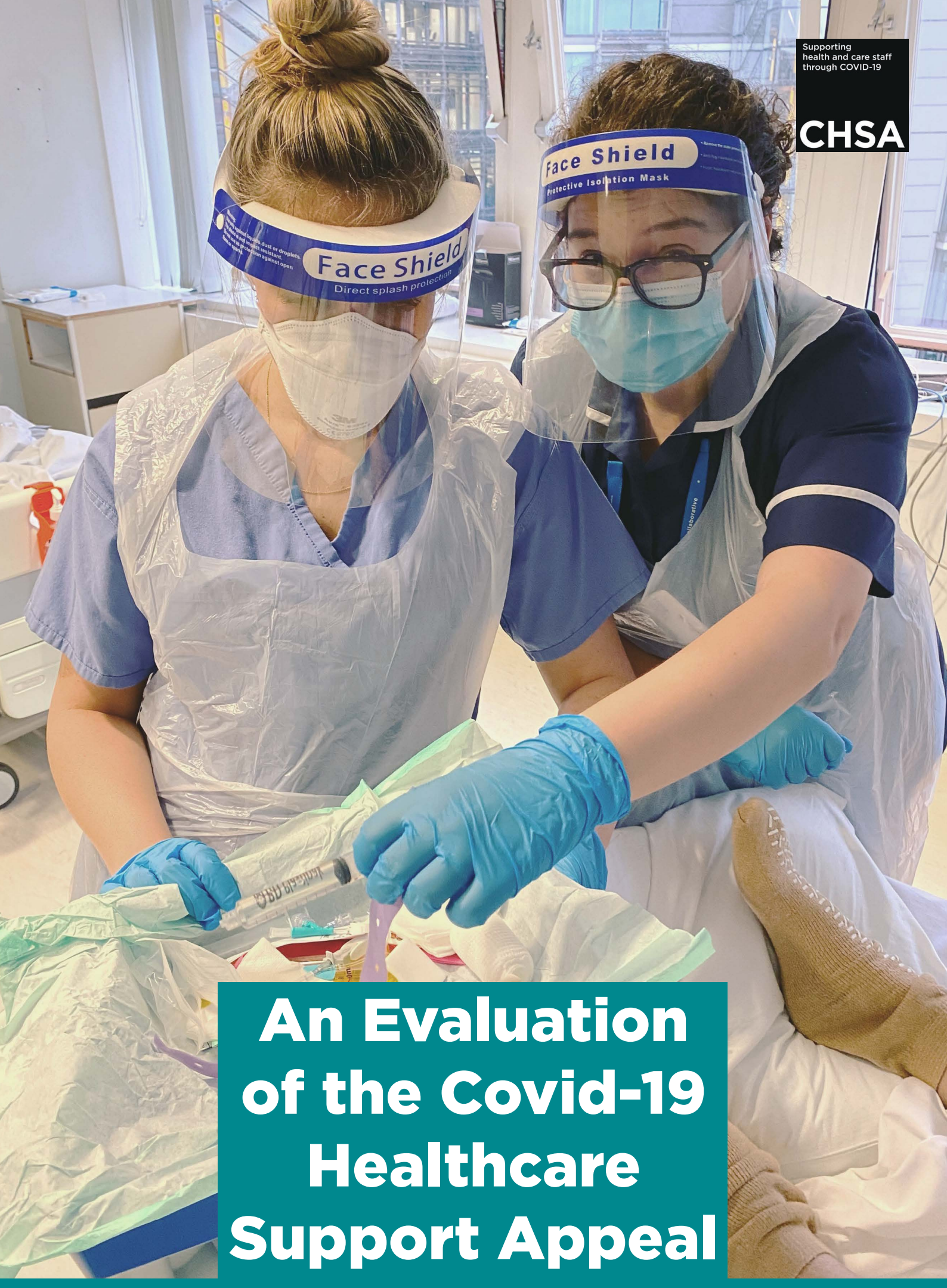

Supporting
health and care staff
through COVID-19

CHSA

An Evaluation of the Covid-19 Healthcare Support Appeal


OPERATING INSTRUCTIONS
FULPMATIC ULTIMA
BEWARE OF VERY HOT WATER
Maximum number of staff working in this area
2
SYNERGYLMS

Contents

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Special Thanks
CHSA would like to extend a very special thanks to TikTok, without whose generous donation this work would not have been possible.

Executive Summary

The Covid-19 Healthcare Support Appeal (CHSA) delivered against its objectives during the Covid emergency to ensure that:

- Psychological support grants awarded did help to reduce the psychological impact of the pandemic.
- Recovery and resilience grants awarded did help to strengthen the workforce, improve leadership and bring about positive change across the sector.
- Emergency aid and hardship grants awarded did relieve the financial pressures that healthcare workers were experiencing during the pandemic.

Across all areas of work, fewer than the targeted proportions of beneficiaries were from Northern Ireland. The Hardship grants exceeded their targeted beneficiary ratio for engaging individuals from an ethnic minority background. In both the Recovery and Resilience and Psychological Support grant areas the beneficiary proportions of individuals from an ethnic minority background were less than targeted.
CHSA's approach provided an effective model for delivering funding to funded organisations in ways that reach beneficiaries.

The effectiveness was drawn from the whole staff and trustee team's emphasis on:

- Speed of decision making and responsiveness to change.
- The proactive search for potentially effective partners.
- Willingness to take a risk with emerging organisations showing signs of success.
- Clear grant criteria.
- Simplified application processes.
- Forums to connect delivery partners.
- An engaged grant officer who balanced collaborative leadership with hands off engagement with funded organisations.
- Delivery messages for speedy response and to encourage effective reach among target groups:
- Make use of organisations that are already in contact with the target groups you wish to reach.
- Ask for and listen to feedback early. Respond promptly to adapt delivery to meet emerging needs.
- Include target group members where possible within the delivery team. Include target group images in communications.
- Where there is stigma, word of mouth can be a useful means to encourage engagement.
- Make use of non-employer organisations to encourage engagement in psychological support.

While these are the headlines, this report explores what the funded projects did to reach key target groups and what CHSA did to help them do that.

Implications and questions about approaches for funders wishing to best support delivery are explored.

Introduction

The COVID-19 Healthcare Support Appeal (CHSA) was set up as a time-limited charity in 2020. It has made grants to organisations supporting health and care staff who have been adversely affected by the COVID-19 pandemic, focusing on hardship, psychological support and resilience and recovery. Its work has been enabled through a donation of £5 million from the global video sharing company TikTok.

This report commissioned in July 2022 and reporting in December 2022, explores the learning arising from CHSA's operation to deliver grant funding to target groups during the pandemic.

Background to CHSA and its charitable objectives

CHSA was registered as a charity on 20 April 2020 and registered as a company limited by guarantee on 3 April 2020. The RCN Foundation is its sole member.

The objectives of CHSA are:

- the relief of suffering, poverty, hardship and distress among nurses and other health and social care workers and their families and dependants.
- the protection of the physical and mental health of nurses and other health and social care workers and their families and dependants.

CHSA is unique in its reach and ambition. It helps to support the whole spectrum of health and social care workers, from doctors and nurses to hospital porters, administrative staff, social workers, ambulance and care home staff, health care assistants, physiotherapists, radiographers, housekeepers and community workers.

The charity is a subsidiary of the RCN Foundation. The RCN Foundation facilitated the donation from TikTok and set up the charity.

When the pandemic hit, a group of stakeholders from across the health and care sector quickly came together in May 2020 to help map the sector and identify urgent needs caused by COVID-19. This research informed priority areas for grant-making for CHSA as well as providing geographical and demographic targets to work towards.

A key objective has been to reach those most in need and disproportionately affected by COVID-19, including, but not limited to, those within lower salary bands, people from an ethnic minority background, or people in vulnerable groups with an underlying health condition.

Grant applications have been received and considered on a rolling basis and the Board meets regularly to review them, being fully aware of the need to respond quickly so that recipient organisations can meet urgent need.

Grant priority areas

CHSA has provided grants to organisations supporting health and social care workers across the UK under three themes:

"Frontline health and care staff are at the forefront of the fight against COVID-19 and for many, this presented unexpected challenges in making ends meet."

a) Emergency aid and hardship

Frontline health and care staff are at the forefront of the fight against COVID-19 and for many, this presented unexpected challenges in making ends meet.
Grants were made to organisations whose beneficiaries were experiencing financial hardship as a result of COVID-19. Funding was awarded to help in a number of ways including:

- living costs for those unable to work if they were self-isolating, particularly those on zero hours contracts
- living costs for those whose financial situation had been directly impacted as a result of the virus, including as a result of Long-COVID
- financial support for families of health and care staff who have died from COVID-19 to pay for funeral costs.

b) Psychological support

The impact of COVID-19 on the mental health of health and social care staff is profound. CHSA funded projects that offered tailored psychological support to those who were experiencing the traumatic effects of working on the frontline.

c) Recovery and resilience

CHSA Trustees recognised that the pandemic would have a long-term impact on the health and social care workforce and that new ways of working and projects for recovery were vital. They therefore agreed to support evidence-based projects that aimed to strengthen the workforce and bring about positive change across the sector, including through better leadership and peer-to-peer support.

Grant-making

At the start of its operations in April 2020, CHSA had a total of £4,875,000 available for grant making.

In total since the charity began its grant-making activities, CHSA has now made grants to 30 organisations working across the health and social care sectors totalling £4,867,447.

Evaluation purpose and methods

Scope of the work

CHSA's team aimed for this work to identify whether CHSA had delivered on its core objectives and what were the lessons learned for:

- Deliverers about reaching target groups.
- Funders.

See Appendix C for details of the formal scope description and its development.

Methods

Data sources

CHSA monitoring data provided a key source of data for analysis of target group reach. Forty semi structured interviews were conducted with funded organisations, CHSA Trustees and CHSA grant team members.

Analysis

CHSA monitoring data generated pictures of the reach and engagement levels overall and among target groups.

The purpose of the interviews with funded organisations and CHSA's grant team was to draw out the experience of the participants, lessons they had learned and methods they had deployed. The interviews formed a key data source to help understand the picture of reach described within the quantitative monitoring data.

A framework analysis was undertaken to understand lessons relating to reach, access, benefits, costs, hinderances and helps in the delivery of the work. A separate framework analysis was undertaken to explore the funded organisations experience of the behaviour and processes deployed by CHSA.

A constant comparative analysis was undertaken to explore areas of convergence, divergence and silence in the outcomes from the organisations.

Organisations participating the interviews

All funded organisations were invited to participate. The organisations that consented to participate were:

- Body and Soul (B&S)
- British Association of Social Workers (BASW)
- British Medical Association (BMA)
- Care Workers Charity (CWC)
- Cavell Nurses' Trust (CNT)
- Central and North West London Foundation Trust (CNWL)
- College of Paramedics (CoP)
- Doctors in Distress (DID)
- Frontline 19 (F19)
- Hospice UK (HUK)
- Hospital Consultants and Specialists Association (HCSA)
- Institute of Health Visiting (IHV)
- Intensive Care Society (ICS)
- Listen Up Storytelling (LUS)
- Nurse Lifeline (NL)
- Prison Officers Association Welfare (POA)
- The Queen's Nursing Institute (QNI)
- The Queen's Nursing Institute Scotland (QNIS)
- Royal College of General Practitioners (RCGP)
- Royal College of Nursing
- Royal College of Nursing Foundation (RCNF)
- Royal College of Occupational Therapists (RCOT)
- The Ambulance Service Chasity (TASC)
- There for You - Unison (TFY)

We are very grateful for their time and thoughtful insights. Thank you.

Summary of achievements

We have drawn on CHSA monitoring data together with our discussions with funded project delivery teams to form the following conclusions.

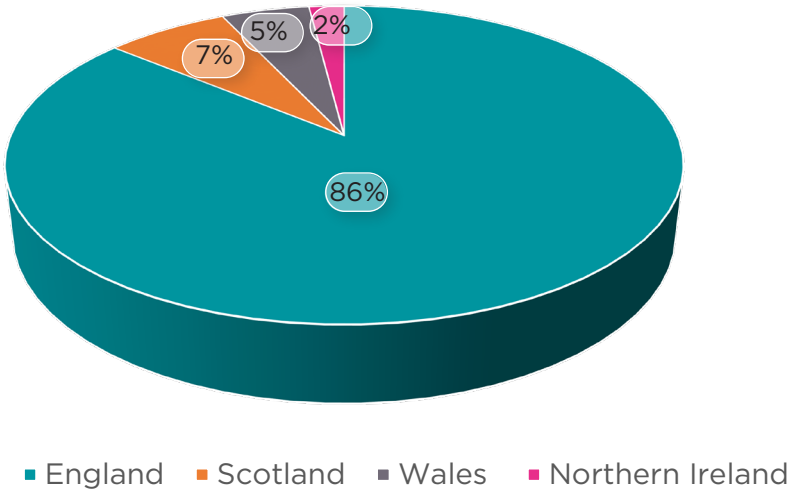
In overall terms CHSA delivered against its objectives to ensure that:

- Psychological support grants awarded did help to reduce the psychological impact of the pandemic.
- Recovery and resilience grants awarded did help to strengthen the workforce, improve leadership and bring about positive change across the sector.
- Emergency aid and hardship grants awarded did relieve the financial pressures that healthcare workers were experiencing during the pandemic.
- CHSA was close to its grant giving targets around:
  Ethnicity; there were 10852 beneficiaries. Made up of:
  - 4284 who benefited from the Hardship grant work.
  - 5587 who benefited from Psychological Support.
  - 981 who benefited from the Recovery grant area.

