Creating inclusive services

How community organisations help tackle acute health inequalities

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VCSE health & wellbeing alliance

locality
the power of community

Contents

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The role of community organisations in creating inclusive services

Cultural competence and inclusive services are essential for tackling health inequalities. If health services are to produce positive health outcomes for communities and tackle health inequalities, they need to be culturally competent and inclusive. The VCSE sector have an important role to play in this. In particular, local community organisations are well placed to ensure that the services they provide are accessible, acceptable and available for their communities.

There are four key roles which community organisations play in helping to create inclusive services which tackle health inequalities:

1. Service design and adaptation
2. Service provision – holistic approaches to health and care
3. Voice and advocacy for marginalised groups
4. Information and insight gathering

However, there are challenges and barriers which prevent community organisations from carrying out this role. These are:

- Information and awareness
- Structural and systemic barriers
- Funding and capacity
- Accessibility and language
- Trust
- Leadership and culture

Key messages for the health system:

- Community organisations are rooted in their communities and know the nuances of the local area and the problems and issues people face.
- There are pockets of good practice where the VCSE sector and health system are working well together to create inclusive, culturally appropriate services which address health inequalities.
- Pockets of good practice will only ever be pockets if there is not system change to enable the VCSE sector to work collaboratively with commissioners and get lived experience, expertise and local knowledge into the heart of service design.
- This requires ICB-level commitment to culture change to make collaboration with the VCSE sector at all stages of commissioning possible and ensure that commissioning is driven by outcomes and not solely by price.
- Current engagement practices with the VCSE sector are not sustainable – collaboration is not free yet often relies on the resources and capacity of the sector and often happens late in the commissioning processes with short timelines.
- At all levels of the health system, there are actions which Primary Care Networks, local authorities, and Integrated Care Boards can do to support the creation of inclusive services.

This report sets out how the health system can can recognise the role of the VCSE sector and support them to play their vital role to benefit all communities.

Executive summary

Community organisations are rooted in their places. On average, they provide 13 different services for their communities, ranging from CQC-registered social care to gardening clubs and beyond.[1] All of these services are tailored to meet the needs of their communities, whether that is a community of place such as a city, a local authority ward or even a postcode, or a community of experience and identity such as organisations supporting particular inclusion health groups.

Community organisations, and the wider Voluntary, Community and Social Enterprise (VCSE) sector play an important role in tackling health inequalities. Their role as trusted organisations within their communities means that they are well-placed to provide and support the design of services which are accessible for, acceptable to and available in their communities, but, in doing do, they face significant challenges.

A role in tackling health inequalities

Tackling health inequalities is an established duty of the NHS in all its constituent parts, from system to neighbourhood level. The way in which they carry out that duty, as shown in the "Working in partnership with people and communities" guidance, needs to include the VCSE sector in all its diversity. Generic, one-size-fits-all services, created far from communities, will not address the specific needs they may have and fail to produce positive health outcomes.

Inclusive services are ones where barriers to access for all population groups are mitigated, and the inequalities which exist between different groups can be addressed through tailored interventions. Part of this is cultural competence, understanding different cultures to effectively communicate with those groups and design services with those specificities in mind.

Community organisations often work across different communities, their services covering the four domains of health inequalities. They support people across many different protected characteristics, inclusion health and other vulnerable groups, across different geographies and are often operating in the most socio-economically deprived areas of the country.

The role of community organisations in creating inclusive services

This report looks at four key areas where community and other VCSE organisations play an important role in creating inclusive services:

- **Service adaptation and design:** community organisations' engagement with the health system differs from place to place. Where it is working most effectively, they are able to engage fully in co-design processes, ensuring that the services being designed or adapted are able to meet the needs of the communities they serve.
- **Holistic service provision:** VCSE organisations provide a wide range of services and, whether explicitly stated or not, these are often aimed

at influencing the wider determinants of health. From organisations retrofitting old houses to ensure that the most vulnerable have warm homes, to running allotments where those experiencing mental ill-health can engage in therapeutic services.

- **Voice and advocacy:** community organisations, particularly those working with communities of experience, are able to amplify the voices of the most marginalised in society and ensure that lived experience is at the heart of inclusive service design.
- **Information and insights:** Utilising their close, trusting, relationship with their communities, VCSE organisations are able to gather valuable insights about their communities in a way that statutory services are often unable to. This is often vital information which can help to inform commissioning decisions at all levels of the health system.

Challenges and barriers faced by community organisations

In carrying out their work, community organisations face significant challenges and barriers to creating inclusive services.

- **Information and awareness:** for inclusive services to be designed and community organisations to play their role there must be good flows of information. However, the health system is often unaware of the role of the VCSE sector and what their presence looks like from area to area and as a result information is often not fed into commissioning and decision-making.
- **Structural and systemic barriers:** From short timelines in commissioning and very late engagement of the VCSE sector in service design, there are barriers in the system to the

sector playing their role. This is often worsened by wider structural barriers such as how racism and stigmas have become entrenched in our systems, leading to some communities being left in the margins without a voice or representation in the system.

- **Funding and capacity:** The VCSE sector, like the public sector, has faced significant financial and capacity challenges in recent years. This has reduced their ability to take part in commissioning and co-design processes, particularly where there is no remuneration available for their time. This is a particular challenge for community organisations representing racially minoritised communities which have been historically underfunded and often underrepresented in commissioning processes.[2]
- **Accessibility and language:** From the physical accessibility of buildings to digital inclusion, health services risk increasing inequalities and poor health outcomes if they are not designed to meet the needs of communities. This extends to language where the VCSE sector is often left confused by the use of internal health sector jargon in engagement, and service users are often faced with inaccessible services as a result of language barriers.
- **Trust:** At a time where we have seen a disintegration of trust between communities and statutory institutions, community organisations hold the key to trusting relationships with the people they serve. However, there is often a lack of trust between these organisations and the health system where engagement has been poor and a lack of cultural competency in services has led to a further decline in trust.
- **Leadership and culture:** Staff working throughout the health system are often left waiting for permission from senior managers to work in new ways with the VCSE sector. From commissioning and procurement to frontline service delivery, senior NHS leaders need to enable their staff to work effectively with the sector and bring about a culture of collaboration in all their practices.

Recommendations

While the health system continues to go through a sustained period of change, there is an opportunity to embed a new way of working with the VCSE sector to ensure that services are created to be inclusive and help to tackle health inequalities. As laid out in Locality's Keep it Local for Better Health report, an approach which prioritises neighbourhood-level coordination, place-level collaboration and system-level investment in the VCSE sector can help to tackle inequalities by supporting those organisations which are closest to, and most trusted by their communities.

Information and awareness

1. NHS England and Department for Health and Social Care should work with the VCSE sector to produce training materials on the role and value of the VCSE sector in health and care. This should be tailored at a system and place level to inform staff about the local VCSE sector.

   NHS England DHSC ICS Local authorities VCSE

2. ICSs should support VCSE Alliances and local authorities should support their local VCSE sector, to feed in real-time information about their communities to inform commissioning decisions.

   ICS Local authorities VCSE

Tackling structural and systemic barriers

3. DHSC should produce commissioning guidance for ICS and public health to ensure that there is early engagement of the VCSE sector in commissioning processes.

   DHSC

4. Those delivering health services at a community level should be trained in trauma informed practice.

   ICS PCN Local authorities

5. The VCSE sector must strive to be representative of all the communities that they represent and ensure the voices of the most marginalised communities are heard in the health system.

   VCSE

Funding and capacity

6. ICBs should ringfence part of the health inequalities and unmet needs adjustment in their core allocations to provide renumeration for community organisations to play a role in service design.

   ICS

7. ICBs should demonstrate a long-term commitment to sustaining community approaches to tackling health inequalities by investing a portion of their health inequalities budget in the VCSE sector in their areas.

   ICS

Accessibility and language

8. NHS England, DHSC and all other bodies responsible for commissioning of health services should encourage the use of the health equity assessment (HEAT) tool in commissioning processes.

   NHS England DHSC ICS Local authorities PCN

9. NHS England should produce language guidance for all levels of the health sector to ensure that the language used is accessible to those engaging with the system - from patients to partners.

   NHS England

Leadership and culture

10. Senior NHS leaders at all levels of the health system should commit to work proactively with the VCSE sector and put in place principles across their organisations for new ways of working with the sector.

    NHS England DHSC ICS Local authorities PCN

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1.

