SIGs)
    - Equity vs efficiency (it is possible to have a model that is both equitable and efficient, but the two are at odds under conditions of tight resources).

- **Inherent power dynamics** mean that, unless Hackney CVS seeks funding from outside the borough, the VCS Enabler or its equivalent/replacement needs to do what the statutory health system wants; yet doing so positions the VCS as *unequal* partners.
- **Outcomes from VCS infrastructure support are limited/constrained by the health system:**
    - First of all, in terms of **how the health system is set up**. Infrastructure support is limited in what it can do/ the difference it can make until the health system changes to be more conducive to partnership with the VCS (ie. prioritises preventative approaches to health, and changes procedures to make it easier for funding to flow to the VCS). Statutory professionals highlighted a few factors:
        - **Ingrained culture**: it was difficult for those in the statutory health system to see how the system could shift to providing the long-term and core funding that is needed for VCS to do their job well and for a strong/equal partnership to develop due to *"the way we think and the way we work... it would require quite a different way of working [conceptually] and also practically."*
        - **Internal processes and regulations**, which are tangibly resistant to new ways of working - e.g. procurement processes that allow for longer-term decisions. Procurement and funding is particularly complicated for VCS whose work straddles more than one health and care 'department'.
        - **Limited resources**: most of the health and care budget is tied up in contracts that run for years, so *"money is tied up"* because it's already been allocated. Moreover, the NEL ICS operates in a deficit, and often receive their own budgets on a yearly basis, which means money cannot be moved around flexibly.
    - Second, in terms of **the health system's willingness to 'come to' the VCS**. Until the VCS is appropriately resourced, it is not possible/appropriate for the health system to stipulate what the VCS should do, especially if the priorities don't reflect what the VCS have recognised as a priority. There is a risk that, if the VCS contributes to the statutory health priorities without funding, the VCS will effectively be providing 'free labour'. This transpires as a constraint because what essentially came through in the workshops is that statutory professionals would like the VCS to map itself on to the statutory health system - as 'outposts'. But unless/until a significant amount of funding is flowing into the VCS, the health system will in fact need to *"come to the VCS, rather than expecting the VCS to come to them"*.
- **Capacity to keep resources updated**: workshop participants made it clear that the top priority for them was the support to chart the landscape of one another's sectors through a mapping of the VCS and of the statutory health system. However, City and Hackney's Health

and Care Board expressed concerns that this would 'drink' a lot of the VCS Enabler team's capacity.

6. Sustainability planning

With the recommendations set out in the previous section considered, **Figure 4** sets out the bare bones of three models for delivering place-based infrastructure support in City and Hackney - a Gold, Silver and a Bronze option.

Figure 4: topline overview of the Gold, Silver and Bronze models

GOLD	SILVER	BRONZE
Core functions	Core functions	Core functions
• Enable VCS and statutory health partners to locate one another and navigate each others worlds	• Enable VCS and statutory health partners to locate one another and navigate each others worlds	• Enable VCS and statutory health partners to locate one another and navigate each others worlds
• Facilitate the VCS to participate in decision-making (equitably)	• Facilitate the VCS to participate in decision-making (equitably)	
• Enable statutory health funding to flow into the VCS		

All three models:

- Are **structured according to core functions** (not the original aims in the grant agreement) as the statutory health system have identified them.
- **Prioritise**, given the practical realities to present a model that will be effective/efficient as well as equitable.
- Are stripped-back, including and especially by **cutting down on the number of networks, forums and working groups** in favour of the development of one quarterly VCS Health and Social Care Forum (albeit in different ways). The new VCS Health and Social Care Forum would take the form of quarterly place-based meetings that provide a forum to: (1) bring all VCS up to date on system priorities and (2) raise/discuss VCS concerns using an intersectional lens.
- Can be **measured in terms of outputs, not outcomes** - with a view to support the VCS Enabler to focus on its role, and better report on what it's doing with KPIs that are easy to track.
- Promise greater **alignment with the statutory system** (albeit to varying degrees).

The key point of difference between the three models is the number of ‘core functions’ being delivered, and the level of support on offer under each core function area. Gold delivers all three core functions; silver, two; bronze, predominantly just the first (although some contributions to the second core function). As the health system chooses between the three options, this plan steers decision-makers to identify its priorities as it will be necessary to choose between which of the three functions are most needed. The options are framed in this way in acknowledgement that it is not possible simply to do more, better work with less resources.

a. Meet the three recommended models

i. Gold: if the same level of funding is able to be sustained - probably from other sources

The Gold model can be characterised as:

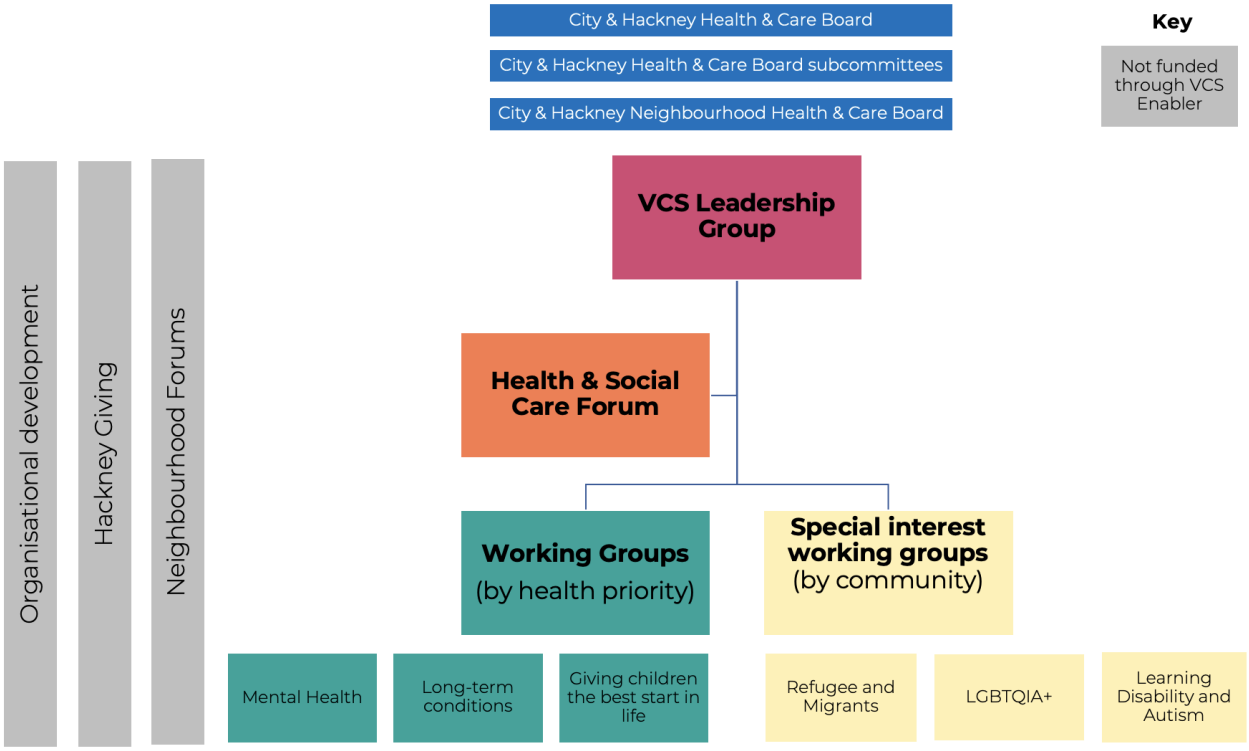
- **Refocused, optimised version of the current model**: Gold demonstrates what amazing looks like. It is a model for delivering on ***all three core functions***, really well, and includes some of the current activities that are working well (reframed). The Gold model takes what is working well, sheds what is not, and orients all the activities towards the three core functions of the VCS Enabler.
- **Restructured but uncompromising on moral principles**: The Gold model acknowledges that to integrate VCS into the new integrated care system, the structure of the VCS Enabler needs to be closely tied to the statutory system's. It provides a simplified structure that is more closely aligned with the healthcare system. However, Gold still maintains a good number of VCS-led spaces/entities. Broadly, the Gold option prioritises doing what's right by the VCS, what is needed for VCS to be an equal partner in the ***long term***. This includes ensuring equitable access for organisations led by and for marginalised communities. Therefore, while the Gold model is more closely aligned with the statutory health system, it keeps VCS-led spaces/entities intact, with a view to promote a genuine cultural shift over time.
- **Long-termist**: Gold answers the infrastructure needs of today, whilst promoting a culture that will reduce the need for infrastructure support in the future.

Core functions	Desired outcome	Key activities	KPI
1. **Enable VCS and statutory health partners to locate one another and navigate each other's worlds**	- Increased knowledge of each other's sectors; - Robust, long-termist relationships develop between statutory health system and VCS organisations in key priority areas; - Having been identified, community assets are leveraged.	• **Maps**: ○ **Produce and keep-updated an interactive 'map' of City and Hackney's VCS**, so that it is a visual representation of the complexity and diversity, having consulted statutory health professionals to understand what it is they want to know about VCS organisations. This could be done via community mapping platforms or existing platforms at North East London level. ○ **Support the statutory health system to develop a 'map' of itself**, with key information for VCS to better navigate the statutory system. ○ **Provide active support** to all stakeholders needing to use the map	High levels of satisfaction and positive feedback on the maps, or number of VCS organisations reflected on map

		as/when needed. • **Robust and considered communications**: ○ **Monthly newsletter** that outlines key updates (e.g. changes to the system), good new stories (case studies to inspire), and upcoming events/forums. ○ **Improvements to the website**, which sets out clearly what the VCS Enabler is from the perspective of a potential user (and other key constitutional documents) with clear 'calls to action' to get people signed up to the newsletter; provides digital, interactive displays of the maps; and provides key links to other resources. • **Active support to get VCS participating in health system meetings**: ○ Identify VCS representatives to participate in statutory meetings. ○ Support, encouragement and coaching to VCS representatives to engage in statutory system meetings. ○ Administration and provision of remuneration to VCS representatives. • **Restructured networks** that are fewer in number: ○ Maintain the VCS Leadership Group in its current form ○ One larger intersectional VCS Health and Social Care Forum (with breakouts to discuss specific issues previously covered in SIGs) ○ Six working groups, keeping three of the current SIGs, which meet quarterly and focus on prepping for the statutory health system's development meetings as well as other system priorities. ○ Coffee mornings (outreach) ○ Continue to link to Neighbourhood forums ○ Discontinue assemblies unless needed ad-hoc for a specific purpose. • **Advocacy on behalf of the VCS, via quarterly meetings**, including on improvements to commissioning processes, according to intelligence already gathered and issues raised in the VCS Health and Social Care Forum. ○ Anti-racist commissioning - work with system partners to continue to improve equity of commissioning processes for VCS to have equitable access to funding, and increase accessibility of service provision.	
2. Facilitate the VCS to participate in the statutory health system's decision-making (equitably)	- VCS are included at all appropriate place-based decision making panels and solutions co-produced with VCS; - VCS are connected with each other to alleviate competitive dynamics, co-produce solutions and present a united front; - Lesser heard VCS and community voices are represented as much as those of larger more established organisations; - VCS co-produce solutions with the statutory health system and drive them forward.		- Attendance from VCS reps at statutory health meetings; - Positive feedback from VCS reps on their experience participating in statutory health meetings; - Participation of statutory health professionals in VCS strategic groups and the VCS Health and Social Care Forum.
3. Enable statutory health funding to flow into City and Hackney's VCS organisations	- VCS organisations are funded, and have the tools, resources and staff to be even more active partners in the ICS		- Participation of statutory partners who have participated in a conversation about anti-racist commissioning (and positive feedback)