There were differences between CHSA grant giving targets and actual grant beneficiaries around:

- Countries (England received 8% more than targeted; Wales 20% more; Northern Ireland 50% less and Scotland 20% less).

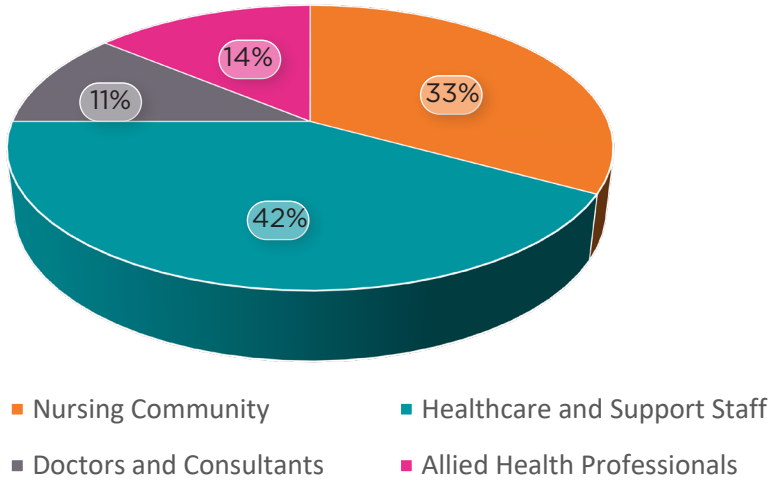
Figure 1. UK Countries Actual %



"The grant giving was split between the independent sector and the NHS."

- Professions (20% more than targeted Health Care and Support staff received support; roughly 30% fewer than targeted Doctors and Consultants benefitted).

Figure 2. Professions Actual %



- Pay grades (90% of beneficiaries were at Pay Band 6 or less. The target was 80%).

The grant giving was split between the independent sector and the NHS. No target was set for the desired ratio of beneficiaries and the monitoring data is very patchily reported and we should be cautious about drawing conclusions about who was supported.

However, from the data that is reported:

- Overall, the ratio of grant beneficiaries for the NHS : Independent sector was (61%:39%)
- Hardship grant beneficiary ratio was (52%:48%)
- Psychological Support beneficiary ratio was (69%:31%)
- Recovery and resilience beneficiary ratio was (93%:7%)

There were differences in the way CHSA's objectives were met within the different streams of work. Hardship, Psychological Support and Recovery and resilience grants differed in how far they reached each group (Ethnicity; Professions; Countries).

These differences will be unpicked and lessons learned explored in the next sections.

Lessons for impact (engagement and reach)

In this section we will draw out lessons from each the three areas of grant giving. Each section begins with a summary of who was reached and goes on to explore what the funded organisations did well that others may wish to pay attention to and what they learned about trying to reach the target groups.

Psychological Support grants

Grant giving in this area helped to reduce the psychological impact of the pandemic for 5587 people.

The grants reached:

- (Countries) Only 25% of the beneficiaries targeted for Northern Ireland.
- (Ethnicity) ~25% fewer than targeted beneficiaries from an ethnic minority background.
- (Pay Band) Pay band data was too weak to be useful in this area.
- (Professional groups) 60% more Allied Professionals, 40% more Doctors and Consultants and 40% fewer Healthcare and Support staff beneficiaries than targeted.

Figure 3. UK Countries Actual %

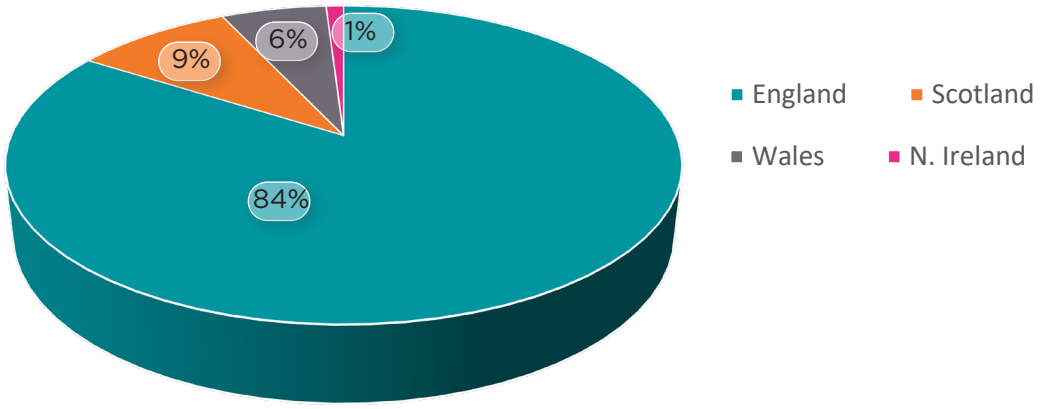
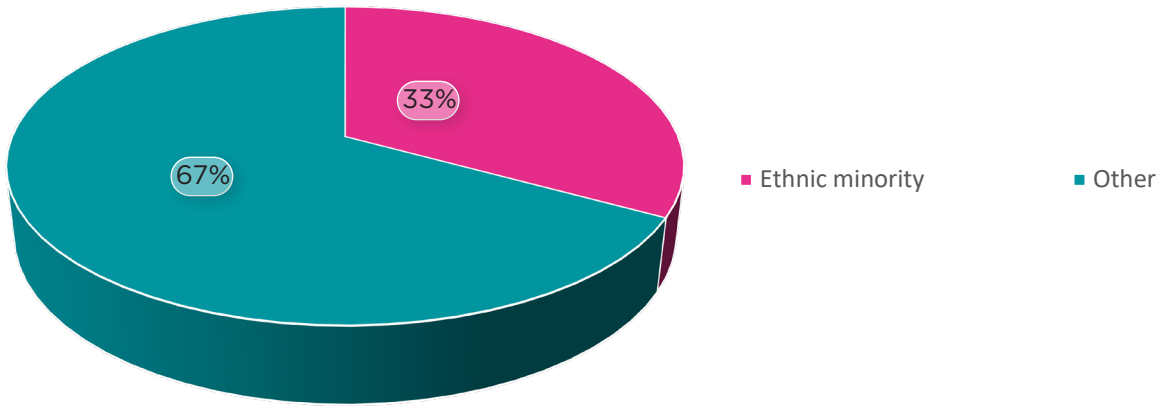
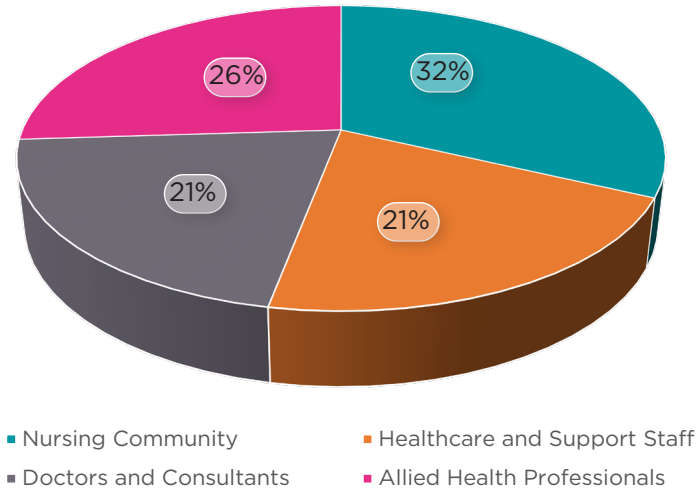


Figure 4. Ethnicity Actual %



"There were 5587 people who benefited from Psychological Support. Roughly 30% benefitted through the work of Frontline19 and just under 20% through Body & Soul."

Figure 5. Professions Actual %



What lessons are there for the delivery of Psychological Support grants? Who was funded?

There were 5587 people who benefited from Psychological Support. Roughly 30% benefitted through the work of Frontline19 and just under 20% through Body & Soul. What were their organisational characteristics and grant delivery experience?
CHSA selected two big volume deliverers for Psychological Support, one was a start up CHSA took a risk to fund after rejecting them initially. The other was an established organisation but which had been working hand to mouth within the third sector.

The start up, Frontline19, was new to grants had virtually no history. CHSA's team started to hear good things as their delivery method matured and it started to receive attention. CHSA then provided funding to help them scale up (and so speed up) their delivery enormously.

The other organisation, Body and Soul, was not new, and were experienced in surviving a hand to mouth third sector existence. They did have a track record of engagement with target groups and had been developing new communication routes as well as using new processes for engaging the help of relevant partners to facilitate access to a wider range of target groups.

Body and Soul was particularly successful in reaching independent sector beneficiaries. Data from Frontline19 on this matter is less reliable as anonymity was prioritised over data collection. From the data available, the suggestion is that about one quarter of Frontline19 beneficiaries were from the independent sector.

What did they do well?

Flexibility to develop delivery modes that beneficiaries would find acceptable:

"We developed two types of service. Half sessions as many times as possible to offload, not unpack. Then people could ask for a short course of therapy."
(Body and Soul).

"Two thirds of our funds were spent on low cost therapy. The rest paid for administration and promotion."
(Body and Soul).

"Many of the therapeutic supports available to paramedics and those in the ambulance sector have traditionally been based upon a one-to-one therapeutic model. Whilst we know that this is very beneficial for many people, others prefer more practical therapies that encourage expression. For our project, we wanted to widen the modalities of therapy available. Funding from CHSA has allowed us to provide outdoor therapies and supports such as wellness walks facilitated by mental health trained instructors, and skills courses - which allow members to learn the skills they need to keep themselves safe whilst hiking - thereby giving them a positive coping strategy. We also held a two-day psychological wellbeing retreat - enabling members the time and space to take a breather and take time out from their daily lives, and have access to coaching, counselling, mindfulness and yoga whilst in a beautiful setting."
(College of Paramedics).

"[We developed a] digital platform to combat covid constraints in a way that would enable good reach for peer to peer coaches. We got good representation from those using service."
(British Association of Social Workers).

Ensuring the content was linked to practical examples:

"Finding time to ensure we have enough focus in our [online] inputs to ensure there is a strong practical link to the workplace; We have learned that doctors will want to be practical and sometimes quite technical."
(Hospital Consultants and Specialists Association).

For example: *"Speakers … help develop the content. For example for a recent webinar developed on neurodiversity we had two leading presenters from Herriot Watt university who knew a lot about this; they brought great material. I then went to speak to other colleagues to bring in real examples from our regional rep's experiences of helping people with neuro-diversity in the workplace. Sometimes we have to tease the relevance out on the night."*
(Hospital Consultants and Specialists Association).


Formula
theatre packs
Store Room

Being separate from Employer offered support:
Often people are directed to their employer's assistance programmes whereas maybe this is not always the best approach to provide psychological support to a workforce. Peer to peer, volunteer support (separate from employer offered support) was seen as acceptable to the Nurse Community:

"Most nurses and midwives even though they have employer support in their place of work, they don't want to use it as they don't want to be seen to be using it. The Nurse Lifeline is completely separate from their place of work."
(Nurse Lifeline).

"What was different was they were not in our organisations. 'Talk to us' was used by people that did not want to talk to people based in their own trust."
(The Queen's Nursing Institute).

Peer to peer support through anonymous listening:

"Set up peer to peer support. Email on a dedicated site and a nurse would ring back. Some then signposted to grant manager. Offered emotional support. The structure was to ring every week … volunteers to do it."
(The Queen's Nursing Institute).

"And also manned by volunteers that have been there before who can say 'I have done that before and I know others who have done it'. It calms them down – for example if they have given the wrong medication to someone. Another person had been bullied and was on the fence about reporting it. The volunteer said next to nothing as the caller was speaking out loud about the scenarios and weighing it up out loud and came to a decision themselves while the person was listening. We are not just a generic helpline. The value in peer to peer comes through in the feedback we have had."
(Nurse Lifeline).

Therapist support online or over the phone:

"The volunteer therapists are all qualified and insured and dedicate one hour a week to help a health worker. As soon as they pass they checks they get some training if they need it, paid for by CHSA, from specialist trauma therapist so they are well trained. We support with paperwork and background."
(Frontline19).

"We delivered everything online or over the phone … our members were able to access trauma therapy at a time of pandemic."
(RCN).

Using mainstream media to gather volunteer resources that could help meet needs:

"Some therapists came to volunteer and I used PR on TV and newspapers and people came to me."
(Frontline19).

"Being able to refer is a bit of a god send. If you are looking for psychological support but also need hardship support [being able to refer someone on] is a great thing."

Developing marketing in line with evolving capacity:

"[The grant] meant we could train more nurses in the team so that we could truly advertise the service. We had been concerned that we would have too much demand. But now we could be more intentional about advertising."
(The Queen's Nursing Institute).