Introduction

Community organisations are rooted in and led by their communities, whether that is a community of place or of experience. They understand and are experts in those communities and provide countless activities and services to meet need as it arises.

In delivering their purpose, community organisations play a vital role in the health and care landscape. Whether that is in health creation, prevention or supporting the delivery of acute care, they tailor and adapt services for the population they serve. In all of their work they ensure that service meet the needs of their community ensuring accessibility, inclusivity and cultural competence in their delivery.

In the United Kingdom, we have seen health inequalities continue to widen.[3] In order to tackle these "unfair and avoidable differences in health", services need to be tailored to meet the needs of different populations.[4] They must be accessible to all, inclusive of and acceptable for all communities and available in the places where they are needed most. Community organisations are a vital piece of the puzzle in ensuring that this happens, and across the system, work must be done to champion and support this way of working.

In recent years, Locality has carried out research highlighting some great practice where community organisations are working to provide culturally competent and inclusive services alongside their partners in the health system and local authorities.[5] Indeed, as Integrated Care Systems (ICSs) continue to mature and put in place strategies for how they work with their communities, there is a perfect opportunity to think about the role which community organisations can play in supporting the health system at all levels, to make services more inclusive. As one research participant said, "pockets of good practice will only ever be pockets if it is not accompanied by system change which enables this work to come into the mainstream."

Our work on Keep it Local for Better Health has explored what this culture change might look like where "collaboration rather than competition" is the guiding principle of commissioning processes, where the health system proactively supports the local Voluntary Community and Social Enterprise (VCSE) sector and enables them to play their full role in helping to develop and deliver inclusive services.

However, in playing this crucial role, community organisations have faced significant challenges. Ranging from a lack of information flows to resource and capacity constraints in the VCSE sector, these barriers can hinder their ability to tackle health inequalities in their places.

This report sets out:

- The importance of cultural competence and inclusive services in tackling health inequalities.
- The role the local VCSE sector plays in helping to create inclusive services.
- The challenges and barriers they experience.
- Best practice examples for how these barriers are being addressed in different places.
- Recommendations for how partners can all work together to make services more inclusive.

This report was compiled using insights from engagement with VCSE organisations, colleagues from public health, ICBs, and NHS England and members of the government's VCSE Health and Wellbeing Alliance. Engagement was carried out through in-depth interviews and a series of national workshops in 2023.

2.

The importance of cultural competence and inclusive services in tackling health inequalities

Over the last decade, Locality has been championing the Keep it Local approach to people-centred public services.

A duty to tackle health inequalities

The Covid-19 pandemic highlighted, more than anything in recent history, the stark inequalities which exist in the UK. These health inequalities, however, cannot be addressed without health and care services which are culturally competent and inclusive, and therefore meet the needs of all communities. Tackling these inequalities has become increasingly important and legislation has placed increased health inequalities duties on the NHS. For example, the Health and Care Act 2022 amended the NHS Act 2006 to extend the NHS's legal duties on reducing and tackling health inequalities. The Equality Act 2010, and the duty to make reasonable adjustments to ensure that services are accessible to all, is a further example of this increased salience.

National frameworks such as the Inclusion Health Framework published in 2023, also set out how NHS bodies should plan, develop and improve health services to meet the needs of inclusion health groups, often those most at risk of poor health outcomes and experiencing health inequalities. Some of this has also been codified to state that NHS bodies have a legal duty to include in their annual reports a review of the extent to which they have exercised their functions in line with the Statement on information on health inequalities. This mandates a need for NHS Trusts to have robust and accessible data on health inequalities.

"Inclusive" approaches to tackling health inequalities

The NHS Core20PLUS5 approach shows the increased value and prominence that tackling health inequalities currently has. The vision of the approach is to deliver "exceptional quality healthcare for all ensuring equitable access, excellent experience and optimal outcomes".[6] This emphasises that for inequalities to be tackled, health services need to be created as inclusive for all.

If health interventions are to work in this way, and meet the specific needs of communities, these cannot be generic, one-size-fits-all solutions. They must be tailored, inclusive and culturally competent.

NHS training defines cultural competence as the "ability to interact with people from different cultures

and respond to their health needs".[7] The training shows that increased cultural competence decreases health inequalities and can help to increase the health literacy of different populations.

The idea of "inclusive services", goes wider than just responding to cultural difference between populations. Locality's research has shown that for services to be inclusive they must be rooted in the lived experience of those who they are designed to serve. They must be fully accessible at the point of use by all individuals, regardless of what their needs might be and be acceptable to communities within the bounds of their cultural practices and beliefs, so that this does not present a barrier to access.

So, in order to tackle health inequalities, culturally competent and inclusive services are needed. And in order for services to be culturally competent and inclusive, they need to be designed in a way which addresses the local or even hyper-local needs of specific communities.

The role of the VCSE sector in reducing inequalities

NHS England's statutory guidance on working in partnership with people and communities states that an important focus of Integrated Care Boards (ICBs) must be "improving understanding of the experiences, perspectives and needs of people and communities".[8] This matters, because without that understanding of what is happening in each individual community and neighbourhood, truly inclusive services cannot be created.

Community organisations are vital partners in this work as experts in their communities – whether those are communities of experience or place. They know the assets which they have at their disposal to tackle health inequalities prevalent in their communities and the challenges which the population faces. As shown in the diagram below, there are four overlapping groups or factors which contribute to health inequalities.

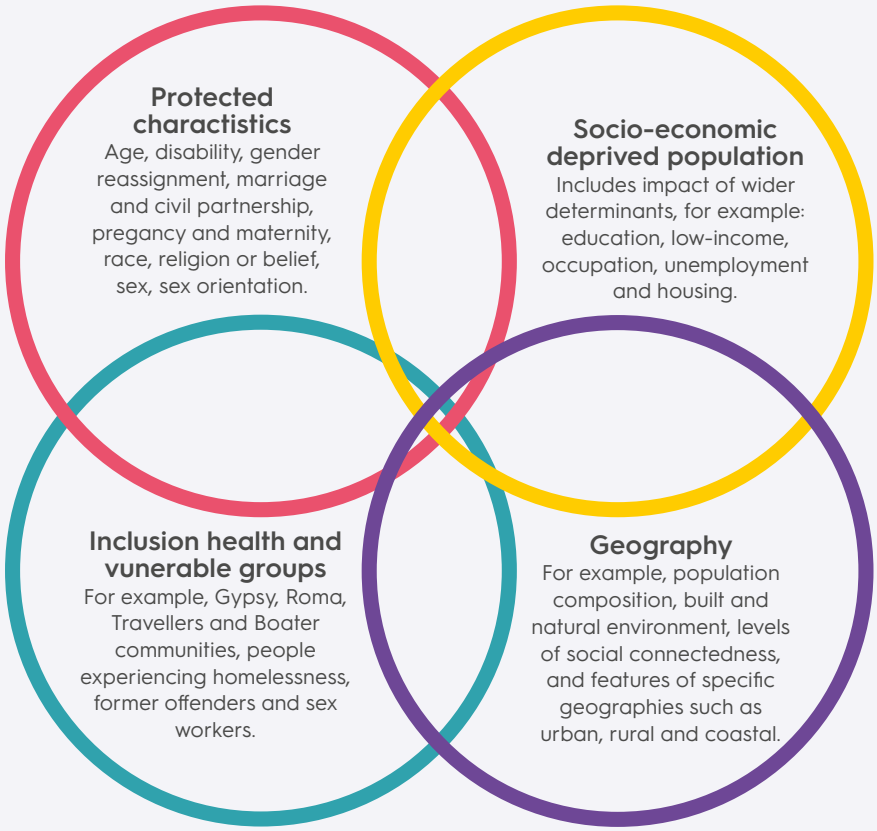

Figure 1: **Domains of Health Inequality (adapted from Public Health England Placed-based approaches to health inequalities, 2019)**

Community organisations sit between all of these areas. They are often located in the places of greatest socio-economic disadvantage, working with

the most vulnerable groups in society and cater and tailor their work towards different population groups whether that is people with certain protected characteristics, or inclusion health groups. Geographically, they often work at neighbourhood level and will understand the contexts of their places – the rural deprivation and inaccessibility of services or the challenges of high inner-city population density, for example.

Indeed, within Locality's own network of over 1,800 community organisations in England, over two thirds of the membership are located in areas in the top 30 per cent most deprived neighbourhoods in the country.

