Community Chests in London: External Evaluation Report

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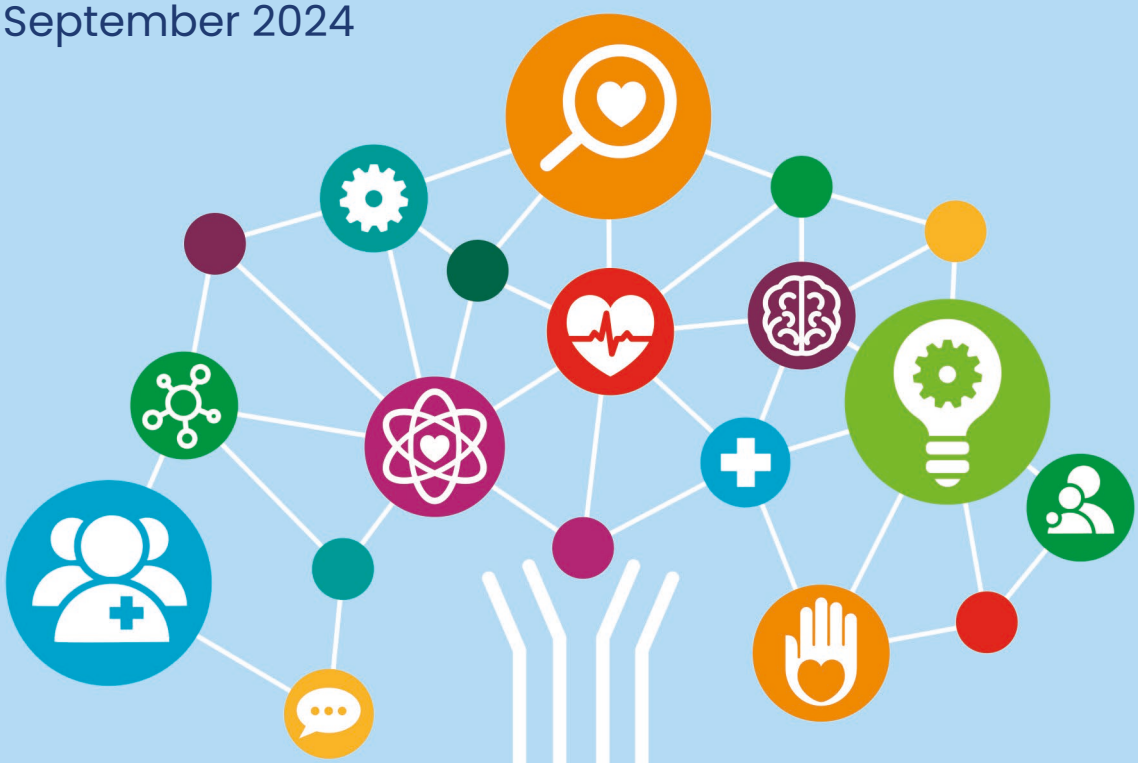

Care City

Transformation Partners in Health and Care

About Care City

Care City is an innovation centre for healthy ageing and regeneration. Our mission is a happier, healthier older age for East Londoners. We pursue this mission by working as an innovation partner to East London's health and care system. We do research, innovation, and development work of local benefit and national significance. Care City was commissioned by TPHC to deliver this independent evaluation of the Community Chest programme in North East London.

About Transformation Partners in Health and Care

Transformation Partners in Health and Care (TPHC) is a regional transformation function on behalf of London's Integrated Care Boards, NHSE London, local authorities, and wider partners. The Community Led Prevention programme aims to improve the health and wellbeing of Londoners to close the gap on health equity using community-centred and personalised care approaches.

Executive Summary

The Community Chest programme, developed by Transformation Partners in Health and Care (TPHC), is a mechanism for statutory and non-statutory partners to work collaboratively towards the larger aim of reducing health inequalities. It involves the creation of shared investment funds at the place level (matched funding between NHS and local authority) that are co-produced and co-owned across the system, take a local needs-led approach to commissioning and ensure accessibility and equitability of funding. To date, the programme has been piloted across seven boroughs in North East London (NEL), with a new pilot underway in Haringey. Local borough reports have already identified positive outcomes regarding patient access and outcomes, VCSE capacity and capability, and cross-sector relationships and partnership working. TPHC commissioned Care City Innovation CIC to conduct this independent evaluation of the programme in two London boroughs to assess the wider system benefits the programme can deliver in terms of: system integration; trust between partners; collaboration and partnership working; and social prescribing service maturity.

This external evaluation of the Community Chest programme examines the impact of the programme on relationships between local stakeholders including Local Authorities, the NHS and the VCSE sector. Two different approaches to local development and delivery of the programme (in two London Boroughs) were compared as part of the evaluation: one which took a traditional grant model approach to distributing funds and outsourced the ongoing delivery of the programme to a third party; and one which took a more collaborative, participatory and VCSE-led approach to programme development, fund distribution and ongoing delivery. Both approaches demonstrated strengths and weaknesses in relation to the aims of the Community Chest programme with the former approach better meeting the aim of addressing local unmet needs, and the latter better developing collaborative working between sectors and improved relationships. This evaluation sets out key learnings and recommendations from these differing approaches to inform other local places which are considering adopting the CC programme.

