An investigation into how appropriate funding models can help build sustainable partnerships between business, communities and health organisations

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This research was carried out as part of a Master's thesis in Creative Health (MASc Creative Health at University College London), in partnership with the National Centre for Creative Health. The main findings are provided in this summary report.

The National Centre for Creative Health is a charity established to advance good practice and research, inform policy and promote collaboration, helping foster the conditions for creative health to be integral to health and social care and wider systems.

Aim

The aim of this research was to investigate how appropriate funding mechanisms could help build sustainable partnerships between business, communities and health organisations. The study highlights the essential criteria for scalable and transferrable partnerships for future developments. A better understanding of funding models in the post-COVID era will support organisations such as NCCH to achieve greater integration of creative health and non-clinical approaches into health and social care systems.

Background

Creative health, as defined by NCCH, refers to creative approaches and activities which have benefits for our health and wellbeing. Activities can include visual and performing arts, crafts, film, literature, cooking and creative activities in nature, such as gardening; approaches may involve creative and innovative ways to approach health and care services, co-production, education and workforce development. Creative health can be applied in homes, communities, cultural institutions and heritage sites or healthcare settings. It can be part of a non-clinical, preventative approach to health and wellbeing through which arts, culture, creativity, nature, or debt or legal advice can be used improve health outcomes and tackle the socio-economic factors which influence health and health inequities. Collaboration between the private and public sectors can tackle these social determinants of health, creating better health outcomes for all.

Many grassroots, community-led creative health programmes or non-clinical interventions are short-term (typically six to 12 weeks), but evidence suggests that longer-term engagement is required to bring about significant behaviour and lifestyle changes[1]. To this

[1] NICE (2007) 'Overview - Behaviour change: general approach Public health guideline [PH6]' Available at: https://www.nice.org.uk/guidance/ph6 [cited 2022 Aug 5].

end, the question of how to fund more sustainable community-led health solutions and partnerships, to make them scalable and transferable to the mainstream, needs to be addressed. To date very little research has explored the financial and economic impacts of community-led creative health approaches, much less the financial models underpinning partnerships between communities and health[2].

Ideally, the relationship between business and health should be one of 'enlightened self-interest'[3]. There is a long history of grassroots organisations providing non-clinical health interventions, either through charity or small, purpose-driven businesses. At the other end of the spectrum, large corporates are showing an increasing appetite for providing health solutions for their own staff, but also actively engaging with academia and the NHS.

Our communities contribute hugely to our health and wellbeing. Community support through partnership building can reduce structural health inequalities[4] . How these partnerships should be sustainably funded is less well evidenced. Therefore, this study focused on how to build these partnerships and asked:

How can appropriate funding mechanisms build sustainable partnerships between business, communities and health organisations?

Methods

The research reviewed existing literature relevant to funding models and sustainable partnerships between business, communities, and health organisations. A series of interviews were then carried out with a range of stakeholders with an interest in funding partnerships between business, health and community sectors in order to gain a more in-depth understanding of their experiences.

Literature Review

The study took a broad approach to establish an overview of different funding models drawn from current practice. The search strategy included peer-reviewed literature, academic reviews (including scoping reviews), reports and other grey literature. Studies were included if they explicitly related to 'funding mechanisms in health for community partnerships', including reference to business, funding models, health organisations and types of sustainable partnerships in health. Searches were limited to during and post-COVID pandemic (2020–2022). For peer-reviewed studies four databases (ProQuest, Web of Science, Science Direct and Taylor and Francis Online) were searched, and when searches reported several hundred results, only the first 100 were reviewed.

[2] Kimberlee, R., Bertotti, M., Dayson, C., Asthana, S., Polley, M., Burns, L., Tierney, S., and Husk, K. (2022). 'The economic impact of social prescribing'. National Academy for Social Prescribing. Available at: https://socialprescribingacademy.org.uk/wp-content/uploads/2022/03/Evidence-summary-the-economic-impact-of-social-prescribing-.pdf [cited 2022 Aug 12].