Community organisations offer on average 13 different services, offering everything from mental health support for children and young people to services targeted to specific ethnic groups at higher risk of certain health conditions.[9] They play a role in everything from emergency food provision to long-term employment and skills provision to get people into long-term employment. The case studies set out in this report show how community organisations play an important role in tackling inequalities including providing culturally appropriate environments for exercise within communities (see **Labriut Healthy Living Centre**, p. X) and providing voice and advocacy services for Disabled people (see **WECIL**, p. X).

Within their communities, these organisations are trusted by the population, often more than statutory institutions, and they are valuable partners for the health system. They can act as enablers and conduits for the information about communities which is needed in the design of services.

So, how are community organisations already helping to create inclusive services and what are they doing to overcome the challenges and barriers to this?

3.

The role of community organisations in creating inclusive services

The role of community organisations in creating inclusive services is multiple and varied. This role is often carried out in partnership with other local community organisations and charities, partners in primary and secondary care, and local authorities.

Community organisations act as a "cog of connection" to other services (their own or others in the local area), to other local organisations, to the local people and to the local place.[10] This role as a connector is one which is incredibly valuable in creating inclusive services which meet the needs of local people and is available to them within their communities.

There are four key areas where community organisations are playing this vital role in working towards inclusive services which are accessible, acceptable and available for their local population:

- Service design and adaptation
- Service provision – taking holistic approaches to health and care
- Voice and advocacy
- Information and insight gathering

Service design and adaptation

Across the country, the level and success of engagement between the VCSE sector, health system and local authorities differs. At its best, collaboration is happening, and community organisations are able to play an important role in the co-design of health services for their community. Where it is not working, it is often rushed, reactive or happens too late in the commissioning process for communities to have meaningful input in service design. It may be tokenistic and extractive and fail to tackle inequalities or produce the desired health outcomes for the population.

Service design to create inclusive and culturally competent services requires full and ongoing engagement with those who know their communities best. Community engagement must be embedded at the beginning of service design processes and form a core component of any service planning or commissioning activity.

Community organisations should be welcomed around the table as vital partners, contributing to co-design and co-production sessions. These should be an opportunity to feed information about their communities into the health system and inform new pathways for health and care, whether that is into services or out of secondary care.

In addition to being part of the design of services, community organisations should also play an important role in the adaptation of existing services. They can tailor health messaging to be most relevant for their communities, can advise professionals in both primary and secondary care of cultural requirements. In some cases, they can design services alongside the health sector to fill gaps left by services which do not reach certain communities. These service adaptations can help to reduce barriers to access, ensuring that the services developed are acceptable to the communities they are serving and inclusive by design.

Labriut Healthy Living Centre

The Jewish Community Council of Gateshead (JCCG), established in 1997, serves as a vital bridge between a community of around 4,000 individuals and the services and support they need, delivered in a culturally appropriate way. The Labriut Healthy Living Centre, which operates under JCCG, focuses on the health and wellbeing of the community, in particular tackling the health inequalities prevalent in the local area.

These inequalities include poor health outcomes, with only a third of residents reporting "adequate" exercise opportunities. This is closely linked to cultural and religious barriers to accessing health provision resulting in further entrenched inequalities. These barriers include a lack of culturally appropriate provision, including single-sex spaces for activities such as exercise. The local areas in which JCCG operates faces considerable challenges in the most deprived 10 per cent per cent of areas on the Indices of Multiple Deprivation. The community also has a limited access to internet and social media with more than 90 per cent per cent relying on local print media for information. This has meant that health messages broadcast through other channels have not been reaching the community.

In their mission to support the health of the local community, Labriut runs a large number of activities for their community. From exercise classes to mother and baby sessions, they are helping to reduce social isolation, enhance opportunities for members of the community to connect and to get healthier too. JCCG plays an incredibly important advocacy role for the local community. They have built strong relationships with local GP surgeries and the Integrated Care System to ensure that clinical and other operational staff understand the specific needs of the community and can therefore adapt services to meet that need. As a result of the cultural awareness training delivered to over 150 individuals, all attendees reported that they felt better equipped to interact with the local Jewish community.

The Healthy Living Centre is having a significant impact. For mother's attending the mother and baby sessions, 91 per cent per cent reported improved mental wellbeing after four sessions. As a result of the exercise sessions which have around 100 participants each week, 96 per cent per cent felt an improvement in their overall health and resilience and the same proportion also reported improved mood and lowered stress.

Labriut and the JCCG are trusted partners with the local statutory sector. Their proactive advocacy for their community has equipped clinical staff and those commissioning services with the knowledge which they need to create services which are inclusive of the local Jewish community. In partnership, community organisations such as JCCG can not only adapt existing services but enable better access to existing ones. They can ensure that health messaging reaches the local population in the most accessible way and achieve better health outcomes for local communities facing entrenched inequalities.

Service provision - holistic approaches to health and care

A golden thread running through the work of all community organisations is the holistic nature of their services. Not only do community organisations play a role in service design, but they often provide these vital services for their communities as well. In doing so, they often support the most marginalised and disadvantaged communities with the ability to extend their reach into communities in a way which most statutory services are not able to do.

Their role spans a huge range of activities: CQC-registered social care; NHS-commissioned prevention services such as weight management and smoking cessation; mental health support groups for young people; knit and natter groups for isolated older people; running green spaces so communities can connect with nature. Community organisations provide services which address the full range of the wider determinants of health, whether they label their services as such or not. Locality's previous work has highlighted this role, including in our report on "The impact of community anchor organisations and the wider determinants of health".

The approach of community organisations to this service provision is holistic and often more asset-based than a traditional medicalised model. The Inclusive and Sustainable Economies Framework (shown in Figure 2) gives a good visual representation of how community organisations and other community-led approaches have an impact on so many parts of people's lives and wellbeing.

Figure 2: **The Inclusive and sustainable economies (ISE) framework, OHID – PHE, 2021**

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Across the Locality network there are incredible examples of community organisations which are taking holistic approaches to health and care, whether they openly badge their work as focussing on health. As the ISE framework shows, this can be across anything from providing good work to improving the natural environment.

In Leeds, Canopy retrofits and renovates empty and derelict properties to provide affordable, high-quality, warm homes for the most vulnerable population groups in the city including those experiencing homelessness. In doing so, they provide good work, education and training to equip local people with new skills and are helping to achieve better health outcomes by providing homes which are not damp, mouldy and causing health problems in the long term.

In the North West of England, Let's Grow Preston run an allotment and outdoor spaces, providing support to many different inclusion health groups and individuals with a range of mental and physical health conditions. Their work helps to reduce isolation and loneliness, gives individuals a sense of purpose and builds connection in the local community, one of the most deprived neighbourhoods in the country.

These organisations, and thousands more like them across the country, carry out vital work in the local communities. They often work hand-in-hand with primary care, and other statutory services, to ensure that there is join-up between the services which they provide, and the formal clinical services offered in different settings.

NHS community-based programmes such as the Core20 Connectors Programme also play an important role at this level. In this programme, individuals with lived experience are recruited and supported to work with their local health services and community to improve access to healthcare. In addition, many community organisations run peer-led health promotion programmes themselves (see Labriut Healthy Living Centre case study) and are valuable to NHS programmes at community level.

Voice and advocacy

Locality's research with community organisations has shown the value and importance they place on holding a wealth of information about their communities. In sharing this information at different levels of the health system, they are able to effectively advocate on behalf of the needs of their communities. This happens at different levels depending on the size of organisations. Some, often large community anchor organisations or Councils for Voluntary Service (CVS) sit on Integrated Care Partnerships or Boards to advocate for the sector as a whole. Many smaller VCSE organisations work at a more local level, feeding into Joint Strategic Needs Assessments (JSNAs) produced by councils or speaking with their local Primary Care Networks (PCNs).

Community Anchor Organisations are independent, and community led. They tend to be multi-purpose, employing staff, providing services and activities and managing community assets to tackle local challenges. They are committed to positive economic, social or environmental change in their community, with surplus funds reinvested in local impact.

As key part of this advocacy role in service design is ensuring that the voice of lived experience and local communities is fed into the process. Community organisations, as trusted voices for their communities, carry out this role continuously, whether they are advocating for the needs of a community of place or for a specific demographic or group within that population.