Key learnings regarding how the programme can strengthen stakeholder relationships include:

- Stakeholder relationships are strengthened through a shared understanding of the local aims and purpose of the programme (which will fundamentally shape the local approach taken), and an acknowledgement of the nature of existing relationships between stakeholders (particularly that between statutory and non-statutory services). Acknowledging and actively addressing existing relational tensions through programme development takes time and capacity but is a vital step in maximising the potential of the programme to build more interconnected systems and stronger relationships between sectors and organisations.
- Relationship development also benefits from an approach which maximises VCSE participation and cross-sector contact through identifying local champions, and running face-to-face events (including 'pitching' for funding rather than written submissions) which facilitate networking and trust-building and increases accessibility for smaller organisations.
- Financial compensation for VCSE organisations to engage with all aspects of the programme was also noted as a key mechanism in ensuring fair accessibility and engagement.

However, whilst a more relational VCSE led approach can strengthen relationships and collaborative working, it was noted that this can reduce the focus on the intended outcome of the programme of reducing health inequalities through addressing local unmet needs. To balance relationship development with desired outcomes, local programmes should:

- Ensure that a strong link is maintained between identified unmet needs (determined through data analysis and qualitative work with social prescribers), the development of transparent funding criteria and the reporting requirements of funded organisations.
- Implement a clear management structure and defined roles and responsibilities which are essential to support programme delivery and avoid relational difficulties between stakeholders.

- Potentially consider outsourcing the programme delivery to a third party. This alternative was explored by one of the boroughs and can enhance delivery efficiency but risks reducing partnership cohesion and relationship building.

Places must also carefully consider the support needs and reporting requirements of the organisations in receipt of funding. Smaller organisations in particular might require support with regulatory documentation in order to receive the funding and fully engage with the programme and where this support can be provided by key stakeholders this can have the additional benefit of further building relationships. Organisations should also be supported to engage with any existing referral platforms in order to both support social prescribing pathways and minimise additional data reporting and monitoring requirements. The monitoring requirements for organisations receiving funding should also be proportionate to the size of funds distributed and focus on the minimum viable data set required to satisfy the needs of the programme.

The Community Chest programme can both build stronger relationships between organisations and sectors, and address local unmet needs providing careful consideration is given to the recommendations in this evaluation. An approach which balances the mechanisms for VCSE engagement and collaborative working with clear decision making, project management and support structures, will maximise the benefit of the programme to the local population.

The Community Chest Programme

The Community Chest programme is a mechanism for statutory and non-statutory partners to work collaboratively towards the larger aim of reducing health inequalities. It involves the creation of shared investment funds at the place level (matched funding between NHS and local authority) that are co-produced and co-owned across the system, take a local needs-led approach to commissioning and ensure accessibility and equitability of funding. This has enabled insights from social prescribers and communities to target funding towards health and wellbeing activities delivered by the Voluntary, Community and Social Enterprise (VCSE) sector that addresses local unmet needs.

To date, the programme has been piloted across seven places in North East London (NEL), with a new pilot underway in Haringey. The Community Chest Programme is led by the Transformation Partners in Health & Social Care (TPHC) Social Prescribing and Community Led Prevention team, in partnership with NEL Integrated Care Board (ICB). SODA, an independent consultancy, was also engaged by TPHC to support delivery capacity in certain areas.

The ambitions of the Community Chest programme are:

1. More integrated, resilient neighbourhoods with collaborative, place-based partnerships and more mature, better connected, sustainable social prescribing systems
2. A stronger, more sustainable voluntary and community sector; more able to serve the needs of the local population engaged through social prescribing
3. A better quality of life for those most impacted by health inequalities

Each NEL borough (supported by TPHC) has developed its own approach to identifying local needs and distributing these funds (see Figure 1 overview) and has produced a borough-level report detailing the local impact of the programme through:

- Capacity building for grantees and the borough as a whole
- People accessing activities in terms of well-being, health and their experience
- Relationships between grantees and the Social Prescribing service
- Health inequalities and the ability of VCSEs to meet local needs

Borough	Approach to distributing funds	Funding priorities	Management of the fund
Barking & Dagenham	Participatory budgeting	No pre-agreed priorities - must evidence there is a need for the activity proposed and complements the priorities outlined in the Joint Health & Wellbeing Strategy	VCSE Steering Group, with funds held on Open Collective
Havering	Traditional grant model	Cost of living, learning difficulties and disabilities, LTCs, MH and isolation	Local authority
Newham	Co-produced proposal for new VCFSE health-focused activity	Grass-roots led peer support, health literacy, community development	One Newham / Newham New Deal Partnership
City and Hackney	Traditional grant model	Access to health services, access to financial support	City & Hackney Place (NHS led)
Redbridge	Traditional grant model	Cost of living, MH, asylum seekers and refugees, learning difficulties and disabilities, elderly people support	Redbridge CVS
Tower Hamlets	Traditional grant model	Social isolation/loneliness, mental health, culturally targeted health and wellbeing activities for Black Caribbean and African communities and cost of living	East End Community Foundation
Waltham Forest	Traditional grant model	MH & loneliness, cost of living, learning disabilities, digital exclusion, health access and literacy	Local authority

Figure 1

External Evaluation Approach

In addition to the borough-level reports detailing the local impacts of the programme, TPHC commissioned Care City Innovation CIC to conduct an external evaluation of the evaluation programme. The aims of this evaluation are to:

- Understand how the Community Chest impacts integration in terms of perceived integration and established markers of integration
- Understand how the Community Chest impacts trust, in terms of perceived trust across all stakeholder groups
- Understand how the Community Chest impacts collaboration and partnership working between different stakeholders
- Understand how the Community Chest impacts social prescribing services maturity from the perspective of different stakeholders
- Understand what is useful about the process and what is not, and to develop recommendations

The goals of this external evaluation are to:

- Inform the future direction of the programme by sharing the impact
- Make the case for the Community Chest and scaling of the approach
- Identify the vital barriers and facilitators to implementation
- Share these to influence key stakeholders
- Enable the promotion of the Community Chest approach in other places

Care City used a comparative qualitative network evaluation approach to address these aims. In discussion with TPHC, two places in North East London were selected for evaluation. They had taken different approaches to distributing their funds and managing the programme and differed in their ongoing delivery of the programme after year 1. The two places selected were Tower Hamlets (TH) and Barking and Dagenham (B&D):

- TH took a traditional grant model approach to distribute funds and does not plan to continue with the Community Chest programme
- B&D took a VCSE-led participatory budgeting approach to distribute funds and is continuing with the Community Chest programme

This comparative approach to evaluation between two places allows the identification of key barriers and facilitators to the programme's ongoing delivery and how differing approaches impact trust, integration, and collaboration.

Through interviews with key stakeholders across both places, Care City conducted a qualitative network evaluation underpinned by Social Network Analysis principles. This approach examines the structural relationships of the Community Chest programme between the key stakeholders through four areas of inquiry:

- Interrelationships - the structure of how network members are connected
- Attribution - explaining the formation and evolution of ties
- Perceptions - understanding how members perceive relationships, such as the value of partnering
- Agreement - the degree to which network members are 'on the same page'

Representatives from VCSE organisations involved in programme delivery, VCSE organisations in receipt of funding, local authority representatives (including public health and social prescribers), NHS NEL (local integrated care board), primary care social prescribers, the programme delivery partner in Tower Hamlets (EECF - East End Community Foundation - a grant making charity), and SODA were interviewed.

Initial insight also surfaced from early engagement work in the new Community Chest Programme pilot in Haringey, which has also contributed to this evaluation.

Evaluation

Agreement on the purpose of Community Chest

Stakeholders in each borough tended to agree on the aims of their local Community Chest programme, and these aims (which differed between the boroughs) were clearly reflected in the local approach which was taken. This suggests the importance of a carefully considered and agreed upon local purpose of the Community Chest Programme between all stakeholders, as it will inform the local approach taken.

This indicates that locally agreeing on a clearly articulated purpose for the Community Chest programme will support the definition of the delivery approach to take.

In **B&D**, the majority of stakeholders stated that the purpose of the Community Chest was to:

- Provide additional capacity to the Social Prescribing system
- Meet unmet needs
- Provide more pathways for referrals
- Improve health outcomes/well-being for residents.

There was also agreement that the contribution of the VCSE sector will become increasingly relevant as time goes on and that the Community Chest sets out to strengthen social prescribing to facilitate this. An alternative response was that the purpose was to help the VCSE sector improve the lives/well-being of residents. This latter response indicates what actually occurred in practice, with outcomes primarily being seen within the VCSE sector, and social prescribing priorities becoming lost during the process. This was due to a local focus on relationship building between partners rather than a sustained focus on unmet needs.

In **TH**, stakeholders noted that the purpose was to find a way to reach previously 'unmet needs' in the borough. They also wanted to increase access to community services for people accessing GPs' health services, and determine which services people were returning to repeatedly. There was agreement from the local authority and community-based stakeholders that they had delivered projects that supported a previous 'unmet

need'. However, NHS colleagues expressed a desire to have been more prescriptive by requiring more demonstrable health outcomes of the programme. This focus on more objective, service based, outcomes as opposed to a more relational approach, is reflected in the model of delivery in TH.

Key learnings:

- The locally agreed upon purpose of the Community Chest programme will define the approach taken to delivering the programme
- The local outcomes of the programme will be influenced by stakeholders' understanding of its purpose

Recommendations:

- Places should be provided with a clear purpose statement for the Community Chest programme, e.g. (as provided by TPHC): *'The Community Chest is a mechanism for statutory and non-statutory partners to work in partnership towards the larger aim of reducing health inequalities. This is achieved by using insights from social prescribers and communities to target funding towards health and wellbeing activities delivered by the VCSE sector that addresses local unmet need'*
- Places should ensure time is set aside to bring all stakeholders into agreement around this purpose statement (ideally through codesign) or adapt the purpose statement into one that is already locally agreed upon. Development of a local logic model for the programme upfront, with all stakeholders, could support this agreement.

Initial context/early decisions

Examining the existing relationships prior to the Community Chest programme and the ways in which early decisions about programme delivery supported the development of these relationships is key to understanding its impact on integration, trust, and collaboration.

In both TH and B&D, there was recognition of a difficult historical relationship between the local authority and the local VCSE sector:

'So it's been quite a turbulent time. The voluntary sector were tempted to have nothing to do with this project. And that's just politics, sadly.'

TH

'Historically there has not been the most positive relationship between [the] council and VCSE' '...Very cautious that the council have been accused by VCSE of having power and control.'

