Rapid review of Local VCSE Infrastructure in Integrated Care

26 April 2021

Alex Boys
Head of Business Development, NAVCA
alex.boys@navca.org.uk
0114 312 2602

Contents

Introduction

NHS England and NHS Improvement's (NHSE/I) Voluntary Partnerships Team commissioned NAVCA to deliver a rapid review of the landscape of VCSE infrastructure organisations within the 22 integrated care system (ICS) areas not currently involved in its VCSE Leadership Programme. The review focused on understanding:

- the level and scope of VCSE infrastructure in each of the areas, including any provider alliances, infrastructure organisations or VCSE Leadership groups;
- its current role and experiences within the local system at each level (system, place and neighbourhood) and;
- how the programme might benefit from different models/approaches to working with VCSE infrastructure in these areas.

Following publication of proposals for accelerating integrated care and, in particular, placing ICS's on a statutory footing[1], NAVCA was commissioned by NHSE/I to deliver a series of engagement events for LIOs and wider VCSE organisations and collate their feedback.

This report summarises the findings of both commissions.

NHS England and Improvement's VCSE Leadership Programme

NHSE/I's VCSE Leadership programme was established in 2018/2019 and, to date, has worked with 20 of the 42 ICS areas. The programme aims to enhance the role of the VCSE sector the design and delivery of integrated care. The programme supports development of VCSE leadership groups or alliances primarily at a system and place level, to:

- Encourage and enable the sector to work in a coordinated way;
- Provide the ICS with a single route of engagement with the sector and links to communities;
- Better position the sector in the ICS to contribute to the design and delivery of integrated care and have a positive impact on heath priorities, support population groups or reduce health inequalities.

NAVCA

NAVCA is the national membership body for local VCSE infrastructure organisations (Local Infrastructure organisation, LIOs). LIOs provide support and development for voluntary and community action across England. Our 180 members support over 200,000 local charities, voluntary groups and social enterprises at a community level, helping them to thrive and deliver essential services. NAVCA members are an integral part of local health and care systems, representing people and organisations; influencing and coordinating; offering different perspectives; acting as their local sectors' voice in strategic discussions, and supporting frontline sector organisations to deliver effective services and collaborations. The majority of organisations currently engaged in NHSE/Is Leadership Programme are NAVCA members.

Alex Boys, Head of Business Development at NAVCA, has worked within and alongside the VCSE in roles at national funding bodies, local authorities, and local and national charities. Prior to joining NAVCA in 2020, Alex held the post of Chief Executive of a local VCSE infrastructure body in the West Midlands and was an active member of both the local Health and Wellbeing Board and Integrated Care Partnership, working alongside neighbouring LIOs to engage with the local ICS.

[1] Integrating care: Next steps to building strong and effective integrated care systems across England, NHSE/I, November 2020

Methodology

Data analysis

Utilising data on local infrastructure organisations from the VCS Emergencies Partnership programme[2], which includes members of NAVCA, NCVO and ACRE[3], we mapped local infrastructure provision to each ICS/STP footprint.

Survey

An online survey was sent to every NAVCA member during March 2021. We encouraged all members to respond, and promoted through a range of events and communications, we later targeted members operating in ICS areas that have not yet been involved in the VCSE Leadership Programme. The survey received 42 responses (24% response rate). We received slightly more responses from ICS areas that haven't been involved in the VCSE Leadership Programme than from areas that have but the overall response was fairly evenly split. In 12 ICS areas we received more than one response. In 17 areas we received no response was received (seven of which were areas not yet engaged by the Leadership Programme). A table of responses by ICS area can be found at Annex A, with the ICS areas not yet engaged in the Leadership Programme highlighted in red.

Interviews

Building on the survey, we conducted semi-structured interviews with the CEOs of eight respondent organisations to discuss their views in more detail. Each of these organisations was operating in an area not yet involved in the VCSE Leadership Programme. A balance was sought between those representing unitary/single-tier local authority areas and those operating within county or larger areas.

Engagement Events

In December 2020 NAVCA held two online engagement sessions for LIOs and wider VCSE organisations including members of the Health and Wellbeing Alliance. Supported by NHSE/I Leaders, and VCSEs, the events provided an opportunity for feedback on the four key questions in NHSE/Is engagement paper *Integrating care: Next steps to building strong and effective integrated care systems across England, NHSE/I*, (November 2020). Two subsequent follow up sessions were held in February 2021, to outline NHSE/I responses to the feedback to the paper, and a final event in March 2021, was held to outline and gather feedback on the draft recommendations to inform this report. In total, over 100 VCSE organisations were engaged through the events.

[2] Co-chaired by NAVCA and British Red Cross, the Voluntary and Community Sector Emergencies Partnership is a partnership of local and national voluntary and community sector organisations, formed in response to learnings from several national crises in 2017; https://vcsep.org.uk

[3] Until 2021, NCVO hosted the National Volunteer Centre Accreditation standard and, as such, held a membership of organisations that have been included in the sphere of local VCSE infrastructure. ACRE (Action with Communities in Rural England) is a national charity and England's largest rural grouping of county-based local development charities. Some LIOs are members of more than one national body.

