Shared Ambition

Stage 1 Report May 2021

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Background

Our health and social care system faces a range of ongoing challenges. These stem from demographic and lifestyle changes as well as the need to address inequalities and meet the needs of all people within our communities in a holistic way.

In response there is a strategic commitment to move towards a way of working that focuses more on prevention and supports integration between different organisations and services. A key part of this is an effective working relationship between public and VCSE (Voluntary, community, and social enterprise) sectors.

There is a history of engagement and dialogue between these sectors, the result of which has not always met the expectations of those involved. There are also pre-existing tensions between the sectors representing different cultures, objectives, access to resources, and working practices.

As part of the ongoing efforts to strengthen our health and social care system, the Shared Ambition work forms part of the wider VCSE Assembly initiative to try and improve the relationship between the sectors.

Part of the original inspiration for this activity was work undertaken in Manchester. This combined a VCSE Assembly with the development of an MOU (Memorandum of Understanding) that was signed up to by VCSE and public sector parties. It was also accompanied by a £234K annual investment to support effective engagement.

Norfolk and Waveney is not Manchester. Its geography and demographics are significantly different. It also has a different legacy of VCSE and public sector relationships and investment.

In developing the Shared Ambition Initiative, we needed to reflect these facts. We were also keen to incorporate some of our learning from activity during the first wave of the Covid-19 pandemic.

Principally this translated into looking to adopt both a more agile way of working and the intention that this was not about creating a static document but an approach to delivering practical change. We also recognised that much of our ultimate success would be determined by our ability to develop a shared understanding, improving relations and supporting empathetic approaches.

A focus on these elements was therefore embedded within the process and approach taken. The intended product for this initial phase of the Shared Ambition Initiative was a set of joint principles and actions that could be committed to and form the basis for further activity.

Process & Approach

The five priority areas were derived from previous sector engagement. These were taken to the August 2020 STP (Sustainable Transformation Partnership) Oversight Group to seek senior Public Sector leader buy-in. At this session STP Oversight Group members committed to supporting addressing these areas. The five priority areas are:

- **Equal partnership:** Support for the development of a culture, behaviours and processes that are consistent with whole system working, and that recognise the VCSE sector as an equal partner within our health and social care system.

- **Sustainable resources model:** A model of resourcing that ensures VCSE services that support the system's effectiveness are resourced in a sustainable, effective and efficient way. A commitment that delivery models understand the externalities they create and recognise the resource transfers necessary to compensate for these.

- **Digital integration:** An approach to digital integration that is inclusive of VCSE organisations and seeks to enable the best use of digital tools across the system as a whole, with a focus on enabling integrated working for our teams.

- **Data sharing:** The commitment to share operational and intelligence data appropriately and effectively, within information governance protocols, across the sector and organisational boundaries. The creation of the governance and technical capability to achieve this.

- **Consistent evidence and evaluation:** The identification of a consistent set of evaluation and evidence tools recognised by both sectors and used across organisations consistently in order to reduce reporting demands, support comparable results and enable stronger evidence led delivery.

A workshop was help in November 2020 where VCSE and public sector leaders were further asked to discuss whether these areas encapsulated the key high level issues. As part of the discussion participants were polled. The results were:

- 62% thought these are the right high-level headings
- 27% thought these are good but some key areas are missing/need more development
- 2% thought some of these are right areas but significant key areas are missing
- 0% thought this is the completely wrong set of priorities

It was a key design criteria to ensure that all stages of the Shared Ambition development process supported interaction between VCSE and public sector partners. General experience has suggested that improvements to mutual understanding and the building of individual connections and relationships are critical in overcoming key systemwide challenges.

In order to progress the five priority areas representatives from both sectors were invited to put themselves forward for a series of workshops. Anyone who wanted to participate was included as well as some pro-active targeting of individuals to ensure relevant perspectives. Thirty-nine individuals were included on the participant list. 46% were from the NHS, 5% from other public sector bodies and 48% from VCSE organisations. Of the VCSE organisations 21% were from organisations predominantly based in Suffolk with a number of others operating in both Norfolk and Waveney areas.

The first stage workshops were held in December 2020. These focused on developing a common understanding of the problems within the five priority areas, drawing on different perspectives from

around the system. They also sought ideas on potential solutions and began work on creating personas for key roles within the system.