B&D

However, whilst this was recognised across stakeholders in B&D and informed the basis of their Community Chest approach, it did not inform the nature of the approach in TH.

In **B&D**, from the beginning of the process, the local authority recognised that there has not always been a positive relationship between themselves and the local VCSE sector. The local authority has been explicit about wanting to find a way to work more closely and equitably with the VCSE sector and that this would necessitate a shift in power around decision-making and fund distribution. This devolved power approach was agreed upon by the local authority from an early stage and eased the process of confirming matched funding. VCSE organisations, which had previously felt that the local authority has exerted too much power and control, were enthusiastic about this approach to address historical power imbalances, resulting in all parties coming to the table with a shared perspective on shifts that needed to take place.

Additional early decisions which supported the more relational approach within B&D included:

1) **A commitment to funding VCSE participation in the delivery of the Community Chest**
   In B&D, the Public Health team offered additional funds from the Borough Partnership's Health Inequalities Programme to support Voluntary, Community, Faith and Social Enterprise organisations (VCFSE) remuneration. The payment of VCSE organisations to engage in all aspects of the delivery of the programme (from workshop attendance to attendance at the participatory budgeting event and steering group meetings) was noted as absolutely vital by all interviewees. This was a key enabler to the collaborative VCSE-led nature of the B&D

programme, further enabled by the use of the existing BD Collective 'Open Collective' online portal for the holding and distribution of funds.

2) **Additional support from facilitation partners and champions**
B&D was selected as one of the places to receive additional support from the programme facilitation partner. This provided more capacity for relationship building and establishing more equitable power dynamics within the programme. Also, whilst there was a noted lack of GP engagement within B&D, a clinical champion for the programme (also the NEL personalised care lead) provided vocal support to the programme.

In contrast to this shared recognition of relational changes that needed to occur in order to develop relationships, the approach in **TH** was more focused on the specific deliverables of the programme (i.e. meeting unmet social prescribing needs). The management of the Community Chest programme (and distribution of funds) was outsourced to another organisation—East End Community Foundation (EECF), a local grant making charity. The programme, therefore, did not seek to address these relational difficulties from the outset, although stakeholders in TH noted that this was not a stated objective of the fund.

Key learnings:

- As the Community Chest programme involves partnership working, existing relationships between stakeholders can impact its delivery
- Historical relationships e.g. between the local authority and the local VCSE sector, have an impact on delivery
- Where all stakeholders recognise these difficulties upfront, the approach can be tailored to address these
- This tailoring can involve shifting power in regard to decision-making, ensuring the VCSE sector is financially compensated for involvement and ensuring there is time and support to address existing power dynamics

Recommendations:

- Places need to carefully consider the existing relationships between statutory and non-statutory partners that already exist, and spend time understanding

these upfront
- A local clinical champion for the programme should be identified to promote the programme with health partners
- Where there are existing difficult relationships/unequal power dynamics, these should be openly discussed between stakeholders
- The programme should be locally adapted to address these issues through shared decision-making and ensure full inclusion of the VCSE sector
- VCSE sector stakeholders should be financially compensated for all involvement

Establishing priorities

Both B&D and TH worked with existing data and social prescribing link workers to identify unmet needs/priorities related to social prescribing. However, while in TH, these priorities informed the rest of the programme and which organisations received funding, in B&D, these priorities became lost in the process as they were not built into the selection process for those receiving funding.

In **B&D**, SODA worked with the London Borough of Barking and Dagenham public health data and link workers/social prescribers to establish local social prescribing priorities. This approach to identifying unmet needs through social prescribers was reflective of the locally agreed aim of the programme, to address unmet need and increase social prescribing capacity. These unmet needs were relayed to the VCSE sector in an early engagement session about the programme but did not form part of programme delivery beyond this point and were not built into the selection processes for those receiving funding. Of the 15 organisations that applied for funding, all 15 were successful, including a higher proportion for work with children and young people than was reflected in the social prescribing priorities. The open, collaborative nature of the Community Chest programme within B&D was at the expense of a more focused prescriptive approach, which would have supported Social Prescribing capacity. However, although this aim of the programme wasn't met, their relationships were built within the VCSE sector and funding was made available to a number of small organisations that had not previously received funding. This more open approach is perhaps a vital aspect of the first year of such a programme, especially where there have been historic relationship challenges between partners.

In **TH**, it was agreed by the management team (comprised of the NHS Transformation Lead, Local Authority Public Health Lead with a focus on social isolation, Partnership Programme Lead, Senior VCS Development Officer, CEO of Tower Hamlets Council for Voluntary Service, and a PCN Social Prescribing Lead) that there was no current way to formally identify unmet needs and that there was little data and no agreed pathway to approach the needs once identified. The management team was presented with anecdotal information about the current unmet needs in the borough following conversations with social prescribers. They also used data analysis from the EMIS NHS health records to identify some issues for the management team to consider.

The TH Management Team felt that to progress the programme they would need to use an intermediary, a community connector organisation, that would help them establish links for the agreed areas of isolation, befriending, mental health, culture, well-being, cost of living support. The East End Community Foundation (EECF) was selected as the community connector organisation and commissioned to administer the Community Chest fund. By identifying clear priorities and building these into the commissioning of an external organisation for delivery, TH ensured that the work funded through the programme would meet these priorities.

