Leeds Community Foundation

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COMMUNITY FOUNDATIONS AND HEALTH

Seizing the opportunities for collaborative working

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with thanks to Vicki Papworth

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Community Foundations and Health: seizing the opportunity for collaborative working

Introduction

There is an increasing recognition in policy and practice for a need to shift the balance of healthcare from hospitals to communities and to get 'upstream' to prevent people becoming unwell[1].

As part of this, the voluntary and community sector (VCS) has a role to play providing pathways to community support. Local health systems have been slow to respond, however, often because they lack systematic connections to their local VCS.

Community Foundations have a potentially important role alongside local health systems to develop and deliver a more strategic approach to supporting local VCS organisations, which balances VCS values and contemporary health care policy imperatives. The good practise that currently exists has, however, not previously been captured.

About this report

The aim of this report is to map the relationships that currently exist between Community Foundations and statutory health organisations in England and to present some suggestions for future directions. We asked Community Foundations in England about their relationships with local health systems. This report summarises the key things they told us.

What we did

We used a mixed-method data collection procedure in order to gain a 360° view of the relationships between Community Foundations and statutory health organisations.

An online survey was emailed by UKCF to the forty-four Community Foundations in England. The survey asked about their past and present relationship with the statutory health organisations in their patch. It also asked respondents to volunteer to share more details of their relationship with health via **a telephone interview**.

Thirty-seven Community Foundations, representing all regions of England, responded to the survey and **fourteen volunteered to be interviewed**.

From the Community Foundations that volunteered to be interviewed, ten were randomly selected:

- Essex Community Foundation
- Suffolk Community Foundation
- Lincolnshire Community Foundation
- Cumbria Foundation
- Oxfordshire Community Foundation
- Devon Community Foundation
- Staffordshire Community Foundation
- South Yorkshire's Community Foundation
- London Community Foundation
- Leeds Community Foundation

These Community Foundations vary in age, size of endowment, annual grant making, staff numbers, and local demography and geography (i.e. urban, rural). They were asked about their relationship(s) with statutory health organisations and the challenges and benefits of working together.

[1] NHS England (2014) *Five Year Forward View*. London: NHS England

The role of Community Foundations in health

Community Foundations have priorities based on their local resources and context, along with the perceived needs of their communities, that are broader than purely 'health' agendas.
Whilst 'health' may not be the explicit focus, **the work of Community Foundations contributes to the health and wellbeing of individuals and communities**.

Community Foundations often **work in areas of deprivation** with individuals and communities at risk of health inequalities. Their input can have "huge implications for health and wellbeing" (CF3) by **influencing the broader social determinants of health**, including but not limited to housing, employment and skills, social isolation, physical activity, flood relief, and sexual exploitation.

Community Foundations have **a complementary role working alongside statutory health** organisations to add value to provisions. However, in an era of austerity, Community Foundations may feel pressure to have a role "replacing the state" (CF1) in terms of funding health and wellbeing related services.

Example 1: Lincolnshire Community Foundation

Lincolnshire Community Foundation covers all of greater Lincolnshire. It has a population of around 1 million people spread across the second largest county by area in England.
The Foundation sees its role in health as filling gaps in provision where statutory funding has been cut or withdrawn, and pooling funding into grass-roots and place-based solutions. They are connected to their local statutory health organisations through formal partnership working and informal networking.
Lincolnshire Community Foundation is currently working with 2 of the 4 Clinical Commissioning Groups in the county; one CCG sponsoring the development of a social prescribing programme (£150,000 for three years) and the other CCG working on an intermediate care solution expected to be worth about £1.5million. They also work with their local Department of Public Health, who provide funding for a range of research and development projects, including social prescribing. With DPH support, the Foundation is developing a £2million Social Impact Bond for preventative domestic abuse services. It will be risk funded by investors benefiting from 'social investment tax relief' (30% concessions on capital gains).
The Community Foundation is informally networked into the local statutory health organisations through different avenues. Whilst they have only 3.5 F/T staff members, Lincolnshire Community Foundation are well connected across the sector. They have a number of influential associates (i.e. on CCG scrutiny boards) and are connected to a number of General Practitioners that they have met during project workshops. The introductions to the CCGs came through the Community Foundation's relationship with Public Health, who had assistant directors attached to each CCG able to broker a connection.