Following the workshops the problem definition descriptions were widely circulated together with initial ideas for solutions to gain further input. General discussions were also held with a range of partners and as part of aligned activity to help develop these areas further.

The second stage workshops were held in April 2021. These focused on developing solutions further, feeding back on draft personas and reviewing an initial draft of the Principles and Behaviours document.

The output of these workshops were consultation versions of the Principles and Behaviours document and Plan document. These are being distributed for a final round of feedback before taking them through an agreed sign-off process.

This report was also developed to provide a summary of the process to date and provide final versions of the problem definition statements and personas for future reference.

Problem Definitions

The purpose of this section is to outline the perceived problems that VCSE organisations articulate under each of the five development areas for the Shared Ambition Initiative. As stated above the five development areas were drawn from previous consultation activity. A short descriptor of each is included in quotes at the start of each section.

The problem definition statements were created to help ensure a shared understanding of the issues being considered, challenge any assumptions and provide a reference point for considering solutions.

Equal partnership

"Support for the development of a culture, behaviours and processes that are consistent with whole system working and that recognise the VCSE sector as an equal partner within our health and social care system. "

Equal partnership is one of the areas that VCSE organisations most often articulate as being a key issue, but it is one the hardest to identify clear actions and performance measures around. Some of the key elements that are raised in relation to this as an area include:

There are significant disparities in size and scale of organisations and their budgets. The VCSE sector is made up of smaller organisations but larger in number. This creates power asymmetries as well as difficulties in effective stakeholder engagement and decision making processes. The gap in ability to invest in the conversation perpetuates challenges in the ability to deliver meaningful partnership.

Often discussions are framed around what is important to the NHS, with the NHS setting the agenda, prioritisation, and success criteria. This is despite expectations being set or statements made that this is a 'whole system' approach.

There is not a joint approach to identifying and agreeing strategic priorities. This needs to be in place, with acknowledgement of the differing sector priorities, politics and pressures at local and national level.

Behaviours suggest a hierarchy of importance with acute clinical care at the top and VCSE services at the bottom. Decision making structures often reflect this. This approach runs counter to stated priorities around prevention where interventions are often non-clinical and VCSE-delivered in nature.

It is not always clear what the limitations and constraints are on the development of policies, services, strategies etc. This needs to be transparent to support understanding, helping ensure requests are reasonable but also that opaque constraints are not used to justify inaction.

Workforce pay and conditions for similar roles tend to be significantly better within the NHS and Public sector in general. This impacts workforce wellbeing and esteem. This can also impact workforce sustainability as staff are drawn from the VCSE sector into the NHS. The differential is often enforced through the budget made available to VCSE within NHS contracts.

Decisions and planning that effect the VCSE sector often do not include the VCSE sector in their design and decision-making process. The resource and capacity impact on VCSE organisations of service changes are not accounted for in NHS, and public sector service design and resource transfers rarely accompany demand transfers.

NHS structures are very hierarchical in a way that most VCSE organisations are not. There is often an imposition of NHS structures and policies as though they are the best way or absolute requirements. This is often experienced as a looking down on VCSE alternative approaches.

An insistence on clinical leadership tends to undermine joint leadership and a co-production approach by elevating the position of one set of stakeholders.

Partnership is fundamentally about trust. The size and scale of the VCSE sector can make building trusted relationships more challenging. Regular restructures within the Public Sector also harm the ability to build trusted relationships.

Sustainable resources model

"A model of resourcing that ensures VCSE services that support the system's effectiveness are resourced in a sustainable, effective and efficient way. A commitment that delivery models understand the externalities they create and recognise the resource transfers necessary to compensate for these."

There is a key strategic shift that looks to make use of assets and services within the VCSE sector and communities to support prevention activity across health and social care. Part of the driver for this shift is responding better to service users' needs, the other part is reducing the cost of services

delivered by public sector partners. This strategic approach to a shift in demand is not accompanied by a strategic shift in resources to meet that demand. This is mirrored at an operational level where clients are signposted or referred to VCSE services without any consideration of resourcing or capacity.

Many VCSE organisations rely on short term grant funding or contracts to deliver their services. This creates significant uncertainty and impedes strategic planning and limits integration efforts as the service models to integrate cannot be guaranteed. It also, together with funding that precludes investment in 'overheads' and restricted budget envelopes, limits the ability for VCSE organisation to invest in ICT, innovation, workforce development and service improvement. The lack of 'overhead' and 'development' capacity then makes it more difficult for VCSE organisations to engage effectively with public sector partners.

