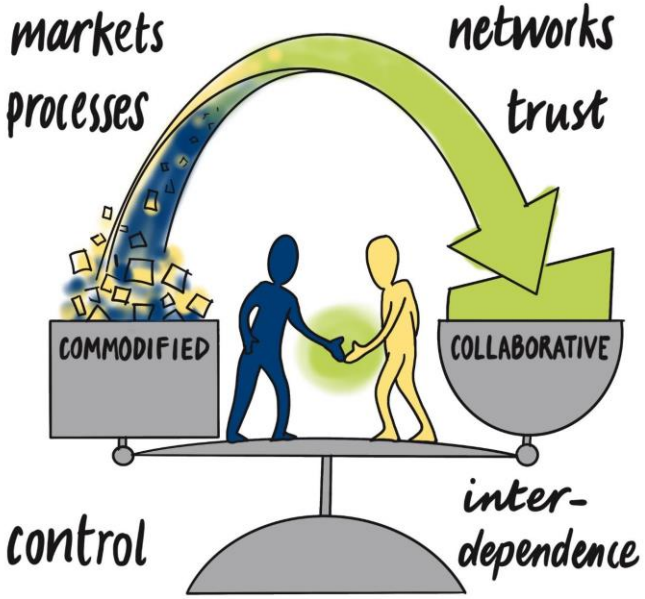

VCSE and health and care commissioning relationships

WELCOME!

Creating collaborations conference

Sharing insights from research, policy and practice

@CommissioningVCSE

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Session 1: What's the expectation? Insights from policy

Pauline Allen & Alex Baylis

Centre for Charity Effectiveness
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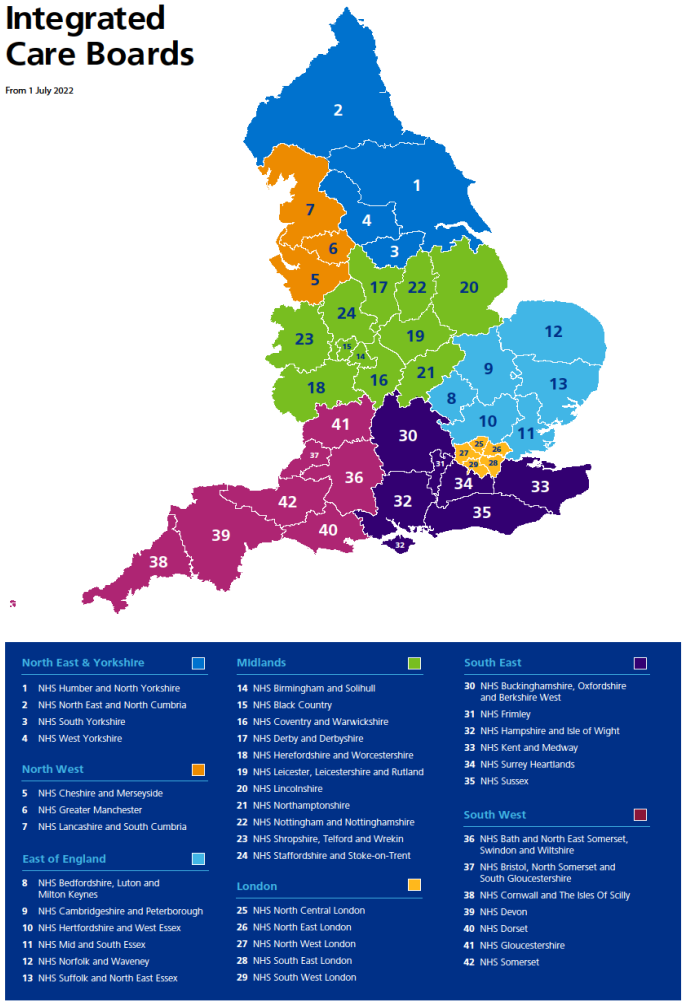
The architecture of the NHS and social care system in 2023

Pauline Allen
London School of Hygiene & Tropical Medicine

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

Integrated Care Systems – integration through collective decision making

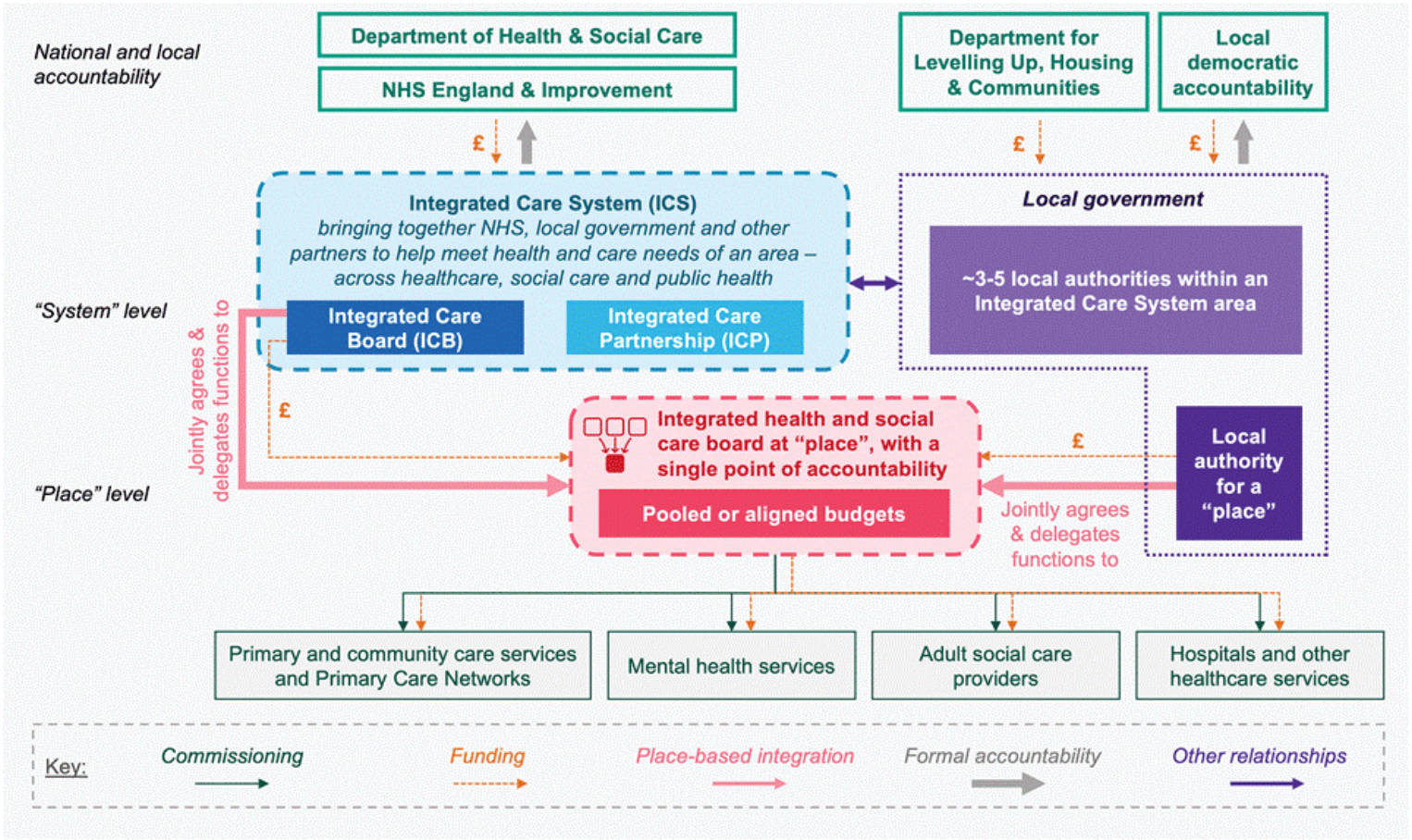
- Change from market driven system introduced in 1990
- Direction of policy since 2015 and legislated in Health and Care Act 2022
- Collective decision making (NHS, local government, third sector, private sector participation) to deliver joined up health and care services on geographical footprints
- Collaboration thought to be better design to lead to:
  - improve outcomes in population health and healthcare
  - tackle inequalities in outcomes, experience and access
  - enhance productivity and value for money
  - help the NHS support broader social and economic development



Integrated Care Systems – tiers and functions

Level	Functions	Priorities from the NHS Long-Term Plan
Neighbourhood (c.30,000 to 50,000 people)	• Integrated multi-disciplinary teams • Strengthened primary care through primary care networks – working across practices and health and social care • Proactive role in population heath and prevention • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).	• Integrate primary and community services • Implement integrated care models • Embed and use population health management approaches • Roll out primary care networks with expanded neighbourhood teams • Embed primary care network contract and shared savings scheme • Appoint named accountable clinical director of each network
Place (c.250,000 to 500,000 people)	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance	• Closer working with local government and voluntary sector partners on prevention and health inequalities • Primary care network leadership to form part of provider alliances or other collaborative arrangements • Implement integrated care models • Embed population health management approaches • Deliver Long-Term Plan commitments on care delivery and redesign • Implement Enhanced Health in Care Homes (EHCH) model
System (c.1 million to 3 million people	• System strategy and planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes	• Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system) • Collaboration between acute providers and the development of group models • Appoint partnership board and independent chair • Develop sufficient clinical and managerial capacity
NHS England and NHS Improvement (regional)	• Agree system objectives • Hold systems to account • Support system development • Improvement and, where required, intervention	• Increased autonomy to systems • Revised oversight and assurance model • Regional directors to agree system-wide objectives with systems • Bespoke development plan for each STP to support achievement of ICS status
NHS England and NHS Improvement (national)	• Continue to provide policy position and national strategy • Develop and deliver practical support to systems, through regional teams • Continue to drive national programmes e.g. Getting It Right First Time (GIRFT) • Provide support to regions as they develop system transformation teams	

NHS and social care architecture



Governance of leadership and co-operative arrangements

Pre HCA 2022

Minimal requirements for membership of governance forums

In practice, LA representation on Partnership Boards, and place-based partnership (commonly Directors of Adult Social Care)

More limited representation of other wider partners, including VCSs

Post HCA2022

More prescriptive requirements for LA membership of statutory ICSs (ICB and ICP)

Still much left to local discretion, including involvement of wider partners such as VCSs

Governance of leadership and co-operative arrangements (under HCA 2022)

Integrated Care Board (ICB) constitutions

- Requirement of at least one member jointly nominated by the LAs whose areas coincide with or are included in ICB area
- 7 ICBs have designated a board post for a VCS member

Integrated Care Partnership (ICP)

- Fewer formal membership and governance requirements (only ICB and LAs are statutory members)
- Recommendations for input - health, social care, public health, social care providers, housing providers, LA directors of public health, representatives of adult and children's social services, providers of health, care and related services, the VCS sector and Healthwatch

Further information

NIHR Policy Research Unit in Health and Care Systems Management and Commissioning (PRUComm)

www.prucomm.ac.uk

Sanderson M, Allen P, Osipovic D, et al (2022) '*The Developing Architecture of System Management'* final report

https://prucomm.ac.uk/integrated-care-systems-final-report-published.html

Sanderson M, Allen P, Osipovic D, et al *'Developing architecture of system management in the English NHS: evidence from a qualitative study of three Integrated Care Systems' BMJ Open 2023;13:e065993. doi: 10.1136/bmjopen-2022-065993*