[3] Enlightened Self Interest (ESI) is a form of utilitarianism, altruism: doing what you need to do to make things better for others. Even if you work in corporate, you still act for the greater good. See Vearrier, L. (2020) Enlightened Self-interest in Altruism (ESIA). *HEC Forum* 32(2):147–61. Available at: https://www.proquest.com/docview/2407552557/abstract/5E70109D382D43BBPQ/7 [cited 2022 Aug 22];

[4] Crisp, N. (2021) Health is made at home, hospitals are for repairs. 1st ed. London: Salus

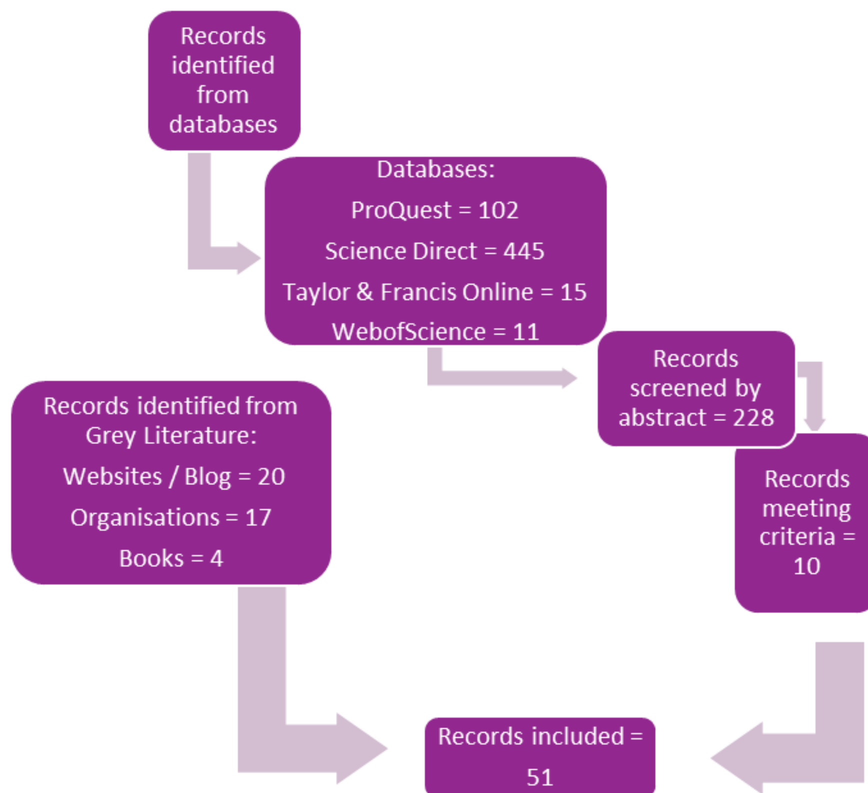

Figure 1: Literature search process and number of papers identified and included

Through this process a total of 10 studies were identified as relevant to the research, and were categorised as addressing 1) sustainable partnerships in the community, 2) business and funding and 3) health and community. From the grey literature, an additional four books, 20 websites (including blogs) and 17 organisational websites were included. References to the literature included in the review are collated in Appendix 1.

The literature supports the hypothesis that integrating community assets and partnerships improves health outcomes and wider flourishing of participation[5]. There is a significant gap in the research around sustainable partnerships between businesses, communities and health organisations, which means the impact of inputs on funding on outcomes is often not clear.

Interviews

Semi-structured interviews were carried out with 24 participants selected for their knowledge and expertise in different roles across business, community and health.

[5] Downward, P., Rasciute, S. and Kumar, H. (2020) 'The effect of health on social capital; a longitudinal observation study of the UK'. *BMC Public Health* 20(1):466. Available at: https://doi.org/10.1186/s12889-020-08577-w