The lack of sustainable funding not only impacts organisational capacity and the ability to plan strategically, but the uncertainty it creates also causes issues around psychological safety that may inhibit wellbeing as well as collaboration opportunities.

Savings due to prevention are often hard to realise in cash-terms. Causality is often harder to evidence. Although the strategic shift is intended to move towards prevention, the ability to move resources away from existing acute provision is constrained. The time path between realising the benefits of prevention focused activity and the activity itself can also complicate both the evaluation process and business case.

Workforce pay and conditions for similar roles tend to be significantly better within the NHS. This impacts workforce wellbeing and esteem. This can also impact workforce sustainability as staff are drawn from the VCSE sector into the NHS. The differential is often enforced through the budget made available to VCSE within NHS contracts.

There is often an issue with 'pilotisous' – the repeated focus on piloting activity without any onward plan to roll-out or scale that activity if effective. Funding is geared around new or innovative activity with two detrimental effects. It is harder to fund and sustain proven services. There is no pathway of continuing a successful pilot into a long-term delivery model.

The funding cycle pulls significant VCSE resources away from focusing on service delivery. Many small very grassroot organisations or those run directly by disadvantaged groups have the least capacity to navigate the funding process whilst often being the closest to those in need.

Commissioning asks are often not proportionate to the scale of delivery. This can both be directly in terms of the budget available for the service specification as well as in terms of expectations around reporting, contracting and wider engagement. Timescales for responding to opportunities keeps getting shorter. Service design often has engagement processes with insufficient lead-in time and limited opportunities to co-design outcomes and service models. There is limited commissioning of services against outcomes. Where this does take place services are often then performance managed against output. Requirements can often shift without any notice or discussion – particularly around reporting requirements. There is a lack of trust and flexibility to use total resources to meet total needs. However, the size and scale of the VCSE sector can make building trusted relationships more challenging.

VCSE services have value for money criteria and reporting requirements applied to them that internal public services do not. In some case the time taken for the bureaucracy means the operational context and community needs have shifted before a response is realised. 'Paperwork' is often seen as a compliance issue to protect the funder with little benefit to service quality.

VCSE organisations often have less depth of finances and structure to be able to mitigate and manage risk. The lack of corporate support (HR, Business Intelligence (BI), Governance) within VCSE organisations limiting capacity in some key areas. This lightweight organisational approach also has the benefit of making VCSE organisation more agile.

Different funding models such as 'core funding', 'block contract', 'unit costs' or 'payment by results' have different risk levels associated with them to both funder and provider. This risk level will be reflected in the pricing model and it is important to find the right risk and price balance across the system as whole to avoid activity that is either too risky or too costly.

Public sector organisations increasingly seek to make use of grant funding opportunities increasing competition for the VCSE sector. Where public sector organisations do this they are able to bring resources in development and match-funding that means there isn't a level playing field.

There are challenges with the understanding of volunteers as part of the workforce. Recognising that volunteers are not a free source of labour and that they cannot be expected to respond in the same way as paid staff as well as there being ethical consideration about their use in certain contexts. With the public sector trying to make increased use of volunteers this again this risks increasing competition for a limited resource.

Digital integration

"An approach to digital integration that is inclusive of VCSE organisations and seeks to enable the best use of digital tools across the system as a whole, with a focus on enabling integrated working for our teams."

There is very little join up between VCSE and public sector ICT systems. There is also very little overlap in the ICT systems used in key functions. This risk's limiting operational integration.

Co-location can be made less efficient through limitation in accessing physical-site-internet-access or remote services.

Digital integration is closely aligned with challenges in ensuring the secure sharing of data and technical integration of data sets.

There are no common data standards between sectors limiting ability to integrate data sets in a meaningful way.

VCSE organisations often have an advantage in that some software tools are available at significantly reduced costs. However, they often lack the technical capacity to make use of these tools.

There are no agreed standards between sectors for security approaches.

Data sharing

"The commitment to share operational and intelligence data appropriately and effectively, within information governance protocols, across the sector and organisational boundaries. The creation of the governance and technical capability to achieve this."

There are difficulties with sharing information about individuals across organisations due to governance, legal, and technical issues. This limits the ability to deliver a 'tell my story once' experience to service users. It increases risk to the organisation and users when relevant information to their support is not passed between organisations. The ability to ensure feedback between organisations and monitor outcomes for individuals is limited as a result. The ability to have a joined-up view of the service user and therefore create a joined-up service and support package is limited.