Being flexible and creative to find and retain volunteers:

Being overwhelmed by the demand from the Nurse Community was a risk until enough peer volunteers could be recruited and retained. Newly retired nurses became a critical resource:

"We found retention was difficult as some volunteers needed to stop. So we revisited the idea of newly retired nurses and midwives. Newly or partially retired in the last 5 years (up to date still with systems and language and terminology still). They did not have to on the register so long as they signed to say [they stopped working] because they have retired not some for professional standards reasons. Our volunteer pool now seems steady. Retention had been the issue. Not now through the use of recently retired."
(Nurse Lifeline).

Developing approaches and marketing using customer relationship data to identify gaps and needs:

"CHSA enabled us to have the Customer Relationship Management (CRM) process so we could collect the data. I can't tell you how effective that has been! We had funding to design the CRM. We have a huge amount of sensitive data. We keep this off line safely. We could analyse the data."
(Frontline19).

"It came along with HCSA transitioning to using new CRM and campaigning tools. There has been lots of use of these to help engage with people in this project. In particular, we are able to tailor comms better; receive feedback from our members better; we have used these tools to help collect feedback from people on these sessions."
(Hospital Consultants and Specialists Association).

Connecting with the wider system:

Some made good use of other grant funded organisations within the system to help deepen the impact for beneficiaries by enabling the access to different types of provision. For example,

"In the initial phases of the project, we ran two peer support groups through the charity, Doctors in Distress" (College of Paramedics); and, "Being able to refer is a bit of a god send. If you are looking for psychological support but also need hardship support [being able to refer someone on] is a great thing."
(Body and Soul).

"I talked to doctors in distress all the time. Really useful to get connected with others. THe RCN Foundation have a strong voice."
(Frontline19).

"Where people were not suitable for trauma therapy we were able to signpost to regular therapy. Referring on to other agencies." (RCN).

Developing mental health resources for use by the membership themselves was sometimes a new departure:

"Filling a learning gap, providing something aimed at members. It was nice to do something catered to them and how the pandemic was affecting them. We produced two eLearning courses, a podcast and webcasts, webinar, a module on best practice for remote learning, podcasts and other modules focussed on GP well being."
(Royal College of General Practitioners).

Re-focussing on *"Video counselling, telephone counselling and online CBT"* and away from face to face counselling. (British Medical Association).

What were the successes in reaching these groups?

Gatekeepers and access:

In many settings getting access to staff was through a gate keeper and often *"entirely to do with individual personal relationships"*. For example, with *"a manager in A&E – we got referrals once we'd struck up relationship."* (Body and Soul).

Some ideas were tried usefully to reach staff in Care Homes:

"We launched care couriers on bikes to-do welfare checks around London. They took things into care homes. Very local and small scale."
(Body and Soul).

"We started doing group work in hospitals and care homes. That meant that people who wouldn't come [normally] would see what it looked like and build up trust. 60% of people we worked with would identify as something other than white. Pushing 50% of people mention poverty as well."
(Body and Soul).

Communications to engage:

Using ambassadors to understand issues and to explore how to engage different groups:

"[We developed] Ambassadors who had difficult conversations and opening things up to see where we were hitting the mark and where we were not. Most of the people were white initially. So we had the hard conversations. I wanted people who understood healthcare. We needed people as ambassadors who within the health service and also people who were representative of those who were not coming forward. Largely we wanted people that were not white women. We had groups to talk about their experiences to understand what stopped people seeking support. We used that to help them to have conversations with others to understand how they were experiencing things and to share understanding of the service. Using face to face [conversations] and on social media. They talk to their peers and feedback to us. We have six ambassadors doing this officially but we also have lots of referrals from word of mouth. [They are an] eye doctor, a community nurse, an ambulance technician; people up and down the country."
(Frontline19).

Finding distinctive communication forms was recognised as a challenge.

"[The] hardest thing was standing out against the plethora of offers. Lots of people were not paying attention for their own self protection."
(Intensive Care Society).

"The NHS might be baffled but see you are trying to help. A care agency will treat you like scum, [asking] what are you trying to sell?"

Some people expanded their work through word of mouth (Body and Soul, Frontline19, TASC, ICS, RCN).

Others spent time usefully improving the inclusivity of the messaging in website (language, diversity in images):

"*Increased awareness of what we do among target group. Really helped us – taking it to another level.*"
(TASC).

Others used their existing connections with organisations:
"Biggest thing that helped was me pushing things through other organisations"; *"Work in partnership: Speakers take a role in promotion."*
(Hospital Consultants and Specialists Association).

Social media played a role and using but *"not relying on Twitter – nurses prefer Facebook."* (ICS).

Where funded bodies were targeting their members, they reached out directly using existing internal communications routes.

"We had GPs predominantly accessing [the resources]. Our eLearning site is aimed at GPs. We couldn't focus more to other groups. Mainly GPs in England."
(Royal College of General Practitioners).

"Promotion of the service was very high during the pandemic. Internally comms was on board. This raised the profile of the service considerably and increased calls to it."
(British Medical Association).

"We did really well … We were lucky as we have access to member databases. Particularly for the independent sector and overseas nurses … Amazing marketing support – direct emails, social media. We worked with the independent sector branch to deliver webinars. Direct emailing to members was the most successful out of all of them."
(RCN).

"Diverse groups of [hospital consultants and specialists] attending – not the same people turning up every time. It was good to reach out to members we might not otherwise have had a lot to do with. That has been good … Facebook and Twitter are big channels for us. Twitter is good for engagement as speakers will advertise there and engage there. LinkedIn is good too for speakers and potential speakers and participants (popular with academic doctors)."
(Hospital Consultants and Specialists Association).

Using their own members to reach non-members:
"Nurses in our networks are telling others that are not in our network to distribute info to others."
(The Queen's Nursing Institute).

Using data to identify gaps and needs. Action was then taken to understand how to address those needs. That information was used to appropriately design communications and messages:

"CRM helped as we knew that men and non gender specific individuals were not seeking support so we recruited ambassadors locally to encourage engagement. Similarly with BIPOC people. The CRM data supported our TV campaign to get the right people represented. Long term this will be the foundation to do specific work looking at frontline workers, their family and their children. It gives us the data that helps with spreading understanding and messages to the mainstream media."
(Frontline19).

What were the failures in reaching these groups?

Gatekeeping within the NHS was contrasted with the Care Home environment.

"The NHS might be baffled but see you are trying to help. A care agency will treat you like scum, [asking] what are you trying to sell?"
(Body and Soul).

Some engagement methods had unpredictable or intermittent success,

"[I was] delivering flyers to hospital. I delivered flyers to a hospital and got load of bookings that day. The next day, hardly any, then none."
(Body and Soul).

Data on missed calls suggested an opportunity to connect with the Nursing Community during a particular time window:

"Missed calls to the service are from 4-7pm. There is a period of time where we suspect people are going onto or off shift where people want to get something of their chest before they go in or off home to the madness of home. This is a noticeable thing. When we are in a position to we will open the lines to cover that period."
(Nurse Lifeline).

Face to Face counselling did not have expected demand:

"We were disappointed that face to face uptake wasn't higher. Always wanted to offer this option but couldn't do it financially. People did use it, but we had hoped to help more people with this offer. If it'd been offered outside of a pandemic (lockdowns etc.), we expect uptake would have been higher"; "video counselling and telephone counselling" were preferred over face to face."
(British Medical Association).

Some were regretful that though they did well in reaching the Nursing staff in the Independent sector because it is a *"vast industry"* with many different organisations, it remains difficult to engage (RCN).

Stigma about accessing Mental Health support was suggested as part of the explanation for lower psychological support participation rates among individuals from an ethnic minority background. Useful methods to encourage engagement for trauma counselling included *"direct emails, webinars and posts [and] especially word of mouth"* (RCN).


EMERGENCY
AMBULANCE
1624

What sustains and what was the legacy?

Legacy

Nurse Lifeline:	*"Now we have a solid pool of volunteers to deliver the work as we grow and want to reach more people our strategy will be to reach out to all trusts and nurses and military and the prison service to reach all those we could".*
Body and Soul:	"The RCN as an organisation, they are totemic. To have that as an endorsement is powerful. Felt like a great endorsement of what we were doing … Collaboration and partnerships too. If you are the person there to catch the director of an NHS teaching trust it creates powerful relationships. We have developed great partnerships off the back of that".
The Queen's Nursing Institute:	*"We believe that after the call we are making a difference to retention of nurses in the workforce. Nurses are saying 'I feel like I can go to work tomorrow'. We feel like we are playing a significant part in that".*
Royal College of General Practitioners	"Still running now. As part of grant there was a 12 month hosting fee. Free online for a year. Still there but only free to RGP members". British Medical Association: "It raised the profile of the service more widely … We're already doing video counselling and CBT and telephone counselling. We also learnt face to face is not something we would offer again".
College of Paramedics	*"Developing this project has allowed us to build up a network of specialist organisations that will allow us to move it forwards into the future. Within the profession, we are seeing evolution in terms of acknowledgement and understanding of the impact of mental health, and its vital importance in terms of the ambulance sector workforce. It is now high on the agenda of senior leaders".*
RCN:	"We were able to understand the membership and what have been through. Hearing that nurses have had it tough is one thing but experiencing it gives us knowledge. We have improved understanding of what members have gone through".
British Association of Social Workers:	*"There were reputational benefits – it's been well received. We can go out and say we received charitable funding. It has helped BASW with external relationships across the UK nations". Also, "We talked directly to a number of organisations. We met with doctors in distress to discuss delivering groups for social workers. There are potential collaborations and opportunities for working together. We learned about what worked in other places, particularly about access and communications building a shared understanding".*
Frontline19:	"I would like to meet with the RCN to share knowledge of the challenges and how we could collectively help the health care community to create positive long lasting change".
Nurse Lifeline:	*"Now we have a solid pool of volunteers to deliver the work as we grow and want to reach more people our strategy will be to reach out to all trusts and nurses and military and the prison service to reach all those we could".*
Hospital Consultants and Specialists Association:	"The grant empowered us – because we had secured the grant it forced us to do a series of things and to see this project through and turn it into something long lasting. We normally do one offs. So this has been a useful learning curve. We have learned a lot during this including setting up a well being steering group to assist us in getting the right topics on it"; "Another benefit is having built better relationships with Royal Colleges and others. In future we can deliver things better together"

"We will continue to run these into the new year. It is a positive experience that we would like to continue. I am hesitant to speak beyond the life of the funding."

Sustainability

Nurse Lifeline	*"Next we will reach out to health and well being coordinators to make the offer clearer. Already have a short intro video. Targeting is next and is starting to happen. We have been building up to the Nursing Times awards where we were the chosen charity partner. We see this as a huge opportunity to build funding beyond this grant so we needed to talk to potential sponsors."*
Body and Soul	"From a grant perspective – we have used the funding – so we are back to running on fumes. We are scraping by and will have to find funding elsewhere. We are involved in joint bid to DOH for support to social care. It is about creating a sustainable model of support for the sector."
The Queen's Nursing Institute	*"I am talking to NHS England and I'm talking to them about whether this model of anonymous listening can be used to encourage retention in the workforce and scale it up."*
College of Paramedics	"When the funding from CHSA comes to a close, we hope to continue the psychological wellbeing supports through other means as we see the value that this has brought to our members; substantiated by their positive feedback, and how the supports have been important in terms of addressing previously unmet psychological health needs."
Frontline19	*"Now on the cusp of getting more funding to sustain us for the next couple of years."*
Royal College of General	"Yes and No. Mental Health aspects are aimed at pandemic but could be applied more generally. May need to be rebranded from context of covid to post pandemic."
British Association of Social Workers	*"There is a sense of permanency embedding it into our core offer. The funding has enabled us to develop a sustainable footing. We have entered into contract with Scottish, Welsh and NI Social Work. This is a positive story for us. The funding gave us a kick start and confidence to build a service."*
RCN	"We are going to wind the project down and analyse the data and look at next steps… From a clinical perspective this was really valuable. The NHS should provide it. It is unusual for a union to provide this to get people back to what they love doing."
The Ambulance Charity	*"Funding options are being considered."*
Hospital Consultants and Specialists Association	"We will continue to run these into the new year. It is a positive experience that we would like to continue. I am hesitant to speak beyond the life of the funding. We will have established the skills and process and know how to do these. Whether we could do them with regularity this is much less certain."

What other ideas, learning and tips for funders emerged?

Recurring themes among the Nursing Community noted by some funded organisations were:

- **Staffing issues and pressures.**
- **People left in charge of wards with agency staff.**
- **Too much responsibility too soon for newly qualified staff.**
- **Can't provide the kind of care needed because of the staffing issues.**
- **Bullying and toxic environments, unsupportive management, no career progression.**
- **Patient related issues.**
- **Pressures at home adding on top.**
- **Emotional distress about not being able to do the job you are trained to do.**
- **Being a nurse facilitating a situation where loved ones are not able to be with the person dying.**
- **The rate at which people were dying**
- **Care home nurses and hospital nurses seeing huge numbers of people dying.**
- **Now there is a shortage of people as some decide to leave and those staying are seeing the work becoming less satisfying as the workforce depletes.**

Developing and maintaining connections with the wider system:

CHSA Network sessions were helpful for connections.

"[The Grants Officer] at CHSA connected us to other counselling services that we could and did signpost to them. These were really good." (QNI).

"A digital space – a space to throw ideas about; put ideas forward; share successes to share what works... A slack space or an email thread where people can check in or engage as much or as little as they want to. My generation who are quite IT heavy on education and in our personal lives we are ok with digital methods."
(Hospital Consultants and Specialists Association).