		○ Create data and evidence to support changes in how funding is transferred between the public sector and VCS ○ Help statutory partners and VCS to understand their roles in improving how transfers of funding could be done more equitably and reduce health inequalities. • **Active funding support**: ○ **Act as an intermediary grant-maker** - e.g. via Hackney Giving/providing active support to identify and assess VCS organisations that are in the position to be funded ○ **Facilitate VCS consortia to produce joint funding bids**, leveraging the previous outputs from the current networks, forums, working groups and assemblies.	

Figure 5: Coordination/governance structure of a Gold model, including the restructured networks, forums and working groups



The key features that differentiate Gold from the current model or Silver and Bronze are:

- **All advocacy messages are channelled one workstream**; advocacy is no longer integrated across all the various activities carried out by the VCS Enabler, and all messages are conveyed through one channel (e.g. a monthly or quarterly meeting).
- **Continued promotion of a movement around anti-racist commissioning**, improving how funds are transferred from statutory partners to VCS organisations.
- **Six working groups**: three of the current SIGs are maintained and the rest incorporated into three new working groups themed according to the health priorities, as well as the quarterly intersectional VCS Health and Social Care Forum.

- **Robust and considered communications**: quarterly newsletter and much-improved website ensures that clearly sets out what the VCS Enabler is, how to engage and spotlights programmes of work and collaboration.
- **Active support to get health funding flowing to VCS**, by acting as an intermediary grant-maker (potentially via Hackney Giving) and continuing the active focus on getting funding from outside the borough (leveraging the existing bank of solutions co-produced by the VCS. This is a new feature and is not included in Silver or Bronze.
- **May require funding from outside the health and care system**: if the health and care partners ICS favour the Gold option, but can't justify the spend, funding will be required from other sources.

i. Silver: if the dedicated VCS Enabler budget was cut by around 30-50%

The silver model can be characterised as:

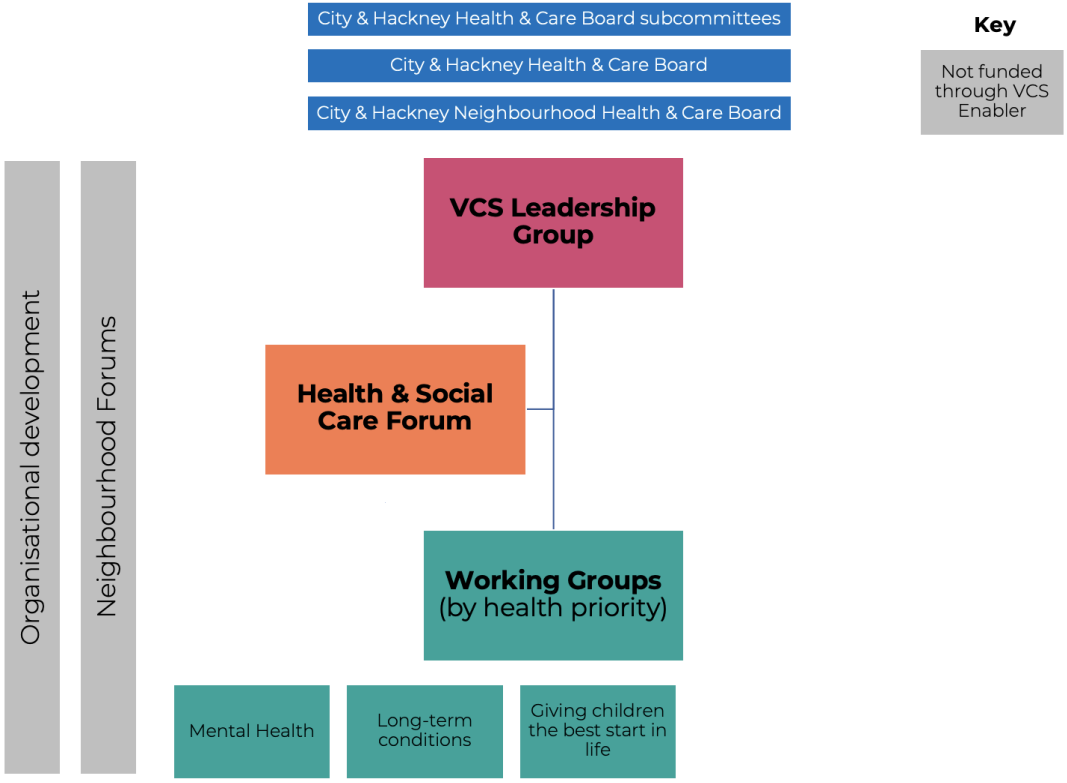
- **Slimmed down**. Failure to prioritise erodes trust between all stakeholders, because it becomes impossible to keep up with expectations; Silver acknowledges that on a reduced budget, the VCS Enabler would need to drop one of the core functions, and sets out a way for carrying out the two most rudimentary functions to a high standard. Silver leaves funding to the statutory health system, based on the logic that funding of the VCS will happen as a natural result of strong relationships and VCS participation and that, unless empowered as an intermediary grant-maker, there is little the VCS Enabler can do to ensure statutory health funding flows to the VCS.
- **Closely tied to the statutory healthcare system and its priorities**: Silver makes the compromises that the statutory health system wants to see in terms of restructuring to align with its structures and priorities. Silver focuses on providing high quality support to integrate VCS representatives into the statutory system, rather than statutory health professionals participate in the VCS's systems. There are therefore fewer VCS-led spaces: 'Strategic Groups' are oriented more towards the statutory health system's priorities and more unstructured/informal.
- **Efficient but prosaic**: Silver entails VCS Enabler having less agency - less of an active role. The silver model prioritises efficiency, not necessarily *over* equity, but inevitably the less of an active role that the VCS Enabler takes to ensure lesser heard voices are heard, the less those voices will be heard. Whilst the silver model does not work against a cultural shift, it prioritises the current needs over and above future needs.