There is often not a clear understanding of the ability to segment and make available relevant client data (for example making a provider aware of a dementia diagnosis but without sharing a medical record).

Data literacy as well as technical understanding of specific client needs is often limited. There is a need for training and support to ensure that any data shared whether more statistical or specific client data is understood and can be responded to in a meaningful way.

Complying with GDPR and privacy legal requirements are key and difficult. There are also competing policy regimes which place restrictions on data sharing approaches.

There are no consistent data governance standards across sectors.

There is a distinction between profiling data that identifies areas and data that identifies individuals in a way that is actionable. Both need to be shareable to ensure meaningful joined up delivery.

Consistent evidence and evaluation

"The identification of a consistent set of evaluation and evidence tools recognised by both sectors and used across organisations consistently in order to reduce reporting demands, support comparable results and enable stronger evidence led delivery."

There is not a consistent approach to evaluation between services and across contracts and sectors.

Often different contracts for similar activity will have completely different reporting models. This duplicates the reporting efforts for VCSE organisations that can take resources away from frontline delivery. It also makes comparison between different services and models difficult. Different organisations can also take radically different measurement approaches making comparisons difficult.

Reporting data is underutilised to support system intelligence and improvement. Data in commissioning workbooks is rarely utilised to its fullest extent or pooled. Where comparisons between services are made there is often a lack of sufficient understanding to ensure comparisons are meaningful. There is a lack of confidence that despite the significant resources expended in putting together reports, that they are read, understood and used.

There is no regular process for agreement of what is important to achieve and therefore what should be the key focus of evaluation. Within this the goals and desired outcomes of the service user are rarely, if ever, a key component in overall evaluation.

There is a lack of real time data feedback loops within operations and commissioning to drive quality and performance.

There is too great a focus in measuring outputs and not outcomes. Even where outcomes are commissioned, very often reporting is based on outputs alone.

Service impact is often looked at in isolation. There is need to have a systemwide perspective as well as an understanding of impact at micro, meso and macro levels.

Key performance indicators drive activity and often this can create incentives that are not in the best interest of delivering overall system outcomes.

The lack of an agreed evidence and investment model harms the ability to make the case for new service delivery models and the value of existing models can sometimes be unclear. There is often a lack of real data driven decision making.

Reporting requirements can often shift without any notice or discussion. VCSE services have value for money criteria and reporting requirements applied to them that internal public services do not.

A number of organisations do not have a consistent approach to evaluating their impact through a lack of capacity or resources. This is particularly true of smaller VCSE organisations.

There can be a lack of acceptance or understanding of the limitations of certain data and evaluation processes both in terms of what they tell us and the practicalities of their usage. The evaluation process itself is rarely evaluated for effectiveness.

There are no consistent standards applied to what constitutes valid evidence or standard measurement approaches. This can create confusion. It can also create wasted effort when evidence is gathered in a way that is invalid or seen as such. It also creates the opportunity for evidence to be accepted when it is politically convenient and rejected when it is not.

There is often a lack of clarity on value for money criteria or acceptable unit costs. Where models do exist, they are often not flexible enough to recognise the extra costs associated with, for example, rural delivery or working with harder to reach groups. Evaluation data can be presented without accurate cost information making value for money impossible to determine.

There are significant gaps in our ability to track the outcomes for an individual overtime and across services. This hampers both ability to understand systemwide demand and outcomes but also measure the effects of prevention activity.

There is often a challenge in how the experience of people with lived experience is incorporated into the evaluation process. The balance between hard and soft data in reporting and evaluation models is often not right with a focus on numbers above user stories and experiences.

Sometimes despite a lack of hard evidence a benefit can be clearly observed and this common sense model needs to be incorporated into our overall evaluation model to avoid focusing on what can be measured over what is beneficial.

There is a consistent challenge in evaluating the impact of prevention activity in terms of demonstrating the effects of something that doesn't happen particularly when working at a small scale service level where longitudinal population shifts can't be observed.

There is a consistent challenge in measuring our collective impact against systemwide problems and long terms social justice and inequality issues.

There is often a challenge in combining the desired outcomes of individuals, providers and commissioners into a comprehensive evaluation approach.