Key Findings

Level and scope of local VCSE infrastructure in ICSs
• With some notable exceptions, the number of LIOs per ICS broadly correlates to the size of population served and number of lower-level local authorities within each ICS footprint. • On average, there are between four and five (geographically focused) local VCSE infrastructure organisations operating in each ICS area. • Local infrastructure is predominantly arranged to operate on a footprint synonymous with 'place', reaching down to neighbourhood as their recognised audience or operating area. • There is limited information readily available from which to map the full range of VCSE infrastructure operating on a thematic basis (e.g. for specific communities or issues) in each ICS.
At neighbourhood
• Quality of VCSE engagement with neighbourhood-level structures is primarily dictated by the level of understanding of the VCSE's role and potential amongst PCN Clinical Directors, which is not consistent. In turn, this leads to inconsistency in the levels of support and funded activity (for instance via Social Prescribing) that is delivered in collaboration. • The impact of Covid appears to have consistently improved PCN engagement with the VCSE sector, perhaps driven most by practical action to support activity such as volunteering at vaccination sites.
At place
• A high proportion of place-based LIOs report having limited or no engagement in place-based health and care partnership structures such as ICPs and Health and Wellbeing Boards. This the case for many who work at a county level, but also for those whose area of operation is coterminous with their 'place'. • Where place-based engagement does exist, there is widespread concern about tokenism, and about how well understood the role, potential and limitations of the VCSE sector is among health and care partners.
At system
• Working at system level can present challenges for LIOs, where new forms of collaboration and relationships need to be formed, and concern around losing existing relationships is high. This is seen as a strain on the limited capacity of LIOs, especially given the fact that despite expectations, very few are funded to engage with health structures. • LIOs in ICS areas that have been involved in the Leadership Programme are far more likely to be directly involved in system level partnerships, and have a more positive view of their engagement. Where LIOs work across more than on ICS they find significant variance in approach and commitment to engage the VCSE and this can stretch limited resource.
VCSE sector collaboration for strategic representation, coordination, leadership and service delivery
• The vast majority of LIOs are collaborating with one another to support their engagement in health at place and system, mainly via informal networks and leadership groupings to share information, experiences and best practice. • There is a very varied picture in terms of how effective this collaboration is. Collaboration is considered more effective in ICS areas that have been involved in the VCSE Leadership Programme than in those that haven't. LIOs recognise the need to improve this themselves. • The lack of consistent approach to funding the VCSE sector's role in integrated care structures, coupled with the high demand on LIOs, is leading to inconsistency and reducing effectiveness.

- Where engagement is working well, it tends to be built around long-standing relationships and trust between individual leaders, rather than the result of system structures.
- Only half of LIOs in all ICS areas are aware of local VCSE service delivery alliances/collaboration within their local sector, but around a third of LIOs who are aware of them are directly involved. There is little difference in the level of LIOs awareness or involvement in service delivery collaboration between ICS areas that have been involved in the VCSE Leadership Programme, and those that have not.
- LIOs report concerns about local health partners failing to fully understand the role, potential and limitations of the VCSE sector and, in particular to make a clear distinction between the separate roles of the VCSE as; a voice for users; a point of representation and information on the VCSE sector generally; as a service provider.

Recommendations

Sharing information and experiences

1. Continue to build on the successes in engaging PCNs and the VCSE by sharing examples of successful practical working generated through the pandemic, and the impact they have achieved.
2. The Leadership Programme should continue to support VCSE collaboration at system level to help provide effective mechanisms for system engagement. Continue to work with NAVCA and its members to identify priority areas for engagement based on intelligence and feedback from the VCSE sector as well as health and care system leaders.
3. A more in-depth review of local infrastructure, including thematic and issues specific VCSE infrastructure organisations should take place to give a fuller understanding of the prevalence and role in ICS areas.
4. NAVCA should work closely with NHSE and the VCSE Leadership Programme to provide opportunities for VCSE infrastructure organisations and system partners to engage with one another on a relevant geographic basis, to share experiences and learning and build greater collaboration.

Creating relationships, trust and understanding

5. Increase the systematic support to aid collaboration between VCSEs at place to ensure effective representation and that the experience of a wide variety of VCSE organisations is drawn on. Make it more focused on their experience and the individual characteristics of the VCSE sector at the individual system and place level.
6. Address concerns about tokenistic engagement by clarifying the distinct roles the sector plays, and supporting collaborative mechanisms within the VCSE, and between the VCSE and health systems, which can provide effective engagement to deliver each.
7. Further development of ICSs should not be at the detriment of the important role of the VCSE sector at place. Guidance and support should be provide to make them actively engage the sector in systems in order to avoid making their involvement in place-based partnerships more difficult. Guidance and support to ICSs should to stress the importance of place-based partnerships and give ICS's a clear and active responsibility for supporting the VCSE's engagement as an equal partner at both place and system level.
8. Leadership Programme and NAVCA should provide support and guidance to help VCSEs organisations and health system partners to identify ways to ensure representation at each level is open and transparent to avoid real or perceived competition within the sector, and to help distinguish between the sector representation, user voice and service provider roles.

Supporting Workforce Development

9. Engage local VCSE infrastructure to provide learning opportunities for PCNs to better understand the role, impact, opportunities and limitations of VCSE infrastructure in supporting population health.
10. Work with local infrastructure and other VCSEs to provide opportunities for workforce development within health and care system partners at a middle-management and below; support opportunities for learning about the local VCSE sector and build greater knowledge about, and appetite for, coproduction with the sector.
11. Be clear about how existing structures, such as Health and Wellbeing Boards will work alongside new place-based partnership mechanisms, and where and how the VCSE should focus its limited resource in order to have effective role and support local outcomes.

Providing Funding and Resources

12. Support/direct systems to resource the role they are aiming the VCSE to play at system and place in order to reduce the inconsistency that is currently prevalent. Be clear on the support provided to deliver a strategic influence, intelligence gathering and sharing, representation and leadership role, as distinct from direct service delivery, to address issues of real or perceived competition. The support provided by the Leadership Programme (e.g. to fund a sector-based ICS engagement post) is helpful and should continue, but it does not provide a long-term solution.

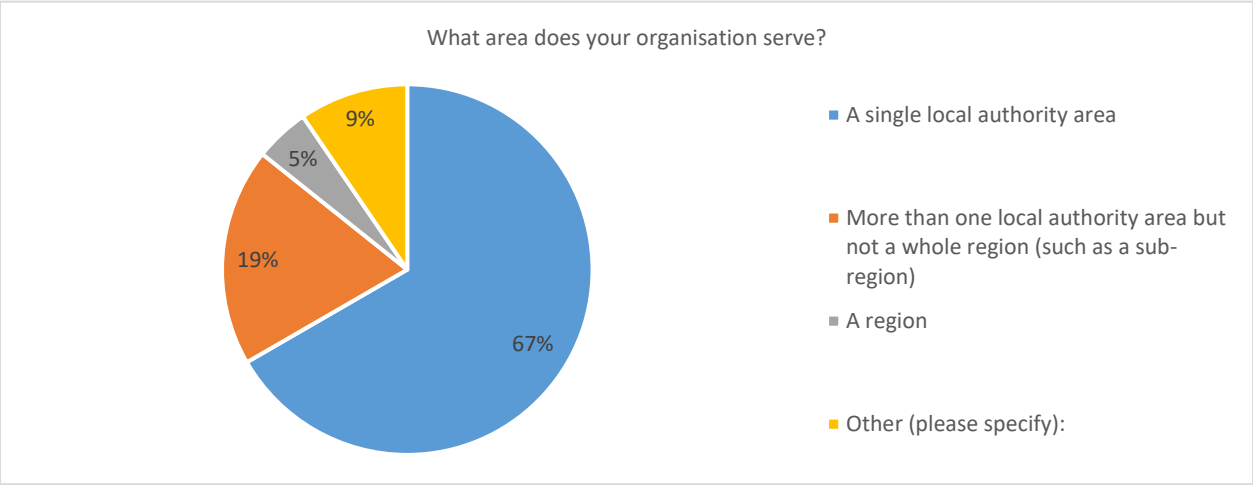
Level and scope of VCSE infrastructure in ICS areas