Key learnings:

- Various formal and informal approaches were taken to identify unmet needs/social prescribing priority areas
- Identified unmet needs should be integrated into programme delivery so that they can be addressed
- It is difficult to develop clear criteria for funding decisions if identified unmet needs do not form part of that decision-making process

Recommendations:

- Places should take a mixed methods approach to identifying unmet needs, including analysis of existing data and discussions with social prescribers from across children and adults services
- Time and capacity must be made available for the identification of unmet needs

- The unmet needs that the programme is to address must be clearly and consistently communicated to all stakeholders (both those involved in programme delivery and potential recipients of funding)
- The identified unmet needs must form the basis of decision criteria regarding funding

Engagement with the VCSE sector and approach to distributing funds

TH and B&D took differing approaches to engagement with the VCSE sector and the distribution of funds, which reflected the underlying contexts discussed above.

B&D took a collaborative participatory budgeting approach, whereas TH employed a more traditional accessible grant model delivered through a third party. The former approach contributed to an increased number of and stronger relationships between organisations, whereas the latter provided greater adherence to the programme's stated aims of addressing unmet social prescriber needs.

All stakeholders in **B&D** recognised that there was enormous value in having a local and well-known VCSE leader involved in the process from the earliest stages to the beginning of the sector engagement. This individual played a vital convening role, identifying other VCSE organisations to join the programme Steering Group and meeting with them personally to explain the programme and build sector enthusiasm and commitment.

In addition to this, there was initial engagement with the VCSE sector through a full-day engagement event with a number of speakers (including the Clinical Lead for

Personalised Care in London) and local VCSE leaders who spoke at it to promote the programme, explained social prescribing and the programme's links to this. This also gave organisers the opportunity to 'filter out' organisations that were unsuitable for the fund (e.g. private organisations). Following this event, applicants had a month to develop a pitch together. Reflecting their open, collaborative approach, B&D was open to any type of project idea from any organisation of any size (including unincorporated groups if they could find a sponsor organisation).

A participatory budgeting event was then held in a local mosque in B&D where all organisations applying for funding pitched their project and scored each other (all scoring was peer scored). However, there was no process in place to vet applications for adherence to social prescribing priorities, and neither was there a cut-off for scoring under which an organisation would not be eligible for funding. Therefore, all organisations that pitched on the day received funding. £65,235 was distributed between 15 organisations with a maximum value of £5,000 per organisation. Applications were still being received on the morning of the event and the organisers experienced the day as being frantic. There was also a lack of clarity from VCSE members of the programme Steering Group about whether or not they could pitch on the day - one member didn't know that they could, which caused some short-term relationship difficulties. However, there was strong agreement across all stakeholders that there were significant benefits to an event of this type. By allowing time, opportunity and lunch for networking, organisations that didn't know each other got to know each other, and the value of getting people in a room and having lunch together was recognised. Feedback from social prescribers was that people found the day really engaging and different and that it was good for them to see this.

Feedback from participants also showed that everyone was really positive about the model and that understanding everyone's pitch was beneficial. The event addressed the issue that '*historically, funding goes to those who write the best rather than have the best idea*'.

Several VCSE organisations (particularly smaller organisations) reflected on the traditional focus on successful bid writing, noting that they do not have dedicated bid writers and find the language of applying for funding '*bureaucratic*'. Additionally, in TH,

some raised concerns that the size of the funding being awarded was disproportionate to the amount of work involved in writing the bid and reporting on delivery. This supports the case for a more interactive bidding approach over a lengthy written bid one.

In **TH,** the local financial processes required that awardees provide three quotes, each set up with a local authority account, and send purchase orders and invoices that could take months to be paid. The procurement group only met once a month, so it also took a long time to enable them to deliver all awardees their funding. The decision to select a single external fund administrator in the form of EECF was partly down to the need to circumnavigate these issues. EECF then established a traditional paper-based submission process for bidding for the grants.

The management team in TH arranged a '*meet and greet*' session at the fund launch with the EECF and potential VCSE applicants. This was the only interaction between the management group and VCSE organisations as part of the programme. The management team had no further meetings, but some representatives from the team formed an Evaluation Committee that met several times during the summer of 2023. They focused on gathering feedback and identifying barriers to project delivery.

Day-to-day programme management was managed by the EECF, which had strong links to VCSE organisations in the area. The EECF administers grants, and they have connections with the voluntary sector in TH. They typically run about 25 programmes per year, so they have established systems to rapidly create funding guidelines and databases to process the funds and monitor their usage. Stakeholders from NHS NEL felt the EECF was very helpful in developing the guidelines and delivering the programme.

The EECF developed bid-scoring guidance for the management team, collated all the bids, and provided a summary report. The management team then met to review and score the bids. The management team selected 12 bids, totalling £60,000, to receive funding. Awards were made in April 2023.

As the EECF could not start work until they had received the funds, and unforeseen absences from statutory partners, the Community Chest didn't launch until the summer of 2023. It was agreed that funding would be short-term, but this shortened the project funding to seven weeks. EECF stated that this was to help coincide with the Evaluation Committee's work with evaluating other pilots the local authority was involved in. The EECF produced a management report about their perspective on the programme's performance.