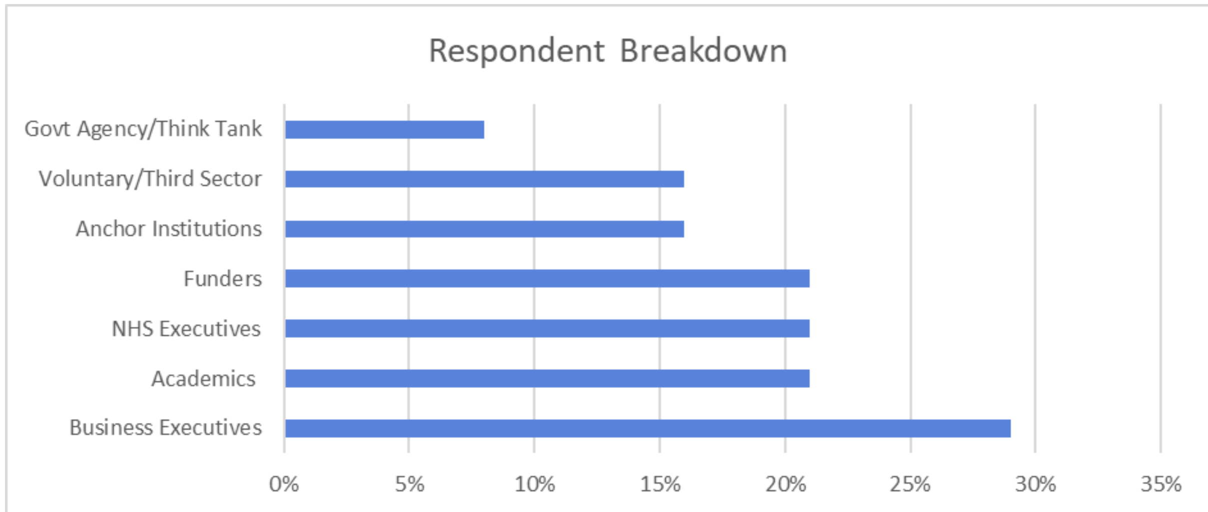

Figure 2: Interview respondent breakdown

Analysis of these interviews revealed key themes around partnerships, community-based approaches and collaborative funding. Analysing the themes emerging from the interviews revealed insightful perspectives around how sustainable partnerships can be built within communities and identified gaps and critiques of existing research and knowledge.

Results

The study drew out key themes which influence the establishment of sustainable funding partnerships between business, community and health organisations.

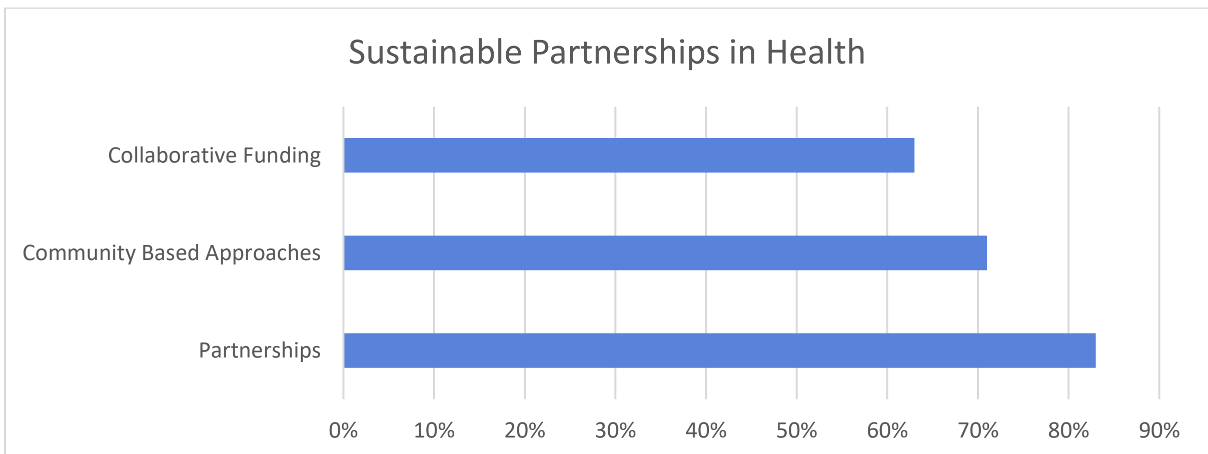

Figure 3: Key themes identified by respondents in building sustainable partnerships in health

Furthermore, the research supported the notion of enlightened self-interest i.e. when businesses get actively involved with community projects, including through funding, communities will do better. Using place-based assets facilitates a systems approach which results in better health outcomes, to the benefit of both business and communities.

The following topics were identified from both the literature review and interview data as important points for discussion:

Partnerships: The research drew out key themes around partnerships including why they are important, how they work in communities and obstacles to partnerships.

"Partnership working has become more critical than ever… never have organisational barriers been so unimportant."

Partnerships across different sectors enable collaborative engagement for better outcomes through an exchange of knowledge and expertise between all partners with vested interests in those outcomes, including beneficiaries with lived experience. People want to 'get things done' and the benefit of like-minded altruistic partnering is recognised across the different types of organisations in trying to find better solutions to big societal problems. Further, relationships are synergistic and build trust and understanding.