Within the time and resource available for this "rapid" review only a partial map of VCSE infrastructure has been possible. The data readily available only takes into account local infrastructure organisations which are members of three key national bodies; ACRE, NAVCA and NCVO. There will be many more LIOs that are not members of these bodies. Furthermore, a focus on this cohort of LIOs means the attention is primarily on infrastructure organisations operating on the basis of *geographic* footprint, and not those operating on a thematic focus (for instance infrastructure bodies with a focus on supporting VCSE activity in the field of disability, housing, BAME or any other specific cohort or topic). Even within the geographic infrastructure group, these are not all doing the same thing; some deliver a wide range of "infrastructure" functions, whereas others have a much more narrow and specific focus, such as delivering volunteer support and brokerage. Additionally, it is key to note the huge variance in size and capacity between these organisations. Within NAVCA's membership alone, the variance in organisational size based on annual income can vary from less than £50,000 per to several million pounds.

Also, it was not possible to find data to clearly identify the boundaries of each ICS, and the populations served. A manual review of information published on the NHS pages relating to integrated care[4] was the only means from which to find this information, and individual ICS pages often provided information in different formats.

The average population served by each LIO is approximately 375,000 and the number of local infrastructure organisations in each ICS broadly correlates to size of population served and number of lower-level local authorities within the footprint; Smaller ICS areas have less individual LIOs, with some notable exceptions, particularly Birmingham and Solihull.

The majority of LIOs which responded to the survey report serving an area equivalent to a single lower-level local authority area, however a third operated across a wider county or similar footprint. None report operating across a whole ICS area, but several report operating across part of two ICS footprints. They universally report finding this a challenge and experiencing significant variation in systems' approach to engaging the VCSE.



[4] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

ICS	NHSE Region	LIOs in ICS	LAs in ICS	LIOs per LA	Population served	Population per LIO
Bath, Swindon and Wiltshire	South West	6	3	2.00	900000	150000
Bedfordshire, Luton and Milton Keynes	East of England	4	5	0.80	1000000	250000
Berkshire West, Oxfordshire and Buckinghamshire	South East	3	11	0.27	1800000	600000
Birmingham and Solihull	Midlands and East	1	2	0.50	1300000	1300000
Bristol, North Somerset and South Gloucestershire	South West	2	3	0.67	1000000	500000
Cambridgeshire and Peterborough	East of England	4	7	0.57	900000	225000
Cheshire and Merseyside	North West	10	9	1.11	2600000	260000
Cornwall and the Isles of Scilly	South West	2	2	1.00	600000	300000
Coventry and Warwickshire	Midlands and East	3	6	0.50	1000000	333333
Derbyshire	Midlands and East	8	9	0.89	1000000	125000
Devon	South West	8	10	0.80	1200000	150000
Dorset	South West	3	8	0.38	787000	262333
Frimley	South East	3	7	0.43	800000	266667
Gloucestershire	South West	1	6	0.17	600000	600000
Greater Manchester	North West	7	10	0.70	2800000	400000
Hampshire and the Isle of Wight	South East	6	12	0.50	1900000	316667
Herefordshire and Worcestershire	Midlands and East	5	7	0.71	800000	160000
Hertfordshire and West Essex	East of England	7	12	0.58	1600000	228571
Humber, Coast and Vale	North East & Yorkshire	6	9	0.67	1700000	283333
Kent and Medway	South East	4	13	0.31	1900000	475000
Lancashire and South Cumbria	North West	7	16	0.44	1800000	257143
Leicester, Leicestershire and Rutland	Midlands and East	2	9	0.22	1100000	550000
Lincolnshire	Midlands and East	4	7	0.57	800000	200000
Mid and South Essex	East of England	4	9	0.44	1200000	300000
Norfolk and Waveney	East of England	2	8	0.25	1200000	600000
North Central London	London	5	5	1.00	1600000	320000
North East and North Cumbria	North East & Yorkshire	14	17	0.82	3000000	214286
North East London (East London)	London	5	8	0.63	2200000	440000
North West London	London	6	8	0.75	2400000	400000
Northamptonshire	Midlands and East	2	7	0.29	800000	400000
Nottinghamshire	Midlands and East	5	7	0.71	1000000	200000
Shropshire (& Telford and Wrekin)	Midlands and East	3	2	1.50	500000	166667
Somerset	South West	1	5	0.20	600000	600000
South East London	London	3	6	0.50	2000000	666667
South West London	London	6	6	1.00	1585000	264167
South Yorkshire and Bassetlaw	North East & Yorkshire	3	5	0.60	1500000	500000
Staffordshire and Stoke on Trent	Midlands and East	2	9	0.22	1200000	600000
Suffolk and North East Essex	East of England	2	8	0.25	953000	476500
Surrey Heartlands	South East	3	7	0.43	1100000	366667
Sussex and East Surrey	South East	8	15	0.53	1800000	225000
The Black Country	Midlands and East	4	4	1.00	1500000	375000
West Yorkshire and Harrogate	North East & Yorkshire	5	7	0.71	2500000	500000

Local VCSE Infrastructure's role and experiences within local systems

We explored engagement in integrated care system structures, including whether LIOs held a seat on relevant governance boards, and how effectively they were collaborating with Primary Care Networks (PCNs), Integrated Care Partnership (ICP or equivalent) and ICS structures to deliver the aims of the VCSE Leadership Programme (as set out in the introduction to this report).