Health and care policy and the VCS

Alex Baylis
Assistant Director of Policy
The Kings Fund

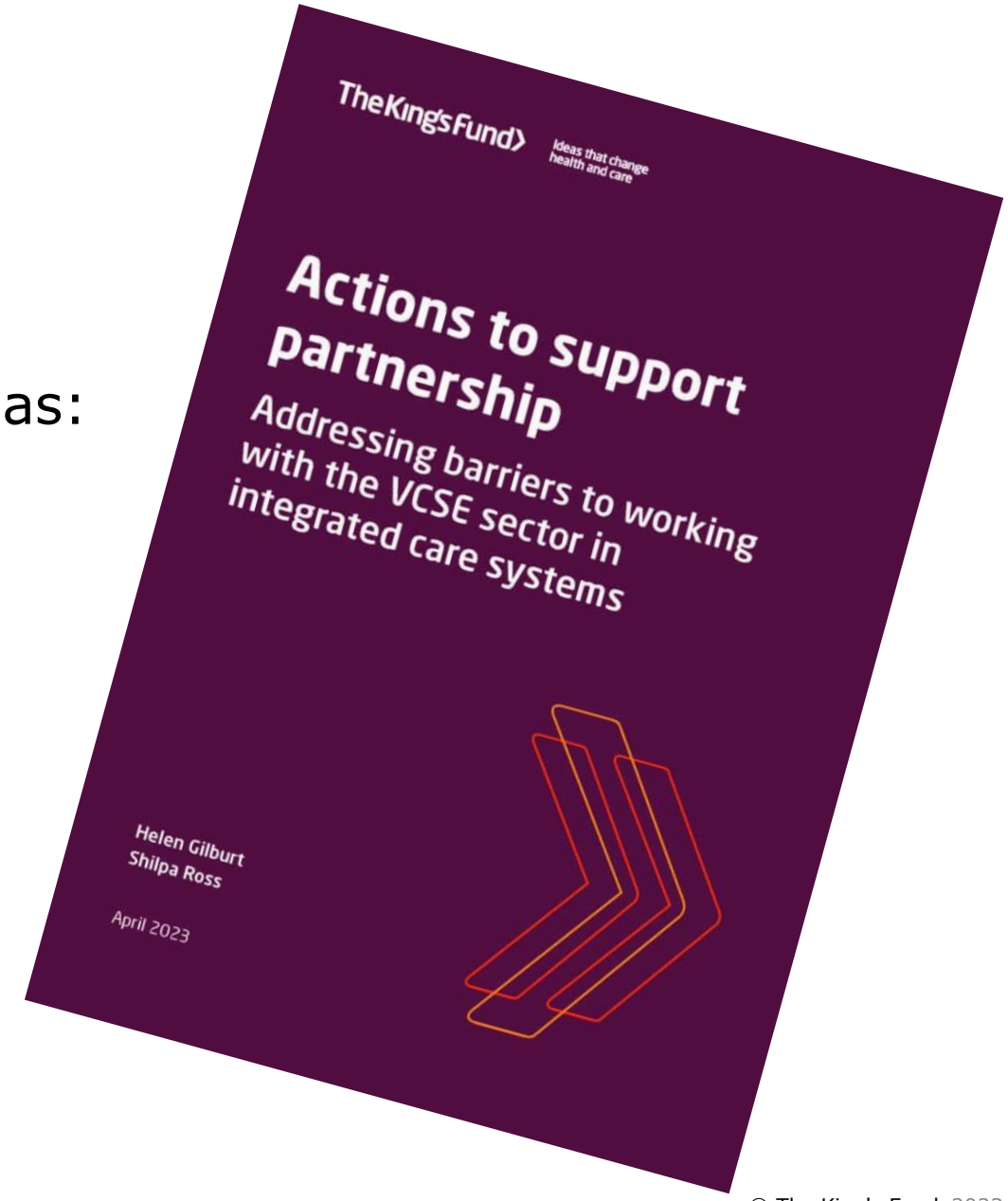
The King's Fund

Integration

- Not just structural change: a means towards improving services, reducing inequality, enhancing VFM and contributing to social and economic development. So the VCS must have a key role!
- But just as the VCS is not one thing, nor are places. A tricky balance for policy makers: how much can/should the centre guide, how much variability to tolerate?
- VCS Alliances provide a means to engage a diverse sector at system level. But much of the actual work is at place or neighbourhood levels. There is a limit to how much national policy, as opposed to bottom-up learning, can guide development at these levels.

Barriers and enablers

- Our research for NHSE looked at commissioning, information and funding.
- Some underlying themes across these areas:
  - Lack of understanding + rigid processes
  - Risks from increasing importance of digital and data
  - History of not recognising full VCS costs



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Some other insights

- Intuitively, there's an important role for the VCS to help manage patients waiting. But there's little or no published evidence to guide policy.
- Similarly, there's very limited evidence for the role of community champions – partly because they are not one thing.
- When local system get short-notice, short-term money, they may not engage the VCS in their plans. Even though the VCS may be the only realistic option for increasing capacity quickly.

Healthy Communities Together

- Three hypotheses, tested in five places: Coventry, Leeds, Plymouth, Croydon, Gloucestershire.

Outcomes for communities (especially reduced inequality) are better served by VCS and statutory bodies working in equal **partnership** towards a shared agenda.

Ongoing **investment** is required to ensure the participation of VCS organisations to engage as equal partners.

Effective and sustainable partnership working is an active learning process which benefits from **expert support** to work differently in relation to a shared leadership of change.

Thank you

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www.kingsfund.org.uk

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Session 2: What's the experience? Insights from practice

Jo Baker, Pip Goff & Nick Grudgings

Centre for Charity Effectiveness
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Forum Central

NHS West Yorkshire Integrated Care Board

Insights from practice

Jo Baker Associate Director, Harnessing the Power of Communities
Pip Goff CEO, Forum Central
Nick Grudgings Head of Population Health Planning

West Yorkshire Health and Care Partnership

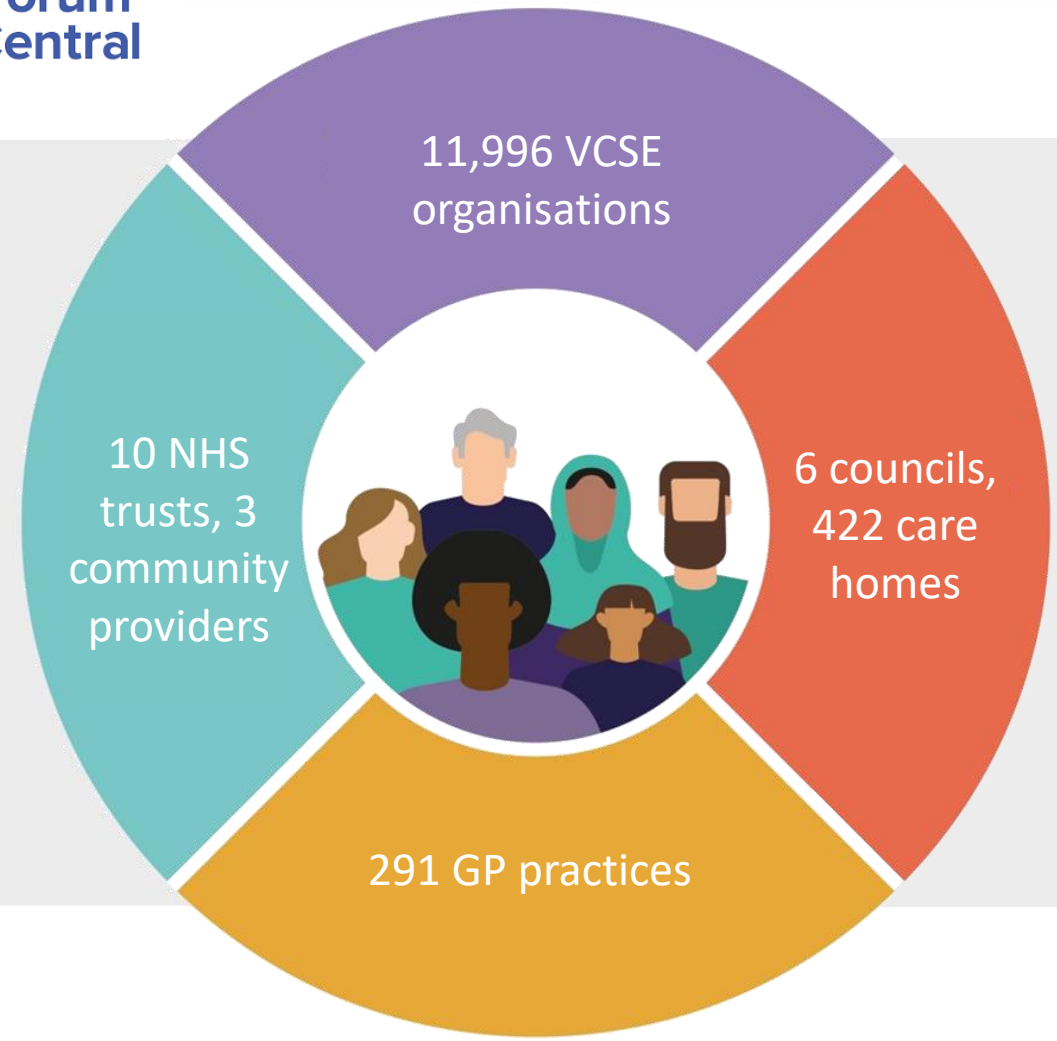
Outcomes and cost (value)

Data and insight

Involvement and decision making

Forum Central

NHS West Yorkshire Integrated Care Board



- 2.6 million people in 5 places (Bradford, Leeds, Calderdale, Kirklees and Wakefield)
- £5.2bn NHS spend per year
- A principle of maximum delegation to place
- Differing local approaches to governance (Population Boards in Leeds – with VCSE)
- Leeds: 51 of 320 contracts with 3rd sector, including IAPT, transport, hospices, high-intensity users, involvement and outreach

NHS West Yorkshire Integrated Care Board

State of the sector report

The State of the Third Sector in Leeds 2022/23

This report examines underpinning data to provide an important insight into the scope and reach of the third sector in Leeds. It demonstrates that in its diversity and range of services, the third sector continues to play a vital role in our city's communities and ecosystem

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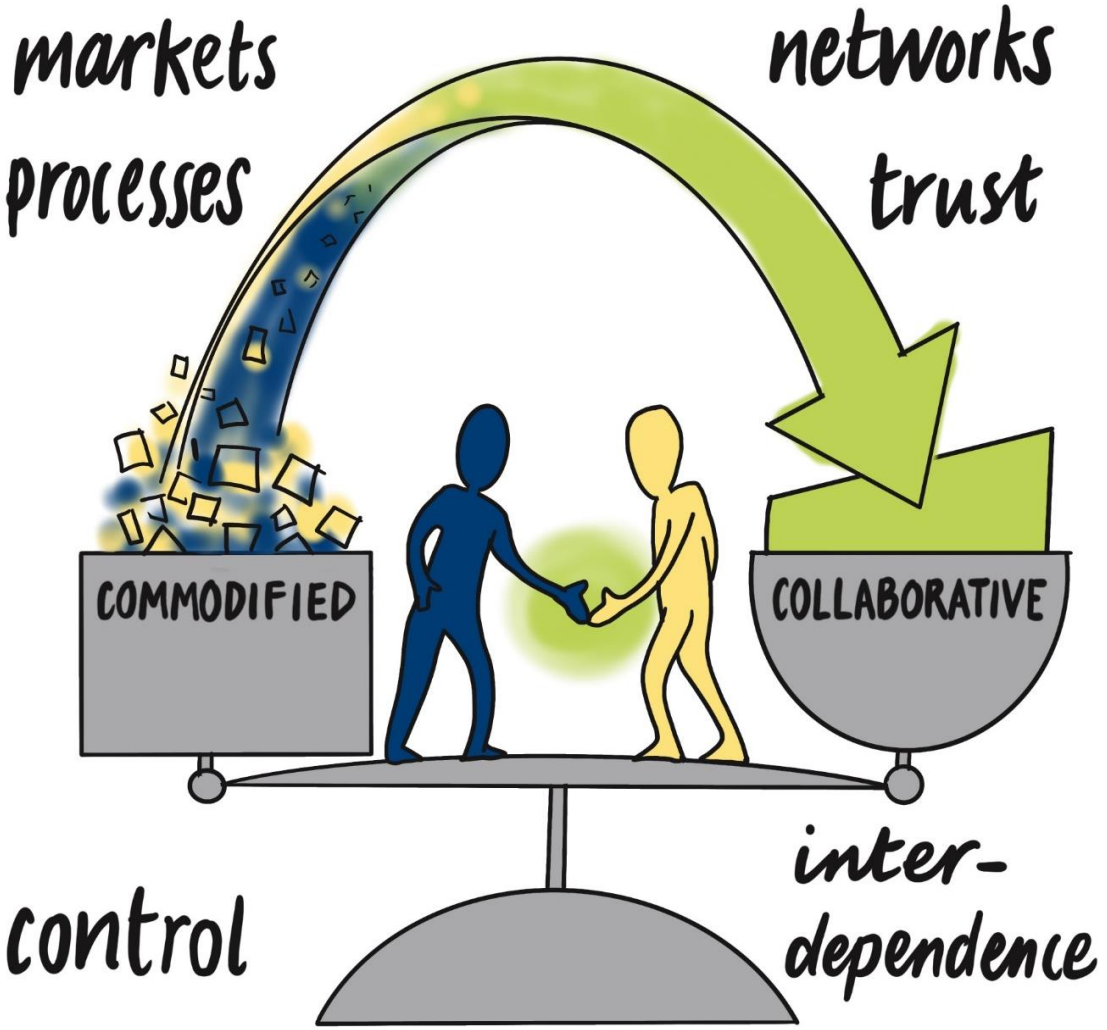
From commodified to collaborative? The VCSE and health and care commissioning

Rod Sheaff, Mark Exworthy, Angela Ellis Paine, Joanna Stuart and Veronique Jochum



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What one word would you use to sum up your experience of VCSE and health and care commissioning relationships?