Furthering the project goals by making the most of the capabilities of partners:

"The lead organisation needs to keep prodding as everyone has competing priorities. This is a lesson for scoping projects and how we choose partners. Choose partners with time and who are communications big hitters"
(Hospital Consultants and Specialists Association).

"Be pushier with partners and hold each other to agreements. We could get more from partners and seek more from others that could help with promotion."
(Hospital Consultants and Specialists Association).

"There were 981 people who so far have benefited from the Recovery and resilience grant area. More than 50% have benefitted through the work of the Intensive Care Society."

Recovery and resilience grants

Grant giving in this area helped to strengthen 981 members of the workforce, improve leadership and bring about positive change across the sector.

The grants reached:

- (Countries) 70% more beneficiaries than targeted for Scotland, ~15% more for Wales, 50% fewer than targeted for Northern Ireland and 8% fewer for England.
- (Ethnicity) ~50% fewer than targeted beneficiaries from an ethnic minority background.
- (Pay Band) Pay band data was too weak to be useful in this area.
- (Professional groups) ~45% more Nursing Community staff beneficiaries than targeted, ~50% more Doctors and Consultants and ~60% fewer Healthcare and Support staff beneficiaries than targeted.

Figure 6. UK Countries Actual %

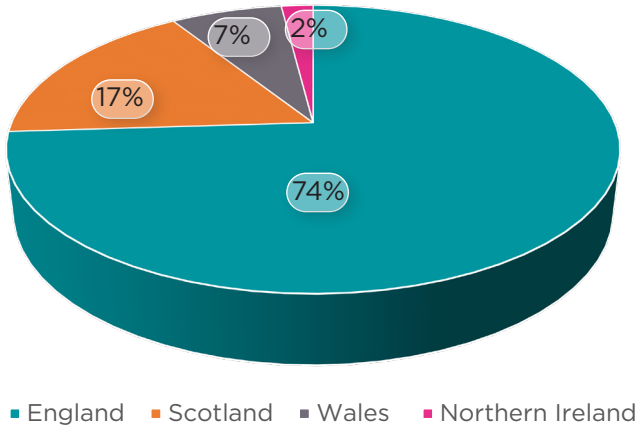


Figure 7. Ethnicity Actual %

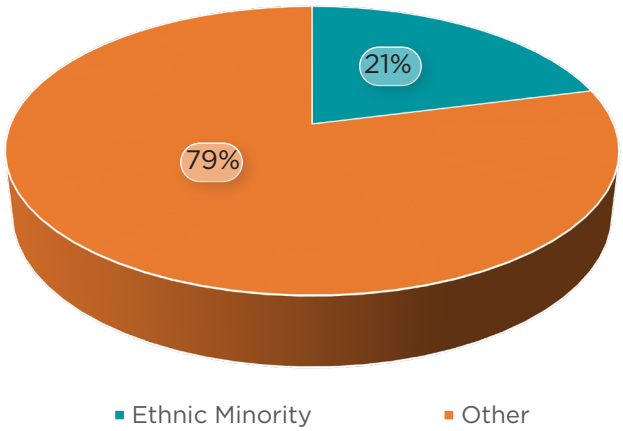
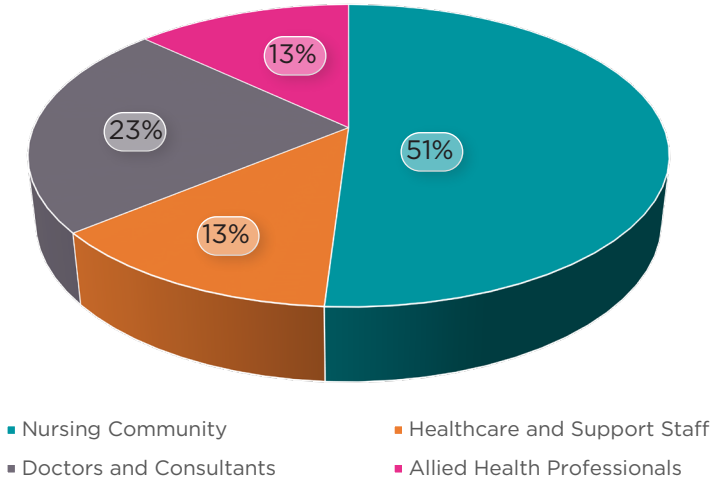


Figure 8. Percentages Actual %



What lessons are there for the delivery of Recovery and resilience grants? Who was funded?

There were 981 people who so far have benefited from the Recovery and resilience grant area. More than 50% have benefitted through the work of the Intensive Care Society.

What were their organisational characteristics and grant delivery experience?

CHSA selected placed its resources on the smallest funded area – Recovery and Resilience – across nine organisations. Two organisations received around a third of the funding – The Intensive Care Society and Hospice UK. The Intensive Care Society (ICS) was the biggest volume deliverer. The ICS is mature in terms of receiving grants. It had a pre-existing connectedness to the target group and it used a clearly articulated approach to deliver its work. There were clear pre-existing routes for communication in place at the beginning of the grant.

Significant volumes of beneficiaries were delivered from some of those receiving smaller levels of grant funding in particular Listen Up Storytelling, CNWL Foundation Trust and Doctors in Distress.

The data is too incomplete to form conclusions about the proportions of beneficiaries from NHS or Independent sectors.

What did they do well?

Using the support, skills and connections of the wider team by having a well connected steering group:

"Helpful to have steering group meeting and use that as backbone to report. Timeline week by week. Able to bring in knowledge from steering group."
(Hospice UK).

"Have a stakeholder group from different societies kept me grounded."
(Intensive Care Society).

Having a tried and tested methodology:

"We knew the process and had tried and tested methodology. The programmes ran for 12-18 weeks."
(Doctors in Distress).

Doing more to ensure beneficiaries maintained their connections with each other:

"We ran some extra groups as people wanted to stay in touch."
(Doctors in Distress).

Going beyond resource development to ensure beneficiaries received the input:

"We provided Training [as well as] videos around wellbeing. We didn't want to be another wellbeing resource."
(The Queen's Nursing Institute Scotland).

Providing an offer that was visibly separate from employer offers encouraged engagement:

"Employers were supplying wellbeing along with people asking to do more. [There was] something about the independence of what we were offering."
(The Queen's Nursing Institute Scotland).

Delivering whilst not being able to meet face to face:

"In beginning online it was online. Does work" (CNWL Foundation Trust); "not expert led and hope that will continue to ripple made us see the power of those practices. Made us realise value of online resources."
(The Queen's Nursing Institute Scotland).

Building stronger connections to deliver jointly with other charities:

"Working collaboratively with other charities. Huge opportunity for us. Had good working relationship but grant gave shared purpose."
(The Queen's Nursing Institute Scotland).

Enabling people to find space for themselves:

"It is still really difficult for people to take out half an hour to do something for themselves."
(Listen up Storytelling).

Helping teams to care more effectively for each other:

"One Health visitor is rolling this out with her teams and she is seeing differences in how their teams are doing self care eg a check in in the morning to see how they are working and take time out at lunch time. They will challenge each other more now as they have a safer space. The first half of the resource is about getting to know each other and then about how to ask questions and raise issues in a good way. This is the impact we want. This relieves stress and it helps people to work better together as they begin to be able to say more difficult things to each other. They begin to be able to tell their own stories to each other."
(Listen up Storytelling)

"Help teams put themselves back together again. Covid was massive for people who still had to go into hospitals. Create a common narrative."
(CNWL Foundation Trust).

"They don't have time or cash. Nurses and Health Professionals don't have time for training. They need [something] available without flooding them with it."

Bringing in peer support to enable ongoing support within teams:

"Thing that worked really well was peer support, we trained group of staff from ICUs, last one last week. Trained to go back to own unit. Mixed up units so created community of story sharing across intensive care."
(Intensive Care Society).

Having time to develop and evolve the offer is important to creating effective, relevant delivery:

"Because had two years, we have maintained and evolved in offer. A lot of things were set up in sept 2020 – but evolution is key."
(Intensive Care Society).

"In order to develop we needed to have space for research and development."
(CNWL Foundation Trust).

What were the successes in reaching these groups?
Communication:

1. Deliberate actions to create communities of interest were deployed, especially with the Nursing Community:

   "A WhatsApp group did come about – we enabled it. Instagram. Lots of people use Facebook." (DID).

2. Using partner organisations existing communication methods alongside social media and word of mouth to get messages out successfully:

   "Massive engagement with peer support and leadership. Biggest thing that helped was me pushing things through other organisations and twitter and word of mouth"
   (ICS);

   "Support from steering group was important to connect more widely."
   (HospiceUK).

3. "Nurses prefer Facebook" (ICS).

4. Good access to the target group through pre-existing membership (Institute for Health Visiting).

Understanding the target group's likely constraints on participation was important in designing the approach offered:

One organisation highlighted the pressures on their Nursing and Healthcare Professional target group:

"They don't have time or cash. Nurses and Health Professionals don't have time for training. They need [something] available without flooding them with it"
(ICS).

Th CHSA grant meant they could respond to the financial aspect of that constraint:

"Free - Biggest thing that enabled that … CHSA meant we didn't have to charge". They were then able to design their approach recognising the time constraints.

Providing whole team interventions can engage everyone across ethnic groups, pay bands and professional groups:

"Something that puts team members in touch with each other"
(CNWL Foundation Trust).

It can take a lot of work and time to set up such interventions.

Being flexible about whole team interventions:

"Some struggled with teams not finding 15 mins to sit down together eg people being pulled away. It is part of the facilitation training that you don't need the whole team there to do this work."
(Listen up Storytelling).

Online delivery can work to enable the inclusion geographically remote participants. Face to face meet ups are valued as part of this:

"In Scotland inclusion issues are often about geography. We worked hard to make sure we delivered online and did have nurses in the Islands and remote communities. We brought them together once, supported them with their travel as this supported equity."
(QNIS).

Key organisational leaders can be important to engage as programme beneficiaries even if they are not initially target group members. They can open doors and help engage others:

"We tried to get everywhere we set up a couple of groups to train Health Visitors to provide emotional wellbeing groups – role modelling and supervision. We wanted to have clinical HVs working at ground level, but found lot of service leads asked for places for themselves. [Our concern was] there were potentially conflicting time priorities for them. One of the pieces of learning was that they could influence the outcome in terms of rolling the programme onwards. It was a strength in the end."
(Institute for Health Visiting).

What were the failures in reaching these groups?

Communication:

1. Some system wide issues inhibited communication on well being matters.

   "There isn't a generic database of people who run wellbeing in trusts … Getting comms out was difficult. Not easy to communicate."
   (Doctors in Distress).

2. One of challenges was the pace:

   "had we had more time to do co-production and talk to them about what would make this more attractive to you the marketing would have looked different and have different uptake."
   (Institute of Health Visiting).

NHS working patterns presents a difficulty for designing approaches to involve the Nursing Community.

"The way of working in the NHS with 12 hour shifts, [it is] hard to give people the opportunity."
(Doctors in Distress).

"[It] felt important to be aware of pressures in sector, wearing PPE and caring for staff in the situations they work in. The way of caring was being taken away. It made more pressure."

Some felt delivery pressures from the outset from feeling unready to translate the idea into practice.

"Surprised we got funding, then we had to make it real. On paper we had a lead in time. Always a longer lead in time [would be useful], then a panic on have we got the right people. Don't always give enough time [to the set up]. We felt pressure at the beginning, a lot to set up in a pandemic."
(Hospice UK).

Working with whole teams meant managing lost sessions from teams who *"had an awayday booked then pulled out due to Covid"*. Also, the constraints arising from Covid meant *"lots of teams were short-staffed, and can't think about this". This meant that the project team needed to spend considerable time "to take it forward to convince others, then still a venue and catering needs organising."*
(CNWL Foundation Trust).

Others experienced Covid impacts on their staff *"[covid] affected our staff too"* (Hospice UK); *"Delivery was more challenging. Our vision was strong then we had staff affected by Covid and our capacity was compromised. Trickier than hoped to deliver on vision in timeframe due to sickness – covid/other long term conditions. High level of absence."*
(The Queen''s Nursing Institute Scotland).

Difficulties were cited in involving people in the Nursing Community from overseas with Asian backgrounds who also do not have English as a first language.

"How do we reach them?". The suggestion was that having a person on the delivery team from the same background would help with understanding needs and with engagement, "Probably need to get someone from their background to help."
(Doctors in Distress).

Individuals from an ethnic minority backgrounds were not always attracted:

"In the CHSA group we didn't attract any [individuals from an ethnic minority background] beneficiaries. Subsequently we have put on a session for social care and there have been more applications in that cohort."
(The Queen's Nursing Institute Scotland).

Recognising the pressures on the workforce meant their work was more difficult to recruit sensitively.

"[It] felt important to be aware of pressures in sector, wearing PPE and caring for staff in the situations they work in. The way of caring was being taken away. It made more pressure."
(Hospice UK).

There were hopes that once trained, facilitators would cascade their knowledge and capability within their regions. This seems not to have happened as expected.
"Thought facilitators would cascade the learning at regional level but …"
(Hospice UK).

What sustains and what was the legacy?