The relationships between Community Foundations and the statutory health sector

There are numerous statutory health organisations that Community Foundations might work with, including Clinical Commissioning Groups (CCGs), Hospital Trusts, Community Trusts, and local authority Public Health.

There is no set structure that Community Foundations have to adhere to when working with statutory health organisations; **relationships can take many forms**. They can be formalised, structured relationships, or more *ad hoc* and free form. They can be based on personal relationships or contact across organisations. A distinction can also be made between purely 'transactional'

relationships, based around administering a grant fund, and more strategic involvement in planning and programme design.

Example 2: South Yorkshire's Community Foundation

South Yorkshire's Community Foundation (SYCF) was established in 1986, and over the past 30 years, have distributed roughly £26million to over 8,000 organisations across the region. They have eleven members of staff (3 F/T) and utilise the support of 62 volunteers across their grant panels.

SYCF's funding priorities cover a range of activities affecting the social determinants of health (i.e. housing, employment, drugs and alcohol, sexual exploitation). They have previously managed a £600,000 fund from Sheffield CCG, focused on keeping people out of hospital, but are no longer formally involved with the CCG. SYCF is involved with statutory health organisations though their involvement in a number of strategic committees and discussions across the region.

SYCF recognise the significance of their work to the health and wellbeing of people in the region. They see local statutory health organisations as 'future donors' and are aiming to be seen as the first port of contact for all future conversations, particularly about VCS infrastructure. However, there is a strong voluntary sector in the South Yorkshire region and SYCF have struggled to be seen as natural partners by statutory health bodies. They hope to persuade local health bodies to be more philanthropic by showing them that they share their priorities and by demonstrating the skills to support statutory bodies to better achieve their outcomes.

SYCF see working with statutory health organisations as stemming from personal relationships. However, there are a relatively large number of statutory health organisations in the region and devoting resources to each is difficult.

Nationally, **35% of Community Foundations are working with local statutory health organisations to deliver grant funding**. In the absence of any nationally coordinated programme or support, this is to be celebrated and a cause for optimism.