Due to outsourcing programme delivery to a third party, the Community Chest approach in TH did not lead to new relationships between sectors and organisations in the way the B&D approach succeeded in doing. Stakeholders noted that improved relationships between organisations were not the fund's original stated objective. In the short timeframe, it was not expected that much would change for the awardees regarding their working relationships.

The early work in **Haringey** has also surfaced these issues regarding the amount of funding available being a key factor to consider. Honest conversations need to be had early about what type of participatory process is commensurate with the grant pot available. Learnings from Haringey suggest that selecting a neighbourhood or thematic focus earlier in the project might support the participatory strategy to be more focused and commensurate with the funding available.

Early engagement work in Haringey has also identified the importance of identifying key local partners (ideally from the VCSE sector) as early as possible to ensure local buy-in to the programme. This work has also identified that making information about the programme available before physical meetings will support better long-term engagement. Also noted from Haringey is the need to take time to build local relationships and create the conditions for a successful Community Chest. This needs to be balanced against the need to deliver a full project within limited budgets.

In Haringey, capturing these early learnings has allowed the local ICB who are leading the programme to review and reset their approach. An approach which is more collaborative with local VCSE organisations is now being taken in response to these insights.

Key learnings:

- The local approach to distributing funds will be defined by the agreement between stakeholders about the purpose of the programme and their approach to existing relationships
- Engaging the VCSE sector benefits from a consistent local VCSE champion to begin to build engagement and trust in the process from the start
- Face-to-face events are vital to building VCSE engagement (and bringing statutory and non-statutory partners together) while also giving the opportunity to network beyond the funded programme
- Investing time in understanding local relationships and historical issues is important to defining the right delivery approach
- Allowing VCSE organisations to '*pitch*' for funding in person (rather than just submitting a written bid), along with participatory decision-making, increases the opportunity for smaller organisations to access funding
- VCSE organisations do not have all the skills, time or resources to engage in a lengthy bid process
- Decision-making criteria for funding and the process of application must be clearly communicated to all stakeholders and VCSE sector organisations upfront in order to avoid confusion and address identified unmet needs
- Outsourcing the programme delivery can help ensure effective delivery. However, there are unintended benefits of partnership working between statutory and non-statutory partners which can be restricted when time and resources are limited

Recommendations:

- Places should identify a consistent VCSE champion(s) from an early stage who can engage the sector and build enthusiasm around the programme
- Local in-person events should be organised to introduce the programme to the VCSE sector, and these should include a clear articulation of the aims of the programme (i.e. addressing identified unmet needs) and the process and decision-making criteria for allocation of funds
- Investing time in understanding local relationships and building these through codesign of the process could help engage participants in the shared success and purpose of the programme
- These events should include input and attendance from all key stakeholders

- Places should consider alternatives (or additions to) written bids for funding to ensure equal opportunity for those organisations less experienced in bid writing
- If participatory decision-making is employed, there must be clarity on the decision-making criteria, a clear scoring process in place, and a defined process for communicating with unsuccessful organisations
- To reflect the programme's aims, it is best when being delivered by statutory and non-statutory partners working together. If delivery is to be outsourced (for example, for reasons of capacity), then places should carefully consider how all stakeholders can remain engaged and informed to build partnership working and mitigate the risk of outsourcing

Negotiating relationships and ways of working

Given the commitment of all stakeholders in B&D to doing things differently and the additional and the additional facilitation support provided, much of the initial set-up period in the borough was spent negotiating the relationships between sectors and establishing shared ways of working. This period, and the associated meetings, were described as '*two months of painful planning meetings*' although all stakeholders recognised that whilst it sometimes felt like '*all the same issues were being discussed*', this was a vital part of relationship building and challenging historic power structures.

During this period (which involved frequent, initially weekly, meetings with the independent facilitator, VCSE colleagues and social prescribers), the different ways of working between local authority and VCSE became salient, with the two sectors working together being described as '*really, really difficult*'. The local authority was characterised as moving slowly and having '*very deep structures… which have to wait for approval*'. Whereas VCSE organisations can '*just make decisions*' and respond more quickly to change. Local authority colleagues also reflected that they often felt the urge to take control in these sessions but recognised the vital relationship development work taking place; therefore, they did not.

During this period, the approach taken by the facilitators was also more closely aligned with VCSE ways of working than local authority, focusing on relationship building and exploration rather than organisational structure and decision-making processes. The policy-and-procedure-driven approach of the local authority clearly differed greatly from the '*more creative way*' in which VCSE organisations were more comfortable interacting. Lack of clear language was noted as one of the biggest challenges during this early period, with a degree of jargon (from local authority colleagues) constituting a barrier to full VCSE engagement.

Despite these difficulties, all stakeholders appreciated the facilitation provided by SODA in building these relationships but noted that a bit more of a challenge from SODA would have been helpful in addressing practical issues such as the scoring system for bids. During this time, and reflecting on a more collaborative approach, a significant amount of time was spent exploring different potential models for the Community Chest.

Key learnings:

- The VCSE sector and local authorities have very different ways of working, which need to be negotiated to ensure partnership delivery of the programme
- Negotiating these different ways of working (and existing power structures) takes time and can be uncomfortable for both sectors
- An independent facilitator can be very helpful for the initial negotiation of these relationships
- These negotiations play a vital role in relationship development

Recommendations:

- Places must recognise pre-existing power structures and different ways of working between statutory and non-statutory partners
- Places should ensure enough time and capacity are built into the programme to address these issues and develop shared ways of working in the early stages
- Attention should be paid to the use of language, particularly jargon used by statutory partners, that can create a barrier to participation
- Places could consider whether independent facilitation might be required to address these issues

Programme Management and Steering Groups

B&D and TH differed significantly (particularly in the set-up stages) in regard to the clarity of programme management responsibilities and who was responsible for driving the programme forward. This produced very different structures of how organisations were connected and the relationships they developed.