Personas

Personas are a generic version of a person that is designed to represent a group individuals and accurate capture their key attributes in terms of factors like needs, motivations, values and behaviours.

They are characterisations that help focus problem solving and design through the lens of what is important to the individuals involved. They can also be a valuable tool for helping to explore mutual understanding and help put yourself in another person's shoes and explore "what matters to them".

From a workshop perspective the personas were challenging to develop. They created many interesting and positive discussions. However, the input tended to focus on the problems or perceived issues with certain roles and a degree of explanation from people in those roles. This is valuable dialogue in terms of developing mutual understanding. The personas shown below are the end product of the workshop process but should not be thought of as definitive and are worth revisiting and evolving.

Commissioners

Commissioners perform a critical role in translating policy and strategic intentions into viable service specifications, commissioning these in an appropriate way and managing the subsequent contracts. The timeline and resource implications can severely limit their ability to ensure specifications are well developed and built around effective engagement. Commissioners often do not have detailed knowledge about the areas they are commissioning in and often have limited training in engagement and development activity.

These constraints, as well as a desire to have contracts that are simpler and easier to manage, often drive behaviour.

Key Motivations:

- Ensuring any investment delivers value to the public purse.
- Investing in the best interest of the population as a whole and that service are safe and high-quality.
- Improving services outcomes and making a positive difference to people.
- Services and contracts that are simpler to manage.
- Meeting budget limitation that are placed on them whilst still delivering.

Key Issues & Concerns:

- Being perceived as uncaring or lacking understanding.
- Ensuring people have a realistic expectation of what the commissioning process can achieve.
- Political pressure to achieve certain results.
- Lack of time, resources, or skills to deliver an ideal process or service.

Frontline workforce in public sector

Frontline workers are often motivated by making a difference to the lives of others – will go the extra mile to care. This drive can come through personal experience. They can be highly constrained by internal processes and systems but this can also represent a way of doing things that they are comfortable with and do not want to see changed. They often have a particular professional culture. They can see their area of delivery as the most important manifesting as both professional pride but also siloed thinking. They can have limited experience and understanding outside their own fields of activity. They are interested in achieving the best for their clients. They are also often motivated by 'getting things off their list'. They are often overstretched. They often have lots of support structures in place, but this can also feel disempowering, with them feeling unable to make decisions without seeking permission - 'a small cog in a large machine'. Procedures or structures can also be used as a shield for avoiding uncomfortable change.

Key Motivations:

- Making a positive difference to the lives of others and delivering the best care possible.
- Working out a package of care.
- Want things to be easy for them and can be driven by targets.
- Want to feel part of a team and well supported.

Key Issues & Concerns:

- Not knowing where to go when working outside their area of expertise.
- Not being listened to or recognised for their knowledge and expertise.
- Not having enough time or support to do the job they want to do.
- Fatigued by endless change and initiatives.

Frontline workforce in VCSE sector

Frontline workers are often motivated by making a difference to the lives of others – will go the extra mile to care. This drive can come through personal experience. Often job insecurity and the transient nature of services can impact behaviours. They will have systems and processes to follow

that constrain their activity, and often have greater flexibility but may still be comfortable with a certain way of doing things. They often have a particular professional culture. They can see their area of delivery as the most important, manifesting as both professional pride but also siloed thinking. They can have limited experience and understanding outside their own fields of activity. They are interested in achieving the best for their clients. They are also often motivated by 'getting things off their list'. They are often overstretched. They tend to have fewer support structures in place which can feel isolating.

Key Motivations:

- Making a positive difference to the lives of others and delivering the best care possible.
- Working out a package of care.
- Want things to be easy for them and can be driven by targets.
- Want to feel part of a team and well supported.

Key Issues & Concerns:

- Not knowing where to go when working outside their area of expertise.
- Not being listened to and recognised for their knowledge and expertise, particularly by other sectors.
- Not having enough time or support to do the job they want to do.
- Fatigued by endless change and initiatives.
- Worse pay, conditions, and job security than other sectors.

Public sector middle Manager

Key role in making services operate effectively day-to-day as well as supporting team delivery. Critical in enabling day to day collaboration and integration between teams. Often pulled in multiple directions responding to team pressures as well as policy, initiative, and performance requirements. Can have received limited training and support on being a Manager. Can be heavily pressured to deliver results without the tools to do this.