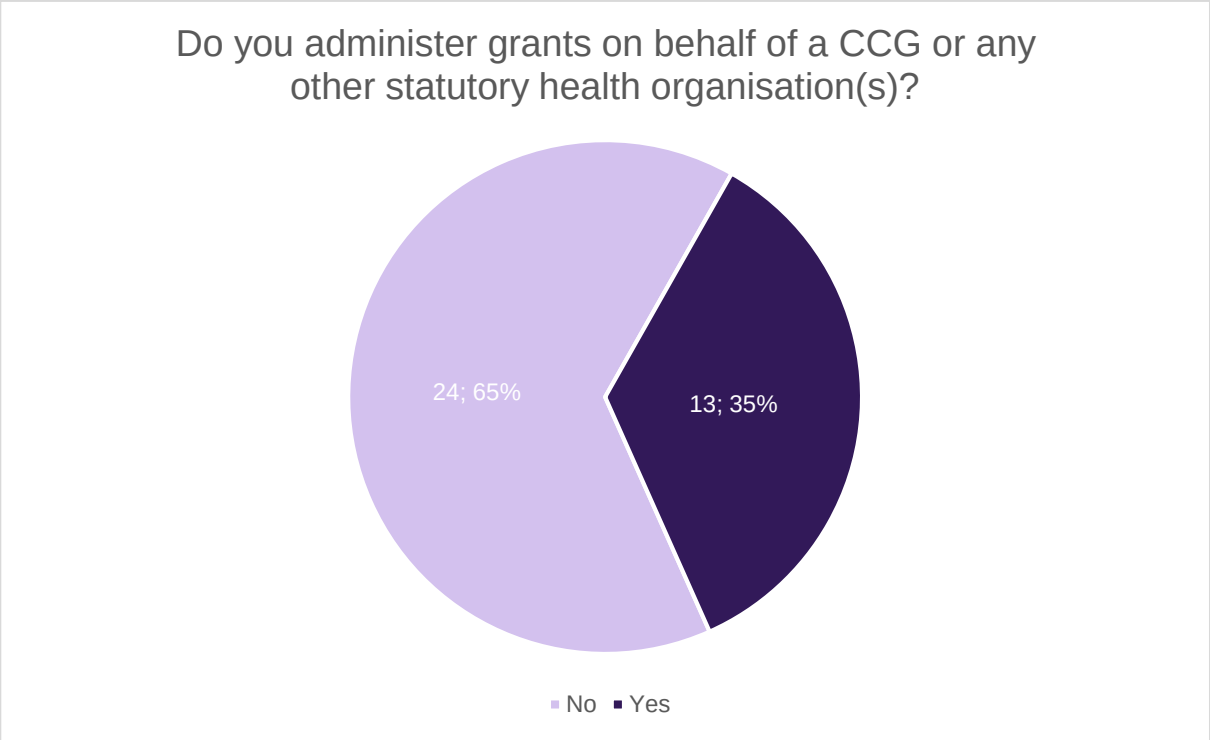

Figure 1 Community Foundations administering grant funding on behalf of CCGs or any other NHS health organisation

Generally, is it the 'bigger' Community Foundations (i.e. in terms number of staff and total grant giving) that are working with statutory health organisations (see Figure 2).

Figure 2 Community Foundations that administer grants on behalf of a CCG or other statutory health organisation in their patch

However, there is still **room for further collaboration across the board**. Only six Community Foundations have delivered grant funding for more than one of the Clinical Commissioning Groups (CCGs) in their patch and only four Community Foundations have delivered grant funding on behalf of all the CCGs in their patch in the past five years (see Figure 3).

Whilst Community Foundations may be working with the statutory health sector in other ways, **statutory health organisations are a potentially untapped source of grant funding**.