There was significant variation in the rating of collaboration in the various structures, even within the same ICS footprint areas. This is likely to be due to the variance in size and scope of the LIOs which responded, and corresponding the expectations of, and capacity for, specific organisations to be engaged at neighbourhood, place and system. Nevertheless, there were still some consistent messages.

At **neighbourhood**, the average rating for collaboration with PCNs was below five (out of 10), with a very marginal increase for those in areas that have been involved in the Leadership Programme compared to those that haven't. Many report their work in practical areas such as mobilising the sector and volunteers in response to the pandemic has greatly improved engagement with PCNs, which now better understand their role and value.

> *"The relationship with PCNs has improved during the vaccination roll out, but there really was no interest in engaging with us before this."*

Others note that good engagement and collaboration at PCN level was highly dependent on the individual Directors' knowledge of the VCSE sector.

> *"Varied joint working with PCN's which seems to largely depend on the level of VCS awareness of the PCN Director"*

At **place**, almost two thirds (65%) of LIOs report having no seat on their local Integrated Care Partnership Board, or its equivalent, but those in areas that have been involved in the Leadership Programme are twice as likely to have a seat on the ICP than those in areas that haven't been engaged in the programme. In all areas, engagement on the ICP board is most likely to be via a VCSE leadership group or some other informal collaborative mechanism.

On average LIOs rate engagement with their ICP(s) at below five (out of 10), but with significant variance between areas demonstrating that it is the local relational aspects of the system that are having a greater impact than the structures themselves. Those that rate place-based collaboration positively focused on these long standing relationships as a primary driver;

> *"We have historically had good relationships with [ICP] stakeholders who are keen to build stronger links in future"*

We heard less positive views from many, who feel engagement in leadership and design at place-level is tokenistic and lacks clarity. Some felt this is symptomatic of a wider lack of understanding within health and care around the role, impact and potential of the VCSE generally, noting the rationale and aims of VCSE engagement are often not clearly articulated or understood by health and care partners. We heard this was true even when engagement was being funded by local health partners.

> *"Any collaboration means being 'consulted', but we feel that our views are not being taken on board"*

> *"I feel like an extra at the [ICP] board"*

"Although communications channels are good, the ethos of the partnership is still forming. In the main partners tend to agree on strategic matters and impacts desired, but there remains partners that find difficultly in being objective in their approach to partnership working."

Several others noted ineffective means of engagement that placed an additional barrier, usually via a statutory partner, we causing challenges:

"Our ICP has a council funded rep who doesn't link or report into the sector. We are aiming to work around them…"

These findings are a concern given the importance of place-based partnerships to drive real change[5].

As an important mechanism for place-based partnership, LIOs were asked about their experience of engagement with Health and Wellbeing Boards. Around 75% of LIOs stated they held a seat representing the sector on their local HWBB. However, whilst the numbers with a seat on the local HWBB were high, the experiences of positive working and perceptions of value were low. Generally, there was concern that HWBB engagement was tokenistic, and many reported being unclear what role HWBB would play in the new integrated care structures. One of those most extreme examples was an LIO, having recently resigned a seat representing the sector on the HWBB due to concerns of tokenism, was informed they are no longer eligible to engage with the ICP and ICS board as a result, and have effectively been removed from all integrated care governance.

"[Our organisation] held a seat on the Health and Wellbeing Board which I recently resigned from mostly as it was a drain on time, there was no opportunity to influence and also the VCSE wasn't being supported to engage… [We] were ticking a box".

Regarding **system**-level engagement, over two thirds of all respondents to the survey report having no seat. The difference between areas that/haven't been involved in the Leadership Programme is stark: 85% of those that have not been involved report not having a seat, compared to 30% of those that have been involved. This is likely to reflect the relative nascence of ICS Boards and the fact that many of the LIOs engaged are focused on areas aligned to place rather than the much larger ICS footprints.

"The relationship with the ICS is patchy as we are [working within] a tiny area within the wider ICS"

"The [ICS] … often comes forth with positive communications about collaborative working, however at present still feels very distant in comparison to the local ICP."

In all ICS areas, engagement with the ICS Board was far more likely to be via a collaborative mechanism rather than as an independent organisation, but the same concerns about a lack of strategic approach to engagement, or clarity of purpose, were outlined at system level.

"I have undertaken 'bits' of work with the ICS reps but at random, nothing that reflects VCS involvement strategy"

When consider the effectiveness of collaboration with ICS's, average ratings from LIOs in Leadership Programme ICS areas is 2 points higher (6) than those that haven't (4). This could demonstrate the positive impact of the Leadership Programme. Whilst this is positive, it does not negate the concern that place-based

[5] See Developing place-based partnerships: The foundation of effective integrated care systems, Kings Fund, April 2021 for further discussion https://www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems

partnerships are not seen as highly effective and there is a risk that a shift to more system level focus will further compound these issues.

> *"Much of this work is in danger of being lost with the move to ICS level. The borough level governance of the system is being monopolised by the [Local Authority]. The governance of the larger ICS area is being monopolised by the NHS."*

LIOs fed back that their role on ICS's is developing, but there is not always clarity of purpose. Many raised concern about relational issues, understanding of the sector and capacity to engage in coproduction, noting a general willingness at strategic level but limited capacity/knowledge to practically deliver at levels below strategic leaders. We heard LIOs felt that three distinct roles should be clarified at place and system:

- to provide the voice of the user (which is mainly, but not exclusively, supported by local Healthwatch organisations);
- to provide understanding of the capacity of the local sector;
- to build local sector engagement and alliances to support performance, outcomes and impact.

At system level there was also greater concern to ensure VCSE representation was considered to be transparent, open and democratic in order to provide the sector assurance and genuine opportunity to engage and be represented. Unsurprisingly, this was a more prevalent concern in ICS areas with higher numbers of LIOs.

> *"A country unelected body… is given places on boards. They do not communicate with the sector nor feedback any information about discussions at board level"*

As with the place-based findings, funding and resourcing the sectors' strategic engagement role is seen as an issue. Representation is expected but not universally funded, which creates disparity in ability to engage, even where relationships are strong and commitment to involve VCSE is strong. Even where funding is provided, many report having little clarity on the purpose – one said they have taken the initiative to bring a VCSE Leaders Group together but this hasn't been explicitly agreed by the local CCG/ICP.