In **TH**, a 'management team' was established, which comprised of the NHS transformation lead, the Local Authority Public Health Lead with a focus on social isolation, the Partnership Programme Lead with a focus on health inequalities, the Senior VCS Development Officer who administered the local authorities existing grants programme, the CEO of Tower Hamlets Council for Voluntary Service, and a PCN Social Prescribing Lead. This management team led the programme prior to outsourcing the delivery to EECF who then became responsible for administering the grants. Once outsourced, EECF had direct relationships with the organisations receiving funding, and there was no interaction between the organisations themselves.

Conversely, in **B&D**, there wasn't a clear programme manager throughout the programme. A local VCSE leader was involved in the early stages of bringing the sector around the programme (and establishing the VCSE-led steering group). However, the available management fee was insufficient for them to take on another staff member and allow them to take the programme lead position. It therefore wasn't clear who was responsible for delivering the programme on the ground, and there was no designated person to keep it on track.

B&D was also unclear about how much involvement social prescribers (who sit within the council) should have. They could have taken on the programme manager role, but the steering group clearly felt it needed to be community-led. There was a feeling of '*walking on eggshells*' to balance this dynamic with social prescribers and public health taking on parts of programme management—*'Even in participatory decision-making, you still need someone making sure it gets done.'*

Delivery of the programme in B&D was ultimately devolved to the programme steering group, which consisted of the leaders of four local VCSE organisations. The group met

frequently during the development phase (weekly - including public health, social prescriber and SODA attendance). Still, capacity and programme requirements reduced this to monthly meetings as the programme continued. These direct interactions were essential for relationship building, allowing the group to work through barriers to the programme and resolving practical issues. As such, the steering group, in particular, developed much stronger relationships between themselves and the other local stakeholders.

Early engagement work in Haringey has confirmed the importance of identifying a clearly defined steering group early on that remains with the programme throughout its delivery.

Key learnings:

- A lack of a clearly defined programme management structure (with assigned roles) can cause relational difficulties between stakeholders through a lack of clarity about who is responsible for programme delivery
- A more distributed approach to programme management still needs clear accountabilities/responsibilities to be defined
- An overly centralised programme management structure can inhibit relationship formation between stakeholders and organisations

Recommendations:

- Places should ensure there is a named individual responsible for programme management and delivery, or if more distributed, that accountabilities and responsibilities are clear
- The role of this individual is to ensure delivery within time frames rather than being the decision-making body
- Sufficient funds/capacity/time must be made available to support this role, particularly if it is to sit within the VCSE sector

Relationships with funded organisations

The different programme set-ups and management structures in B&D and TH resulted in different nature and structure of relationships forming with the organisations in receipt of funding.

In **B&D**, following confirmation of the 15 organisations that would receive funding, each steering group member was assigned three or four organisations to support through the programme. The support needs of these organisations varied greatly, based on organisational maturity and existing processes they had in place, and the steering group supported across two main areas:

1) Ensuring the organisations received the funding by supporting them to have the correct documentation in place if they didn't already (e.g. health and safety policies and DBS checks)
2) Supporting the organisations with evaluation and monitoring requirements. This was noted as a significant challenge for the organisations, with the evaluation form being adapted from a different local authority's reporting format that '*wasn't fit for the VCSE*'

This set-up of support resulted in steering group members (themselves, VCSE organisations in receipt of funding) building strong relationships between themselves and the other organisations they supported. However, relationship building with social prescribers was more limited and only extended to steering group member organisations. Social prescriber managers stated that they were not aware of the progress of all the funded activities and that some funded projects happened so quickly that the social prescribers missed them. Social prescriber managers (who attended monthly meetings with the 5 VCSE steering group members) described social prescribers as being '*completely out of the loop*'.

Steering group members noted that whilst their relationship with social prescribers improved through the programme (with some onboarding to Joy - the local social prescribing referral platform), an opportunity was missed to better link social prescribers with the other organisations. This was at least partly due to social prescribers being absent from the steering group and their priorities not being pulled through to programme delivery. This resulted in social prescribers finding it very difficult to gather the necessary information from organisations about the programmes they were running, in order to support referrals. Furthermore, the fact that the majority of the organisations were not on the Joy platform (which was being introduced in B&D contemporaneously with the community chest programme) also hindered both social

prescriber awareness of organisations and the process of referral. All stakeholders noted that whilst there was a presentation about the Joy platform on the initial engagement day, it wasn't embedded in the programme processes. Moving forward with the programme, B&D will make it a condition that all organisations in receipt of funding must be on the Joy platform, and efforts will be made to clarify the role of Joy in an accessible manner earlier in the programme.

In B&D, public health also became much more aware of organisations in the community sector (particularly those in the steering group), which it was stated would not have occurred without the Community Chest programme. As a result, they have much greater awareness of groups they could approach when other funding opportunities come up.