Core functions	'Best case' outcome	Key activities	KPI

1. Enable VCS and statutory health partners to locate one another and navigate each other's worlds	- Increased knowledge of each other's sectors; - Robust, long-termist relationships develop between statutory health system and VCS organisations in key priority areas; - Having been identified, community assets are leveraged.	• **Maps**: ○ **Produce and keep-updated an interactive 'map' of City and Hackney's VCS**, so that it is a visual representation of the complexity and diversity, having consulted statutory health professionals to understand what it is they want to know about VCS organisations. This could be done via community mapping platforms or existing platforms at North East London level. ○ **Support the statutory health system to develop a 'map' of itself**, with key information for VCS to better navigate the statutory system. ○ **Some support to use the map** available on request. • **Robust and effective communications**: ○ **Quarterly newsletter** that outlines key updates (e.g. changes to the system), good new stories (case studies to inspire), and upcoming events/forums. ○ **Improvements to the website**, setting out clearly what the VCS Enabler is from the perspective of a potential user, with clear 'calls to action' to get people signed up to the newsletter; providing digital, interactive displays of the mappings shown on website. • **Active support to get VCS participating in health system meetings**: ○ Identify VCS representatives to participate in statutory meetings. ○ Administer an increased remuneration budget, with a view to to increase VCS participation in the statutory health system meetings. ○ Support, encouragement and coaching to VCS representatives to engage in statutory system meetings. • **Restructured networks, that are markedly fewer in number** ○ Maintain the VCS Leadership Group in its current form. ○ One larger intersectional VCS Health and Social Care Forum (with breakouts to discuss specific issues previously covered in SIGs) ○ Three working groups aligned to the four strategic system priorities (meet quarterly) (see **Annex 2**) - these meetings will feed into the statutory health system's development meetings. ○ Biannual coffee mornings on topical themes to provide an informal	High levels of satisfaction and positive feedback on the maps
2. Facilitate the VCS to participate in the statutory health system's decision-making (equitably)	- VCS are included at every place-based decision making panel and solutions co-produced with VCS; - VCS are connected with each other to alleviate competitive dynamics, co-produce solutions and present a united front. - Lesser heard VCS voices are represented as much as those of larger more established organisations; - VCS co-produce solutions		Attendance from VCS reps; feedback from VCS reps

	with the statutory health system and drive them forward.	networking opportunity. ○ No assemblies. • **Advocacy on behalf of the VCS, via biannual meetings**, including on improvements to commissioning processes, according to intelligence already gathered and issues raised in the VCS Health and Social Care Forum and other working groups.	

Figure 6: Coordination/governance structure of a Silver model, including the restructured networks



Silver's key features are:

- **Three working groups**: what are currently referred to as SIGs and forums would become 'Strategic Groups', aligned with the three place-based strategic priorities (shown in Annex 2). To ensure VCS have opportunity to come together even though there are fewer
    - **Coffee mornings** provide an informal opportunity for VCS to come together.
    - **Assemblies** are lost altogether
- **Extra support provided to VCS to integrate into the statutory system's structures**, particularly leaders of organisations led by and for marginalised communities (e.g. coaching to the VCS representatives at statutory meetings) - compensating somewhat for the loss of VCS-led spaces and promoting equitable access.
- **Channels all advocacy messages via one workstream** - as with Gold, the advocacy work becomes one 'advocacy function' rather than being integrated across all the various activities carried out by the VCS Enabler.
    - Anti-racist commissioning work reduced.
- **No active support to get funding flowing to the VCS**, which is likely to impact the VCS-statutory partnership in City and Hackney (given the LGA's fourth building block 'capacity and resources: having the wherewithal to take action').
- **Compromises** equality of the relationship between the VCS and the statutory sector — as the VCS are expected to map onto the statutory sector - in favour of efficiency.

iii. Bronze: if the level of funding is severely reduced, and only the bare minimum is possible

The bronze model can be characterised as:

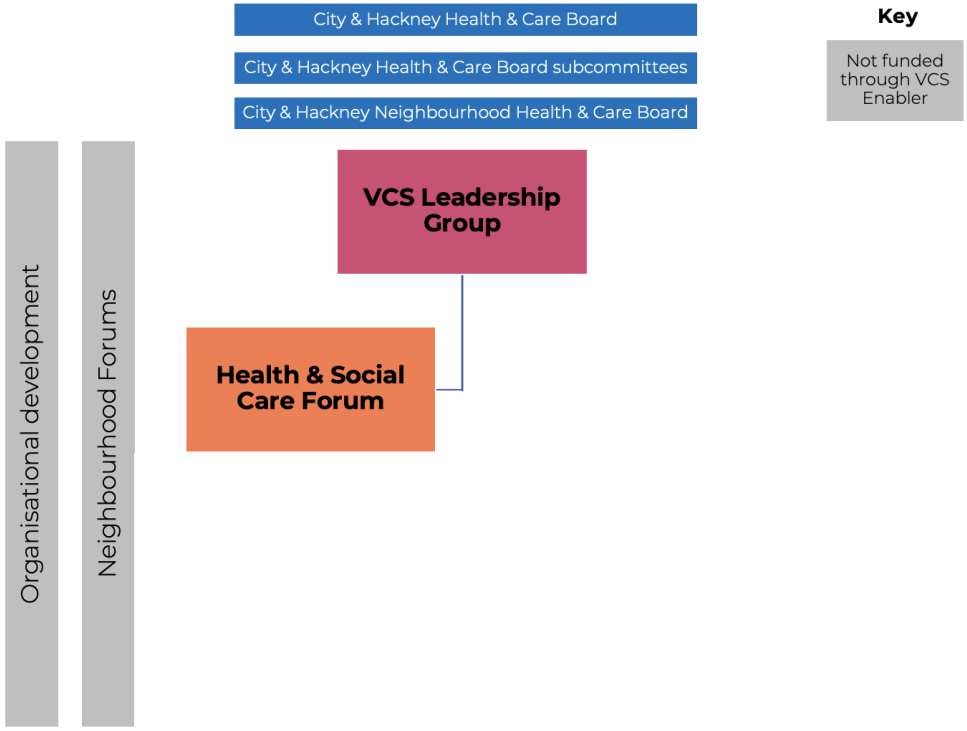
- **The bare minimum**: Bronze focuses on just one core function, which provides a tool for the place-based system to identify VCS organisations, but minimal active support to stimulate and support their integration. In so doing, Bronze shifts responsibility over to health to ensure equitable participation in decision-making and funding, and focuses on providing the basic tools and infrastructure to do so.
- **Tangible infrastructure but minimal active support** to drive things forward in a particular direction:
    - In losing all VCS-led spaces, the Bronze Enabler is heavily dependent on Neighbourhood Forums; there are only unstructured and informal opportunities for VCS to come together outside of this (i.e. the VCS Health and Social Care Forum and coffee mornings). With no active support to drive solutions, Bronze doesn't do much for promoting a culture of equal partnership.
    - There is no active communications under bronze, in favour of a strong, well-managed website.

Core functions	'Best case' outcome	Key activities	KPI

1. Enable VCS and statutory health partners to locate one another and navigate each other's worlds	- Increased knowledge of each other's sectors;
	- Robust, long-termist relationships develop between statutory health system and VCS organisations in key priority areas;
	- Having been identified, community assets are leveraged.
		• **Maps**:
		  • **Produce and keep-updated an interactive 'map' of City and Hackney's VCS**, potentially using Miro so that it is a visual representation of the complexity and diversity, having consulted statutory health professionals to understand what it is they want to know about VCS organisations.
		  • **Support the statutory health system to develop a 'map' of itself**, with key information for VCS to better navigate the statutory system.
		• **Improvements to the website**, which sets out clearly what the VCS Enabler is from the perspective of a potential user, with clear 'calls to action' to get people signed up to the newsletter; provides digital, interactive displays of the mappings; and provides key links to other resources.
		• **Informal get togethers and networking opportunities *only*** (no networks or forums beyond the VCS Health and Social Care Forum)
		  ○ Neighbourhoods continue to operate as currently do.
		  ○ No SIGs or working groups.
		  ○ Quarterly Health and Social Care Forum (with breakouts to discuss specific issues previously covered in SIGs).
		  ○ Quarterly coffee mornings on topical themes to provide an informal networking opportunity.
		  ○ No assemblies.
		• **Active support to get VCS participating in health system meetings**:
		  ○ Identify appropriate VCS representatives to participate in statutory meetings.
		  ○ Some degree of support/encouragement given to VCS representatives to engage in statutory system meetings.
		  ○ Administration and provision of remuneration.
		• **Advocacy on behalf of the VCS, via biannual meetings**, including on improvements to commissioning processes, according to intelligence already gathered and issues raised in the VCS Health and Social Care Forum.
			High levels of satisfaction and positive feedback on the maps

2. Facilitate the VCS to participate in the statutory health system's decision-making (equitably)	- VCS are included at every place-based decision making panel and solutions co-produced with VCS		

Figure 7: Coordination/governance structure of a Bronze model, demonstrating the loss of networks and working groups



The key features that differentiate Bronze from the current model or Silver and Gold are:

- Mappings provided, but **no active support to use the maps**.
- Not live/active communications (i.e. no newsletter) but a **strong website**.
- **Informal networking only**, so no active support to facilitate sessions that will produce solutions. Instead Bronze offers just a Health and Social Care forum meeting every quarter, and regular coffee mornings.
- **Minimal advocacy** delivered via a single workstream and channelled through a single line of communications.
- **Greater onus/expectation on the health system** to drive VCS participation.

b. Our recommendations for sustainability planning

Through the process of developing this sustainability plan, we identified opportunities and threats about the planning process itself - based on our observations as VCS specialists with an independent lens. From these opportunities and threats, Civil Society Consulting offers the following recommendations for sustainability planning:

- **Use this sustainability plan**, which has been developed by independent consultants, as an opportunity for **an honest conversation** about what is needed and/or wanted from infrastructure support. We recommend honesty and openness about:
    - The power dynamic between the statutory sector and VCS;
    - Who are the primary beneficiaries of the VCS Enabler (VCS or statutory professionals?)
    - The operational constraints (outlined in the previous subsection);
    - The presence and impact of local politics; and, most of all
    - The need to prioritise (explained further below).
- **Face the need to prioritise head on**. The VCS Enabler has been hindered by a lack of prioritisation in the past. Looking ahead, failure to prioritise will lead to the VCS Enabler continuing to be spread too thin.