Legacy

Doctors in Distress:	*"Shift in focus: until CHSA we were all doctors. Opened door to work with nurses".*
Hospice UK:	"We became part of wider system through the pandemic … Became secondary arm of NHS, part of this about positive move". There is also a "legacy on the website" and "Organisations regionally have now got engagement with senior leadership team".
Institute of Health Visiting:	*"Outcomes show value of it. Continue to look for ways to take forward. Very positive experience building on previous work. Each project we learn from it – use Prince so log lessons learnt. Small incremental changes".*
The Queen's Nursing Institute Scotland:	"Working collaboratively with other charities. Huge opportunity for us. Had good working relationship but grant gave shared purpose. Working relationships for the future. Still working together – not quite finished. Will work together again", and "[We have] created videos of practices so they can be used more widely and shared with anyone. Ripple effect, powerful".
Intensive Care Society:	*"Shift in perception: Made people realise that problems are in across critical care – we are in it together – not just us here. More accepting of the situation, less angry with managers"; and changed how the society was seen, "it really pushed society forward in terms caring for the intensive care community. In every meeting people say it was a success. Primed it for perpetuity. Gave me a platform to speak out on behalf of people. To talk about working conditions and something beyond mindfulness and cake"; and with visible recognition, "Highly Commended in BMJ awards for 2021".*
CNWL Foundation Trust:	"This has become the only NHS team recovery package that is available to staff. This was team support and team development to provide support to each other. Enabling the team to take care of each other. It has been quite emotional for quite a lot of teams … teams have more effective functioning. We suspect there is an improvement to staff retention. Likely to be better working environment. Helping people to be compassionate to each other. Teams report benefitting in this way".


Queen's Nurse

Sustainability

Doctors in Distress	*"We still have programmes running. We are working with other funders to continue to provide. There is more funding for doctors but do now try to ensure some equilibrium."*
Hospice UK	"The model is championship and cascade. So there is learning in there. It will be sustainable if organisations wish it to be sustained. It is the decision of those involved"; "Theoretically sustainable. Reality is not possible to sustain the program without resources."
Institute of Health Visiting	*"Because of cost we have not managed to do anything since. We now have a programme that could be delivered. Think other orgs aren't in a position to commission. Can also learn from it. We have a bunch of HVs who are still cascading and shared the learning in journals. We haven't been able to keep running it. One of issues was facilitator left at end – still look to be able to do but would require a bit more funding."*
CNWL Foundation Trust	"So successful it is going to an ongoing offer. A post will be funded by Rehab. Putting forward money for one day a week to continue work. Teams will pay for it. Without grant wouldn't have this. The fact that it is going on feels important."
Listen up Story telling	*"CHSA could be very useful to promote the resource beyond just funding it. It is a free of charge resource. Not patented or copyrighted but I am running a business so what we have decided is to charge for the facilitation" and "We have already had some buy in from the NHS Lothian to send people to the training to facilitate this", and "It would be fantastic to have a big organisation to help us market that"*
The Queen's Nursing Institute Scotland	"We got further funding to continue. It's taken on a life of its own. CHSA has taken something small and grown it", and "What CHSA helped us recognise the need and get further funding [for] Nurses who worked in Social Care. We had two. Their experience highlighted need to do more and we have done subsequently"

What other ideas, learning and tips for funders emerged?

Volunteer facilitators: being flexible in the way the delivery method was deployed enabled new facilitators to engage more readily and become confident in using it in ways that would work with different groups.

"Adapting the model to different groups and facilitators having time to adapt. [Having] confidence in using the model and time to [build] that. [Being open to] people implementing parts of model and building up confidence. Include it in induction etc. talk about culture and change in culture."
(Hospice UK).

"Thank you so much. I cannot stress you how much this will help my family out! I am in tears. This was a beneficiary's response to receiving £500 for housing costs."

There are opportunities for CHSA to help to promote new resources now they have been built, for example, to further collaborate on the roll out using the trust's position to promote what has been created and ensure continuing impact (Listen up Storytelling).

Emergency Aid and Hardship grants

Grant giving in this area relieved the financial pressures that 4284 healthcare workers were experiencing during the pandemic.

The grants reached:

- (Countries) 12% more beneficiaries in England than targeted, with only 40% of the target reached for Scotland, 50% for Wales and 75% of Northern Ireland's targeted beneficiaries.
- (Ethnicity) ~20% more beneficiaries from an ethnic minority background than targeted.
- (Pay Band) 96% of beneficiaries were on Pay band 6 or below (target was 90%).
- (Professional groups) 66% were Health Care and Support staff – roughly 200% of the target. 32% were Nursing community staff as per the target and far fewer than targeted Allied Professionals 2% and Doctors and Consultants 0% as against a target of 15% each.

Figure 9. UK Countries Actual %

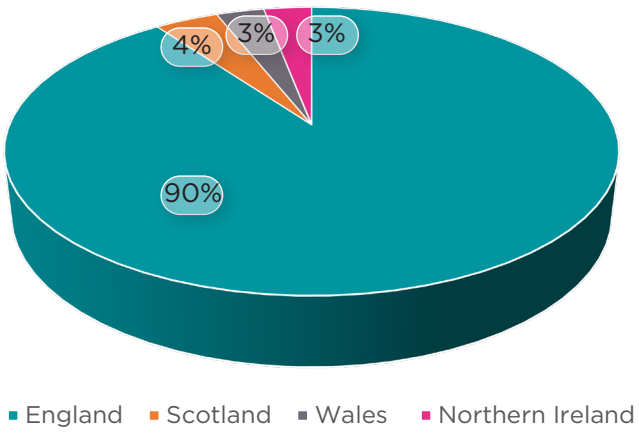


Figure 10. Ethnicity Actual %

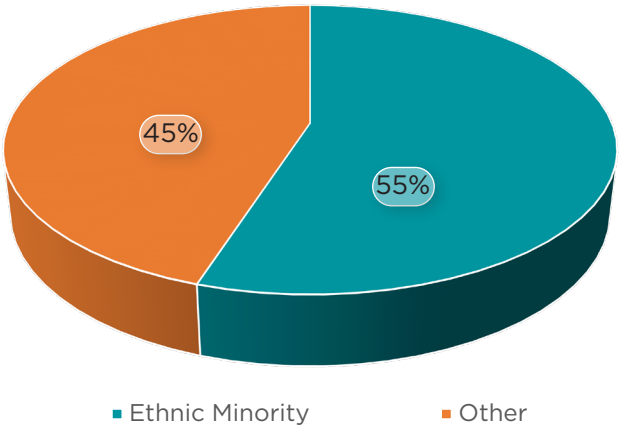
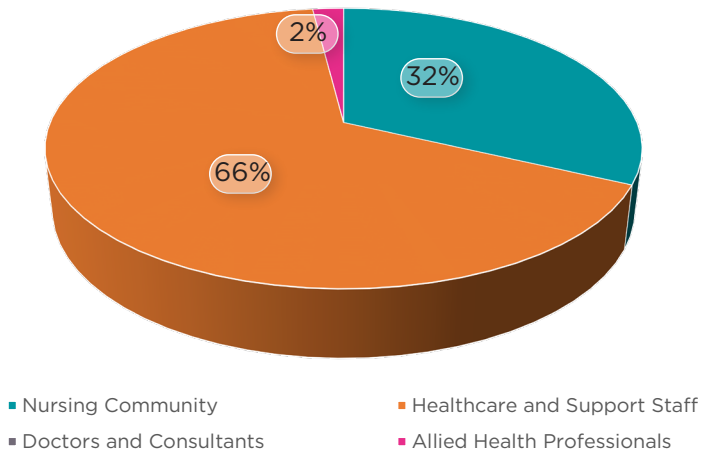


Figure 11. Professions Actual %



What lessons are there for the delivery of Emergency Aid and Hardship grants? Who was funded?

There were 4284 people who benefited from the Hardship grant work.

Three organisations delivered the vast majority of the benefits. Roughly one third benefitted through the work of the RCN Foundation, roughly 30% through the Care Workers Charity and roughly one third through Unison's There for You operation.

What were their organisational characteristics and grant delivery experience?

CHSA selected three big volume deliverers who were established organisations with experience of grant funding. They all had good existing access and connectedness to the desired target groups. They also began with a mature delivery format ie they had already established grant giving methods. Each had pre-existing communication routes. The three organisations that CHSA heavily funded, heavily delivered.

The Care Workers Charity reached into the independent sector. Both There for You Unison and the RCN Foundation beneficiaries were focused on NHS workers with one third or fewer in the independent sector.

What did they do well?

Grant giving methods:

Application forms were adapted to enable a simplified process for potential beneficiaries. Once applications were received, decision making speed was prioritised in order to allocate resources in as timely a manner as possible.

Online application forms were a cornerstone of speedy delivery.

"When we moved [the application process] inhouse we used an online form. We went to an online portal – an automated approach to meet eligibility criteria. CHSA showed us an online approach could work."
(RCN Foundation).

"The pandemic forced our hand to make things more electronic. This has been massively positive in terms of efficiency and speed."
(There for You – Unison).

"The most important thing is that we give an exceptional experience of working with us. This gets over the stigma. The people we support are our best advocates."

A structure of grant giving was put in place

For example, *"£500 for isolating individuals; travel expenses; bank staff with no sick pay; stranded abroad and needing to find a place to stay; shielding agency staff; 96% of successful applicants were awarded £500."*
(RCN Foundation).

"Offered between £200 and £2000 saw single mums who had to isolate, only on statutory sick pay or not if bank workers. If shielding for more than 12 weeks we would go to £2000."
(Care Workers Charity).

"Thank you so much. I cannot stress you how much this will help my family out! I am in tears'. This was [a beneficiary's response to receiving] £500 for housing costs."
(There for You – Unison).

"If £500 or less I could sign off. If more it would go to council. Nobody was turned down if they met criteria of financial difficulty."
(Royal College of Occupational Therapists).

Membership organisations felt trusted:

"Implicit trust as we are a membership organisation. This takes away a challenge that might be there if we were not."
(There for You – Unison).

Diverting Hardship resources to Recovery funds as it became clear that is where the demand was:

"Our initial focus was on covering peoples incomes. Though that wasn't an issue for us as it turned out. We used part of the hardship fund, but it was not really an issue as we persuaded the employers to continue to pay after their sick pay ran out and most of them did - on an individual basis rather than as a national agreement. Employers are not normally generous but in this particular case they were supportive and paid for vulnerable employees."
(Prisons Officers Association).

However they also found that their staff fitness requirements meant that returning fit enough to work was a major issue that required support:

"We ran out of recovery grant very quickly so we transferred money from the hardship grant to the other. It was a faffy process to make the transfer. We asked for more money for recovery than for hardship. Our staff have to do a fitness test so we thought recovery to a fit level would be even more important. A higher level of fitness is needed to be able to return to work."
(Prison Officers Association).

Example *"Our focus was on getting people back to work and getting them well. Some people were never going to be well enough eg one man in his 20-30s and had bad covid that had impacted on his heart permanently and cannot now work on the wards as it was too much of a risk and we have managed to get him redeployed."*
(Prison Officers Association); *"Example: cycling machines to build up their fitness".*

What were the successes in reaching these groups?

During the covid situation face to face support to potential applicants replaced by online and phone support.

The approach was particularly successful in reaching individuals from an ethnic minority background and people on Pay Bands 6 and below.

Communication:
Existing channels: There for You, Unison and the Care Workers Charity, communicated through existing channels though were constrained by Covid controls on the extent of face to face application support they could deliver. However newsletters to members, online and direct communications using existing channels were effective in reaching target groups,

"[We were] always emailing providers across the country."
(Care Workers Charity).

Word of mouth to overcome stigma:

"The most important thing is that we give the person that reaches to us an exceptional experience of working with us as that gives us the word of mouth for people to get help. This gets over the stigma. The people we support are our best advocates."
(Cavell Nurses Trust).

"85% of successful applicants were from ethnically diverse backgrounds. This reflects the demographic in the pay bands where there was most need" (RCN Foundation).
"We reached 86% of applicants were below 25k so this was successful in reaching low incomes."
(There for You – Unison).

"Circulars, I phoned them and asked if they could apply. Every member was approached in the North West."
(Prison Officers Association).

"Members ring me directly. Advertised on website and newsletter, regional groups. Social media and unison aware. Monthly magazine."
(Royal College of Occupational Therapists).

Pre-existing special interest groups within one of the organisations provided a clear route to communicate to target groups.

"We have Self Organising Groups (SOGs) for [individuals from an ethnic minority background] and [other interest] groups – existing [members that are from an ethnic minority background] are accessible through these groups."
(There for You – Unison).

While usual corporate communication channels were in use "Social media; Our website; Newsletter to our mailing list", word of mouth seemed to be the main way people found out about the RCN Foundation hardship grant, "64% of people found out about the fund by word of mouth". The "biggest way was work of mouth" to get word out about hardship grants to low paid workers in the care sector.


NHS

Other methods, for example, direct communication with employers, *"always emailing providers across the country"* and using national TV, for example *"Good morning Britain"* helped messages reach Care Sector workers (Care Workers Charity).

"We had emails from people who couldn't eat or send children to school. The grant really did help. The care sector was not thought about in same way. It let social care workers feel supported and that they were there to help. Helped to have someone in their corner."
(Care Workers Charity).

