How do local NHS and VCS colleagues work together to build relationships and a shared collaborative culture?

It is often said that transformation is a marathon, not a sprint. Well, if we're going to push ourselves to the limit, maybe beyond what we think our limits are, we're going to need to be sure that we are making progress towards that finish line with every painful stride we take. Some of us have been running a long time, into the wind, in bad footwear, maybe in bare feet. Some of us aren't tired, we're exhausted, so if we're going to make it to the finish line from here we're going to need more than encouragement from the race organisers, or from onlookers who cheer as we trudge past.

We are going to need very clear markers every mile, we are going to need to know there will be water en route and WHERE the water will be, we need to know that we are running the same race, that no one will be hopping on the bus and re-joining us, fresh as a daisy, a mile from the end, for a sprint finish.

We need a goal, and a plan for reaching it, that we all sign up for, that is transparent; our collaboration has to recognise that the different roles played by local people, their organisations, NHS and local authority colleagues, are complimentary and deserving of mutual respect.

We are fortunate to have some great people in our local NHS and in our local authorities, and we know we have some great people in our communities and our community organisations? But it's not enough to be good, we have to be brave, we have to stick to our guns, we have to keep making things uncomfortable, drawing attention to the gaps between what we agreed would happen and what is happening. And we know that the easiest way to be brave is to be surrounded by lots of other people who are braver than we are, who are committed to the same goal. We need to be organised, to build strong links of

trust and reliability, not only beyond our organisations, but beyond our sectors. We need to be a rebel alliance!

Communities and their organisations can take some steps in the right direction without waiting for statutory allies. We can have tough, transparent conversations about the trade-offs and choices we face, and what the consequences are for smaller organisations and the people who rely on them. We can face our disagreements and make difficult decisions. We can set red lines for our inclusion and avoid meetings that don't respect our limited resources and don't lead to change. We can refuse to bid for work that doesn't allow us to recover the full cost of doing a good job. We can support and platform and recommend and connect the people who do act with integrity, do look out for local people and smaller organisations, who use their power and resources and take personal risks to make space for others and for change, whichever sector they work in. We can make time to share information and insight, opportunities and contacts, whether it benefits us immediately or not, because we know it will benefit us collectively

How do we work together to enable an holistic approach with a focus on people, early intervention and prevention to reduce health inequalities?

If we are serious about people, then we have to increase the control ordinary people have over their lives and their health, and over the way public money is spent on health where they live. That level of participation is the only way to change the status quo because the organisations and people who benefit from that status quo have both the motivation and the power to defend it, whether because it is the only way they know to do a good job, or because they aren't about to hand over what power they have to affect things to a bunch of people who have never worked in healthcare.

When we talk about health we have to be clear that health outcomes and the quality of people's lives come first, not treatment pathways, not engagement plans, not business as usual. We have to accept that in many cases our established models focus on waiting for people to be sick enough, then on treatment, on medicines…when we know that our approach needs to be a bio-psycho-social one that sees patients and practitioners from other disciplines as valued participants in a multidisciplinary, problem-solving team.

We have to acknowledge that many of the people whose outcomes need the most improvement *work* in health and social care, doing the kinds of jobs that were praised from the rooftops during the pandemic, but forgotten about when the danger passed. We have to invest in those carers, those receptionists, porters, drivers, cleaners, in their futures, in their families, and in their health.

If we are serious about prevention then we have to reduce poverty because that is the primary driver of poor health – insufficient income to eat well, to stay warm in winter and cool in summer, to have a home that doesn't make us ill, is not overcrowded, and close enough to our loved ones to sustain the social connections that provide care and resilience, whether we are experiencing depression, coping with cancer, or managing diabetes. Poverty drives people to take jobs and stay in jobs that exploit them and make them sick, not only poor people, but those of us who fear poverty. So, we need to commit to paying people what they need to live healthier lives, to be able to cash their prescriptions, turn their heating on, take a break, spend time with their children. The more people are able to live healthy lives for longer, the more care the community can provide, the more health and social care systems can focus on what the community cannot provide, and on making those crucial services accessible and inclusive and effective.