https://www.menti.com/alg4yw6ph8ih

Commissioning and the VCSE sector

- Commissioning: the processes involved in planning, buying and monitoring services to solve social problems and meet needs – beyond procurement
- Existing evidence points to highly challenging experiences
- Focus on bi-lateral relationships, little attempt to consider how and why commissioning might vary across localities
- Need to establish what works, in what contexts, and why
- Our research included:
  - Analysis of Clinical Commissioning Group spend on VCSE
  - Over 160 interviews, across six localities
  - Focus on end-of-life care, learning disabilities and social prescribing
  - A series of action learning activities

Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissionin

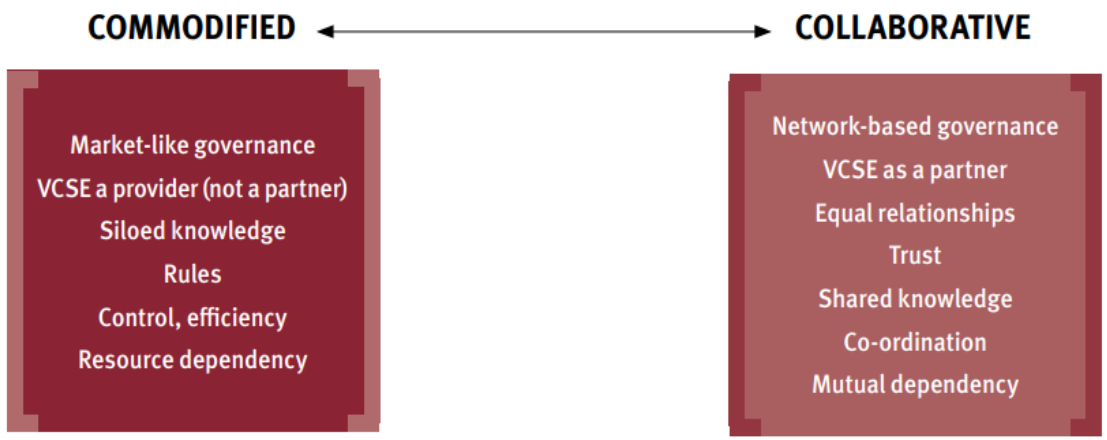
Two co-existing modes of commissioning

- Two modes of commissioning, operating in all localities: commodified and collaborative
- Each mode is based on different governance forms and mechanisms
- Consistent rhetoric about collaborative mode but continued reliance on commodified approaches

  In some places commodified or collaborative commissioning is more dominant

  Shifting at different paces, and in different directions

  Switching between modes can cause confusion and frustration, and erode trust



A varied experience of commissioning

- Reflection from David Fannin, CEO of Lincolnshire CVS

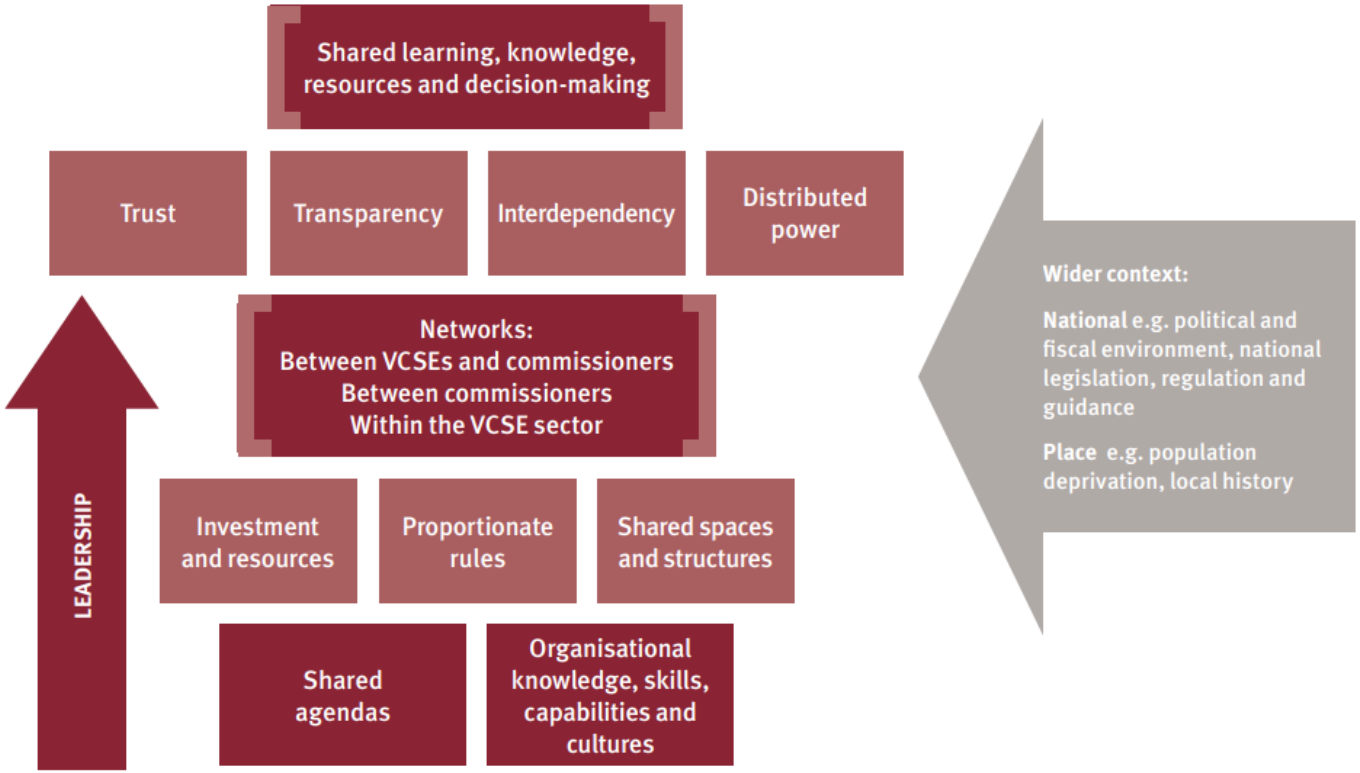
What's your experience?

Talk to your neighbour…

Where on a spectrum from commodified to collaborative would you say commissioning sits within your locality?

How is this changing with the establishment of Integrated Care Systems?

Contexts that favour collaboration



- A range of factors can enable and constrain more collaborative approaches to commissioning
- Networks – at the centre of the diagram – were key
- For networks to act as effective mechanisms, other things first needed to be in place
- Effective networks facilitated the establishment of trust, a realisation of interdependency and shift the distribution of power
- Together, this enabled a sharing of knowledge, resources and decision-making through a more collaborative mode of commissioning

What's your experience?

In a different pair, or small groups:

Which of these building blocks do you have in place, and which need to be put in place?

What else is needed?

Autonomy and decision space for commissioners

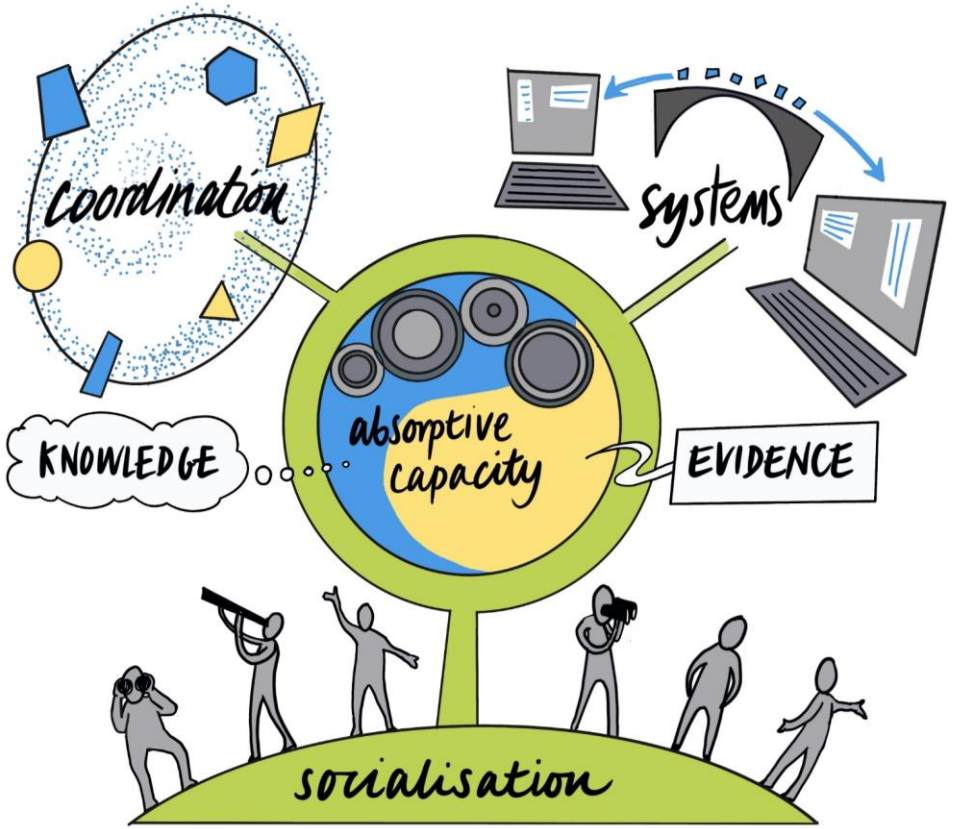
- Many commissioners wanted to work more collaboratively & were frustrated when they couldn’t
- Those who had and used more autonomy and ‘decision-space’ were able to be innovative and build more meaningful relationships
- Commissioners are constrained:
  - Vertically through external controls, such as regulations and directives from central government.
  - Horizontally through local contextual, organisational and individual factors

Relationships amongst VCSE organisations

- Relationships amongst VCSE organisations have been affected by commissioning
- When working together, VCSEs were gaining greater scope to negotiate and influence
- Made possible through local networking spaces, often facilitated by VCSE infrastructure
- Some VCSE organisations act as gateways to commissioning relationships, others as gatekeepers
- Power realised when VCSEs come together, through their collective knowledge, experience and reach

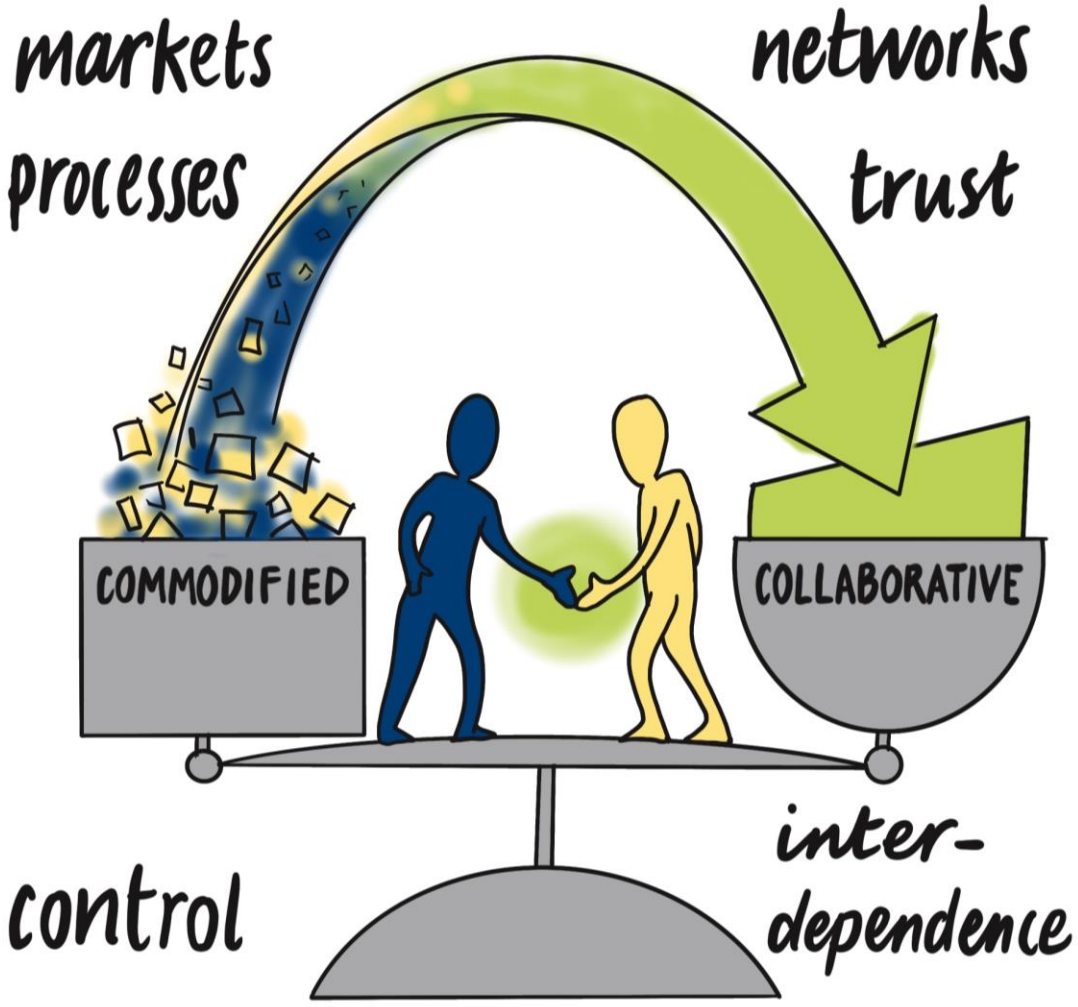
Creating capacity for & from commissioning

- Individual (organisation) and collective (system) capacity to acquire, use, and share knowledge (***absorptive capacity***) affects all stages of commissioning, including outcomes
- Value of sharing knowledge and evidence well recognised
- But there are significant barriers
- Lots of potential absorptive capacity, but it was often not being realised



Conclusion

- A complex combination of factors enable or constrain collaboration in commissioning
- Strengthening commissioning relationships vital to tackling health inequalities
- Six foundational building blocks:
  - Strengthen leadership
  - Develop shared agendas
  - Build and share capabilities, skills and knowledge
  - Invest resources
  - Ensure proportionate rules & processes
  - Create shared spaces
- Together, helping to create networks which act as effective mechanisms for more collaborative modes of commissioning through trust, inter-dependence and a greater balance of power



What do you think?