Branch officers provided phone support to people completing applications:

"We also used branch welfare officers who are on the ground. Good for members that struggle with IT. Sometimes face to face or by phone. This was difficult during Covid as lots of people could not use this function except by phone though that was massively helpful."
(There for You – Unison).

"Take up was helped by face to face as the branches went to visit people when the restrictions lifted. This led to more applications than we could process from the secure psychiatric sector."
(Prison Officers Association).

Close alignment between CHSA goals and the funded organisation's underlying purpose can have benefits for speed and reliability of delivery:

If the work of the funded organisation aligns very closely with the funder goals, systems and processes may already be in place to reach target groups:

"We did not have the list of people who had needs but we have an effective way for people who need our support to find us. We routinely run advertising and have communications function. We were able to predict what might happen. Because we are a specialist we were able to predict demand and we have an effective way for people to reach out to us."
(Cavell Nurses Trust).

In this case there was no specific membership list to rely upon for communications but the organisation adapted its usual methods to deliver effectively into the target group.

What were the failures in reaching these groups?

Covid constraints on personal contact constrained engagement with some people: Some of those who were not comfortable with IT or who did not have access to it were excluded (There for You: Unison, Care Workers Charity, Prison Officers Association). Covid restrictions prevented the usual face to face remedy. Some received support by telephone but for some of those this was not sufficient.

This effect operated in two ways. Lack of face to face engagement meant some people were not:

- Invited to apply.
- Able to make use of the support to help them apply.

"They don't have time or cash. Nurses and Health Professionals don't have time for training. They need [something] available without flooding them with it."

"Constraints for online engagement: Band 2 3 4 staff do not all have smart phones or laptops so we could not do online. Band 3 staff really struggled. Some don't have mobiles and some don't have the internet."
(Prison Officers Association).

It is very difficult to ascertain from the data available how widespread this impact was or the potential level of exclusion these Covid constraints led to.

Some limited their marketing as they were concerned about demand overwhelming the grants available:

"We were conscious we would become inundated so we might be end up giving false hope if the money was already gone. We did not want to advertise too widely so perhaps it meant we would not reach the regions in the North" (RCN Foundation).
When face to face support was no longer possible, sometimes needs were not met: "Non IT savvy members were more difficult to meet during covid. Some older members did not like the on the phone approach either as there was not an obvious solution to support them to apply."
(There for You -Unison).

What sustains and what was the legacy?

Legacy

RCN Foundation	*"We have developed a good portal as a lesson from this so though there are benefits for the one to one phone call [we had previously], we are not best placed to provide that. We now direct people to a third party benefits advice website. We now use partnerships with debt advice organisations – they are better placed to provide it and it will be more efficient"; "Once we reviewed the grants and the data it is a good PR story and internally with the RCN people … Within the nursing world it gave us that recommendation"; "It increased our visibility among the nursing world and in healthcare. This meant we were able to talk about other things too and be heard. We can talk about this with other people to say what we do and to demonstrate our effect and impact".*
Care Workers Charity:	"When CHSA funding started the charity was on a small scale. We have now built up processes, for example to deal with fraudulent applications, complaints. It helped form basis of how we work now. We are more solid as an organisation".
There for You - Unison:	*"The pandemic forced our hand to make things more electronic. This has been massively positive in terms of efficiency and speed"; and "It confirmed what we knew about other grants. This reinforced members experience that under stress they respond best to the small grants where there is less onerous simple application".*
Prison Officer Association	"The beneficiaries have received money they would not have got. Band 3 staff benefitted most as they could not afford to make the recovery in the same way a band 7 and 8".

Royal College of Occupational Therapists	*"In the past we were very broadcast - it enabled the college to see members as people – holistic view of people"; "Members wellbeing is our duty – to support people. Recognition of that. There has been a shift in thought processes for college".*
The Ambulance Service Charity	"We improved the website, working on unconscious biases, language and more diverse imagery. We improved the application form length".
Cavell Nurses Trust:	*"It was a really good bit of teamwork within Cavell. There was a very close group of staff working on the project. Our frontline staff and our project manager who had the link to CHSA were very close. This way frontline staff get sight of the impact they are having in peoples lives which they see accurately on a one to one basis but through the PM they also routinely see the impact of the whole group's work ie they see more than the one to one conversations they were having. This gives them a better sense of them being part of the wider support to help everyone. It is motivational. The project manager benefitted from close contact with the frontline staff by getting know the people in more depth. That is helpful for their motivation too. Our team hear tough things so this is important. I'd like to think that their better understanding gives them resilience and motivation but also they can relay that excellent experience to the funder. That closer way of working is now how we work as a standard".*

Sustainability

RCN Foundation	"We closed the covid support fund in 2021. We are back now to regular benevolent grants – there is a budget for that … We have had other corporates reach out to us, for example a [substantial] Deliveroo donation for education grants for individuals on lower pay bands. May not be directly related but perhaps? We also have had more applications into us for other grant streams."
Care Workers Charity	*"The old way of working was applying to trusts. Now we have decided to go to sectors, talking to big care providers to give us money for their own employees. Hoping to be able to have money. Starting a £500 campaign for everyone in care sector to donate every year to help sustain amount given to care workers. We have got 50 on board, hoping for 100. It will help sustain grant giving."*
There for You - Unison	"Encouraged us to design additional resources and material. This is the COVID guide but even with this scale of issues you cant provide everything and the guide identified other support and guidance that were needed. On the back of this we now have other guides eg for Winter Fuel."

"A network of people in my position to talk things through would be helpful. It is an isolating role sitting where I am."

The Ambulance Service Charity	*"Sustainability is difficult. The requirements for covid grants has gone down, but the requirement for grants is probably at as high a level as in covid. It is the hardest part of budget to keep sustainable. Do we need to ringfence more funds?"*

What other ideas emerged for how to reach these target groups?

Communication

- Use online and well established routes to communicate
- Innovate by engaging partners that have access to key groups
- Use existing face to face routes to encourage applications from those that do not have access to or confidence and skills with IT.
- Word of mouth is important for overcoming stigma when it is endorsing an excellent service
- Application forms
- Online, predominantly, sometimes with support available online, by phone and face to face
- Face to face support is needed for some people to complete the application.

Delivery

- Speedy decision processes
- Clear lines of communication and decision governance between application assessment teams and the financial grant distribution teams.
- "We learned that we need to take time [to ensure] what we are doing is the best option. Because of time [pressures] we were often reactive so would change very quickly. Sometimes we would try things and they wouldn't work. There was a demand for things to change straight away and this made it difficult when assessing applications as things change all the time." (Care Workers Charity).

What other ideas, learning and tips for funders emerged?

Connecting to the wider system:

"A network of people in my position to talk things through would be helpful. It is an isolating role sitting where I am. In particular with this as with this it was so unknown – we could have talked about how we would change things as new information was coming out eg PTSD and mental health of children affecting how far people can themselves work."
(The Queen's Nursing Institute).

"Round table follow up could have been clearer. It seemed like it was 'here you are, have fun together'. They lead on it but it could do with a bit of direction and or follow up event to help the connections to continue and to flourish. This did not happen for us. No other organisation took on the mantel of sharing and connecting so CHSA could do that role."
(There for You - Unison).

"The premise of linking us with like minded organisations is a good role."
(There for You - Unison).

"The round tables were useful for sharing knowledge and it is useful to hear other people's experiences that these are shared in common."
(There for You - Unison).

Relationship management suggestions:
"Establish the frequency and depth of contact at the outset – how much detail and how regularly engagements are needed. Clarity upfront about how much detail would be needed to make changes."
(There for You - Unison).

"Giving details of what they liked about what we were doing. It would have been useful to understand what specifically they found useful and what and why. This would have helped us to understand better which details would be useful among the extra information we should good."
(There for You - Unison).

Wider system issue affecting grant beneficiaries willingness to take up grants was identified:
"It would be useful if the benefits agency would make it clear that they are not doing something wrong accepting support."
(Prison Officers Association).

One organisation struggled to manage the grant application process:
"[It would be] better if beneficiaries could apply directly. It is a bit of a challenge. You are trying to hand out money when the infrastructure isn't there. Better if the RCN had said to us, here are the forms, you get the staff to fill them in and send them over."
(Prison Officers Association).

Funder-funded relationships, behaviour and processes

Introduction

This section will explore the relationship between the funder and the funded organisations.

Matters considered here will focus on how far the behaviour and processes of the funder can influence the effectiveness and efficiency of the delivery of funded organisations in pursuit of the funders goals.

Perceptions of CHSA, its role, behaviours and processes

How was CHSA seen? What were funded organisations experiences of CHSA? What was the behaviour and what were the processes that enabled the right levels of accountability and project control together with appropriate support and engagement to meet CHSA goals? What helped and what hindered?

"Freedom – we were allowed to run the project. [This was] important – didn't spend time in monitoring meetings so we had more time to deliver."
(Institute of Health Visiting).

To understand the learning we have looked at funded organisation's experiences in the context of the different phases of the project lifecycle, from Application through to Delivery and also taking account of what happens when there are changes.

All of is considered this bearing in mind the context of the Covid emergency recognising:

- A requirement for speed in the roll out to meet need.
- Higher organisational risk among funded organisations as ordinary delivery processes were disrupted by:
- Home working;
- Introduction of new IT mediated forms of working;
- Increased uncertainty of staff availability due to their own or family sickness.
- High levels of personal change for staff members who were required to required to adapt to these new situations.

Bearing that delivery context in mind what were the funded organisations experiences of the relationship with CHSA?

Experiences during the Application Process

Overall, funded organisation's experience of CHSA was of supportive behaviour with constructive challenge and feedback. Application processes were generally viewed as straightforward.

The approach was proactive to the extent that it involved not waiting for applicants to arrive at the door. The Grant Officer and others were active in seeking out the best

"Accountability was driven partly through the reporting structure and was supported by the Grant Officer's behaviour."

organisations to meet CHSA objectives (TASC, RCOT, BASW).

The application process was overwhelmingly considered good. Particularly welcomed was that:
- The criteria CHSA was looking for were very clear.
- The application process was straightforward. 'felt like we had to earn it but not tortuous' (TASC, Hospice UK, QNIS).
- Quick process from start to finish (B&S, QNIS).
- Quick decision making.

There was a Grant Officer with the right behaviours; being proactively helpful. Help was offered:
- To find partners.
- To structure application responses.
- Very actively in helping people think through their proposals (BASW, QNIS, Hospice UK).

"Nurturing through conversations" (B&S); *"Straight talking"* (ICS), "Phenomenally supportive … feedback and encouragement" (QNIS).

Other behaviours that were particularly valued at the application stage were:
- Being quick to respond to questions.
- Knowing about both the grant and about delivery *"Someone who knew their stuff"* (B&S).

The behaviour that was offered in the early stages often seems to have set the tone for the entire relationship and for future conversations about delivery and about changes. The positive welcome to the behaviours deployed by the Grants Officer raises a wider the question about the role of Funders. To what extent might it serve the direct interests of Funders to engage actively with funded organisations to assist not just in the application process but also with the delivery of the programme of work?

Lets have a look now at some of the ways in which the Grants officer and others in CHSA supported funded organisations during delivery and the effects that this had.

Experiences During the Delivery Phase

Overall, funded organisation experiences were that there was supportive behaviour, with appropriate accountability. The processes were not inhibiting or overly onerous once the reporting moved to quarterly.

Payments were made as agreed and at points that did not inhibit delivery.

There was a rapid response to questions when funded organisations raised them. The Grants Officer's behaviours were useful: in particular they readily engaged, obviously listening, open to ideas, appropriately supportive and happy to talk things through,

"How fantastic [the Grants Officer] was" (BASW).

"Light touch. They were there if needed." (ICS).

"[I could] ask questions and go back and forward. Any concerns were always shared with [the Grants Officer]." (DID).

"[They] worked hard to create a peer group of those who had received grants. [They] did that well." (QNIS).

Accountability – an important funder consideration for ensuring delivery that remained focused on the criteria -was driven partly through the reporting structure and was supported by the Grant Officer's behaviour.

The reporting structure was generally *"liked", "was helpful – very clear", "provided a focal point", "quarterly not onerous", "keeps the project on the right road".*

Some felt it was better – lighter touch and less paperwork heavy – than other grants. Some felt it was about the same as other grant experiences. Some found the reporting a time consuming activity.

The hard push to get reporting right for the first few months was accepted, if onerous when it was monthly.

The experience of reporting improved when it went quarterly (Numerous).

Beyond the reports themselves, some experienced 'check ins that were also felt to be relational not just about accountability on the numbers. "Are you ok? How are things?" (QNIS). This approach built trust and enabled the useful exchange of ideas on issues of concern to the funded organisation. It is suggestive of a coaching or mentoring role of the grant officer.

From a strategic perspective, thinking about the Funder's wider interests, what do we make of the behaviour of the funding officer? Was this someone that was seen as having a policeman role or a supervisor role? It seems that the Grants Officer by using facilitation, mentoring and coaching methods was displaying behaviour largely consistent with collaborative leadership.

That should not be taken to mean loose on focus or letting things slip. Funded organisations reported that the Grants Officer, and their sense of CHSA generally in its responses, was very focused on delivery to meet the criteria. In addition to that the Grants Officer, and CHSA generally, were seen as open and flexible to any changes or discussions that would further that ambition.