WECIL

The WECIL (West of England Centre for Inclusive Living) is an award-winning, user-led organisation supporting Disabled people to live independently. At the heart of their work is personalisation and the idea that everyone should have the freedom, choice and control to access the support which works best for them.

The biggest part of WECIL's work is their support of those using Direct Payments, providing choice and control over how Disabled people receive support in their own home or in the community. Within this, WECIL actively work to ensure that there are not additional barriers to being able to access the service for certain populations.

A CQC report, published in 2023, highlighted these barriers to accessing care including people from ethnic minority groups being "talked down to about their treatment" and were not treated as individuals. This is the very opposite of the approach which WECIL takes.

A key part of WECIL'S work is their Navigators service. Their dedicated team act as a front door to care service, responding to any disability-related challenge individuals might face. These range from housing and benefits to co-producing personalised support plans to help individuals put together a package of care and support which makes most sense to them.

The expertise which WECIL has built up over a number of years has enabled them to be effective advocates for and alongside Disabled people in the West of England area. In recent years, they have worked closely alongside Bristol City Council on pathways into care and support, ensuring that people aren't telling their stories 14 times before getting support (as was the case with one individual which WECIL worked with).

WECIL is active within many parts of the health system. They work as part of the local VCSE Alliance, and their Chief Executive sits on the Integrated Care Partnership Board of Bristol, North Somerset and South Gloucestershire (BNSSG) ICS. They work with local hospital trusts providing valuable experience and user-led perspectives. Their work with one trust has shown the importance of user-led groups within the health system and their Chief Executive noted that the seniority of staff in attendance at the meetings highlights important learning for others – that more inclusive services require senior buy-in and time commitment to learn from experts by experience.

WECIL faces significant challenges in its work, however. With their focus on personalisation of care services, there are still those who think that this represents a cost increase – particularly at a time when health and care budgets are particularly squeezed. WECIL has seen that personalisation and delivering the services which actually address the needs of individuals can have a cost saving in the long run which cannot be gained from the standardisation of services for cost saving reasons.

As the personalisation agenda continues to go from strength to strength in adult social care, there are valuable lessons for the health sector.

These include:

- The need for culture change and senior leadership to adopt new ways of thinking,
- The need for better data on individuals to allow for health services to be personalised.
- The importance of engaging with advocacy and voice organisations which can help trusts and health systems to obtain the information they need to meet the needs of the communities which they serve.

WECIL

Information and insight gathering

Community organisations know their communities and as shown in the case studies in this report, adapt and design services around the needs of the population. They operate at the heart of their communities. They are trusted by, and have continuous conversations with, different parts of the population. They are perfectly placed to see the challenges and inequalities faced by communities as well as the opportunities for engagement with the health system to address them.

Improving the health system's understanding of the experiences, perspectives and needs of people and communities is an important part of the statutory guidance of working with communities. Community organisations have both the reach and expertise to provide insights and information about their communities into both decision-making and commissioning processes.

Through surveys pushed out to their communities, day-to-day engagement or convening people around a particular subject, community organisations produce a vast array of valuable information. This should be available to ICBs, to councils producing JSNAs and officers leading service design. Many of the organisations we interviewed were part of various public sector forums, health and wellbeing boards, lived experience or patient advocacy boards for local authorities, Integrated Care Partnerships and hospital trusts. However, it is often difficult to push information and insights up to the right part of the system so that they can inform how services are run and designed to be inclusive.

CB Plus

CB Plus, founded in 1979, is an independent infrastructure and community development organisation operating across London. It supports community organisations to deliver culturally inclusive and competent services. It is responsive to the nuanced needs of diverse communities within the areas they work and confidently engages with under-represented communities to ensure that health services meet their specific needs.

CB Plus delivers a portfolio of services aimed at reducing health inequalities and tackling challenges in local communities. In Enfield, CB Plus saw a disparity in access and delivery of community based mental health services. The Black community in Enfield were over-represented in the mental health system with a higher incidence of people – particularly young Black men being sectioned and entering mental health services through the criminal justice system whilst experiencing under-representation in receiving mental health support. It was clear that there was a major problem and that those who needed mental health support, were not receiving it - leading to poorer life outcomes including deteriorating mental health.

CB Plus said, "We knew that people needed earlier interventions, so we began working with local communities developing a peer support programme of mental health champions in schools supporting young people transitioning from primary to secondary school."

This was in response to national research confirming that it often takes 10 years for Black children experiencing poor mental health to receive appropriate support and interventions. Often, in formal mental health support service, practitioners do not reflect the communities they serve and do not have an understanding of local cultural or faith needs. The mental health champions in Barnet reflect the diversity of local communities and have shared many of the same experiences as them. Here, CB Plus has been able to break down some of the structural barriers and stigmas to accessing mental health services which can cause health inequalities. They also aim to reduce the number of young people from minoritised communities being excluded from schools.

CB Plus leads a Wellbeing Service in Barnet delivered in partnership with expert mental health charities that provide mental health services for young people, refugees and asylum-seekers and those with emerging or complex conditions. A forthcoming report from Middlesex University has confirmed that this community-based, bespoke approach has made significant savings to the NHS of approximately five times the initial investment. CB Plus also developed a consortium of five small organisations, supporting racialised communities. Staff and volunteers are trained in mental health services, that are provided for communities who did not have access previously to culturally sensitive support and were unaware or not confident to approach mainstream services.

In Brent, CB Plus delivers a peer-led health promotion programme upskilling local communities to learn about diabetes prevention and wellbeing service. These Health Educators are commissioned by the local authority. These individuals, rooted in their communities are able to speak local community languages, translate guidance and engage on a more equitable basis with the community. Communities had been previously received a simplistic message of "change your diet". The Health Educators are able to have productive conversations with the community and disseminate information, using culturally relevant dietary advice and guidance, which had not been available previously.

These services, and so many more which CB Plus deliver, are dependent

on positive engagement with local authorities and Integrated Care Boards, particularly with commissioners. CB Plus holds regular "hub connection" networking events, that connect mental health service users, community representatives, statutory service clinicians and experts and commissioners. These meetings provide a space for service-users to share their experiences of accessing services and hear feedback from different commissioners. They also provide opportunities for commissioners to hear about the real-life impact of barriers to accessing care and also the positive impacts of health and life changes when these barriers are addressed.

CB Plus has found that engagement with community organisations often happens quite late on in the commissioning processes, due to budgetary and staff pressures in local authorities and health bodies. CB Plus staff champion the message that effective engagement with the sector cannot happen in a one-hour meeting or one-off engagement event. CB Plus knows the benefits of early engagement where services can be designed to reduce barriers to access and tailored to meet the needs of communities.

Engagement can, however, be just as difficult for larger organisations like CB Plus. Even with a turnover of over £1m, staff are stretched and find it difficult to share the workload of attending so many different strategic forums. They believe that if the statutory sector takes a more person-centred approach, builds cultural sensitivity into their programmes, allocates sufficient time and resource to engagement, and contributes a greater effort to understand the VCSE sector and the services they already provide in their areas, then these could be positive first steps towards more inclusive services.

CB Plus

4.

Challenges and barriers faced by the VCSE sector

In carrying out their incredible work, community organisations still face significant challenges and barriers to creating inclusive services.

We have distilled these into six key areas:

- Information and awareness
- Structural and systemic barriers
- Funding and capacity
- Accessibility and language
- Trust
- Leadership and culture

Information and awareness

A lack of information and awareness

For services to be accessible and inclusive, and for different partners in the health system to work together effectively, good flows of information and awareness of each other's roles are essential. Locality's research shows that, on the part of both the VCSE sector and colleagues in the health sector, there were often challenges and frustrations arising from gaps in knowledge and lack of information being shared.

At a fundamental level, there were perceptions in the VCSE sector that the health sector, whether at system, place or neighbourhood level, does not fully understand or appreciate the role which the VCSE sector plays in the health of the communities they serve. As symptom of this, VCSE organisations interviewed reported that engagement they had often felt tokenistic and rushed, a "tick-box exercise" at a late stage in the commissioning cycle.

The lack of awareness of what the VCSE sector looks like within ICS areas, local authorities and within neighbourhoods also meant that they felt commissioners would engage with a very small number of organisations which they had awareness of. This, a number of interviewees felt, meant that important voices, often of the most marginalised communities, were missing from commissioning and decision-making processes.