  The Gold, Silver and Bronze models have been developed to guide and support statutory health decision-makers to identify priorities. If decision-makers decide to deviate from these three options, we recommend being realistic about what can be achieved on a reduced budget.

  In workshops, we observed a real resistance to identifying priorities - e.g. firmly asserting which health priorities or which organisation type should be the focus of the VCS Enabler. It can require some discipline to resist the urge to look for loopholes to avoid tough decisions about what to prioritise; we recommend exercising as much of this discipline as possible.

  In particular, we caution statutory decision-makers against:

    - **Picking and choosing outputs**, without recognising the interdependence between the three core functions. The three options presented reflect the way that the second core function builds on the first and so on: Gold delivers on all three core functions, Silver on core functions #1 and #2, and bronze partially delivers on core functions #1 and #2. We hope this guides decision-makers to understand the tradeoffs that will have to be made if budgets are reduced.
    - **Ignoring the tension between equity vs efficiency**: It is possible for a model to be both effective/efficient and equitable, but it is important to acknowledge that, under conditions of limited resources, these things are at odds with one another.
- **Strike a balance between change and continuity**: Gold, Silver and Bronze all strike a balance between being different enough to inspire faith in the new model, but not so drastic that it leads to more (rather than less) confusion. We recommend this ‘fine line’ be tread carefully: we heard about people’s frustration and disillusionment with a system constantly being changed by government policy, yet at the same time a clear lack of faith in the current model.
- **Anticipate the need for transition planning**: the activities the VCS Enabler carries out over the next two years should be spent laying the groundwork for whichever model the funder chooses on being presented with this sustainability plan (i.e. Gold, Silver or Bronze). Each of the three models will require different ‘groundwork’ to be in place to succeed.

Without knowing which of the three models will be chosen, it is not possible to plan how to transition to the new model. Nevertheless, a transition plan will still be necessary and beneficial.

- **Make a record of the priorities and concerns already identified** through SIGs and Assemblies so that the good work done in the past does not get lost. As much as possible, build on these as themes - e.g. when choosing themes for coffee mornings.
- **Be mindful of the "ikea effect"**: although many key decision-makers and stakeholders have helped to co-produce this plan, this plan has ultimately been produced by independent consultants. Key decision-makers need to develop buy-in to this plan to ensure the learnings and co-produced solutions are not wasted.

Annex 1: context for this sustainability plan (extended version)

a. Why place-based infrastructure support

Across the country, ICSs are attempting to better **integrate the VCS as an *equal* partner in health**, but the transition is proving challenging. As it stands, VCS organisations are, for the most part, not appropriately supported, respected, recognised for their expertise or - let alone leveraged as serious partners in delivering support to prevent and tackle health issues. Certainly, this is what has been reported to us in City and Hackney from those that contributed to this plan - as well as what has been reported directly to Hackney CVS and to the independent evaluator of the VCS Enabler in Spring of this year (2023).

Generally, challenges include the following:

5. **The relationship between statutory services and VCS is not equal**. And it's difficult to get around the inherent power dynamic, since the statutory health system controls the funds so ultimately calls the shots. Since the statutory health system has the decision-making power, they have such a huge say in terms of which VCS organisations get funded, and, across the country, there is a history and culture of the statutory health system *"treating the VCS as outposts"*. As a result, the VCS do not feel comfortable engaging in the system.
6. **The statutory health system's approach does not match up with how the VCS see and do things**.
    - Often, health priorities set by the statutory system do not fully capture community priorities as the VCS see them (or the nuances): *"ideas/priorities have come from the bottom, but once they've reached the top they've not been heard in a way that's recognisable so do not reflect what communities (in which VCS is embedded) originally said".*
    - Also, the approach of the statutory health system (e.g. commissioning procedures) do not match up with the practical realities of frontline work for VCS organisations; for example those working in the NHS favour a Neighbourhood lens, but VCS often don't work in a way that is informed by 'Neighbourhood' boundaries.
    - What's more, the statutory sector is slow to change, whilst the VCS is dynamic because it is made up of agile organisations that can respond quickly to changing needs.
7. **There are widespread funding shortages**. The statutory health system is working with ever-shrinking budgets as well as increasing demand. Meanwhile, VCS funding is mostly short-term and/or project-based. Funding is often for *"new and innovative models"* rather than continued or core investment in what already is meeting the needs of residents. As a result of funding shortages:
    - VCS organisations are not as resilient and sustainable as they could be, because of the limitations of short-term and/or project-based funding.
    - It is not appropriate or ethical for the statutory sector to set the agenda on what the VCS should be focusing on, without funding the VCS sufficiently.
    - Funding shortages lead to high levels of stress among the workforce; in stressful situations, we resort to our 'default settings' and struggle to implement new

behaviours, which is not the ideal conditions for implementing new ways of thinking and developing new systems.

- The VCS doesn't have capacity to engage in tendering or respond to bids from multiple sources, particularly the smaller organisations.
- The VCS is overwhelmed by demand: there is signposting from the statutory sector (e.g. through social prescribing), but not funding.

8. **Both sectors are "vast" and difficult for the other to infiltrate:**
    - The statutory health system is a vast and sometimes inaccessible *"beast"*. What's more, the system is undergoing constant change (e.g. many place-based systems are still reviewing their governance structures and procedures as the new ICS develops).
    - The VCS is similarly vast, but also dynamic and diverse so there is no hard and fast rule for mapping or understanding the local sector in any one area. There is also inequity within the sector which means different VCS organisations have markedly different experiences (e.g. smaller organisations led by and for marginalised communities lack resource, capacity and confidence, yet are extremely well-placed to be partners in health if supported; whilst larger VCS organisations often have more resource and influence and their voices are more easily heard by the statutory health system).