Do these findings resonate with you?

If so, so what? What needs to change? What can we each do, individually and collectively?

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National Academy for Social Prescribing

Sheffield Hallam University | Centre for Regional Economic and Social Research

Community-led social prescribing

Creating collaborations: Sharing learning from research, policy and practice to strengthen VCSE and health and care commissioning

What's the evidence?

30 October 2023

Ellie Munro (SHU) and Olivia Engle (NASP)

National Academy for Social Prescribing

Sheffield Hallam University | Centre for Regional Economic and Social Research

Agenda

- ❏ Welcome and introductions (10 min)
- ❏ The voluntary sector, communities and social prescribing (10 min)
- ❏ Group work: interrogating the definition of ‘community-led social prescribing’ (25-30 min)
- ❏ Feedback (10 min)

National Academy for Social Prescribing

Sheffield Hallam University | Centre for Regional Economic and Social Research

Welcome and introductions

- Organisations:
  - Centre for Regional Economic and Social Research (CRESR), Sheffield Hallam University (SHU)
  - National Academy for Social Prescribing (NASP)
- Today's workshop:
  - Test out our definition of community-led social prescribing
  - Discuss barriers and enablers
  - Hear about any examples from you

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The voluntary sector, communities and social prescribing

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Social prescribing

- Social prescribing is ‘a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription—a non-medical prescription, to improve health and well-being and to strengthen community connections.’ (Muhl et al., 2023)
- In England, social prescribing and is delivered through a **link worker** model based in **primary care**.

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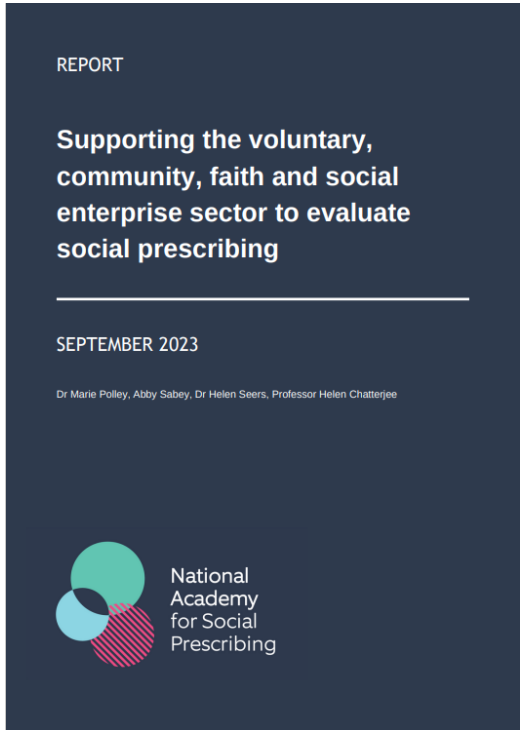
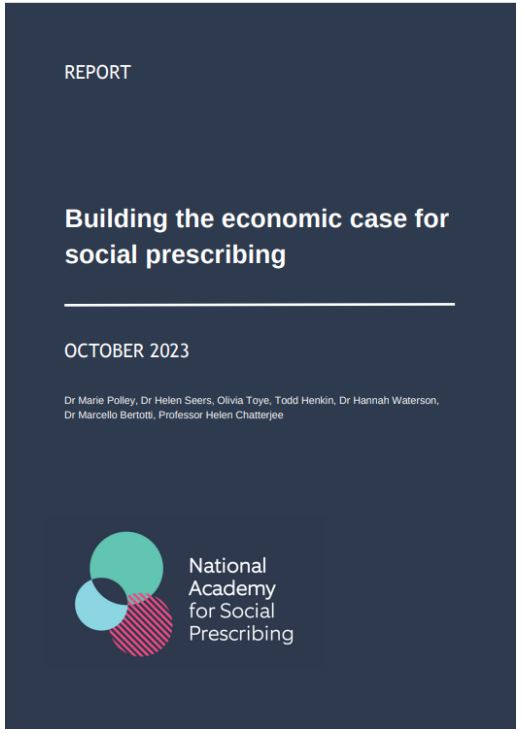
Overview of social prescribing research

- Strong evidence that social prescribing referrals and activities can have a positive impact on mental health and wellbeing
- Strong evidence for older people
- Increasing good evidence for physical health, particularly major conditions like type 2 diabetes
- Emerging evidence on economic impact
- Gaps: children and young people, intersectionality, community approaches, attribution, medium- and long-term impacts





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Commissioning social prescribing, pt. I

- Social prescribing link workers (SPLWs) are predominantly funded by the NHS, generally through the Additional Roles Reimbursement Scheme (ARRS) at the Primary Care Network level.
- The voluntary and community sector may be commissioned to provide link worker services for a PCN or local authority area.
- The vast majority of activities to which people are socially prescribed - e.g., walking groups, museums-on-prescription, community gardens, etc. - are delivered by the voluntary and community sector, with wide variation funding arrangements and commissioning relationships with the NHS.

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Commissioning social prescribing, pt. II

- Across the six localities involved in 'Commissioning, Co-commissioning and Being Commissioned; the NHS and Third Sector Organisations' research, there were different models of commissioning for social prescribing services.
- In some areas that there social prescribing services which had been commissioned prior to PCN funding:
  - This 'original' social prescribing service may have been commissioned by the NHS, or by the local authority, or by both working together with a pooled budget
  - **It may have been more or less 'bottom-up' (VCSE/community-led) in its design**
  - It may have been more or less 'commodified' in the way it was commissioned and managed (e.g., procurement, contract, and target driven)
  - It may have been one service operated by one prime provider (potentially with subcontractors) across a 'place', or it may have been multiple services with multiple providers
  - It may have been limited to funding the social prescription service, or it may have extended to fund the network of voluntary and community group which provide the social activities that people are prescribed
  - It may have been generalist, or have focused on specific, target groups
  - It may come to have a distinct or overlapping role and contribution to the newer PCN link worker social prescribing service

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Local Trust-funded project on ‘community-led social prescribing’

- Background: community health and development, Big Local programme
- What we’ve proposed to do:
  - Conduct interviews with
    - 20-30 Big Local areas which have engaged in social prescribing
    - ~5 social prescribing initiatives which have started in the community
    - Additional workshop days with 5 Big Local areas

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Our definition

Community-led social prescribing is a social prescribing intervention initiated by the local community, often involving other local partners, and based on community-identified needs and solutions.

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Interrogating the definition

1. What do you think of this definition?

   Community-led social prescribing is a social prescribing intervention initiated by the local community, often involving other local partners, and based on community-identified needs and solutions.

1. What are the barriers and enablers of community participation in social prescribing?
2. Do you have any examples of community-led social prescribing?

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Feedback and questions

National Academy for Social Prescribing

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Close

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Olivia Engle olivia.engle@nasp.info OR evidence@nasp.info

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Workshop 3

Mobilising community assets to tackle health inequalities: A blueprint for change

Prof Angela Harden

Dr Katie Rose Sanfilippo

Creating collaborations conference: Sharing learning from research, policy and practice to strengthen VCSE and health and care commissioning, Bayes Business School, City, University of London, London, Monday 30 October 2023

Outline

1. Mobilising community assets and the Well Communities Research Consortium (WCRC)
2. Our blueprint and theory of change
3. Illustrating the Blueprint in action
4. Questions
5. Group discussion

By the end of this session you will have

- Heard about one approach for mobilising community assets for those who experience the worst health outcomes
- Considered how this approach might work in your local system
- Discussed challenges and opportunities for local systems

Area of investment and support

Mobilising community assets to tackle health inequalities

This programme will take an interdisciplinary approach to funding research that aims to use local, cultural, and natural assets and activities to support improvements in health inequalities in the UK.

It is supported by a partnership with the National Centre for Creative Health (NCCH) and will fund projects in three phases.

Budget: £26 million

Duration: This is a single programme with three phases of funding opportunities, running from 2021 to 2027

Partners involved: Arts and Humanities Research Council (AHRC) Biotechnology and Biological Sciences Research Council (BBSRC) Economic and Social Research Council (ESRC) Natural Environment Research Council (NERC) Medical Research Council (MRC) National Centre for Creative Health (NCCH)


LONG
TERM
GOALS...

West Northamptonshire Council

NHS
Northamptonshire
Clinical Commissioning Group

Office for Health Improvement & Disparities

North Northamptonshire Council

University of Northampton

thcvs
Council for Voluntary Service

VOLUNTARY IMPACT NORTHAMPTONSHIRE

WALLSONWALLS

CITY
UNIVERSITY OF LONDON
EST 1894

ROYAL COLLEGE OF MUSIC
London

UCL

NHS
Barts Health
NHS Trust

GREATER LONDON AUTHORITY

NHS
North East London
Clinical Commissioning Group

Aim and outputs of the AHRC funded research consortium building project

Well Communities
Research Consortium

To ***build*** an interdisciplinary and cross-sectoral Well Communities Research Consortium working collaboratively and inclusively to research and develop ways to scale-up, embed and spread community and asset-based approaches within new Integrated Care Systems (ICSs) within and outside of London.

Outputs include: A research agenda, a blueprint and theory of changes and a research bid for a 3 year programme to implement and test the blueprint

Blueprint and theory of change for mobilizing community assets to address health inequalities

Fig. 4.1

Blueprint for change

Mobilizing community assets to tackle health inequalities

Well Communities Research Consortium

Systems Change

Organisational Development

Community Development

Communities living in pockets of deprivation

Focus for change

Interdisciplinary Research

Co-creation & Lived Experience

Participatory Arts Methods

CSEAD

Community & Stakeholder Engagement,
Asset & systems mapping & co-Design

Agenda for change

Desktop Profiling & Mapping

Community world cafés

Street Conversations

Co-producing action workshop

Implementation Planning

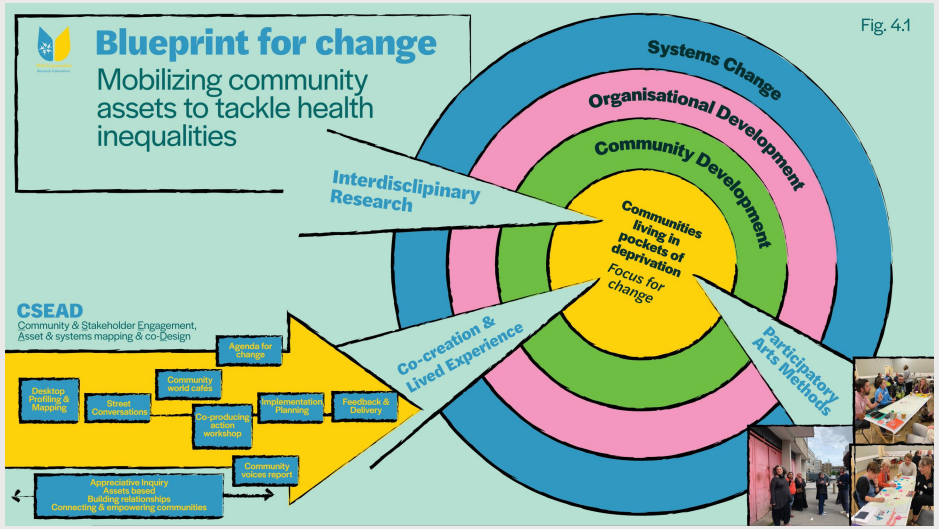
Feedback & Delivery

Community voices report

Appreciative Inquiry
Assets based
Building relationships
Connecting & empowering communities

The 'Blueprint'

- Refocusing investment in pockets of deprivation
  …Well Communities hubs
- Work at very local level – focus in most deprived/highest need areas and 'ripple out' effect – *proportionate universalism*
- Re-focusing of investment to realise and develop community assets - including people themselves in the target areas
- Building on, adding value to, coordinating, integrating and bringing coherence and a more systematic approach to existing local work
- Development of strategic, commissioning and *local* delivery organisations
- Rigorous research and evaluation



Blueprint theory of change

Community development

Community & Stakeholder Engagement, Asset-mapping & co-Design (CSEAD) in pockets of deprivation

i) Insight and priorities for mobilising assets to tackle health inequalities

ii) Community asset maps and system maps

iii) Programme for mobilising community assets

iv) Agenda for systems change to support mobilisiation of community assets

v) Multi-agency planning to identify synergies and resources to deliver the programme for mobilising community assets

vi) Work directly with community members to support them to access, realise and develop their community assets

vii) Work directly with organisations to facilitate strategic, structural, cultural, and practical change which enables the mobilization of community assets

- Higher levels of community participation
- Existing community assets optimized
- New assets developed

Individual & community level↑

- Participation
- Knowledge and skills
- Self esteem & confidence
- Sense of control
- Social support
- Self-care
- Community connectedness
- Community Safety
- Resilience

Integrated care system level

- Greater effectiveness and efficiency in tackling health inequalities
- Reduced demand for/inappropriate use of services

Improved health & wellbeing, reduced health inequalities

Organisational and system development

PROPORTIONATE UNIVERSALISM – HEALTH EQUITY - ASSET BASED –SALUTOGENESIS – COMMUNITY EMPOWERMENT AND CONNECTEDNESS - PARTICIPATORY ARTS – CO-PRODUCTION – DATA AND EVIDENCE – PSYCHOSOCIAL MODEL OF HEALTH

Research questions

1. How does a co-designed blueprint for systems change to mobilise community assets to tackle health inequalities in ethnically diverse pockets of deprivation, enable access and increase participation, including access to culturally appropriate assets?