A lack of information flowing between the VCSE sector and those with responsibility for designing and commissioning services is another barrier to inclusive services. Clear information and communication are especially important for the new Integrated Care Systems where decisions are often being taken far above place or neighbourhood level where community organisations often work.

Community organisations stated that this often results in a situation where they often do not know what services are being commissioned, when they are being designed and by whom. This presents a major barrier in their ability to be involved in co-design processes or to feed in lived experience.

Community organisations were also concerned that they do not know who to feed insights into, or lacked confidence that feeding information into the health system would result in positive changes. Community organisations have important information which can be valuable to how and which services are designed and could contribute to JSNAs and public health planning at a place and neighbourhood level.

A lack of cultural awareness

Operating in highly complex and diverse communities, and across large geographic areas, means that there will naturally be a lack of awareness of all the cultural nuances and needs within a particular place, for all its constituent

groups. In any given area there will be many different population groups, different experiences of the health system, different inequalities overlapping and interacting with each other. It is nearly impossible for both clinical staff and service commissioners to be expected to know and understand all of these nuances.

However, if services are to be culturally competent, and inclusive of all population groups, all those working in the health system need to be culturally aware, have a good degree of cultural competence when it comes to the delivery of services and how they are designed. Ensuring that there are good flows of information, good and accessible training provided to all staff and forums for lived experience to be fed in are vital to ensure that a lack of cultural awareness does not become a barrier to inclusive services.

Structural and systemic barriers

As laid out in this paper, health inequalities present a significant challenge which the NHS is trying to tackle. Community organisations, often working with and led by the most marginalised communities, face structural and systemic barriers to playing their role in creating inclusive services. Whether it is barriers in the way that commissioning practices are carried out or structural racism which has led to historic underfunding of groups led by racialised communities, community organisations of all sizes and the communities they represent face significant challenges to carrying out their role.[12]

Commissioning barriers

The way in which health and care services are commissioned and how it involves the VCSE sector was one of the most common concerns raised by community organisations in our research.

One of the most consistent challenges raised was the timelines for community engagement in commissioning processes. The majority of community organisations said that engagement with the sector and with lived experience groups often happened too late in the process where bigger changes to services could not be easily made, happened on too short a timeline and often felt tokenistic.

In the commissioning of services which are culturally competent and inclusive, lived experience needs to be fed in from an early stage. The experiences of communities to previous services needs to be taken into consideration too, so that the same mistakes around creating services which do not reach certain segments of the population are not repeated.

This requires ongoing engagement. One community organisation involved in conversations with commissioners at local authority level described how at times commissioners thought that they could get all the information that they needed to commission a service from a single meeting with their organisation. These types of meetings, when not part of ongoing engagement can feel tokenistic and extractive on the part of community organisations who have the expertise to support commissioners in their work.

Ongoing engagement can also help to reduce the issues faced by some organisations who do not know what services are being commissioned in their areas, who is commissioning them or how to feed into the processes.

Stigma

There are some big entrenched and systemic barriers which prevent individual from accessing the services which they need in their communities. Much of this is based on various stigmas

attached to different services or health conditions which have not been tackled by health systems. In terms of both internal and received stigma[13], certain population groups can be stopped from engaging in care, making it even harder for poor health outcomes to be addressed and widening inequalities.

For example, this could be barriers for men or individuals from certain cultural backgrounds to access mental health support because of entrenched perceptions which makes it harder for them to seek help. Similarly, some population groups such as gypsy and traveller communities, homeless people and refugees can find it difficult to access services and find it less likely for services to be tailored to meet their needs because of entrenched stigmas against them.

A failure to tackle stigma in health services can lead to even more entrenched health inequalities and poor health outcomes. Yet, through collaboration with local community organisations who understand hesitancy to take up services and know how to badge and adapt health messaging to their communities, these inequalities can be addressed.

Structural barriers faced by communities

The structural barriers faced by some individuals and communities in accessing health care can be seen in the stigmas attached to some population groups. Often, the needs of some groups are assumed rather than investigated by engaging directly with those communities or the VCSE organisations supporting them. For example, refugees and asylum seekers can face significant barriers to health care. They often move between areas and health systems, may not speak English as a first language and have been increasingly stigmatised in the media. Without proper engagement with communities like this, health services are unlikely to meet the accessibility needs of the population and can further accentuate health inequalities.

As recent reports by the Race Equality Foundation have shown, "experiences of racism and racial discrimination are associated with poorer mental and physical health outcomes for people from minority ethnic groups".[14] Ensuring that structural racism and inequalities between different ethnic and inclusion health groups do not continue to persist requires services to be inclusive and tailored to meet the specific needs of those communities.

In the rapidly digitising world, community organisations are also often having to tackle the challenge of the digital divide. While organisations we interviewed did not point to digital exclusion as something they faced themselves, they did note that it was a significant issue within the communities they support and a major barrier to individuals being able to access services. As such, community organisations working with their local populations will know where the issues of digital exclusion arise and are well positioned to support those commissioning services to create services which are inclusive.

The lack of accessible pathways into heath care and support for many communities is a big issue which community organisations can help to address. Across the country, there are examples of where ICBs and local authorities are working proactively with their communities to ensure that the needs of communities are met when it comes to health and care interventions.

Case study

Newham

In Newham, a group of equal partners, including the Council, local VCSE sector and frontline health service, have come together to discuss current issues in the borough and work together on how they can collectively solve problems that they observe. Part of this work has included the co-creation of seven different pathways into key services and VCSE provision including pathways for maternity support, social care and children's centres.

The pathways, developed using cross-sector task and finish groups helped partners to clarify roles and responsibilities, be clear on how to refer into an organisation or service, and to be clear on the processes of each organisation. Having these pathways enabled partners to understand where duplication was happening and aims to reduce the number of times residents accessing these services need to tell their stories or experience delays.

One of the pathways created was for Newham's Maternity Acorn (Acute Children's Outreach Nursing) Team which supports asylum seekers, refugees and vulnerable women with complex needs. Here, partners have worked proactively to ensure that those facing acute health inequalities and are the most vulnerable get the support they need. They noticed that there was a lack of communication between different parts of the systems supporting families in the borough, from health to social care and other community services. This sometimes resulted in pregnant asylum-seeking women not being referred into ante-natal support and coming into labour wards without having received any support. Partners including the Council and Acorn team have worked closely with the VCSE sector locally, organisations such as the Newham Nurture community partnership, to create new pathways into maternity care.

The Council and its partners have been taking a proactive approach in other areas too. Over time, they have developed good relationships with local communities across the borough. The Council, playing an enabling role, has helped to set up forums and created opportunities for communities to set the agenda, raise concerns and request support when issues were identified. There was recognition on the part of the Council that there would not be as much trust in the process if it was a wholly council-run process.

One of the issues identified by the community, through Newham's Diverse Communities Health and Wellbeing Forum, was Vitamin D deficiency. With a large at-risk population in the borough, the public health team put

together a business case and did a literature review to support the case for a programme of vitamin D supplement distribution to the over 65 population. The programme was co-produced in workshops with the voluntary and faith sector and residents to find an approach that would work.

Across the borough, over 60 different organisations offered to become distribution sites and have given out over 30,000 bottles of Vitamin D supplements to older residents. Most of these distribution sites were faith and VCSE organisations, trusted places within the borough which residents felt comfortable going to. The reported outcomes of this intervention included some distribution sites being able to tackle other issues such as isolation and loneliness through their outreach. The approach is an example of how, using a community-based model, partners have been able to tackle a public health challenge, accentuated by health inequalities, and tailor a solution to the local community so that the most at-risk groups were able to access the intervention.

This has been part of a wider approach which Newham has taken. Understanding that while it takes a long time to build trusting relationships, it is a priority. Speaking to the community, which already knows and understands the problems faced by their communities, the Council can then work with them to come up with a plan of how to fix the problem and provide the necessary resources accordingly.

In these interventions, the Newham public health team have been well-placed to take the intelligence they hear from the communities of Newham and feed it into discussion in other parts of the system, whether that is to the Integrated Care Systems or other parts of the council. Public health plays an essential link between communities, the local VCSE sector and the wider system. Newham's work demonstrates the ability of the systems and services supporting residents to work collaboratively to break down the barriers which exist to accessing health services and proactively work directly with communities to make services more accessible.