These challenges are widely reported and can be regarded as the '**root causes**' of many practical barriers; the NHS has recently produced a framework/report which sets out these practical barriers to integration (NHS, 2023). In **Section 3** of this plan, we will report how these challenges transpire as practical barriers to VCS integration in City and Hackney.

Infrastructure support, often provided by an independent intermediary such as a CVS, offers a solution. Infrastructure support like City and Hackney's VCS Enabler — delivered by Hackney CVS — can help to overcome some of the immediate practical barriers to VCS-statutory service partnership working, as well as work to address some of the root causes for said barriers.

There are two key reasons infrastructure support is needed if VCS are going to be equal partners in the new system:

- **VCS and statutory health partners need help locating one another and navigating each other's worlds**. To partner, entities on both sides need to be able to locate people and services relevant to them. Health systems are always going to be vast and relatively complicated for the foreseeable, and likely always changing. The VCS is diverse and dynamic and likely to remain so given the way VCS organisations are formed. It's not VCS' responsibility to know and understand the health system, therefore infrastructure support will always be needed to ensure equitable access to that system; VCS can't be expected to learn, remember and stay up-to-date with everything.
- **Encouragement, support and advocacy is needed to mitigate power dynamics**. Infrastructure support is needed to:
    - Build mutual understanding between people and organisations with different ways of thinking.
    - Mitigate the inherent power dynamics between statutory and VCS (otherwise VCS can't be the *equal* partner they're supposed to be).
    - Create a level playing field for VCS organisations. There is inequity within the VCS: smaller grassroots organisations are best at reaching those most affected by health inequalities, so to achieve its aims, health and care partners need to engage them;

however smaller organisations don't have equitable access to funding and resources. Larger VCS organisations tend to have more of a legacy relationship with funders and commissioners and a greater pool of resources and influence.

Infrastructure support is *particularly* needed now and in the initial years of the new system:

- **Getting systems and relationships in place now will save the need for infrastructure support in years to come**. The early stages of the new ICS system is a window of opportunity to get good practices in place, and make those part of the status quo after 2025. Some of the typical activities of the VCS Enabler will have more impact under these conditions, e.g. stimulating dialogue, relationships, setting priorities co-productively and advocacy.
- **Funding mechanisms need to be set up in order to create the foundations for partnership in the longer term**. As it stands, the health and care system is not set up to partner with VCS or provide long-term funding, therefore Statutory-VCS partnership is fundamentally extremely difficult. *"One of the biggest problems facing the VCS, particularly smaller groups, is the difficulty of getting funding…"* The sooner money starts flowing from the statutory sector to the VCS, the sooner VCS can integrate as an equal partner in the new ICS.
- **An independent intermediary is required to overcome local politics**: The competitive nature of the funding environment has led to the VCS competing for funding through outdated funding/commissioning models. The VCS are forced to regularly compete for short-term low-value contracts, which hinders relationships, particularly between larger charities and smaller VCS organisations. There are many relationships that need to be mediated from the outset in order for the new system to be a success. As the local CVS, Hackney CVS is well-placed to be the independent intermediary. However, there is a risk of VCS Enabler becoming a scapegoat for the frustration that partners feel.

City and Hackney is ahead of other localities, having had, since 2021, infrastructure support dedicated to promoting collaboration, understanding and integration between those working (from both sectors) to address health inequalities in City and Hackney. The infrastructure support is delivered through the '**VCS Enabler**'.

b. Infrastructure support in City and Hackney currently: the VCS Enabler

City and Hackney's VCS Enabler was set up in 2021 prior to the North East London ICB coming into formation, at a time when City and Hackney had independent decision-making powers. When it was set up, the VCS Enabler aimed to support VCS organisations in City Hackney so that they could 'engage better' and 'co-produce more' with the statutory sector, with a focus on providing the mechanism for VCS to develop 'ready-to-fund' solutions to local health issues. See **Figure 8** for the current aims, as listed in the original grant agreement and see **Figure 2** for the current structure of the enabler.

Figure 8: Aims of the VCS Enabler, according to the original grant agreement

Provide organisational development support & capacity building for CH VCS, particularly those working with black & other minoritised communities, to help these VCS engage better & co-produce more with the statutory sector; and provide mechanisms for the ICPB to invest in activities led by local communities and co-produced with them & VCS.

Methods: Focus on processes and ensuring wide membership in the conversations and thus co-production

a) 'System optimisation': VCS work with & support the ICPB, provide expert advice on health inequalities & potential solutions; develop joint working agreements; explore & pilot innovative solutions to address health inequalities.

b) Address health & system inequalities, particularly as experienced by Black, Asian and other minoritised communities, through jointly identifying concerns, priorities & recommendations; ensure community organisations' voices are heard.

c) Develop and support VCS sector development and capacity (e.g. provide or direct to staff & volunteer training, HR, IT support, expertise and leadership skills); and provide leadership & direction where helpful.

d) Help secure funding from both inside and outside CH to enable the VCS to fulfil its potential contribution and be a core partner in the delivery of care