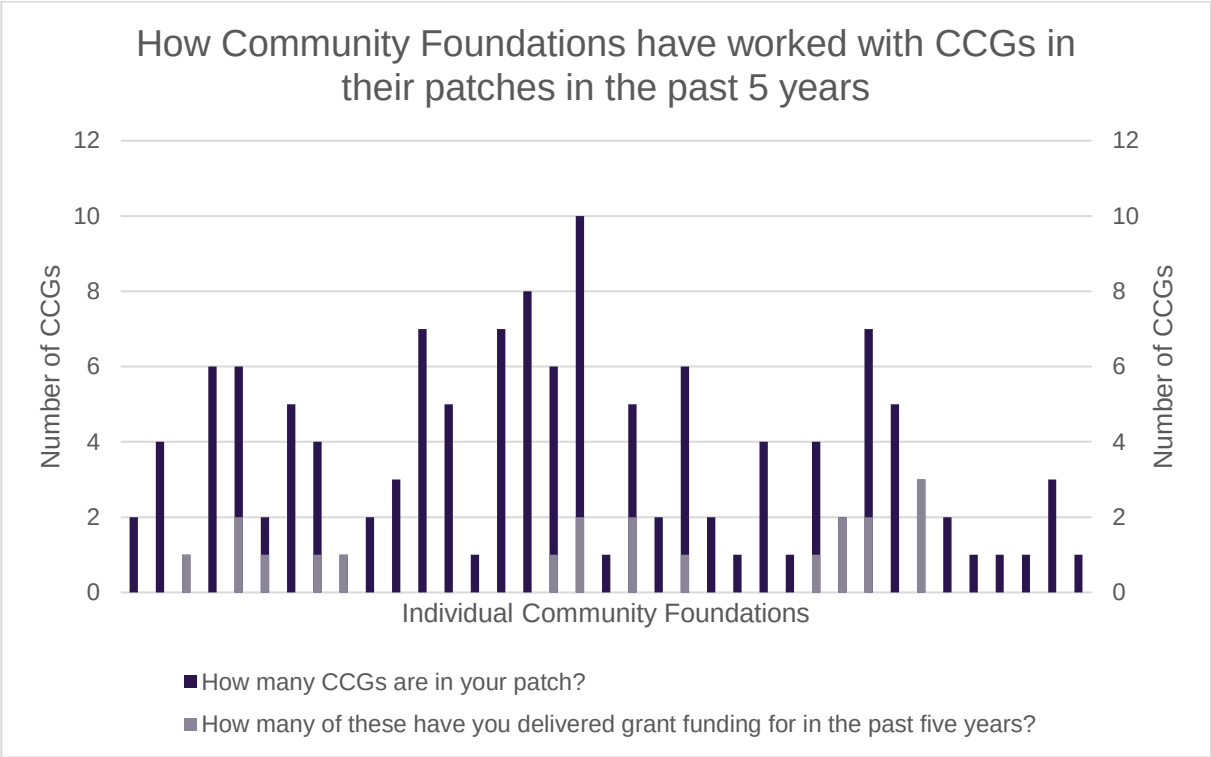

Figure 3 Number of CCGs delivered grant funding for in the past five years, by CCGs in patch

The added value of Community Foundations and Health working together

Joint working between Community Foundations and statutory health organisations **can add value to the work of both organisations, leading to improved health and wellbeing for individuals and communities**.

Joint working between Community Foundations and statutory health organisations can also enhance the local VCS.

Added value to health organisations

Grants distributed by Community Foundations can be **a cost effective method for investing funds** for statutory health organisations. Community Foundations are able to channel monies into organisations, particularly smaller VCS organisations, **without the inefficiencies of health commissioning** procedures.

Community Foundations are relatively mobile, able to provide statutory health organisations with **a strategic route into ever changing and evolving local VCS networks**. Being 'on the ground' and regularly in contact with the community, Community Foundations are able to **quickly and effectively identify local need**, particularly in 'hidden' communities and with hard to reach groups. This is particularly useful in channelling resources effectively towards prevention. A bottom-up approach of working with local communities allows health organisations to avoid criticisms of top-down decision making.

Community Foundations can be **an intermediary, providing a single point** of contact between statutory health organisations (as commissioners) and VCS organisations (as delivery agents). They can provide **managerial overview of funds** to be distributed to VCS groups, including managing expectations on both sides and facilitating communication. As an independent body, external to "local politics" (CF9), they are able to avoid accusations of favouritism in the grant giving process.

Community Foundations are also well networked organisations. They are able to convene business and VCS organisations around an agenda and **link to other funding** that may be beyond the remit of statutory health bodies, giving health authorities 'more bang for their buck'.

Added value for Community Foundations

The primary advantage for Community Foundations of working with statutory health organisations is that they can be **a significant source of grant funding**.

A secondary benefit is that working with a statutory health organisation carries a lot of cachet, **increasing the reputation and credibility of a Community Foundation**, which can be used to leverage funds from other partners.

Example 3: Leeds Community Foundation

Leeds Community Foundation has existed for 13 years and covers the predominantly urban areas of Leeds and Bradford. They distribute about £5million in grants per year and deliver funding for a range of corporate and individual donors and 'partner funders', including Pears and Henry Smith, and local statutory partners.