VCSE representation

The way in which the VCSE sector feeds into the health system was another point of concern for some community organisations we interviewed. With thousands of VCSE organisations working in each ICS area, yet relatively few sitting within the various structures at system and place level, there continues to be concern among community organisations that there is a lack of representation for the sector within health systems. Two major concerns were raised. Firstly, that the voice of their organisations and the organisations they represent were not being heard or contributing to the design of services, and secondly that larger VCSE organisations sitting on ICBs and ICPs could gatekeep access to funding.

Relatively few VCSE organisations are represented in person at system and place level. Where they are, they often tend to be the largest, most established local infrastructure and community anchor organisations. As such, large parts of the sector, particularly those smaller grassroots organisations which represent marginalised communities or do work with certain inclusion health groups are less likely to be directly represented on those groups.

There were further concerns here that commissioners and decision makers only go to the organisations who they already know when designing services or looking to understand the needs of the population. Which can often be those organisations which have the presence on formal boards and forums. This can lead to unintended biases in the information which is used in commissioning services. There is an important role here for those larger VCSE organisations and ICBs to ensure that the voice of these smaller organisations is also heard.

Funding and capacity

As is the case in the statutory sector, the VCSE sector has also faced significant financial and capacity pressures in recent years. Indeed, even before the COVID-19 pandemic, research was showing that small and medium sized charities had seen their income from local and central government fall by up to 44 per cent in the eight years to 2016.[15] With the pressures of the pandemic and the cost-of-living crisis bearing down on charities, recent research showed that 73 per cent of charities are struggling to meet the current demand they face for the public services they deliver.[16]

This funding pressure, and the limitations it causes on staff capacity can be a significant barrier for community organisations being able to take part in commissioning processes and engage with the wider health system. Community organisations we interviewed spoke of both the lack of remuneration for engagement and the short-term nature of funding being significant barriers to playing their role in the creation of inclusive services. This was noted as a barrier for both sustaining the activities which they already carry out and a further challenge for developing new services and initiatives.

Remuneration

When being asked to take part in co-design and co-production processes, community organisations often have to use their own funds and capacity to attend meetings and input their expertise. On the other hand, as a core part of their job, colleagues from different parts of the health sector are paid for their attendance at these meetings.

This can often mean that the same organisations, often those larger, more established ones, are repeatedly

the ones who have enough capacity and resource to be part of creating inclusive services. This can mean that entire sections of communities are not represented in co-design and co-production. This can often be those smaller organisations which focus on a specific part of the community, particularly those working with minoritised communities where there has been historic underfunding. The result can be services which are not inclusive and can ignore the needs of entire population groups.

Research, such as that by The Baring Foundation and Voices4Change, has shown the inequality which exists within the charity sector – between those well-established place-based organisations and small organisations representing marginalised communities.[17] Remuneration of staff time is especially important in those organisations which may not have the same reserves and incomes and face additional barriers to participation in service design.

Remuneration can be a way of ensuring that organisations of all sizes are able to feed into co-design and co-production and provide resource for ongoing rather than one-off engagement with the health system.

Short-term nature of projects and funding

Community organisations interviewed spoke about the difficulty of being engaged in reducing health inequalities through various programmes and supporting the creation of services. This was often due to the short-term nature of funding for interventions and the lack of time to properly tailor services to the population in that short amount of time. For example, one organisation working in the Midlands was asked by their local health system to help cascade population health messaging and preventative interventions around smoking cessation and weight management with their local south Asian community. However, the funding was for six to eight-week interventions in which they did not feel they would be able to show any improvement in outcomes.

Other organisations spoke of being approached to carry out interventions with their communities – often a Core20PLUS5 population group – for piecemeal funding. They were often asked to carry out these interventions and messaging campaigns on a voluntary basis. This speaks to the wider challenge for creating inclusive services of some in the health system not understanding that the VCSE sector is not just somewhere which can produce good outcomes on the cheap, but an equitable partner which requires long-term funding and support in order to attain these outcomes.

There are several examples of where different parts of the health system, both ICBs and public health at place level have looked at how they can proactively support and work with their local VCSE sector to ensure that there is some sustainability to the funding with is required for them to carry out their role.

Accessibility and language

To tackle health inequalities and have services which are inclusive to all, the services themselves must be accessible and available in the places which people need them most. However, community organisations and colleagues from the health systems spoke of a number of barriers around accessibility which can mean that services are not inclusive of everyone.

Accessibility of services

The accessibility of services falls into a number of areas: the geographic location and availability of services, the physical accessibility to buildings and also digital accessibility of services.

Where services are located is incredibly important for the people who may need to access them. In rural areas, there can be significant problems of services being set up in larger towns and villages which might be inaccessible if individuals do not have access to a car, for example. This type of accessibility problem can be accentuated by also needing to pay to get to the locations where health services can be accessed.

One health trust we spoke with noted the issues which can be caused by services being the opposite end of a London borough to where many people live; things like having to take buggies and small children on multiple buses to reach maternity support can be a big barrier to attendance. This highlights the importance of services being accessible within the communities which need them.

The physical accessibility of buildings is also an important consideration, and although there has been a big focus on making buildings fully accessible to all, there can still be issues. Similarly, despite the huge uptake in digital literacy in recent years and shift to online services during the pandemic, there are those who do not have the literacy or equipment to access digital health services. Particularly in the most deprived communities, there are important considerations which health services should make for the sake of accessibility. For example, if living in overcrowded accommodation, an individuals may not have the privacy to access a digital service. Or, particularly for older people, there may not be the same level of comfort to access services which are provided online.

Community organisations can find it a challenge to signpost the individuals they support to services they need when those services are not inclusive. Many community organisations, such as WECIL [link to case study above], are able to support health and care services

to make their support as accessible as possible; whether that is support for digital inclusion or physical accessibility. Community organisations, especially the largest, most established ones, often own buildings and other community assets. These spaces tend to be recognised and trusted by communities, which in many cases can be used for the co-location of health services.[18]

Language

Community organisations and health professionals interviewed saw language as a significant barrier to inclusive services. And this was across two fronts.

Firstly, English will not be the first language of many of those accessing services. We know that when people do not understand something, including health services and health messaging, it represents a significant barrier to access. When health messaging is not accessible in community languages or when translators or translation

services are not available, better health outcomes become harder to attain.

Some organisations and professionals use online translation services such as Google Translate as a workaround. However, this is not always fit for purpose and provides a transliteration of a message (where words are translated letter-by-letter into different scripts or alphabets) or changes the meaning of words rather than being able to provide an accurate account of what is being said and how. This is the case not just for those who do not speak English as their first language but across wider language accessibility. Disability inclusive language such as "easy read" formats of documents, or British Sign Language interpretation can make services more accessible.

Secondly, the NHS, local government and the VCSE sector all speak different languages and have their own definitions of words. For example, while "community services" in the health system may mean the work of district nurses and other health professionals working locally, the VCSE sector may use the same phrase to describe their vital work providing local services for their communities, and local government may see the phrase as relating to purely voluntary work happening locally. When it comes to service design, particularly if these services are to be inclusive, there needs to be a shared understanding of the language being used.

This extends to things like health messaging being communicated in a way which communities will respond to. Community organisations can help both local government and health services to tailor messaging to fit the needs of a particular community, whether in how messages are delivered or how services are described.

In Gateshead, Labriut Healthy Living Centre has worked closely with their local primary care network and council to provide health messaging through physical leaflets as a result of the local Jewish community having limited use of social media and other digital platforms. Similarly, other community organisations can ensure that health messaging is available in community languages. For example, the Health Educators programme run by CB Plus in Barnet, north London uses peer "educators" who can speak a variety of community languages.

Trust

At the foundation of both the working relationship between the VCSE sector and health system, and between health services and those who access them, is a need for a certain level of trust. At a time when we have seen a disintegration in trust of institutions, and where the mistrust of statutory services was highlighted by the pandemic, we have seen how health inequalities cannot be addressed where this trust does not exist. Furthermore, the trust which does exist can be eroded by a lack of culturally competent and inclusive services where the needs of a community are not being met.

Inclusive and culturally competent services require the support and active collaboration of communities. Within these communities, community organisations are often trusted conduits between individuals and certain population groups and the health system. As such, they have the mechanisms to include these groups, their lived experience and their expertise in the local area. Trust takes time to build and requires continuous effort to maintain it.