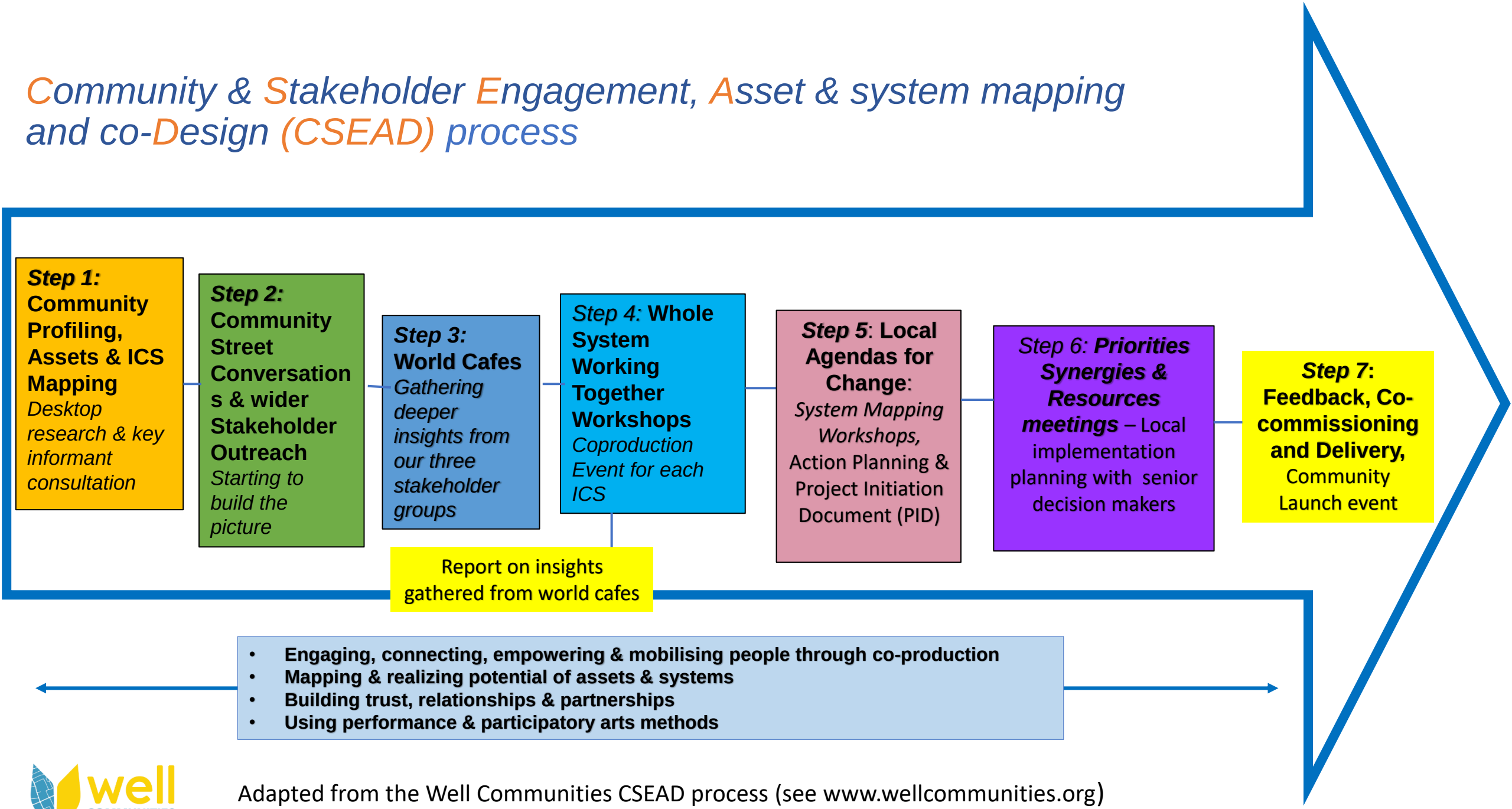
2. How can community asset-based approaches be scaled and spread to maximise their potential to tackle health inequalities?

3. How can the short and longer-term impacts and costs of community-asset based approaches focused on pockets of deprivation be evaluated?

The blueprint and theory of change in action

Old ford, Tower Hamlets

Community & Stakeholder Engagement, Asset & system mapping and co-Design (CSEAD) process



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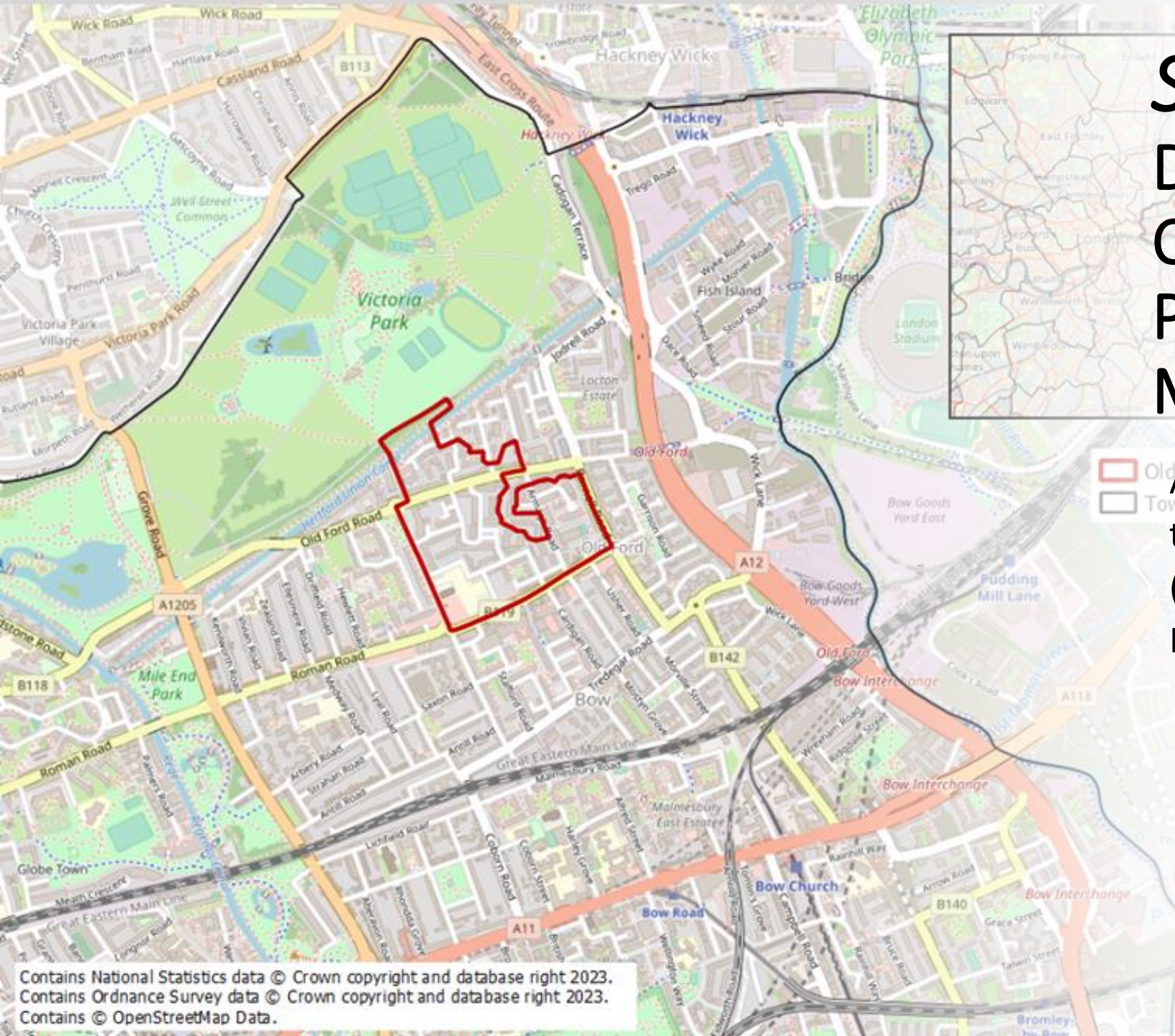


Step 1
Desktop Community Profiling and Asset Mapping

Approximately 3,000 people live in the Old Ford neighbourhood (between Victoria Park/Roman Road)

Data sources used in this profile are from the 2021 census (ONS) unless otherwise stated

Examples of information included in the Old Ford neighbourhood profile summary

Population: 2,735 people live in Old Ford

Deprivation: in the most deprived 20% neighbourhoods (LSOAs) in England; and in the lowest 10% for income and income deprivation affecting older people

Employment: 18% of residents have never worked or are long-term unemployed

Accommodation: 58% of households are living in socially rented accommodation

Living alone: 36% of people live alone

Disability: 1 in 5 residents is disabled, a higher proportion than for Tower Hamlets and England

Ethnicity: 48% of residents are from White ethnic backgrounds, 33% are from Asian backgrounds (less than for Tower Hamlets as a whole), 12% are from Black backgrounds, and 8% are from mixed, multiple or other ethnic backgrounds

Age: there are more older White people in the neighbourhood than for Tower Hamlets as a whole