In Leeds, there are three CCGs, two of which invested significantly in a Third Sector Health Grants Programme with Leeds Community Foundation. Both funds are valued at around £1million, increased from £300,000 and £750,000 respectively. The relationships with the CCGs were initiated through a combination of personal relationships between Community Foundation and CCG staff, a formal pitch to both organisations, and an element of serendipity. After the transition from Primary Care Trusts, the CCGs were more open to "different conversations", and new senior decision makers also wanted to "make their mark", in the context of a city with a thriving third sector but little health grant funding.

Representatives of each CCG sit on the grant making panel of their respective funds. This is to ensure the work remains collaborative and that funding goes towards projects that fit with identified health priorities and complement other existing interventions in the city.
Managing the relationship with each CCG, as with other donors, involves maintaining communication and ensuring positive stories about the fund. A significant amount of work to capture evidence of health outcomes has led to raised profiles for the groups funded, as well as the Foundation.

Over time, the relationships with both CCGs have become stronger. Through the collaboration, Leeds Community Foundation has increased its profile among individuals and organisations, leading to a growing (informal) relationship with local hospital trusts.

Added value for VCS organisations

The principle benefit to the VCS of Community Foundations and statutory health organisations working together is the **additional grant funding** that might become available. This can **support the delivery of specific projects and build capacity in the sector** as a whole.

In working with statutory bodies, Community Foundations are also able to **embed the VCS into health discussions and agendas**. Community Foundations are in a position to advocate and champion on behalf of the sector as a whole.

Community Foundations engaging with health organisations **supports the professionalisation of VCS organisations** in terms of more effective management and evaluation. Demonstrating outcomes, or translating evidence into the 'language' of health organisations, is a perceived weakness of VCS organisations, preventing statutory health organisations investing more in

community interventions. Community Foundations are able to **support VCS organisations to evidence their outcomes** in an appropriate format for health organisations.

The challenges of Community Foundations working with Health

Working with statutory health bodies presents short- and long-term challenges for Community Foundations that need to be overcome.

Example 4: Devon Community Foundation

Devon Community Foundation has existed for over 20 years. In that time, their relationship with the statutory sector has evolved. Prior to 2010, they were heavily involved in delivering government grants and held very little money of their own. Following the 'grass roots match challenge', the Foundation refocused on building their endowment from private individuals, which now stand at around £6.6million and they administer over fifty funds. They employ a Fund Development Director so that the Chief Executive can focus on building strategic relationships.

The Foundation previously had little intention of being involved with 'health', but in less than a year have become members of the strategic steering group for integrated social care alongside their local CCG, County Council, Exeter City Council and the programme lead of Exeter Hospital Trust's social prescribing scheme as part of their integrated care programme. They are not involved in delivery, but manage the grants and mediate between statutory health and VCS organisations. The social prescribing scheme is being evaluated by Plymouth University.

The Foundation were introduced to the relationship through a voluntary sector partner. They have personal relationships with key individuals, including personal relationships between senior colleagues across local statutory health organisations. The Foundation did not have to be involved in the project, they chose to, and so are treated as an equal partner.

The appeal of the Foundation to statutory health organisations is their ability to mediate relationships with the VCS, including distributing and evaluating grant funding on their behalf. They also help to 'professionalise' the sector by supporting VCS organisations with impact measurement.

In the future, the Foundation would like to see a greater funding commitment from statutory health organisations, particularly for capacity building in the VCS. They would like to maintain their programme-management role, using their knowledge and skills as an intermediary between statutory health and VCS organisations.

'Health' is made up of a complex **network of large organisations with structures that can be difficult to navigate**. Networks and organisations can be difficult to access (i.e. to identify the right individual to speak to) or activity can get lost within. **Decision making and administrative processes can be slow** and **maintaining relationships amid organisational 'churn' (i.e. changing staff) is an ongoing issue**. Structural changes within and across health (i.e. CCGs replacing PCTs) creates challenges for maintaining continuity, but also opportunities for new conversations and relationships.