VCSE sector collaboration for strategic representation, coordination, leadership and service delivery

We asked LIOs whether they collaborate with other local VCSE infrastructure bodies in order to engage with health and care structures, and what forms this collaboration takes and about how effective they felt it was. LIOs were also asked if they were aware of any local VCSE sector collaborations focused on providing health and care services within their ICS area and, again, how effective they felt this was.

Over 75% said they do work collaboratively with other infrastructure organisations to deliver strategic engagement and representation of their local sector. The majority do so via some form of informal or semi-informal partnership agreement or network. Only a small minority were collaborating via a legal structure such as a jointly-owned company/charity. There is a small difference in the levels of collaboration between LIOs in ICS areas previously engaged in the Leadership Programme and those in ICS areas that have not been engaged. But there was a high degree of acknowledgement of how the Leadership Programme had supported VCSE infrastructure collaboration in areas it had been rolled out.

In ICS areas not yet engaged in the Leadership Programme, almost 50% stated they were not aware of any local service delivery collaborations. Those that were aware of such collaborations were much more likely to be involved in them (37%) than not (14%). In ICS areas that have been involved in the Leadership Programme,

there was slightly more awareness of local service delivery collaborative (60%) but the numbers directly involved in these was not dissimilar to in ICS areas not yet engaged in the Leadership Programme. Many noted the lack of strategic approach to engaging the VCSE, and a lack of understanding of the roles the sectors plays, was causing difficulty with regard to collaboration *within* the VCSE sector; for instance, when a mix of representative VCSE infrastructure bodies were engaged in structures along with larger frontline service delivery organisations. Interviewees reported links made with larger charities through commissioned services were often used as the means to engage with the sector but this wasn't truly representative and it was often those with the loudest voices who were more likely to be engaged. Some felt the distinction between the role of infrastructure to provide representation, and the role of other VCSE organisations in service delivery was poorly understood, which led to poorer local sector collaboration, and a focus on competition and the need to secure limited resources for engagement.

> *"Competitive commissioning and procurement practices at the local level has not helped"*

> *"a local authority funded project in response to the pandemic led by several larger charities [operating in the area]. We liaise with them on occasion but they have recently come to represent themselves on the ICP Board."*

Others noted that local VCSE infrastructure organisations have an important role to play in improving their approach to working collaboratively with one another

> *"our CVS network itself is not as coordinated and joined up as it needs to be"*

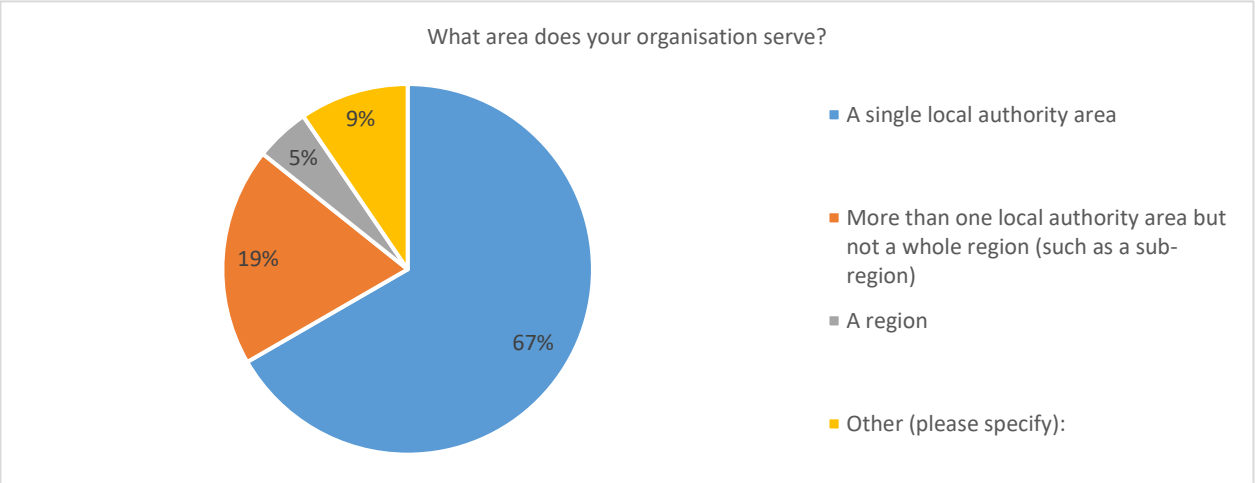
> *"County-wide infrastructure had seats, as do the VCS organisations with loud voices"*

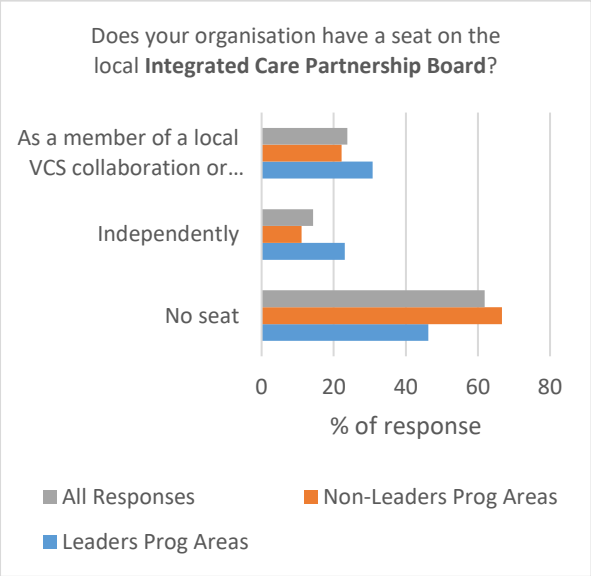
When asked to rate the ability of service delivery collaborative in their area to achieve the outcomes of the Leadership Programme and engage with other VCSE organisations in their ICS area, the average ratings were around the mid-point mark. The notable differences were between the ability of service delivery consortia to *represent the wider sector (e.g. non-consortium members)* and *provide a single route of contact and engagement with the sector and links to communities*. In these areas, respondents from ICS areas that have been engaged in the Leadership Programme tended to provide a lower rating than those from areas that have not yet been engaged with the Programme.