Building trusted relationships between partners takes time and capacity but is worth the effort. Once there is trust and understanding, partners are much more likely to share, authentically, acting in a relational rather than a transactional manner. A good cross section of stakeholders is needed to scale the model.

Partnerships work well when there is a systems approach to interventions, building in complexity. However, there must be humility to recognise where people's knowledge and expertise begins and ends; to be flexible, collaborative and accountable. Coproduction along the 'journey' is essential, as is the ability to change where necessary, based on feedback from the community.

Setting outcomes at the start is essential: funders need financial returns whilst health organisations need health outcomes. Key metrics must be established from the beginning.

Speed of integration can be an obstacle to establishing successful partnerships and building relationships. The business sector and academic and health partners can bring different qualities. For example, the business sector is used to moving at a fast pace to get things done, with an ability to quickly adapt to market conditions. Where academia and health organisations may not have that expertise, the business community can help bring about change. Conversely, the business community do not necessarily have the methodology or empathy that academia or health organisations have, which is why symbiotic, interdisciplinary, systems thinking is essential for community-based projects.

Anchor institutions as place-based assets – Anchor organisations are businesses involved as cornerstones of community activity and have long-term sustainability, often as a large local employer. Anchor organisations may also include healthcare organisations, local government and education providers.

"Anchor institutions are often talked about being the big boys, the big employer, the big charity, the big whoever. In the toughest areas, those that are often making change and delivering outcomes are the small guys. Make a case for the small guy because they are the fabric. There is a lack of infrastructure, place at the table for them."

Anchor institutions include small and big business. Businesses have a responsibility to their community on three levels: goods and services they provide, the quality of the jobs they provide and the health and wellbeing of their employees and their families and therefore the

wider community. Many times, small business are the grassroots organisations and social enterprises doing good things that others do not want to do. There must be space made for these organisations to be involved in place-based decision-making. They form the fabric of the community and often understand what is happening in the community better than other stakeholders.

Larger institutions can raise the profile of smaller businesses and they must take these responsibilities seriously and engage, in part because shareholders and consumers take note when big business avoids or 'washes' their responsibilities.

Funding in community health – The research identified several examples of funding models and began to consider what a sustainable funding model might look like. Understanding the financial landscape and mechanisms that can facilitate integration is essential to the establishment of sustainable partnerships.

"Sustainability of funding is critical. Much funding of social enterprises and charities is very short-term and ad hoc."

A sustainable funding model means that you are less reliant on one source of funding. For community projects to be funded in a sustainable way, they should be built in a collaborative partnership model. Most times, funders do not want to be the sole funder, and the trust and understanding of a community-based partnership helps build reassurance into the system.

The most common form of funding is grant based. However, grants are not efficient in terms of sustainability, effort, and effectiveness. In simple terms, applicants can commit a huge amount of time to filling in application forms with information that is not needed, only to be awarded a time-specific grant which means they must almost immediately reapply, denying them the opportunity to deliver their core services.

Collaborative partnerships engage with many participants in the community, and require commitments to finance to provide a pipeline of funding for sustainable interventions.

The research identified a number of funding models, and summarised the advantages and disadvantages of each in the context of building sustainable funding partnerships between business, community and health organisations. These are summarised below in Table 1.

Table 1 – Funding models

Grant funding
• The largest form of funding small initiatives is through grants but interviews indicated that 84% of charitable giving goes to just 4% of the market. • Some anchor institutions are businesses that give money to large charities but most grassroots charities have a frugal existence; funding can be anything from a few hundred to a few thousand pounds. • Regardless of the size of the grant, applying for funding is a highly complicated, onerous and criteria-driven task. • The complexity of the system, in contrast to the inexperience, lack of time, and largely volunteer workforce of grassroots organisations, accounts for many failed attempts to gain funding.
Shared Investment Vehicles (SIV)
• A Shared Investment Vehicle is one way of providing collaborative funding: a simple financial product, like a bond, that can pay a return on an investment depending on the structure, which some funders use to 'share' the investment risk between different stakeholders. Many of the investments are very small.
Pooled funding
• Pooled funding is combining money from different stakeholders. • This kind of structure may be referred to as a 'Community Bank' and it is a sustainable model that can be scaled and transferred. • Pooled funding might give a community the opportunity to commission projects in addition to NHS commissioning, to build local capacity. If this approach were adopted, a key partner would have to be the local ICS. One suggestion from the interviews was to use such a funding consortium to pilot six projects for two years. At the end of the two years, those projects can be commissioned by the NHS for the next few years, or not, and a source of activity in the locality might be enabled.