Key Motivations:

- Making a positive difference to the lives of others.
- Want to see their team and services perform well.
- Can be looking for the step-up or can be looking for a 'below the radar' easy life, some may not have wanted a management role but 'progressed' from frontline work where their heart is.

Key Issues & Concerns:

- Can feel stuck in the middle between expectation of senior Managers, frontline teams and clients.
- Unrealistic expectations placed on them.
- Not empowered to make changes to policies and procedures.

- Policy and priorities change frequently – needs one 'initiative' to end before another starts.
- Not trained or supported to cope with the complexity of challenges they face.

VCSE sector Manager/Leader mid-sized organisation

Often very passionate about their area of delivery and committed to the social issues it concerns. Whilst having the role of a strategic leader can be very hands on, operational activity can be limiting to the ability to focus on the strategic activity. Highly constrained by the need to 'keep the lights on' and often short-term limited through the flexible nature of funding. Limited support in terms of specialist HR/Data etc. Can have received limited training and support on being a Manager.

Key Motivations:

- Making a positive difference to the lives of others.
- Addressing the social issue in their area of delivery but often beyond just their services.
- Want to see their team and services perform well.
- Maintaining funding for the organisation or service.

Key Issues & Concerns:

- Doesn't have the resources (including time) to do the things they would like to do.
- Has trouble navigating the system. Particularly finding key public sector partners.
- Lacks access to specialist support.
- Sustainability and flexibility in funding.

VCSE grassroots leader/volunteer

Volunteered to do something in their community. Mixture of motivations from doing something good, part of their social life to a particular personal experience. May not see themselves as a volunteer but 'just doing their bit'

Often took on a leadership role by default or accident. May have no training in running organisations/services. Little specialist support (HR, finance). Passionate about what they do but didn't sign-up to be a 24/7 service provider. Challenged by need to manage the paperwork, navigate the system, or demands of other agencies. Enjoy their volunteering but don't see it the same as a full-time job

Key Motivations:

- Got involved to do some good or because of a personal experience.
- Part of their social/community life.
- Can feel responsible and unable to let go once started.

Key Issues & Concerns:

- Didn't volunteer to do the paperwork.
- Being asked to take on more and more, and to manage key services.
- Was supposed to be a fun/good thing to do not an unpaid job.

- Lack of support on specialist areas whether in terms of managing an organisation or delivering a service.

Public sector senior Manager/Leader

Often motivated by sense of public service and wanting to do good. Responsible for a wide range of services across large organisations and therefore can have limited insight and control over individual areas. Wants to deliver positive strategic change. Often constrained by legal and other requirements and often find they have limited ability to make actual changes.

Key Motivations:

- Making a positive difference to the lives of others.
- Want to see their team and services perform well.
- Meeting regulator, legal, political and budget constraints placed upon them.

Key Issues & Concerns:

- High profile and responsible even when they have little direct involvement in the issues.
- Can feel the actions they can take aren't sufficient to deliver the changes needed.
- Needs to find compromising solutions.
- Need to balance system and organisational considerations.

VCSE senior Manager/Leader in larger organisation

Often very passionate about their area of delivery and committed to the social issues it concerns. Needs to balance commissioning type relationships with social campaigning relationships. Can still need to be very focused on the funding side, limiting time for strategic development and collaborations. Limited support in terms of specialist HR/Data/population health management etc.

Key Motivations:

- Making a positive difference to the lives of others.
- Want to see their team and services perform well.
- Maintaining funding for the organisation.
- Addressing the social issue in their area of delivery.

Key Issues & Concerns:

- Not seeing the social changes they want to see.
- Want to undertake meaningful engagement and partnership but can find this doesn't fit with commissioning timescales/structures.
- Clarity around the roles and expectations of VCSE and public sector services.

Wider Reading

Manchester Memorandum of Understanding

https://www.gmcvo.org.uk/HSCEngage/TheMoU

Work by Suffolk and North East Essex ICS Partnership looking at anchor institutions

https://www.sneeics.org.uk/thinking-differently/anchor-institutions/

Collective Impact Approaches

https://ssir.org/equity_and_collective_impact

https://ssir.org/articles/entry/collective_impact

https://www.councilofnonprofits.org/tools-resources/collective-impact

https://www.sopact.com/perspectives/collective-impact-model

https://insights.theberkeleygroup.org/collective-impact-model-for-non-profits-f45a9a2dadcc

Compact Voice

http://www.compactvoice.org.uk/resources/briefings-and-guidance/compact