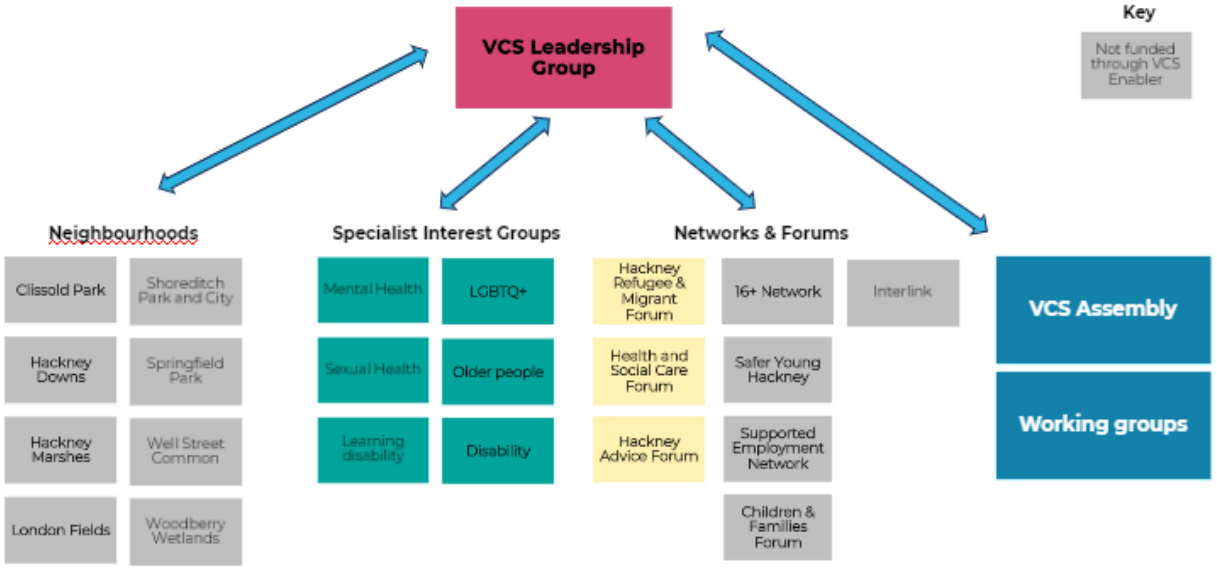
Since its inception in 2021, the VCS Enabler has been acting as a 'system convenor': the Enabler brings together the skills, expertise and passion of those working (from both sectors) to address health inequalities in City and Hackney. To do this, the VCS Enabler also convenes networks and forums, shown in **Figure 2**, as well as assemblies, which are thematic gatherings that welcome residents as well as VCS professionals. Hackney CVS convenes a range of other networks and forums, which are funded through other means but which are synergistic with the VCS Enabler activities.

To give a sense of the scale and capacity at which the VCS Enabler has been operating, here is a rundown of some key outputs from the last 12 months:

- Six assemblies
- 58 SIG meetings
- Eight coffee mornings with 185 attendees
- 14 VCS Leadership Group meetings
- 22 VCS leaders supported to represent City and Hackney's VCS at statutory meetings
- Capacity development and training provided to over 40 organisations.

In total, 229 VCS organisations engaged and 40 statutory sector partners engaged.

Figure 2: how is the VCS Enabler structured?



Here are some of the most noteworthy outcomes from the last 12 months, which have contributed to the four original aims from the grant agreement:

a) System optimisation:
   - **Provided evidence on mental health/wellbeing**, via the Mental Health SIG (Assembly 1), which City and Hackney's Public Health used to produce a successful bid for £500,000, which was then redistributed to the VCS via grants.
   - **Supported co-production of several policies and strategies**, by convening VCS and statutory sector partnerships, e.g. Hackney's new LGBTQIA+ strategy; and resident involvement approach.
   - **Contributed to the development of many other policies**, e.g the Health and Wellbeing Strategy, place-based outcomes, the Equalities Impact Assessment and Resident Involvement model.
   - **Supported development of the processes and criteria of a £150,000 pot of non-recurrent funding**, through the Integrated Communications and Engagement Group. A VCS organisation was funded £30,000 via the process developed.

b) Address health and system inequalities:
   - **Helped progress Public Health initiatives** with less often reached' priority groups, on issues such as obesity, long-term health conditions, smoking and physical activity.
   - **Led on development of four City and Hackney anti-racist commissioning principles**, which have raised the profile of a structural challenge impacting health inequalities.

c) Capacity development for VCS organisations
   - **Delivered cultural humility training to 17 local VCS leaders**. One person reflected *"'I had internalised everything that had been dumped on me, through years of racism, but the cogs started turning, I gave myself permission to embrace the bigger picture, the tools you have can carry value and meaning. I'm working on it with what I have, it's about the people that you serve, not about me. I am now at a place where I say to myself I am good enough, a rebirth."*

d) Secure funding from both inside and outside City and Hackney
   - **Supported a consortium of smaller organisations to submit a successful tender** to Hackney Council to produce 'easy read' tools, via the Learning and Autism SIG.
   - **Facilitated development of a 12 strong VCS consortium working to reduce discrimination in school exclusions**, bringing £20,000 external funding into the organisations and creating a consistent and holistic approach to advocacy support across Hackney for young people at risk of being excluded from school, preventing occurrence of the exclusion to prison pathway.
   - **Helped secure £70,000 funding for local VCS organisations to support asylum seekers** in City and Hackney, who are subject to the 'No Recourse to Public Funds' rule.

e) Other:

- **Helped a university to engage an African women's group in participatory research around vaccine hesitancy** and distrust of health institutions. The study is written up in the BMJ.
- **Provided a platform for better dialogue and more 'solid' strategies**, which may improve buy-in to services, via a VCS Enabler programme.
- **Contributed to creating platforms** for other rapid joint responses to unanticipated issues (e.g. a vigil, earthquake).

Annex 2: City and Hackney's health priorities

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