Relationships with health organisations, as with many donors, relies on personal relationships, but Community Foundations **may not have the personal contacts to establish a relationship with health organisations**. Whilst some Community Foundations have developed relationships with key stakeholders in health, others may not have the 'profile' to command meetings with the necessary stakeholders in health organisations.

The competitive marketplace is a challenge for Community Foundations looking to develop relationships with health; they **may be vying with other VCS organisations to be the 'right partner'** for health organisations. Not being a delivery agent may create difficulties for Community Foundations where health bodies may look to work with organisations with those skills (i.e. development trusts).

Community Foundations may face a struggle to work with statutory health organisations that **may not value the role/impact of the VCS** as part of strategies to meet the health and wellbeing needs of individuals and communities. Community Foundations need to evidence the outcomes of their work, and that of VCS organisations, in a language that 'health' understands.
Working with statutory health organisations can be **a resource intensive activity** for Community Foundations. As with other funds, whether the potential return it is worth the investment is a necessary consideration. **Funding from statutory bodies may be short term, rather than a long-term endowment**, while a general reduction in statutory budgets may limit **health organisations' capacity for investment** or willingness to pursue 'creative solutions'.
A **lack of appropriate capacity across the VCS** may create challenges in finding groups to grant funds to. Although this challenge is not unique to health funding, it is pertinent where a health organisation has a responsibility to a particular area.

Working with statutory health organisations may also result in an actual or perceived **loss of independence** for Community Foundations. The concern is that, rather than focussing on pure philanthropy, Community Foundations will be beholden to the agendas of government or become mechanisms for delivering government contracts.

Example 5: Essex Community Foundation

Essex Community Foundation was founded in 1996. They operate over 130 charitable funds, annually granting around £2.5million to charitable organisations across a large geographical area containing a mix of urban and rural. Their primary focus for funding is high net-worth individuals in order to build their endowment.

Although their grant making is guided by donors, they are able to guide donors as to what is needed. Essex Community Foundation recognise that health cuts across many issues and a significant portion of grant making goes towards individual and community health and wellbeing initiatives. Where possible, they try to recognise the services already being provided by the statutory sector and where the VCS can complement and add value to those services.

Essex Community Foundation manage an endowed fund from a Community Interest Company (formerly part of the County Council) but have "limited relationships" with other statutory health organisations. The Community Foundation and statutory health organisations are aware of each other and are part of similar strategic decisions (i.e. Essex Partnership Board), but the Community Foundation do not deliver any grant funding on their behalf.

The structure of the public sector in Essex is complex, with two unitary authorities, twelve district authorities, the County Council, and seven CCGs. It is difficult for the Community Foundation to identify who the 'influencers' are, where the money is, and how decisions are made. It is also difficult to align agendas so that statutory organisations appreciate the role of, and are prepared to work with, the VCS. The Community Foundation only have a small staff team and so, without knowing what the outcome will be, investing time building relationships with statutory health organisations is not prioritised.

Moving forward: what needs to change for Community Foundations and Health to work together?

The majority of Community Foundations are not dissatisfied with their relationships with statutory health organisations. Unsurprisingly, it appears that Community Foundations who

are currently administering grant funding on behalf of a statutory health organisation are more satisfied with the relationship than those that are not (see Figure 4).