Leadership and culture

Something which came up frequently in our research was the need for those in leadership positions across the

health system and local government to set a culture and take a leadership role in ensuring services are culturally competent and inclusive. While there is a huge amount of good practice across the country, this is not always in the mainstream and often goes against the grain. This includes a call on senior leadership in ICSs, local authorities and PCNs to encourage a more proactive form of engagement with communities. Building inclusive services in partnership with communities takes time. It requires trust and often frontline staff, commissioners and other staff within the health system are left waiting for permission to engage with communities in new ways within a culture that lacks proactive joint working.

When it comes to commissioning and procurement, a number of community organisations we interviewed raised concerns that in their view commissioning decisions were taken based on the need for cost savings rather than the potential health outcomes for a community. This was joined by a frustration that in an effort to save costs, VCSE organisations were asked to deliver outcomes at increasingly cheaper costs. While squeezed budgets make value for money and cost considerations an important part of the commissioning process, this needs to be balanced alongside the quality and value for money which can be obtained through the expertise of community organisations in their places.

Culture change, to recognise and promote the value of the local VCSE sector and work collaboratively, is also vital. This too must be led from the top with ICS leadership putting in place the principles and direction of travel for important collaborative relationships at system, place and neighbourhood level. A more collaborative culture can set out a new way of doing things where short-term engagement late in commissioning processes can be replaced by ongoing engagement. Here, lived experience should also be placed at the heart of services which can be tailored and adapted to different communities. Without this type of culture change, the barriers around tokenistic engagement, short-term engagement and a lack of trust of institutions will continue to hamper efforts to create inclusive services.

5.

Recommendations

The health system is going through a period of sustained change. From NHS England reforms to the continued development of the Integrated Care Systems, this period provides an opportunity for system change and new ways of working.

As such, Locality's recent work has looked at how constituent parts of the health systems from those working within neighbourhoods to those at system level, can ensure that the principle of subsidiarity is embedded within the system so that decisions are taken at the most local level as possible. Our recent report 'Keep it Local for Better Health', sets out guidance for how neighbourhood-level coordination, place-level collaboration and system-level investment in the VCSE sector can help to tackle inequalities by supporting those organisations which are closest to, and most trusted by their communities.

To support the vital role of these community organisations in creating more inclusive, culturally competent and accessible services, action at these three levels is also needed. There must be a top-down commitment to inclusive practices, support and investment in the VCSE sector to sustain the incredible work they do in their communities and a transformation in how the sector is supported to play a role in the design and commissioning of services for their communities.

The following recommendations set out how the NHS from system to neighbourhood level, central government and the VCSE sector can work together more effectively to create inclusive services which tackle entrenched health inequalities within our communities:

Information and Awareness

1. **NHS England and DHSC should work with the VCSE sector to co-design training materials at a national level, for staff in both clinical delivery and operational roles, on the role and value of the VCSE sector in health and care.**

   At a system and place level, these national training materials should be tailored, with the help of the local VCSE sector, to ensure that staff are aware of the role of VCSE sector and the work they are doing in that area.

   NHS England DHSC ICS
   Local authorities VCSE

This type of training delivered alongside other courses on cultural competence and inclusion health could benefit both new and existing staff. It would support understanding within the health system of where the sector can and already is adding value to the provision of health services. Improved awareness of the VCSE role in health and care would lead to a more informed consideration by staff and commissioners about the funding and sustainability of the sector's activity in supporting health and wellbeing. Tailoring this training at a system and place level would enable staff to understand the local VCSE landscape in their area and be an opportunity to make commissioners aware of the organisations working in their area. This should be provided at primary, secondary and system level as well as offered to Public Health colleagues within local authorities.

KEY

2. Integrated Care Systems should support VCSE Alliances, and local authorities should support their local VCSE sector at large, to feed in real time information about their communities to inform commissioning and decisions around service delivery.

This should be done by:

a. Health and Wellbeing Boards at local authority level making provisions for teams charged with producing Joint Strategic Needs Assessments to consult with their local VCSE sector and provide forums for community organisations to feed in qualitative and quantitative evidence into the process.

b. Integrated Care Boards providing funding for VCSE Alliances to carry out engagement with their local sectors (in all places within an ICB area) to ensure that commissioning and strategic decision-making is informed by current data and insights provided by the VCSE sector.

ICS Local authorities VCSE

While VCSE Alliances in all 42 ICSs are at different stages of development, it is essential that their systems support two-way flows of information so that commissioning and needs assessments can be based on information provided by those closest to the communities they serve. Similarly at place level, local authorities should ensure their processes for producing JSNAs are inclusive of the insights, often anecdotal and qualitative, of local community organisations. This would enable a better cultural awareness among those making commissioning decisions.

Tackling structural and systemic barriers

3. DHSC should produce commissioning guidance for Integrated Care Systems and public health to ensure early engagement of the VCSE sector (particularly voice, advocacy and lived experience groups) in the commissioning of services so that they are created as inclusive of all groups from the start.

DHSC

This would ensure that engagement with the sector was not an afterthought or happening too late in the commissioning process for any real changes to be made. Commissioners should be encouraged and empowered to carry out ongoing engagement with these groups and experts by experience to understand, within different services, what is working and what is not. This guidance should sit alongside existing guidance on working with people and communities and provide practical, best practice guidance of how early engagement with the VCSE sector can support the design of inclusive, culturally competent services.

4. Those delivering health services at a community level should be trained in trauma informed practice and ICBs, ICPs, PCNs and local authorities should ensure that inclusion health training is open to all staff.

ICS Local authorities PCN

Being able to identify where stigma is stopping certain minoritised communities and inclusion health groups from accessing services is important for removing barriers. In implementing the Inclusion Health Framework and developing a workforce for inclusion health in their areas, ICBs, ICP, local authorities and PCNs should ensure

KEY

that staff are upskilled in trauma informed practice and that this training is extended to colleagues in the VCSE sector.

5. **The VCSE sector must strive to be representative of the communities they represent and ensure that the voices of marginalised communities are fed into the health system at all levels by those organisations with a seat at the table.**

VCSE

Engaging with the health system takes resource and capacity which is often lacking in smaller VCSE organisations. Community organisations representing particular inclusion health groups and marginalised communities tend to be in this group of small, often grassroots organisations which have been historically underfunded and do not have the capacity or reach to sit on strategic groups. Addressing inequity requires long-term and sustained investment and support. Within VCSE Alliances larger organisations, community anchors and Councils for Voluntary Services (CVS), must ensure that they play a support role for smaller grassroots organisations. This should include helping to get funding down to groups representing marginalised communities and feeding up the vital information and insights that these organisations collate to all levels of the health system.

Funding and Capacity

6. **ICBs should ringfence part of the health inequalities and unmet needs adjustment in their core allocation to provide remuneration for community organisations and other VCSE voice and advocacy groups to play a role in engagement around the design of services.**

ICS

While the time of staff from statutory organisations to engage in various strategic forums, VCSE Alliances and commissioning consultations is paid for, the time of VCSE sector colleagues often is not. This can be a major barrier to participating in service design and means that value insights and lived experience can be excluded, including in the ongoing management and evaluation of services at a local level. Small amounts of remuneration funding from public health teams engaging with local organisations, as well as funding from ICSs to ensure that lived experience is part of commissioning processes, would be a valuable way to support the creation of inclusive services.

7. **ICBs should demonstrate a long-term commitment to sustaining community approaches to tackle health inequalities by investing a portion of their health inequalities budget in the VCSE sector in their areas.**

ICS

As this report has demonstrated, across the country there are community and other VCSE organisations providing inclusive and culturally competent services at a local level. NHS England programmes such as the CORE20PLUS Connectors programme are valuable ways of providing resources at a local level to understand the issues faced by those communities most at risk of health inequalities. They can proactively identify those services and support networks which already exist within a place and help to connect and develop them and avoid duplication of services. Through this programme, NHS England has provided small pots of pump-prime funding to get Connector sites established. ICBs should consider how their funding to tackle health inequalities can be invested in their local VCSE sector to sustain community centred approaches to health.

Accessibility and language

8. NHS England, DHSC and all bodies responsible for commissioning health and care services should encourage use of the health equity assessment tool (HEAT) in the commissioning process to ensure that considerations around intersectionality are used in decision making around services.