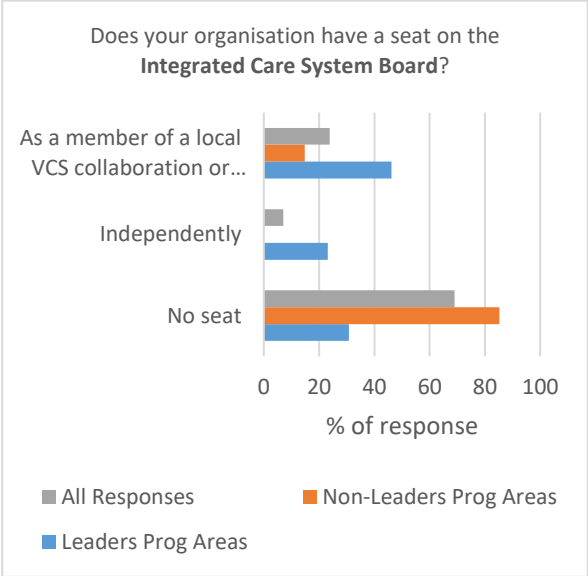
Annex A – Survey responses by ICS area

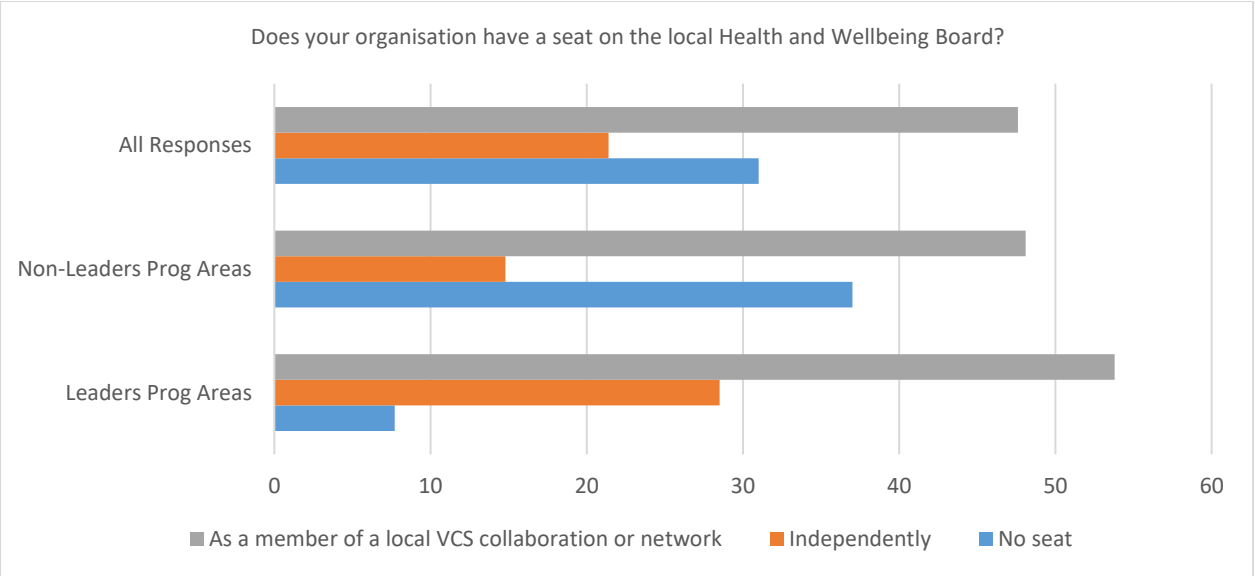
Table 1: **STP/ICS (by response rate)**	**Responses**
Hertfordshire and West Essex	5
Hampshire and the Isle of Wight	3
Herefordshire and Worcestershire	3
Bath, Swindon and Wiltshire	2
Cambridgeshire and Peterborough	2
Cheshire and Merseyside	2
Devon	2
Greater Manchester	2
Kent and Medway	2
Staffordshire and Stoke on Trent	2
Suffolk and North East Essex	2
The Black Country	2
Berkshire West, Oxfordshire and Buckinghamshire	1
Bristol, North Somerset and South Gloucestershire	1
Cornwall and the Isles of Scilly	1
Coventry and Warwickshire	1
Derbyshire	1
Frimley	1
Lancashire and South Cumbria (Blackpool & Fylde Coast)	1
Mid and South Essex	1
North Central London	1
Northamptonshire	1
South East London	1
South West London	1
Surrey Heartlands	1
Bedfordshire, Luton and Milton Keynes	0
Birmingham and Solihull	0
Dorset	0
Gloucestershire	0
Humber, Coast and Vale	0
Leicester, Leicestershire and Rutland	0
Lincolnshire	0
Norfolk and Waveney	0
North East and North Cumbria	0
North East London (East London)	0
North West London	0
Nottinghamshire	0
Shropshire (& Telford and Wrekin)	0
Somerset	0
South Yorkshire and Bassetlaw	0
Sussex and East Surrey	0
West Yorkshire and Harrogate	0