Religion: 35% Muslim and 28% Christian

Language: 12% of households have no one who speaks English as a main language

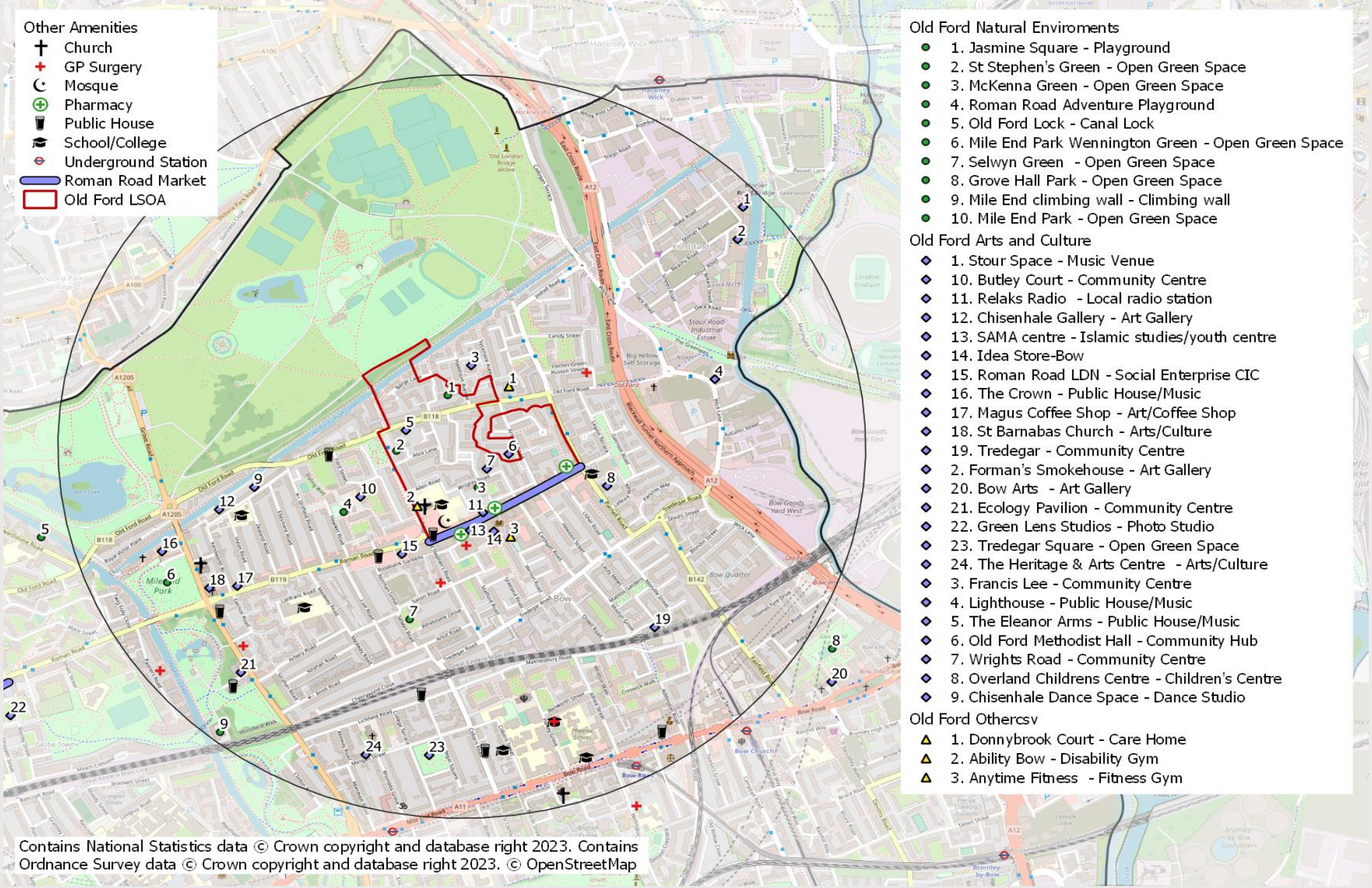
Qualifications: residents are less qualified than average for the borough - around 1 in 4 residents over 16 have no formal qualifications

Crime (1) : crime rates in Old Ford LSOA are in line with those for the borough. There were 202 crimes per 1,000 people for the area - higher than the London average, with a high percentage of violence against the person.

Source: (1)recorded Crime: Geographic Breakdown – London Datastore

Asset Mapping

- Worked with GIS team to map local assets
- Brought map out to community events to be further developed


Other Amenities
Church
GP Surgery
Mosque
Pharmacy
Public House
School/College
Underground Station
Roman Road Market
Old Ford LSOA
Old Ford Natural Enviroments
1. Jasmine Square - Playground
2. St Stephen's Green - Open Green Space
3. McKenna Green - Open Green Space
4. Roman Road Adventure Playground
5. Old Ford Lock - Canal Lock
6. Mile End Park Wennington Green - Open Green Space
7. Selwyn Green - Open Green Space
8. Grove Hall Park - Open Green Space
9. Mile End climbing wall - Climbing wall
10. Mile End Park - Open Green Space
Old Ford Arts and Culture
1. Stour Space - Music Venue
10. Butley Court - Community Centre
11. Relaks Radio - Local radio station
12. Chisenhale Gallery - Art Gallery
13. SAMA centre - Islamic studies/youth centre
14. Idea Store-Bow
15. Roman Road LDN - Social Enterprise CIC
16. The Crown - Public House/Music
17. Magus Coffee Shop - Art/Coffee Shop
18. St Barnabas Church - Arts/Culture
19. Tredegar - Community Centre
2. Forman's Smokehouse - Art Gallery
20. Bow Arts - Art Gallery
21. Ecology Pavilion - Community Centre
22. Green Lens Studios - Photo Studio
23. Tredegar Square - Open Green Space
24. The Heritage & Arts Centre - Arts/Culture
3. Francis Lee - Community Centre
4. Lighthouse - Public House/Music
5. The Eleanor Arms - Public House/Music
6. Old Ford Methodist Hall - Community Hub
7. Wrights Road - Community Centre
8. Overland Childrens Centre - Children's Centre
9. Chisenhale Dance Space - Dance Studio
Old Ford Othercsv
1. Donnybrook Court - Care Home
2. Ability Bow - Disability Gym
3. Anytime Fitness - Fitness Gym
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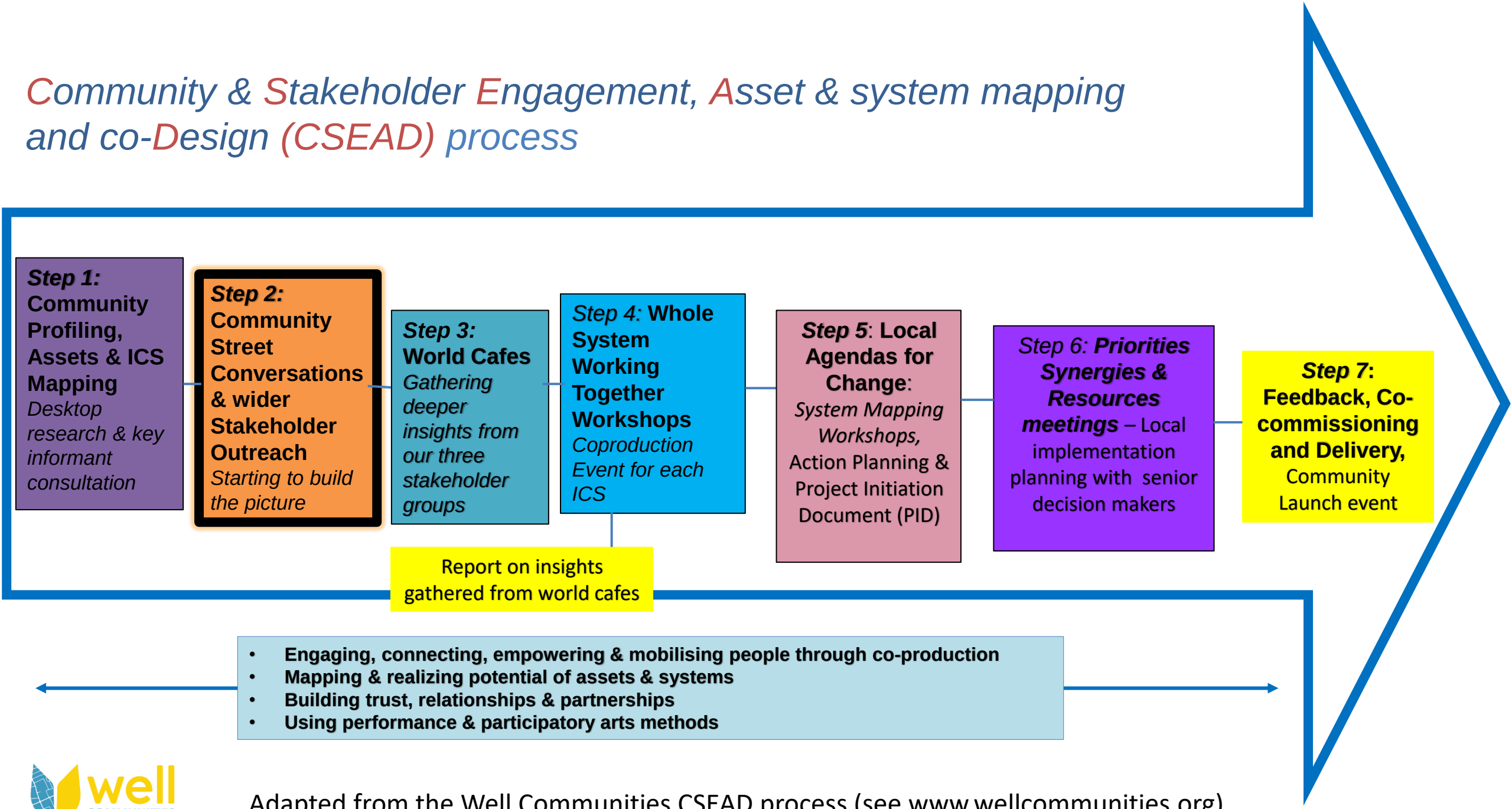
Community & Stakeholder Engagement, Asset & system mapping and co-Design (CSEAD) process

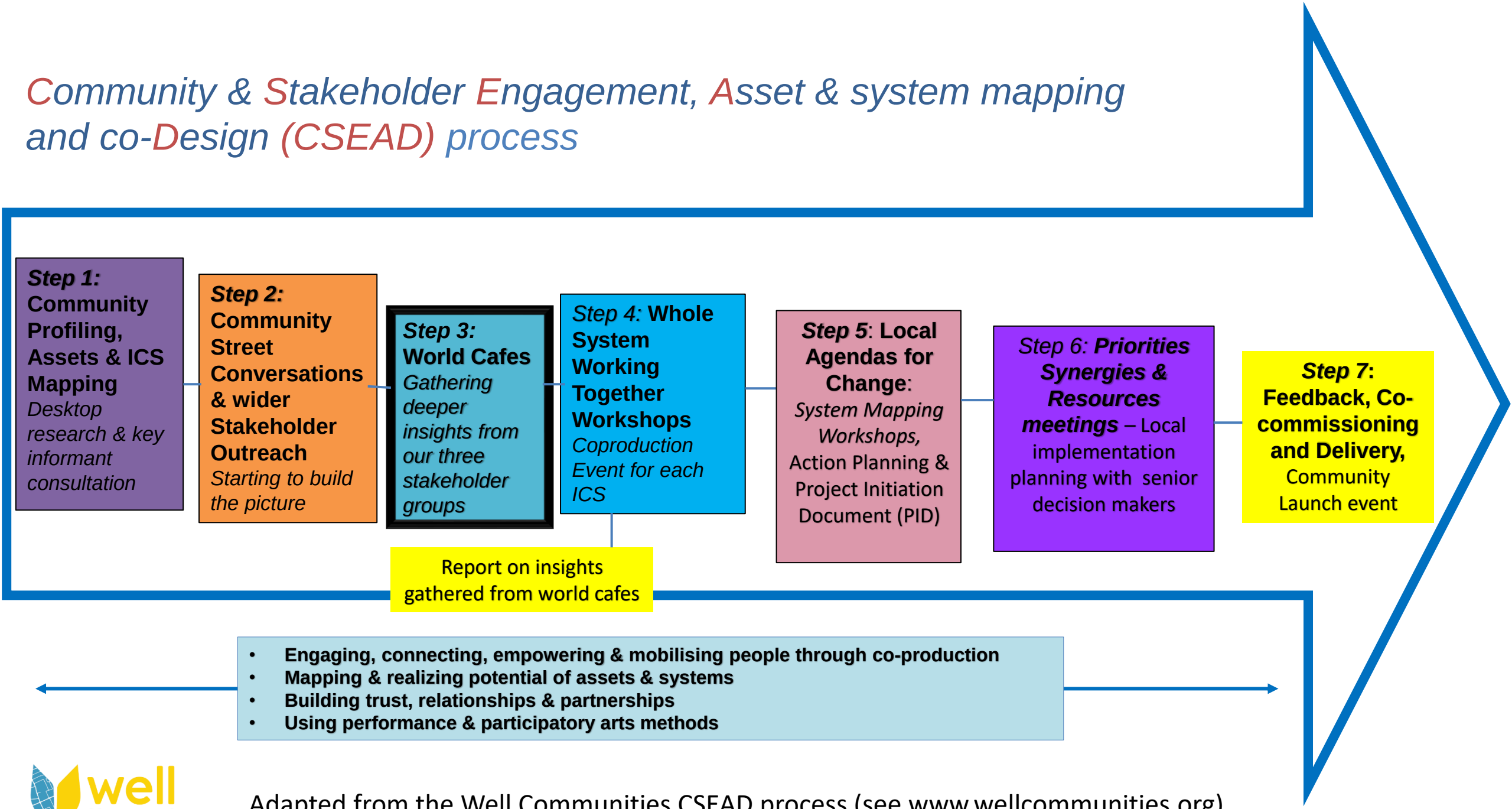


Adapted from the Well Communities CSEAD process (see www.wellcommunities.org)

Step 2: Community Street Conversations

- What do you think would make Old Ford a healthier place to live?
- Do you do any creative activities (such as music, dance, art, theatre etc) and/or outdoors activities (such as gardening, walking, visiting parks etc)?
- What other opportunities to enjoy creative activities and/or outdoors activities do you think would help improve your health and wellbeing and your family's and your community's?