In other words these Grant Officer behaviours seem to encourage effective delivery.

Another aspect of the Delivery phase was CHSA's deliberate efforts to build the delivery capacity of the system.

The Forums which brought the grant holders together had many effects that built the capacity of the wider system to deliver against CHSA criteria, for example:
An organisation delivering Psychological Support found places to refer to for Hardship grants (Body &Soul).

"We made connections, it made an immense difference … we got learning from each other."

It created a something of a community that helped build confidence and learning:

"[it was] good as I could see other people doing it."
(Hospice UK).

"We made connections, it made an immense difference … we got learning from each other."
(QNIS).

"It was refreshing to hear what others were thinking."
(DID).

"We explored different ways of working."
(DID, TASC, CoP, Frontline19).

We listened and changed: "We redefined what we are doing on the basis of that"
(Hospice UK).

The forum experience raises a couple of questions for Funders about their role. It seems that building these connections was of great value to some of the organisations we spoke with.

The suggestion is that connecting people like this is a way to build the resources of the whole system on the agenda that you are seeking to address (Hospice UK changed what they did when they got new ideas). It is also a way to ensure that the system makes best use of what is available (B&S running Psychological Support found someone to make referrals to for hardship grants). Some of the connections seem to have outlasted the grant funding adding to the sustainability of these parts of system. How far should Funders actively seek to connect the funded organisations in pursuit of delivering the best immediate and longer term impact across the wider system within which they are all operating?

Changes

When changes were needed funded organisations experiences were that there was supportive behaviour with challenge and that processes for making changes resulted in usefully quick decisions being taken.

For example, when there had been an underspend

"I asked [the Grant Officer about] vireing the money – I had a response in hours."
(TASC).

When there were changes in response to emerging demand, new learning or new circumstances *"CHSA was completely flexible"* (ICS).

There was trust in the competence of the deliverers with challenge to ensure proposed changes would lead to outcomes aligned to CHSA criteria,

"Well if you do that slightly differently that is fine– so long as it stays in line with original aim."
(QNIS).

Some contractual conflicts over Intellectual Property (IP) issues had caused "terror" among funded organisation staff:

"But then we asked [the Grants Officer] and she asked the board and [the response was] 'yes of course we are supportive."
(ICS).

CHSA listened and in this case took away the terror that was inhibiting their development.

Covid affected some staff teams and when this impacted the delivery timeline change was *"very straightforward to do"* (QNIS).

The Grant Officer's approach seems to have been aimed at ensuring a smooth change process. She was proactively supportive to ensure the board got the right information and enabled the funded organisations work to stay aligned to CHSA criteria.

For examples when completing a change decision report for the board, one funded organisation noted:

"We made tweaks on [the Grants Officer]s advice", "She saw things I didn't that the board needed to know" (CoP). Some saw this approach as unusual. She was *"supportive unlike other grants"* (QNIS).

So, in considering what are the key issues for Funders in ensuring effective grant delivery to meet outcomes and to reach target groups, then it seems important that not only is it useful to pick the right partners. The way in which a Funder themselves functions in relation to those partners is important too in the speed and the focus with which those ambitions are achieved.

Better if ...

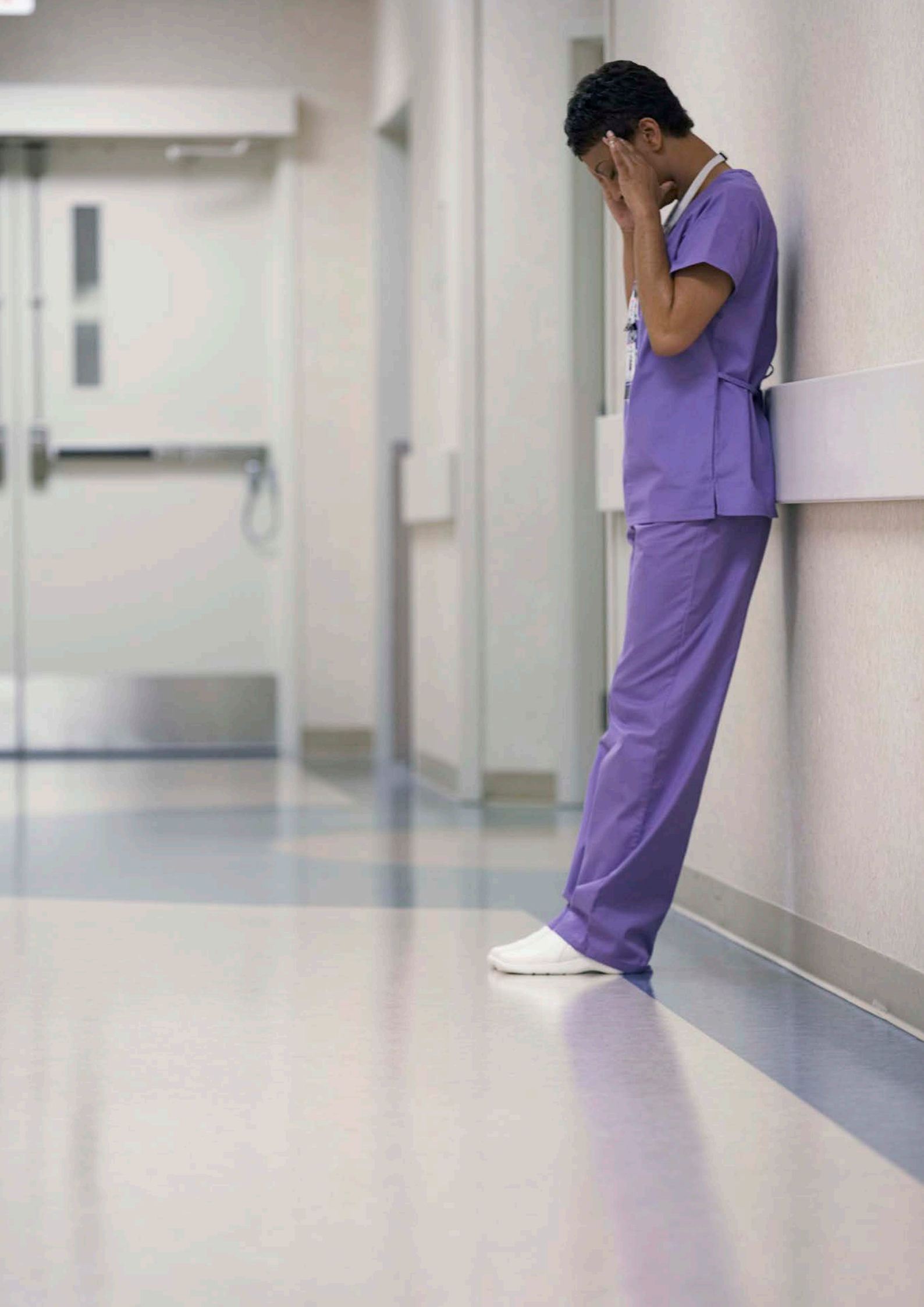
Were there any things that could be improved. Reporting is a burden, though generally accepted. Even if monitoring it is not always achievable in the ways that may be desirable, people would like feedback and acknowledgment of their work delivering it. It could be as simple as a 'thank you'. Or even better a question that shows an interest in what is going on.

Specific items in the evaluation specification

The following sections deal with specific items in the evaluation scope.

Why was there less engagement with the independent sector?

Was there in fact less engagement with the Independent Sector?
The ratio of NHS to Independent sector engagement, by volume, differed between grant funding areas.



Hardship: 52% NHS to 48% Independent Sector beneficiaries.
The Care Workers Association delivered roughly half of all Independent sector beneficiaries, and 100% of their own beneficiaries were from this sector. Some funded organisations balanced Independent and NHS beneficiaries fairly evenly eg Cavell Nurses Trust and The Queen's Nursing Institute. There was more success reaching NHS beneficiaries through the work of the Prison Officers Association Welfare, The Ambulance Service Charity, RCN Foundation and There for You – Unison.

Psychological Support: 69% NHS to 31% Independent Sector beneficiaries.
Body and Soul delivered just over two thirds of all the Independent Sector beneficiaries. With the exception of Pharmacy Support, the other funded organisations reported most success reaching NHS beneficiaries.

Recovery and resilience: 93% NHS to 7% Independent Sector beneficiaries.
The Institute of Health Visiting and Listen Up Storytelling delivered almost all of these Independent sector beneficiaries. There is however too much missing data on this topic to give a useful picture for this area of work.

With such wide differences between organisations and between grant funded areas, what can we see that might help us understand what was happening?

Is there anything more complicated to explain why beneficiaries were reached in these proportions than by looking at who these organisations touch most easily with their communications?

In some ways the Hardship area is easiest to begin with as there was a fair balance between Independent Sector and NHS beneficiaries overall. However, this masks what happened as the grant funded organisations delivered different proportions of these types of beneficiary.

The Hardship beneficiaries for the three main deliverers depended upon who applied for the grants and that in turn was dependent upon who would hear the message that the Hardship fund was available.

The Care Workers Association communicated with their members. They delivered Independent Sector beneficiaries because that is where the members they targeted largely work.

But what about the major grants for the work of the RCN Foundation and There for You – Unison?

The RCN Foundation targeted *"Nurses, nursing associates, midwives, student nurses and midwives and health care support workers, NHS and independent".* Roughly one in five of their beneficiaries were from the Independent sector. Perhaps a different, targeted awareness raising strategy might have impacted who came forwards to apply: *"We were conscious we would become inundated so we might be end up giving false hope if the money was already gone. We did not want to advertise too widely".*

There for You – Unison targeted *"Non NHS carers, care assistants, support workers, cooks, cleaners, social workers and drivers. NHS occupational therapists, healthcare assistants, domestic support workers, admin and housekeeping".* Roughly two in five of their beneficiaries were from the Independent sector. Their communications were

"Engaging Independent Sector beneficiaries for psychological support may require specific marketing efforts to reach through organisational boundaries and barriers."

largely with their members. Their focused engagement activity was to ensure good regional and individuals from an ethnic minority background engagement.

The Prison Officers Association only reached NHS beneficiaries. They noted that *"It was more difficult to get the message out about the funding availability to private sector eg to residential units".*

The Ambulance Staff Charity focused its work on the NHS, *"All ambulance trust staff grades; mostly ambulance staff".*

With two thirds of the Psychological Support to the Independent sector delivered by Body and Soul it is useful to understand that Body and Soul developed their networks and were agile in adapting the approaches they used to engage beneficiaries. Their work was delivered in the face of a good deal of challenge and rejection in engagement with the Care sector, *"the NHS might be baffled but see you are trying to help. A care agency will treat you like scum, 'what are you trying to sell'."* It is not clear how far the Body and Soul experience was replicated by others bringing psychological support work to the care sector.

It is also important to understand that some of the funded organisations ambitions on the ground were mainly or wholly to work with NHS staff (Intensive Care Society, STS Charity, TASC and RCGP to an extent).

The RCN felt they did really well with reaching their target groups. Roughly one third came from the Independent sector,

"The Independent sector is always difficult as there are smaller nursing homes … We did a series of webinars to the independent sector. The team produced the posters etc". "Particularly for independent sector and overseas nurses … Amazing marketing support – direct emails, social media. Worked with independent sector branch to deliver webinars. Direct emailing to members was the most successful out of all of them." (RCN).

With Frontline19, beneficiary engagement depended partly on awareness of the service. Frontline19's awareness raising included the use of national TV and media as well as NHS contacts and connections.

In conclusion, engaging Independent Sector beneficiaries for Psychological Support may require specific marketing efforts to reach through organisational boundaries and barriers. This may be a challenging, potentially resistant environment to interact with. Establishing relationships with key stakeholders seems to be important "[Access was] Entirely to do with individual personal relationships" (Body and Soul). For Hardship grants, the use of existing connections to Independent sector membership groups guided beneficiary applications.

Why was the take up lower for psychological support for individuals from an ethnic minority background?

There were roughly 25% fewer that the targeted individuals from an ethnic minority background taking up Psychological support. This meant that one third of beneficiaries receiving psychological support were from ethnically diverse backgrounds.

Roughly half of these beneficiaries were delivered through the black led organisation, Body and Soul for whom more than three quarters of their 840 beneficiaries were individuals from an ethnic minority background. Pharmacy Support, BMA and RCGP reached or exceeded the targeted 45% beneficiaries from an ethnic minority background. While they did not meet the programme target the British Association of Social Workers engaged the expected proportion of individuals from an ethnic minority background aligned to the make up of their profession. Other organisations fell short in engaging individuals from an ethnic minority background.

Was there anything about the character of the services that might have made a difference?

Frontline19 relied on awareness of potential beneficiaries and their willingness to pick up the phone or engage with psychological support online. They also used a small number of Ambassador to spread the word personally and to understand issues and needs. Roughly a quarter of their beneficiaries were from ethnically diverse backgrounds. Could this mode of delivery somehow be relevant? It is unfortunate that we do not have data from take up of The Queen's Nursing Institute and Nurse Lifeline to allow comparisons with other similar delivery services.

How did different services try to engage individuals from an ethnic minority background?