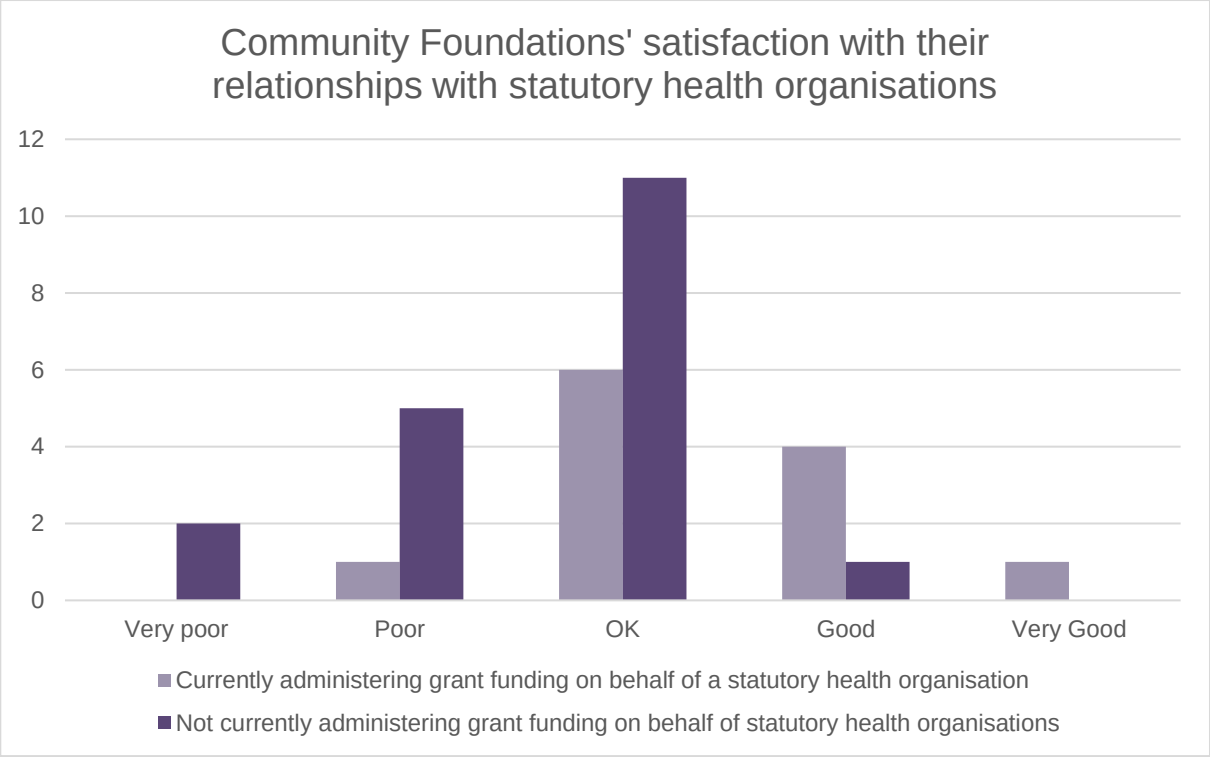

Figure 4 Community Foundations' satisfaction with relationships with statutory health organisations

For Community Foundations, “health is a huge market that’s totally untapped” (CF3). There is currently an opportunity for Community Foundations to expand their relationships with statutory health organisations for the betterment of the ‘health system’ and individuals and communities.

National policy presents a conducive environment for Community Foundations and statutory health organisations to work together. The positive health and wellbeing impact of the VCS and of the need for new ways of working is highlighted in the ‘Five Year Forward View’[2], ‘GP Forward View’[3], and Care Act 2015. To build on this momentum, UKCF should be having **strategic conversations with health about getting collaboration on the agenda**.

At a local level, both Community Foundations and statutory health organisations need to be ‘ready’ to work together. Health organisations need to **continue to recognise and value the contribution of the VCS** to health outcomes. In order to work with Community Foundations, health organisations also need to be **more philanthropic and appreciate the value of grant giving**. Despite the positive rhetoric, health organisations need to be allowed, and **resourced appropriately, to take the ‘risk’** of working with a Community Foundation.

Community Foundations – and the VCS as a whole – need to **continue to see ‘health’ as something that they can contribute to** as part of their business. In order for this contribution to be recognised, Community Foundations need to **continue to evidence their impact** in a way that is familiar to health. It may be beneficial for Community Foundations **to clearly ‘package’ their offer to health organisations**, setting out what they can offer and expect from relationships.

[2] NHS England (2014) *Five Year Forward View*. London: NHS England
[3] NHS England (2016) *General Practice Forward View*. London: NHS England