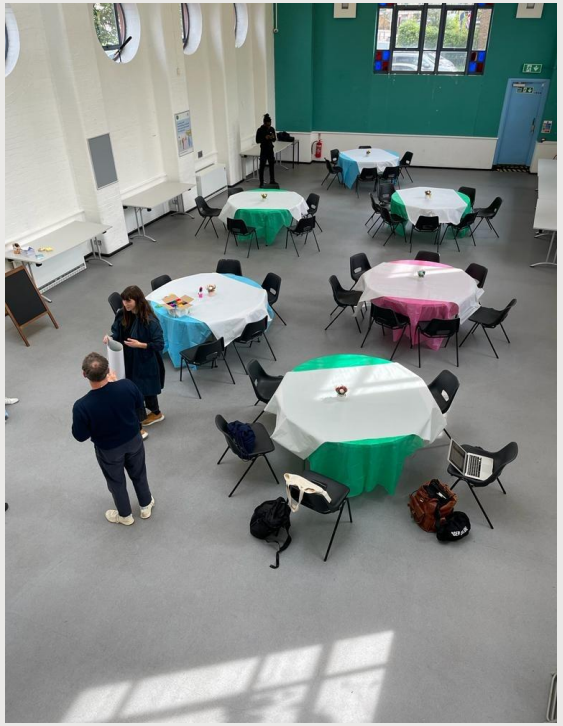
Community & Stakeholder Engagement, Asset & system mapping and co-Design (CSEAD) process

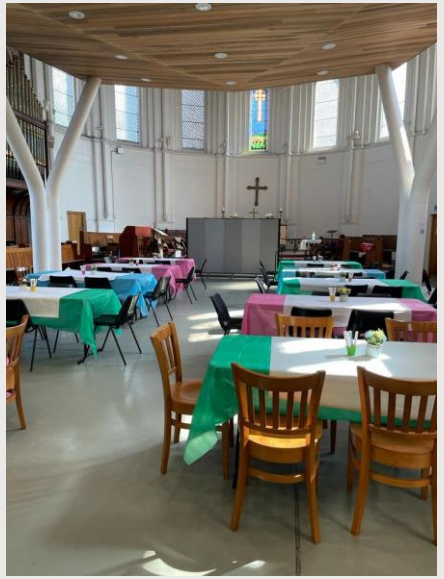


Adapted from the Well Communities CSEAD process (see www.wellcommunities.org)

Step 3: World Cafés

1. Community World Café
2. Community Asset and CVS World Café
3. ICS professionals and health professionals world café





Insights from the street conversations and World Café with Old Ford residents

1. Change and loss
2. Bringing people together
   - More spaces to bring people together
   - Clean green and public spaces
   - Intergenerational and inter-faith activities
   - Face-to-face community events
3. Wider offering of activities for ALL residents
4. Community safety
   - Anti-social behaviour and drug use
   - Poor housing conditions
   - Pollution and poor air quality
5. Communication about local events and activities

Insights from all World Cafés

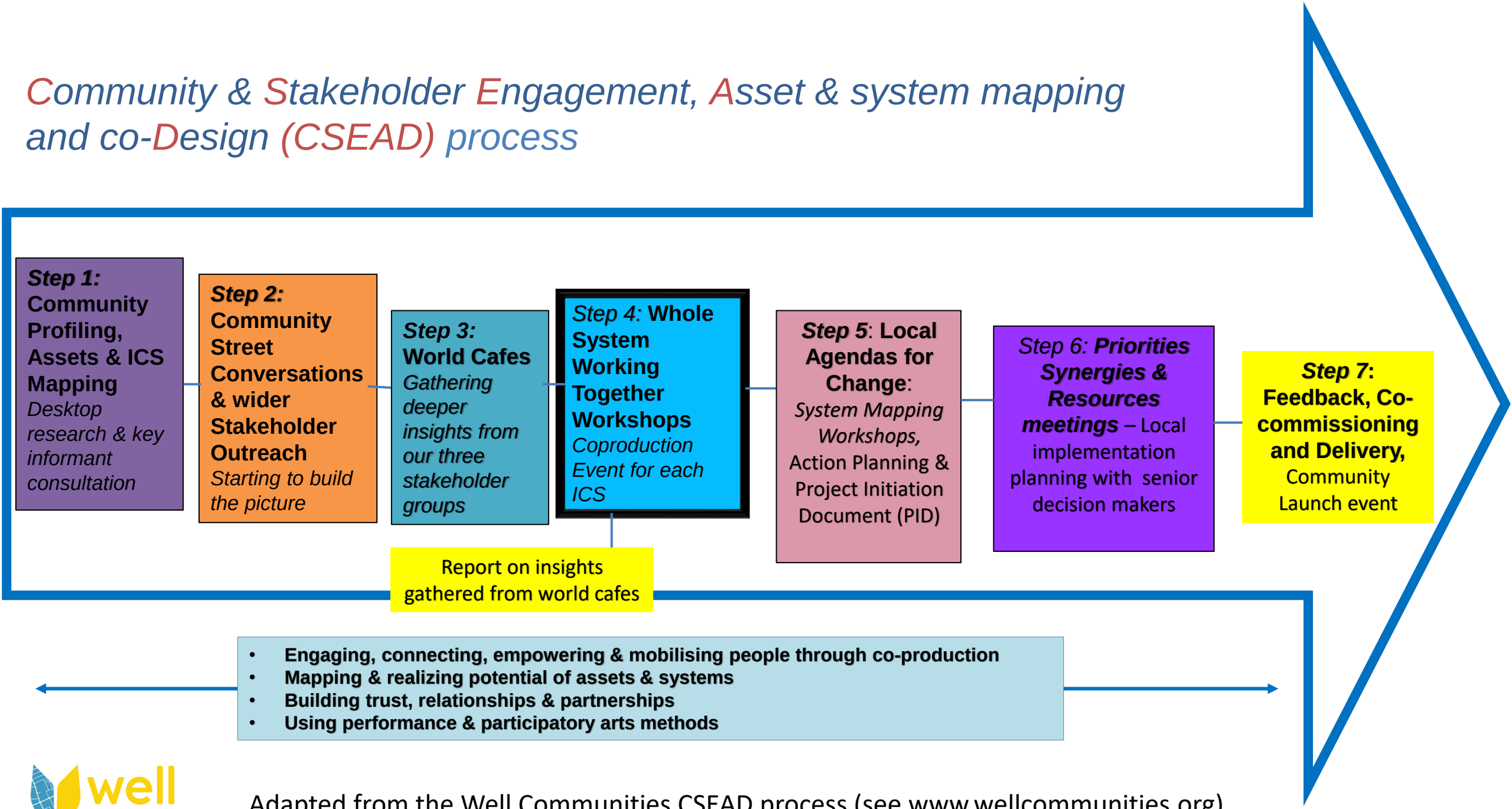
1. Building trust and collaboration
   1. With residents
   2. With community organisations
   3. Though knowledge and data sharing
2. Hyper-local focus - the ‘15 minute neighbourhood’
3. Redefining ‘Care’
4. Funding

’We will act’ really means ‘putting on a show’ – Notes from resident world cafes

We need to see that making access to culture and creative activities is a priority for health and wellbeing. That cultural provision is just as essential as primary or social care – Notes from community organisation world cafe

£5,000 is not a social prescription, it is a band-aid – Notes from community organisation cafe

Community & Stakeholder Engagement, Asset & system mapping and co-Design (CSEAD) process



Adapted from the Well Communities CSEAD process (see www.wellcommunities.org)

Step 4: Working Together Workshop: Table Themes and discussion

Focussing in on *Old Ford** and *similar communities*

1. Restoring local community spaces and ‘services’ – *especially for children, young people and families*

2. Community safety and cleanliness

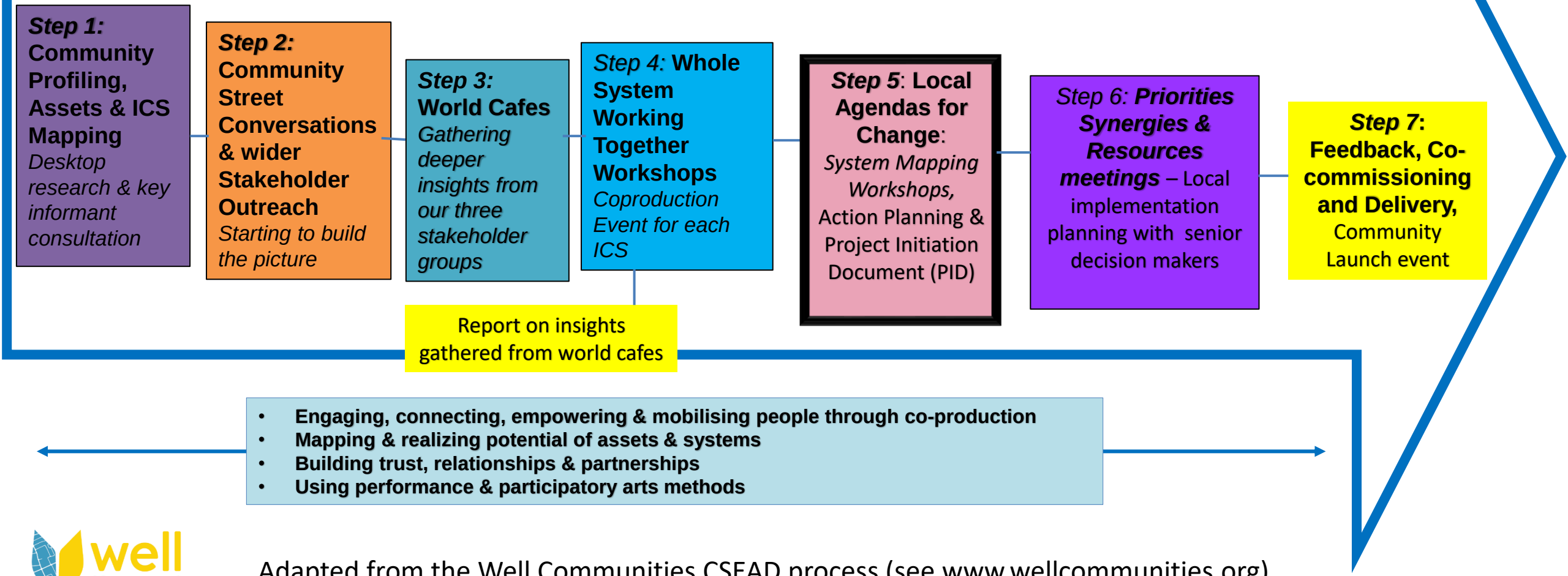
3. Housing conditions

4. Investment in community assets - long-term, sustainable funding

5. Building collaboration, communication, and trust

Idea	Votes
Recruit and assist local champions to organise and promote community activities in community spaces; Supported by small grants program and training	**28**
Make Buckley Court an asset that is free for the community to use and provide activities suitable for the community (collaboration between Clarion, LBTH, NHS and other funding)	**25**
Local panel and THT partners to identify needs with residents and ward councillors and reopen closed assets (Buckley court, Common room) by SHA	**23**
Local sharing of knowledge through WhatsApp, word of mouth, schools, GPs, pharmacies, faith groups and use of the Idea Store	**23**
Research into VCS impact on health ecosystem	19
Agree to pool budget and resources to deliver prevention activities (e.g., Youth clubs)	18
Set of honest principles (with appropriate resource allocation) as to when we co-produce and when we don't	18
Same amount of effort into dissemination and feedback of outcomes (changes to the community) as there is for initial engagement	15
Propose the different housing associations pool funds to support advocacy work	12
Identify gaps for communities at risk (e.g., men young people) -->ring fenced funding for local areas (e.g., mayor's grants and neighbourhood improvements for local agencies to apply to)	11
The system must talk to people to work out the best preventative measures to spend agreed budget on (e.g., youth club vs street infrastructure vs newsletter) and allocate leadership	11
Use THT housing focus at September's meeting as an opportunity to hear residents' views - gather this in advance (use community voice slot to explore commitment to be antiracist and explore advocacy funding)	11
Agreement across the system that prevention is important and commit to tangible deliverables to reduce inequalities	7
Space Hive to support residents ideas by crowd funding for activities. Authorities could match money raised. Tap into corporate responsibility funding and use local celebrities	7
Presentative services need to be restored --> Early intervention (e.g., locally based connections; maintain hyperlocal services (e.g., ESOL, sewing groups, company connectors) to increase access and decreased urgent care; Invest in the most needed projects in the area which have good uptake.	6
Elevating the visibility of the community voice and assets in senior strategic spaces	5
Check whether Tower Hamlets housing forum has the right representation from health	3
Pilot community voice VCS and redesign a public health PCN and wider locality H + WB group	3

Community & Stakeholder Engagement, Asset & system mapping and co-Design (CSEAD) process



Adapted from the Well Communities CSEAD process (see www.wellcommunities.org)