The VCSE organisations in B&D also believe that the programme has improved their relationships with the local authority, particularly in developing an '*honest and transparent relationship*'. For those organisations that engaged more with social prescribers, they now describe their relationship as '*knowing them very well*', and it has significantly improved their referrals.

Conversely, in **TH**, there were no facilities for organisations to work more closely with each other. There was only one meeting where they met any other organisation, a 90-minute meet-and-greet session to launch the fund, and all other contact was made via email. As previously stated, stakeholders noted that improved relationships between organisations were not the fund's stated objective. In the short timeframe, it was not expected that much would change for the awardees regarding their working relationships.

Regarding relationships with social prescribers in TH, there was procedural ambiguity regarding how the partners would carry out their projects. A number of awardees felt that it was the social prescribers responsibility to provide referrals, whereas others looked for self-referrals. About halfway through the funding window, all organisations were encouraged to start soliciting self-referrals as it was clear that there were low referral numbers via the PCN.

Various stakeholders had different views about the reasons for the low referral numbers. These included low awareness of the programme within GP and social prescribing circles, low awareness of who qualifies from both the GP, social prescribing and patient perspective (i.e. some carers did not identify themselves as carers and were not identified by GPs as carers), and the scarcity of identifying those with an unmet need within the timeframe.

Key learnings:

- Organisations in receipt of funding (particularly smaller and less mature/established organisations) require additional support and time to engage with the programme fully
- Where programme stakeholders provide this support, it can greatly benefit relationship formation
- Where key stakeholders are missing from ongoing programme delivery, this can negatively impact both relationship formation and key programme aims
- If using a digital platform, sufficient time needs to be given to help people understand the benefits of using it and for implementation

Recommendations:

- There must be support mechanisms in place to support organisations in receipt of funding with compliance, reporting and monitoring requirements
- Key programme stakeholders should provide this support to maximise the relationship building necessary for partnership working
- Organisations receiving funding need to engage with referral platforms (e.g. Joy) to support social prescribing referrals and evaluation and monitoring
- In the future, explore the use of other digital technologies to support collaboration between partners and the sharing of information could bring additional benefits for participants
- Social prescribers need to play a more active role with the organisations receiving funding, e.g. there will be an assigned social prescriber to each steering group member and will be directly linked to the organisations they are supporting
- Careful consideration needs to be given to the minimum viable data set required for evaluation and monitoring, and data collection tools need to be adapted to/co-developed with the VCSE sector

Conclusion

The Community Chest programme's success relies heavily on strategic planning, stakeholder engagement, and clear communication. It highlighted the cracks in the relationships between VCSE and statutory partners but more importantly helped these two groups re-engage and learn to work together again. Often, people said the Community Chest programme helped them see the real person on each side.

A summary of the recommendations included the following requirements for a successful Community Chest programme launch:

Shared clear purpose with local adaptation: Places should articulate a clear purpose statement for the programme, tailored to local needs and agreed upon by all stakeholders. Developing a local logic model can facilitate agreement and alignment.

Addressing existing relationships and power dynamics: Places must openly address any difficult relationships or power imbalances between statutory and non-statutory partners. This should be supported by an approach to communication which is free of jargon on both sides, and could be supported by independent facilitation where required. Shared decision-making and inclusion of the VCSE sector are crucial, and financial compensation for their involvement in the process is also essential.

Using local insights to identify unmet needs: A mixed methods approach should be adopted, combining existing data analysis and consultations with social prescribers. It is essential to clearly communicate identified unmet needs to all stakeholders and integrate these needs into funding decision criteria.

Strong communication and engagement strategy: Early identification of VCSE champions and the organisation of local events are vital for introducing and building enthusiasm around the programme. These events should involve all key stakeholders and clearly articulate the programme's aims and decision-making criteria. There could be consideration for additional training and frequent opportunities to bring participants together to share learning, allowing a more iterative approach to developing and implementing the programme.

Collaborate with local champions: identifying and collaborating with local VCSE and clinical champions for the programme is vital to engaging and solidifying the support of these sectors around the programme.

Transparent and accessible application process: Places should consider alternatives to written funding bids, ensuring equal opportunities for organisations less experienced in bid writing. Clear decision-making criteria and communication processes with unsuccessful organisations are essential.

Co-leading and partnership working: Ideally, the programme should be delivered by both statutory and non-statutory partners working together. If delivery is outsourced, strategies should be in place to maintain stakeholder engagement and partnership working. Regardless of delivery method the programme should also ensure there is focus on building the relationship between funded organisations and those referring to them (i.e. social prescribers and GPs).

Ring-fenced programme management and support: A named individual responsible for programme management should ensure timely delivery. Support mechanisms for funded organisations, including compliance and reporting, are crucial for relationship building.

Complimentary to social prescribing services: Engagement with digital social prescribing referral platforms and the active involvement of social prescribers with funded organisations are necessary for effective social prescribing referrals, evaluation, and monitoring.

Proportionate data collection and evaluation: Careful consideration should be given to the minimum viable data set required for evaluation and monitoring. Data collection tools should be co-developed with the VCSE sector to ensure relevance and effectiveness.

The Community Chest programme's implementation requires a holistic approach prioritising local adaptation, stakeholder engagement, transparency and support. By

addressing these areas strategically, places can foster collaboration, enhance community impact and effectively reduce health inequalities.

Social Network Maps