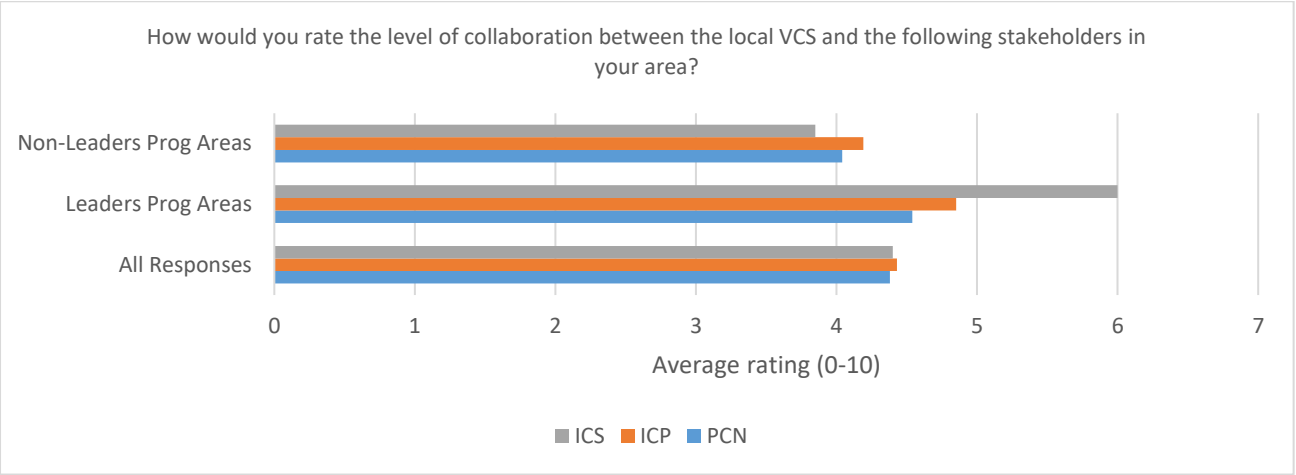
Annex B – Summary of survey responses

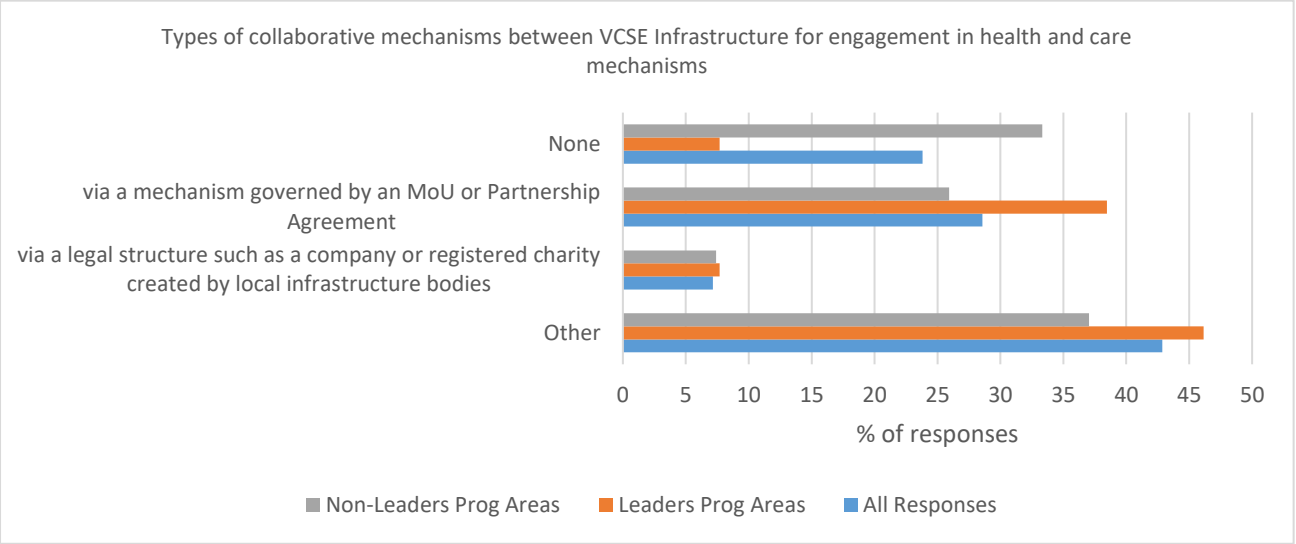


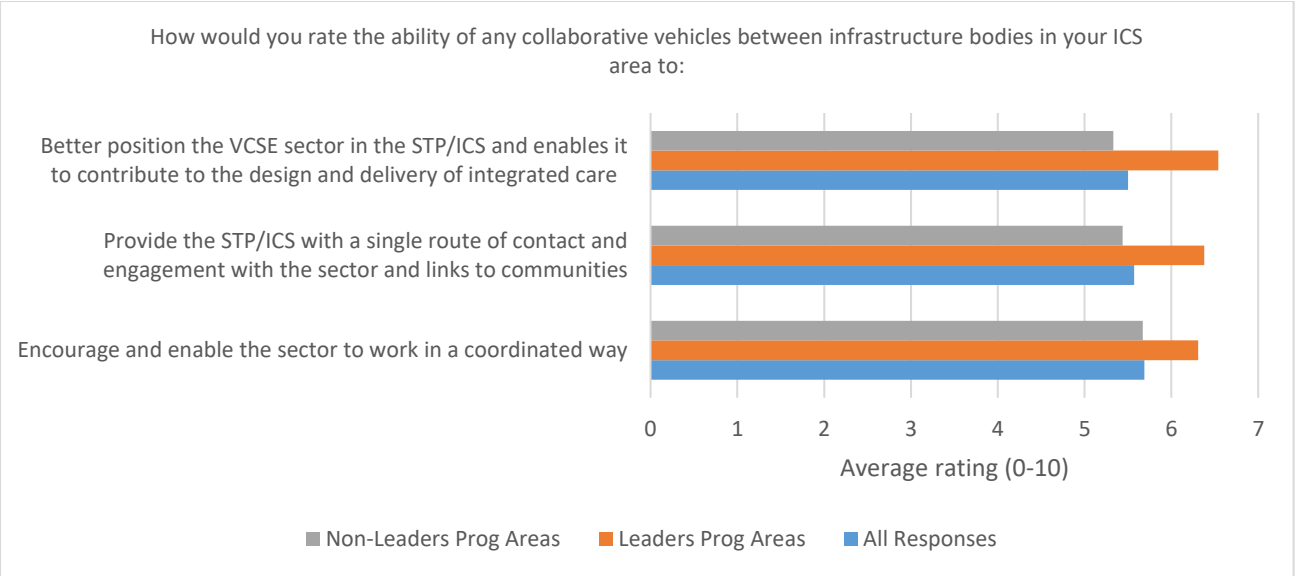


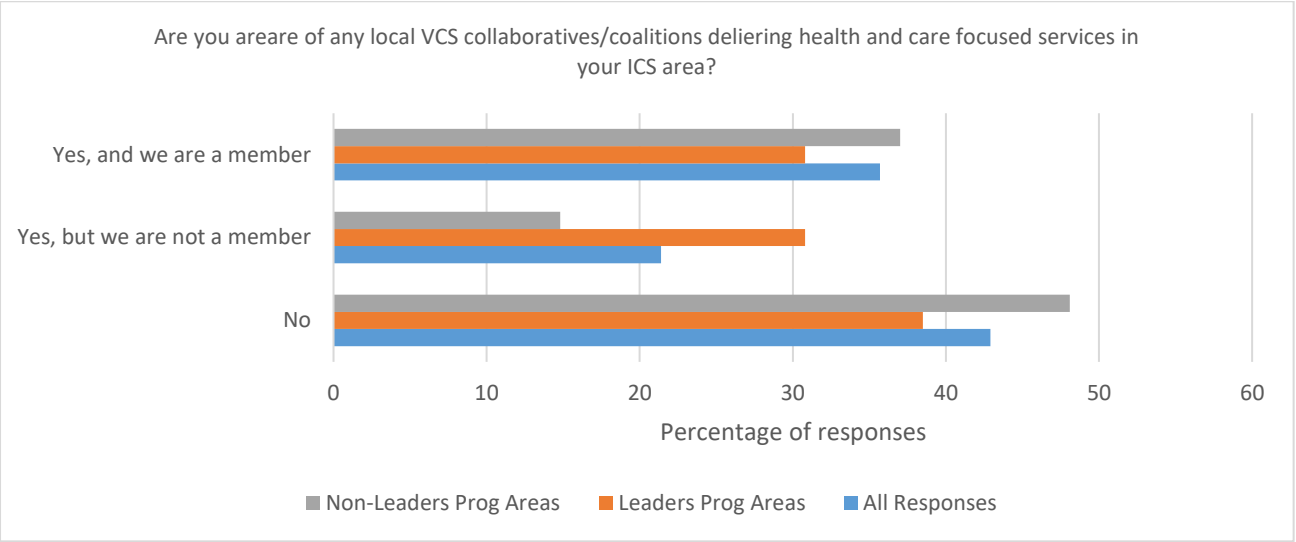


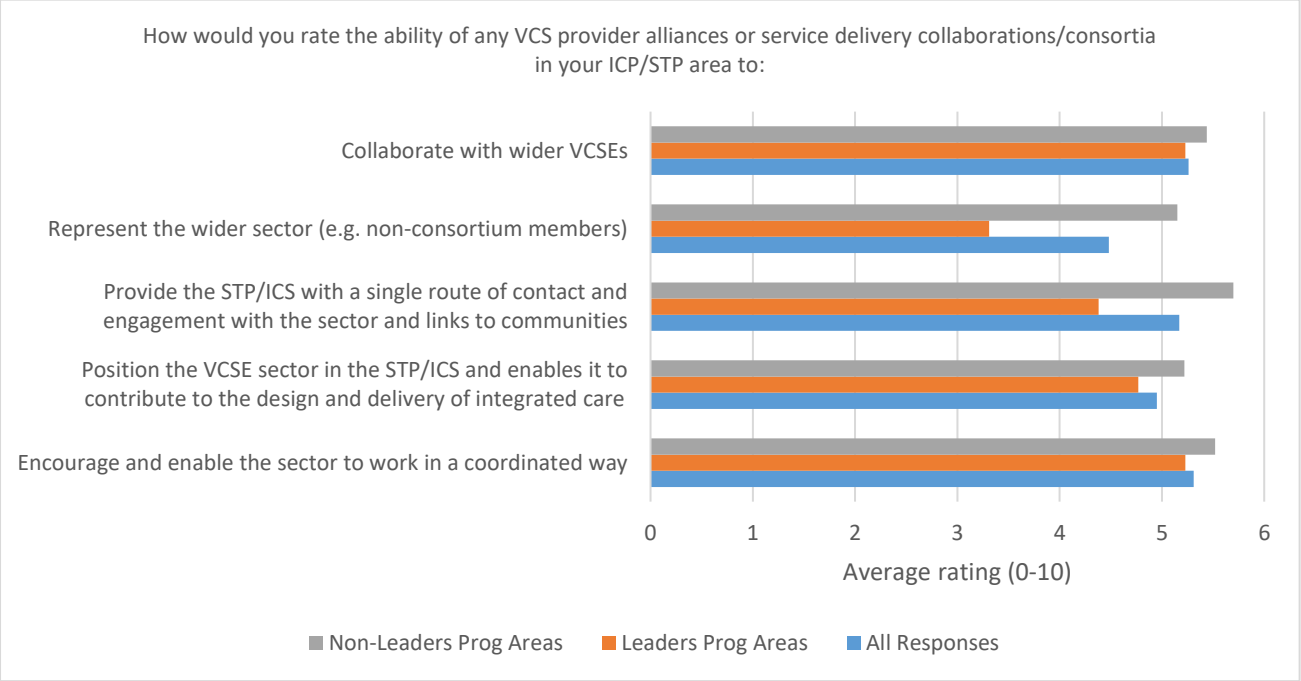



How would you rate the level of collaboration between the local VCS and the following stakeholders in your area?
Non-Leaders Prog Areas
Leaders Prog Areas
All Responses
0
1
2
3
4
5
6
7
Average rating (0-10)
ICS
ICP
PCN


Types of collaborative mechanisms between VCSE Infrastructure for engagement in health and care mechanisms
None
via a mechanism governed by an MoU or Partnership Agreement
via a legal structure such as a company or registered charity created by local infrastructure bodies
Other
0
5
10
15
20
25
30
35
40
45
50
% of responses
Non-Leaders Prog Areas
Leaders Prog Areas
All Responses


How would you rate the ability of any collaborative vehicles between infrastructure bodies in your ICS area to:
Better position the VCSE sector in the STP/ICS and enables it to contribute to the design and delivery of integrated care
Provide the STP/ICS with a single route of contact and engagement with the sector and links to communities
Encourage and enable the sector to work in a coordinated way
0
1
2
3
4
5
6
7
Average rating (0-10)
Non-Leaders Prog Areas
Leaders Prog Areas
All Responses


Are you areare of any local VCS collaboratives/coalitions deliering health and care focused services in your ICS area?
Yes, and we are a member
Yes, but we are not a member
No
0
10
20
30
40
50
60
Percentage of responses
Non-Leaders Prog Areas
Leaders Prog Areas
All Responses


How would you rate the ability of any VCS provider alliances or service delivery collaborations/consortia in your ICP/STP area to:
Collaborate with wider VCSEs
Represent the wider sector (e.g. non-consortium members)
Provide the STP/ICS with a single route of contact and engagement with the sector and links to communities
Position the VCSE sector in the STP/ICS and enables it to contribute to the design and delivery of integrated care
Encourage and enable the sector to work in a coordinated way
0
1
2
3
4
5
6
Average rating (0-10)
Non-Leaders Prog Areas
Leaders Prog Areas
All Responses