Step 5: System Mapping and Action Planning

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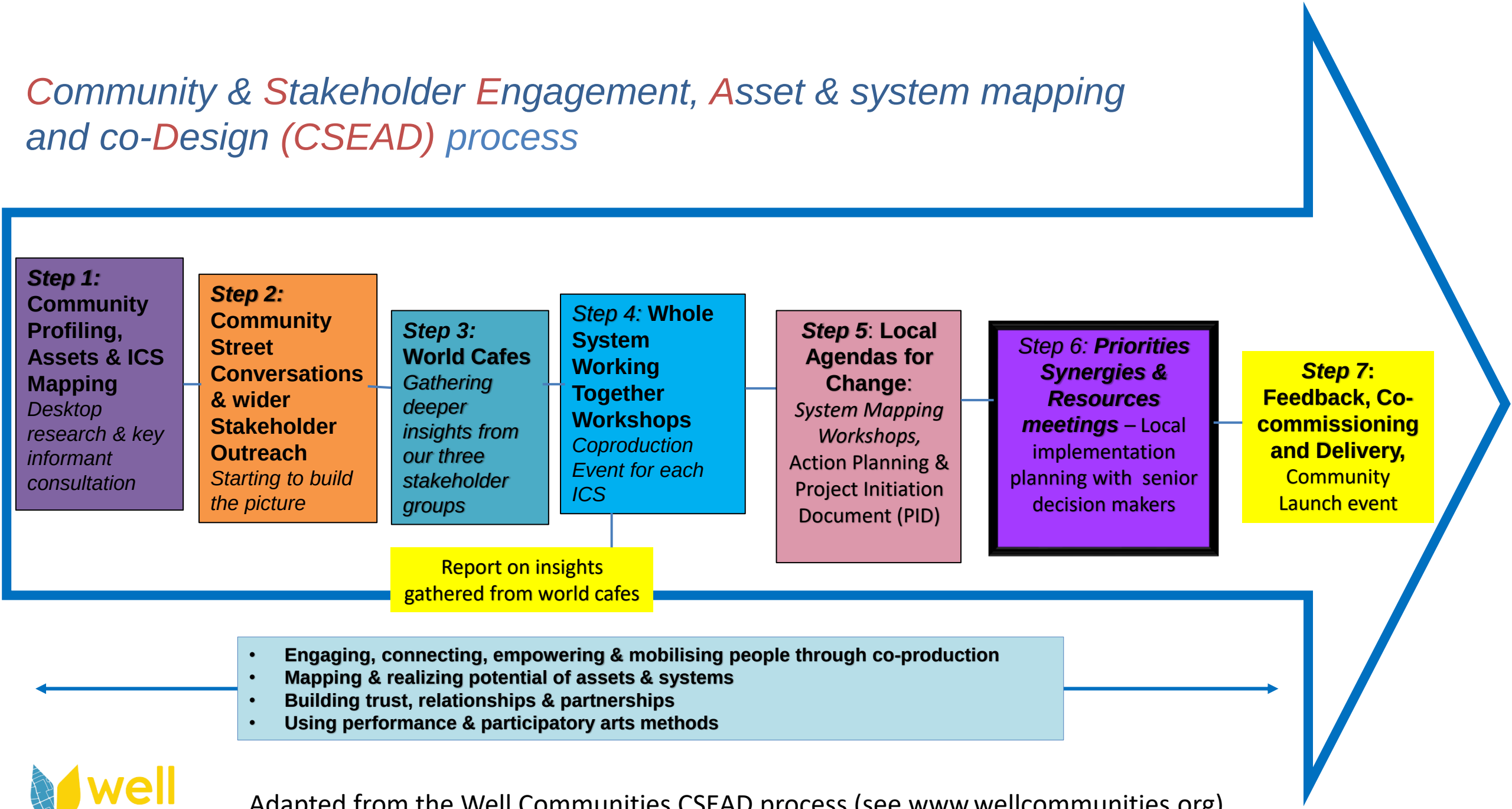
Community & Stakeholder Engagement, Asset & system mapping and co-Design (CSEAD) process



Adapted from the Well Communities CSEAD process (see www.wellcommunities.org)

Step 6: Priorities Synergies & Resources meeting

Examples of priorities for action

- Restoring local community spaces
- Restoring 'services' – especially for children, young people and families
- Community safety and cleanliness
- Housing conditions
- Investment in community assets - long-term, sustainable funding
- Building collaboration, communication, and trust

Meeting considers:

- Existing local resources available to take forward priorities for action
- Other priorities not yet resourced
- Opportunities and barriers to investment and policy change

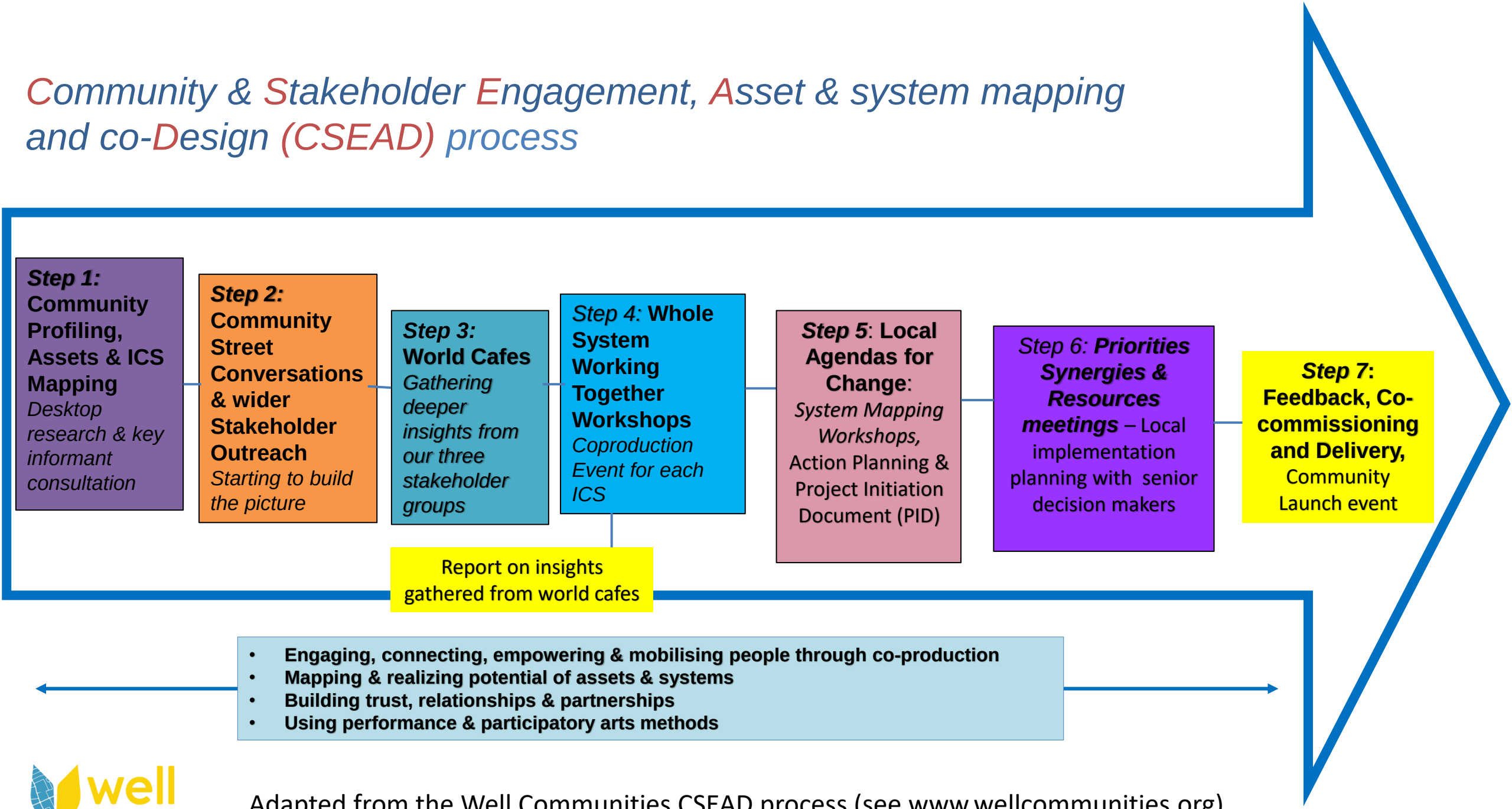
Examples of existing local resources available to take forward priorities for action

- Clarion Housing is developing new policies and practices around health and well-being and safety and appointing new roles within their housing developments.
- Clarion Housing starting a community transfer programme
- TH Public Health have developed a specification for investment of the health inequalities long-term condition prevention
- Existing multi-agency forums on community safety issues such as MARAC, and services such as Find it Fix it where residents can report neighbourhood cleanliness concerns

Examples of a) action on priorities not yet resourced and b) barriers and opportunities for investment

1. Prioritise investment into areas with the highest level of deprivation ('pockets of deprivation' – PODs)
2. Work with housing developers & providers to prioritise housing improvement & better housing quality in *PoDs*
3. Neighbourhood forum of local service providers to improve communication, collaboration, & joint working
4. Collaborate to invest in community spaces at free or very low-cost for residents following community asset transfer
5. Preventative neighbourhood services (e.g., warm hubs and luncheon clubs, etc) be reinstated.
6. All ICS partners look at long-term investment in local community assets and activities.
7. Work with Clarion Housing to ensure safety & cleanliness policies prioritised to improve use of green spaces.
8. Strongly consider focusing the health inequalities long-term conditions investment into PoDs, including Old Ford
9. Current community champions scheme refocused in PoDs to improve communications about opportunities and services

Community & Stakeholder Engagement, Asset & system mapping and co-Design (CSEAD) process



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Any questions?

Small group discussion

In small groups, consider the following

- How would this approach work in your area?
- What might be the challenges?
- What opportunities might it offer?

Thank you !

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Session 4: So, what's next? From insights to actions

Alex Boys, Jacob Lant, Carrie McKenzie & Feodora Rayner

Centre for Charity Effectiveness
Intellectual leadership: developing talent, enhancing performance

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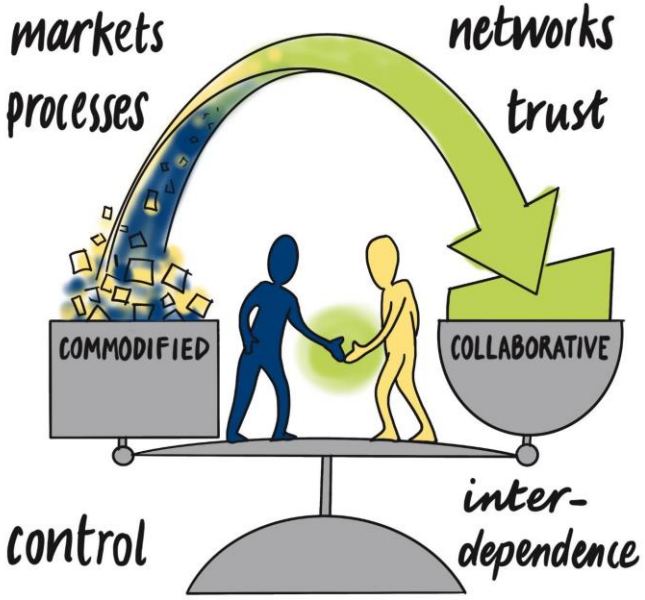
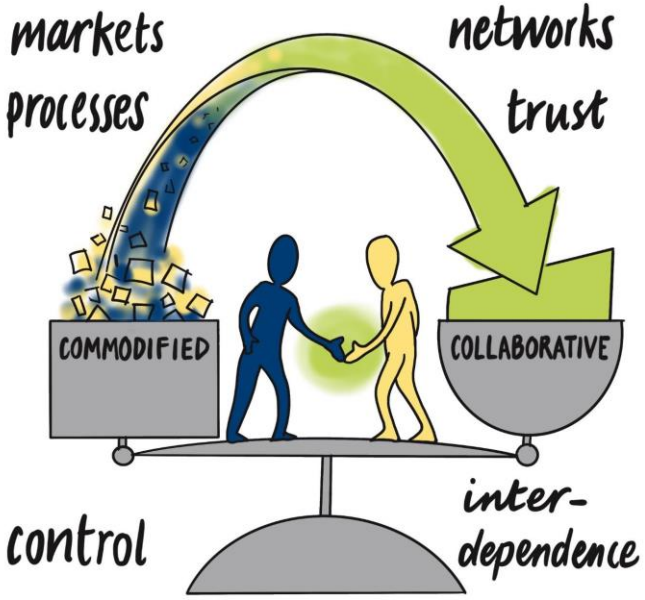


VCSE and health and care commissioning relationships

SO, WHAT'S NEXT? FROM INSIGHTS TO ACTIONS

*What action can **I** take to deliver the change in commissioning relationships I want to see?*

Join at menti.com use code 3214 7971



VCSE and health and care commissioning relationships

SO, WHAT'S NEXT? FROM INSIGHTS TO ACTIONS

What do we need others to do to deliver change?

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Thank you for joining us at the Creating Collaborations conference