Collaborative provider models

- Collaborative provider models are good at linking grassroots organisations with social enterprises to provide funding.
- They work well on a small scale where the providers of the service lead the model, with funding secured from other partners.
- The model takes a holistic view of funding around a population group and providers take their wider roles responsibly, holding recipients of funding to account or upholding funding.

Philanthropic giving

- Philanthropists have, at some point, been successful in business and can play a role similar to angel investors or venture capitalists to the third sector.
- Makes use of different funding models, including making grants, matched or pooled funding, to spread their risk by investing with other partners usually wanting accountability through reporting.
- Can help organisations grow sustainably if they trust in the clarity of the mission, aims and objectives and ability to deliver value.
- Target sectors or geographical areas based on personal interest.
- Large charitable organisations may be funded through a philanthropic endowment which they then use to finance projects in the wider community.

Matched funding

- Many providers look to other funders to match the funding they have received from different sources.
- This funding relies on good due diligence to attract funders to join. When lots of grants are very short term and ad hoc they are not sustainable.

Matching grants can increase sustainability by spreading the risk across more partners.

Core funding
• Core funding comes from the state, which, for many organisations, can require a strong partnership with government and ensuring a high degree of confidence in project delivery through performing good due diligence. • Core funding is non-specific, and the partner organisation is expected to top-up the funding. • Core funding can be used on a larger scale and organisations use it to source other funders to join a particular venture. It is a good example of public and private money and social ventures coming together to enable something greater than either part would be able to do on their own. • Core funding is not applicable in many contexts.
Outcomes contracts or Social Impact Bonds (SIBs)
• These contracts are generally between public and private sector funding. • Outcomes contracts offer a longitudinal funding stream for a coordinated and comprehensive healthcare strategy at the population level. • Generally, outcomes contracts tie some proportion of a funder's payment to the achievement of specified (and measurable) performance. • There are clearly defined objectives between the provider and the recipient and regular assessment of the success of the project and if it needs to change to meet key performance indicators. • Outcomes contracts are binding financial products and the funder only receives payment if the intervention delivers, necessitating rigorous evaluation throughout the process to ensure delivery.
Founder/patron model
• Built on relationships, trust and delivery skills, the model is another mix of private and public contributions where unrestricted grant funding is requested from local councils, philanthropists, and businesses for a multi-year commitment. Funders contribute to each part of the delivery, trusting in the entirety of the project and have confidence in the partners to deliver a successful and sustainable model. • Accountability comes from an operating agreement, not a contract, based upon commitment to deliver certain services.

• This type of model can build a broader base 'pyramid of donors', with lower levels of donors giving less, and other funding streams joining.
Subscription model
• When several sources contribute to funding, it de-risks the investment and creates greater ownership between collaborators. • In certain settings, participants need to feel they are contributing and paying a nominal subscription fee to use the service, which helps them feel entitled to quality project services, increases a sense of ownership and gives greater investment to delivery.

Measuring and evaluating partnerships: Evaluation is essential to understand the broader impact of interventions.

"We've got no common approach to measuring benefit and that's where it seems to be falling down. There's no longitudinal data that I've seen that puts healthcare costs together with activity effectively."

The drive to measure is correct but we must find ways to measure intangibility and to attach funding to individual outcomes. Evaluating how many times an individual uses a community service is not the same as measuring the impact. Effective data analytics must be used to measure impact and evaluate interventions. Understanding the difference between productivity and efficiency is critical and can only be really understood by measuring and evaluating collected data.

Financial organisations and health organisations look for different outcomes, so each partner must be able to see their metrics clearly and comprehensibly. If decision makers work together, they can leverage significant impact, and this ticks boxes for both sides. Recognising the order of priorities is critical.

Measuring cost-effectiveness is very difficult. Partnerships must work towards how to measure contextualised intangibility where it is known that success in one area of someone's life will '*spill over*' into different areas such as employment, quality of life or health.

People need to understand why they are measuring, what they are measuring and how it is to be measured. They need the skills to be able to interpret data. Enabling these skills would help bring about valuable change to the third sector and allow them access to greater resources and better funding, simply by measuring and understanding, so they can talk about what they are doing and the impact they are having.