NHS England DHSC ICS Local authorities PCN

Equality impact assessments are often used as tick-box exercises to show that consideration has been made to how inclusion health groups, and others, may be impacted in service design. These assessments do not allow for the nuance and intersectionality or encourage commissioners to go out and find up-to-date intelligence from the communities a service is being designed alongside. The HEAT tool developed by Public Health England is a more action-based approach to help commissioners meet the Equalities Act (2010) requirements while prioritising actions to help overcome and limit health inequalities which communities might face. The tool should also be adapted to prioritise on-the-ground insights from the VCSE sector at whatever level commissioning decisions are being made and provide steer on the types of accessibility and cultural competency they must consider.

9. NHS England should produce language guidance for the health sector, at all levels, to ensure that the language used in the sector is accessible to those engaging with it whether they are a patient or partner organisation.

NHS England

A major barrier to effective engagement is a lack of understanding of the terminology used within the commissioning processes and service design. While great strides have been made in making clinical health messaging more accessible – for example working with communities during the COVID-19 pandemic to ensure that health messaging reached all communities – community organisations can struggle to understand the language spoken within the health sector, leading to a lack of engagement. Any language guidance produced must encourage a move away from transliteration software to more community informed translations.

Leadership and culture

10. Senior NHS leaders at system level, within secondary and primary care and ICBs, should commit to proactively working more inclusively with the VCSE sector. They should put in place principles for their organisations to work in a way which ensures that the services they provide are inclusive from the point of design. The ICB should have oversight of these principles and monitor their implementation.

NHS England DHSC ICS Local authorities PCN

Culture change should be led from the top. Senior health system leaders have an opportunity, by proactively committing to create inclusive services, to build trust with the local VCSE sector and wider population. This would ensure that staff who hold the day-to-day relationships with the sector are empowered to work in a way which recognises their value and role in the health system. Co-designing these principles with the VCSE sector would ensure buy-in and ICBs should have responsibility for monitoring these principles and ensure they are included in yearly monitoring.

6.

Conclusion

Community organisations play a vital role in tackling health inequalities. However, they often play this role in spite of challenges which they face rather than because the health system is fully enabling them to do so.

Up and down the country, community organisations work at a local level to create health services which are accessible, inclusive and acceptable for their communities and meet the needs of their local populations. Often in partnership with statutory partners, they tailor existing services and create new ones to ensure that access to health care is equitable for all.

The impactful work of organisations like CB Plus and Labriut Healthy Living Centre have demonstrated this crucial role, helping to make communities healthier and adapting services so that they are culturally relevant and break down structural barriers to access. Voice and advocacy organisations, such as part of the role played by WECIL, also play a vital role in advancing the personalisation agenda and ensuring that the voices of those most at risk of experiencing health inequalities are present within service design.

However, in carrying out this role, community organisations face significant challenges. Issues around the lack of information flowing between sectors and lack of awareness of the role of the VCSE sector can cause barriers to the creation of inclusive services. Structural barriers around exclusionary commissioning practices which do not put lived experience at the centre of service design and can lead to services which do not meet the needs of communities and create stigma around service use for some groups. Funding, in an already pressured system, can also be a barrier to effective engagement with the local VCSE sector which can struggle to engage where there is not funding provided to do so. Accessibility of services and language is a barrier to both service users and community organisations.

For all of this to change, there needs to be more trust between sectors – the lack of which is a barrier to creating inclusive services. NHS leaders across the system have an opportunity to tackle health inequalities in a way which both recognises the vital role of community organisations and supports them to carry out that role effectively.

Additional reading

- **Core20PLUS Connectors Programme Interim Report, SCWCSU (2023)**

  Available at: https://scwcsu.nhs.uk/doclink/core20plus-report-july-2023/eyJ0eXAiOiJKV1QiLCJhbGciOiJIUzI1NiJ9.eyJzdWIiOiJjb3JlMjBwbHVzLXJlcG9ydC1qdWx5LTIwMjMiLCJpYXQiOjE2OTI4NzYwMDIsImV4cCI6MTY5Mjk2MjQwMn0.gEmWM7xsScY-cHOw2NU83SHJY66v3ayW2ZuPNfig3_m8

- **Inclusion Health Framework, NHS England, (2023)**

  Available at: https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/

- **NHS England, Statutory Guidance on working with people and communities (2022)**

  Available at: https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/

- **Inclusive Digital Health Care – A framework from NHS digital inclusion, NHS England, (2023)**

  Available at: https://www.england.nhs.uk/long-read/inclusive-digital-health-care-a-framework-for-nhs-action-on-digital-inclusion/

- **Creating Health and Wealth by Stealth, Locality (2023)**

  Available at: https://locality.org.uk/reports/creating-health-and-wealth-by-stealth

- **Keep it Local for Better Health, Locality, (2024)**

  Available at: https://locality.org.uk/events/launch-keep-it-local-for-better-health

Endnotes

1. The Power of Community, Locality (2020) available at: https://locality.org.uk/assets/images/Power-of-Localitys-Network.pdf
2. Queen Mary University of London defines racially minoritised groups as "a term that aims to recognise that individuals have been actively minoritised through social processes of power and domination, rather than just existing in distinct statistical minorities. This term speaks to an understanding that some groups have been treated differently and subjugated (minoritised) because of their racial identities, within a context of a racial hierarchy. This term is less well used in the mainstream but is increasingly preferred by some who wish to capture the importance of power when talking about race."
3. Quantifying health inequalities in England, Health Foundation (2022) Available at: https://www.health.org.uk/news-and-comment/charts-and-infographics/quantifying-health-inequalities
4. What are healthcare inequalities? NHS England, Available at: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/
5. Creating Health and Wealth by Stealth, Locality (2023), Available at: https://locality.org.uk/reports/creating-health-and-wealth-by-stealth
6. Core20PLUS Connectors Programme Interim Report, SCWCSU (2023) Available at: https://scwcsu.nhs.uk/doclink/core20plus-report-july-2023/eyJ0eXAiOiJKV1QiLCJhbGciOiJIUzI1NiJ9.eyJzdWIiOiJjb3JlMjBwbHVzLXJlcG9ydC1qdWx5LTIwMjMiLCJpYXQiOjE2OTI4NzYwMDIsImV4cCI6MTY5Mjk2MjQwMn0.gEmWM7xsScYcHOw2NU83SHJY66v3ayW2ZuPNfig3_m8
7. Developing Cultural Competence, Health Education England, Available at: https://heeoe.hee.nhs.uk/sites/default/files/cult_comp_psu.pdf
8. NHS England, Statutory Guidance on working with people and communities (2022). Available at: https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/
9. Locality, 2020. As above
10. Keep it Local: How local government can plug into the power of community, Locality (2020) Available at: https://locality.org.uk/assets/images/LOC-Keep-It-Local-Report-40pp-WG08.pdf
11. Inequalities, Care Quality Commission, 2023 Available at: https://www.cqc.org.uk/publications/major-report/state-care/2022-2023/inequalities
12. Bridging the gap in funding for the BAME voluntary and community sector, Voice4Change England (2015) Available at: https://baringfoundation.org.uk/wp-content/uploads/2015/07/Funding-for-BAME-VCOs-Report-July-2015-V4CE-II.pdf
13. National Institutes of Health Define **internal stigma** as the shame and expectation of discrimination that prevents people from talking about their experiences and stops them seeking help. **Received stigma** can be defined as: a strong lack of respect for a person or a group of people or a bad opinion of them because they have done something society does not approve of. For example: stigma associated with low-income food programmes
14. Racism is the root cause of ethnic inequalities in health, Race Equality Foundation (2023), Available at: https://raceequalityfoundation.org.uk/press-release/racism-is-the-root-cause-of-ethnic-inequalities-in-health/
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17. Bridging the Gap, Voices4Change, as above
18. See "Creating Health and Wealth by Stealth" Locality (2023) Available at: https://locality.org.uk/reports/creating-health-and-wealth-by-stealth

Locality

Locality supports local community organisations to be strong and successful. Our national network of over 1,800 members helps hundreds of thousands of people every week. We offer specialist advice, peer learning and campaign with members for a fairer society. Together we unlock the power of community.

VCSE Health and Wellbeing Alliance

The VCSE Health and Wellbeing Alliance (HW Alliance) is a part of the VCSE Health and Wellbeing Programme (HW Programme) which is delivered by Department of Health and Social Care and NHS England and NHS improvement (the system partners).

The HW Alliance is new network of 18 member organisations (and one coordinator) established to collaborate and coproduce to bring different solutions and perspectives to policy and programme issues. All HW Alliance members represent communities that we need to hear from as we develop health and social care policy and programmes.

VCSE health & wellbeing alliance

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