Innovation: This was understood as acknowledging biopsychosocial impacts and new kinds of partnerships to support preventative health solutions and tackle health inequities.

"The medical model understands the alternatives will have an impact."

There is widespread research acknowledging the impact the environment of where people live or work and who they mix with, has on both mental and physical health. COVID-19 showed that isolation and loneliness are big factors in impacting health.

Individuals must be enabled to monitor their own health and helped to make better choices around their health. There is no 'one-size fits all' solution to health – people make choices pertinent to their circumstances and health care must have a degree of personalised prescriptions. This research shows that building community partnerships to support health and stimulate behaviour change in place-based solutions is equally important as these prescriptions.

A Shared Language: The research shows that shared narrative and finding common language facilitates an understanding and willingness to work together.

"I think you need to be able to speak people's language, which means there's a lot of translation going on between different sectors. So that interdisciplinarity."

There is a need to agree the narrative ahead of intervention implementation. Traditionally, people have been able to 'hide behind' language but in a new collaborative, community-based model, there is acknowledgment of others' expertise and a willingness to coproduce solutions and therefore an acceptance that language needs to change and a new narrative developed to achieve 'buy-in' from all stakeholders.

Space should be provided for voices that often go unheard. Lived experience, in particular, can be valuable to academia, government and business.

Language helps break down siloed thinking and can lead to deeper integration and knowledge exchange.

Siloes - How a systems approach might remove obstacles posed by siloes

"Sometimes professional boundaries get in the way of collaboration."

Professional boundaries can get in the way of collaboration. An interdisciplinary or systems approach can integrate knowledge, resulting in better outcomes. Nevertheless, it is hard to get people a) in the room, b) to make commitments and c) do it together. Yet, the research demonstrated a willingness to overcome these challenges and recognise that benefits can be multiple in the complex health field.

Siloed thinking impacts funding: decision-makers make decisions based on their sector, but many times these impacts are multiple, and funding must be viewed holistically. To test the hypothesis, participants in the research suggested a fund should be set up to allow an integrated systems approach.

Outcomes from sustainable partnerships

""We wouldn't have touched health with a barge pole but actually if we do our job on getting people better jobs, stronger communities, education, people out of unmanageable debt, that's all health outcomes"

COVID-19 showed the possibilities of enlightened self-interest and of altruistic behaviour to solve big societal problems. Stakeholders are aware that if the social determinants of health are tackled, better health outcomes can be achieved.

Recommendations

The research identified several recommendations:

- Access to streamlined and simpler funding applications would help both top-down and bottom-up organisations be more productive and reduce the concern around short-term interventions.
- Small, grassroots projects are like start-ups in the private sector: they do not have access to funding. Taking a more entrepreneurial stance, they might 'pitch' their ideas to regional or national level forums to widen their access to funding, relationships, and resources.
- Government, regulators and shareholders should encourage business collaboration in communities and adherence to Environmental, Social, Health and Governance (ESHG) goals.
- A cross-fertilisation of contributing partners can bring interesting ideas; for example, putting community-funded, non-clinical health interventions into GP surgeries for more holistic approaches to community health.
- Building 'Community Diamond' partnerships of academia, business, health organisations and communities would bring more sustainability, using robust evidence, methods of working and rigorous accountability, for example, in the new Enterprise Zones in the most deprived areas of the country.

Conclusion

The three key ingredients to building sustainable partnerships were found to be:

- relationships,
- collaborative coproduction
- place-based expertise

A move to invest in creating place-based relationships will align interests in targeted approaches and long-term health outcomes. Collaboration and partnerships between academia, business (small and large), community and health organisations will form the bedrock of place-based interventions, with an integrated free exchange of knowledge and expertise, and will allow for the development of long-term funding solutions and better outcomes.

Next Steps

Further work should be undertaken on a larger scale, gathering additional data from a wider and more diverse sample, incorporating business (social enterprise and large scale). Economic modelling could be used to demonstrate the effectiveness of funding models from an interdisciplinary perspective. Further work should be undertaken to understand how outcomes contracts and social impact bonds can be made more applicable and appropriate for health interventions.

A pilot study is being built to test the hypothesis of the Community Diamond, involving academic, business, community and health partners, with results due to be published in 2023.

Appendix 1 – References Identified in the Literature Review

Database search results

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