In terms of ethnically diverse engagement, some relatively successful projects offered support to people involved with Pharmacy, BMA members and RCGP members. Their approaches accessed members directly with provision that was marketed directly to them.

Body and Soul provided direct engagement including both individual and group work, targeting all health and care professionals. However, neither they nor Frontline19 began with established membership contact lists. They worked out how and where to engage people as they developed. Body and Soul sometimes undertook direct personal engagement at work locations eg handing out flyers at a hospital. Frontline19 used mainstream media and organisational connections.

RCN used their networks and representatives *"We used the reps a lot as they were at the coal face. We set up posters and leaflets. Posted a lot out to the reps and we explained who we wanted to target. There was a big push to get the message to clinical areas".*

Stigma?

Some organisations cited stigma as a reason for non-engagement of individuals from an ethnic minority background,

"[There is a] stigma about accessing mental health support."
(RCN, Frontline19).

Efforts to combat stigma were attempted by awareness raising (Frontline19) and some felt the challenge of stigma could sometimes be overcome with good information and recommendations,

"Sometimes also people are less informed – direct emails, webinars and posts can be helpful – and especially with word of mouth."
(RCN).

"They don't have time or cash. Nurses and Health Professionals don't have time for training. They need [something] available without flooding them with it."

Conclusions?
It is difficult to draw firm conclusions on why individuals from an ethnic minority background did not take up target levels of psychological support.

The black led organisation, that engaged directly believing that *"[Access was] entirely to do with individual personal relationships"* was by far the most successful in engaging individuals from ethnic minority backgrounds.

May the presence or absence of individuals from an ethnic minority background within the services offering the psychological support sometimes be a relevant factor?

The suggestions are that stigma, poor information and possibly poorly designed information may be reasons for lower take up.

Using a constant comparative analysis approach, in relation to the combined impact of the grants made to the individual organisations, what were the areas of divergence, convergence and silence in respect of the outputs and outcomes from the organisations to benefit from a grant?

A key outcome in common was a response to Covid where funded organisations changed their processes in order to be able to deliver more speedily and more efficiently.

However, the process changes that organisations made diverged, depending on the needs of the fund.

For Hardship funded organisations grant management changes predominated with a more towards online and simpler application processes.
This resulted in improvements in:

- Online portals for grant applications.
- Quicker responses to applications.
- Being able to manage greater volumes of applications and make decisions at speed.
- More robust processes.
- Better application forms.

For Psychological Support and Recovery funds these changes led to better delivery processes. Sometimes these were small improvements on existing processes. Largely these were improvements to online offerings. In some cases this involved a major move over to online offerings. It was not the case that all organisations moved heavily towards online offerings.

Some organisations had grown in size to enable them to deliver. Others were used to delivering grants of this nature. All could point to learning from the experience.

Involvement with the fund and the outcomes generated represented a good PR story for many organisations. This added reputational value in two ways, through raising awareness of their work among:

- Members and potential beneficiaries.
- Partner organisations in the same arena.
- As a result many felt they now had more influence with:
- Members.
- Potential partners and funders.
- Existing partners.

Many identified that this work would lead to greater opportunities for further work together in the future.

Engagement with the work had shifted some internal organisational perceptions. These shifts generally related to relationships and included changes in perception about:

- The need for communications to be more of a dialogue – less broadcast.
- Recognition of their organisations role to support members mental health.
- Broadening their focus of delivery to included professionals in other related areas.
- The way in which the elements of the wider system could now see themselves as part of the whole.

Which priority area had the greatest impact? Why was this the case? Is there any indication as to how this impact can be sustained?

All projects in all three priority areas reported impacts on beneficiaries. It is difficult to compare the value of the impacts of the three areas as they are delivering different things. While some of the Psychological Support and Recovery and resilience priority area projects have conceptual overlaps in what they deliver, their objectives are different. Both are quite different to the Hardship priority area.

The data available from the interviews and monitoring information does not meaningfully allow us to define which of the priority areas had the greatest impact. There are clues that contribute to our understanding of what will help with sustainability. Some projects were more active than others in engaging with elements of the wider system. Where this happened many talked of increased connectedness and future potential collaborations. This seems to be more a function of their willingness to look beyond their own organisation than a function of the grant priority area. The forums helped across the priority areas to connect organisations.
Some projects talked about shifts in internal perceptions. For example, shifts to recognise the value of mental health work and others of the need to re-consider hardship grants.

Some talked of the increased reputation that had accrued to their organisations both among their target members or interest groups and among their potential partner organisations. The feeling was that funded organisations were better placed now to engage with members and partners to deliver work of this nature.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Lessons for funders and funded organisations

In this section we will discuss:

- Dos and Don'ts emerging from the methods adopted by deliverers to reach target groups, whilst overcoming the constraints of the Covid emergency.

- Implications for the relationship between the funder and funded organisation if it is to best support outcome delivery.

The intention is to make explicit the learning can be taken forward. Questions are raised that are relevant for other funders when considering effective delivery.

Dos and Don'ts emerging from the methods adopted by deliverers to reach target groups, whilst overcoming the constraints of the Covid emergency.

In order to understand how organisations can reach key target groups we have drawn out messages that seem to follow from the experiences of the funded organisations.

We might add to this general list that the devil is usually in the detail – and by that we mean engagement approaches need to be accompanied at some point by an understanding of the specific needs, interests and constraints facing the people involved.

However, at the level of a project, we present some thoughts on what might be important to encourage engagement.

What might be the key learning for the future?

When we looked at the data a number of categories emerged about the organisational nature of CHSA's big volume deliverers in terms of overall reach and speed of reach.

- Organisational maturity: were they an established grant user or were they new to grants?
- Did they have existing access and a history of connectedness to the target group already?
- Was there a clearly defined approach for delivering their work or was it a new or developing process?
- Were there established communication routes to get messages out or were they starting afresh?

For these large volume deliverers, where the answer to the above questions was 'Yes' this facilitated speed of delivery and speed of engagement. However, where the answer was 'No' more agile organisations were able to respond. During the pandemic the larger more established organisations became more agile to change their ways of working in several ways to respond to the need for speed and the limitations on face to face engagement.

"Be flexible to develop an offer that truly meets the needs of the target audience even if it differs from your original perfectly well worked through plan."

Figure 12. The experiences of organisations overall suggest a number of Do's and Don'ts.

DOs

Set up with clear processes, eligibility criteria and forms.	**Build good** monitoring systems so you can be clear where you are reaching the target groups and where you are not. Take action as needed.	**Use and develop** connections to organisations that can provide resources and access.	**Work with partner** organisations to generate interest and referrals.	**Develop relationships** with people that may control or facilitate your access to target groups.
Challenge existing barriers to participation.	**Ensure** you are clear on where your target participants can be found.	**Use the contexts** that target group members already inhabit.	**Go** to where target group members are found; go to where they work.	**Whole team interventions** can be effective in reaching across professional group, pay band and ethnic group dimensions to include everybody.
Use mainstream media to raise awareness of the offer.	**Where there is stigma** use mainstream media to encourage discussion and awareness.	**Consider** who the target group will relate to: • Include people from the target group among the engagement and intervention team; there is a greater basic level of trust in people who may have shared experiences. • Word of mouth is important, encourage target group members already engaged to talk about what they received to spread awareness and offer invitations to others in their social groups.		
Test your offer and adapt it to ensure it aligns to the needs of the group you are wanting to work with.	**Actively seek** feedback and use it to change.	**Communicate.** Ensure you have clear messages especially: • What is being offered. • How to access it. • Who is already using it (images should be inclusive of target groups). • How far others will be aware that someone is involved (anonymity is often useful); some people don't want their employer to know (this gives advantages to non-employer deliverers). • Use your Website; use social media (especially Facebook, LinkedIn, Twitter, Instagram). • Maintain engagement with previous participants to get feedback and deliver messages that they can spread (eg WhatsApp groups).		

DON'Ts

Don't assume:	Don't waste time
• The right people will come without targeted communication. • Broad scale advertising will work to reach all groups. • Employer organisations will be trusted by target groups. • That people will want what you initially plan to deliver, even if you know it is potentially useful. • Everyone wants group work or individual work.	trying to recruit target groups before you properly understand their needs. Time spent listening is time well spent.

Implications for the relationship between the Funder and funded organisation if it is to best support outcome delivery.

Beyond selecting grant holders and administering grant delivery what can Funders do to support effective grant delivery to meet outcomes and reach target groups?

The specific behaviour and processes adopted by CHSA affected how well funded organisations were able to deliver during all stages of project delivery.

In particular, these behaviours and processes affected:

- The pace at which funded organisations came forward with ideas.
- The ease of the application process.
- The relevance of the applications that came forward.
- The ideas and resources available to funded organisations to find solutions to problems.
- The responsiveness of individual grant schemes when changes were needed to meet beneficiary needs.
- The ability of the funded organisations to support each other with ideas, resources and joint work.
- The legacy of increased connectedness within the system on this agenda.
- The legacy of increased system capability to undertake work in this area.

The Grants Officer's approach was key during all stages of project delivery. During the application stage, overall funded organisation's experience of CHSA was of supportive behaviour with constructive challenge and feedback.

The positive welcome to the behaviours deployed by the Grants Officer raises a wider the question about the role of Funders. To what extent might it serve the direct interests of funders to engage actively with funded organisations to assist not just in the application process but also with the delivery of the programme of work?

During the delivery phase, overall funded organisation experiences were that there was supportive behaviour, with appropriate accountability. CHSA's processes were not inhibiting or overly onerous once the reporting moved to a quarterly period.

"In terms of impact against objectives we conclude that the Psychological Support grants awarded did help to reduce the psychological impact of the pandemic."

What do we make of the behaviour of the Grant Officer during the delivery phase? Was this someone that was seen as having a policeman role or a supervisor role? In some cases the Grant Officer was quite hands off, and this was felt to be appropriate. In others the Grants Officer displayed behaviour consistent with collaborative leadership. By that we mean taking a facilitating, mentoring and coaching role in the relationship with the funded organisations. That should not be taken to mean loose on focus or letting things slip. Funded organisations reported that the Grants Officer, and their sense of CHSA generally in its responses, was very focused on delivery to meet the criteria. They also felt that the Grants Officer, and CHSA generally, were open and flexible to any changes or discussions that would further that ambition.

When changes were needed funded organisations experiences were that there was supportive behaviour with challenge and that processes for making changes resulted in usefully quick decisions being taken.

The Grants Officer's approach seems to have been aimed at ensuring a smooth change process. She was proactively supportive to ensure the board got the right information and enabled the funded organisations work to stay aligned to CHSA criteria.
CHSA deliberately brought funded organisations together for a number of forum events. The experience of the forums raises a couple of questions for Funders about their role. It seems that building these connections was of great value to some of the organisations we spoke with. The suggestion is that connecting people in this way builds the resources of the whole system on the agenda that you are seeking to address (Hospice UK changed what they did when they got new ideas). It is also a way to ensure that the system makes best use of what is available (Body and Soul running Psychological Support found someone to make referrals to for hardship grants).
Some of the connections seem to have outlasted the grant funding adding to the sustainability of these parts of system.

Beyond selecting grant holders and administering grant delivery what can funders can do to support effective grant delivery to meet outcomes and reach target groups? It seems that not only is it useful to pick the right partners and have good processes but the way in which funders themselves behave in relation to those partners is important too in affecting the speed and the focus with which those ambitions are achieved. The relationship itself can be influential in delivering success.

Funders can also play a key role in helping funded organisations to connect with each other and this can lead to mutual support during delivery, sharing ideas between them and strengthening the system as a whole through improved potential for further action beyond the grant.

Conclusion

In terms of impact against objectives we conclude that the Psychological Support grants awarded did help to reduce the psychological impact of the pandemic. The Recovery and resilience grants awarded did help to strengthen the workforce, improve leadership and bring about positive change across the sector. The Emergency aid and Hardship grants awarded did relieve the financial pressures that healthcare workers were experiencing during the pandemic.

CHSA grant funded organisations have overwhelmingly worked hard to adapt to overcome Covid environmental constraints in pursuit of reaching target groups to provide support and hardship grants. CHSA's encouragement, flexibility and responsiveness to projects to enable change, along with the projects' own keenness to make a difference and overcome barriers, have been very important to this success.

While there are differences between areas of grant funding in terms of reaching target groups, overall, CHSA approach provided an effective model for delivering funding to funded organisations in ways that reach beneficiaries. The effectiveness was drawn from the whole staff and trustee team's emphasis on speed of decision making and responsiveness to change, the proactive search for potentially effective partners, willingness to take a risk with emerging organisations showing signs of success, clear grant criteria, a simplified application processes, forums to connect delivery partners, and with an engaged Grants Officer who balanced collaborative leadership and hands off engagements with funded organisations.

Appendix A: Case Studies

Case study cards – each draws on fieldwork with funded organisations. Each briefly describes what happened to enable effective impact, reach and engagement. Each refers, as appropriate, to critical behaviours and processes.

Case Study One – Psychological Support

This example illustrates the challenges and methods deployed engaging with reluctant or resistant organisations to reach individuals from an ethnic minority background. "60% of the people we worked with would identify as something other than white … A surprising mix of people throughout from care assistants to consultants in NHS trusts". Simply engaging with the system as an outside organisation was not easy, indeed there was a good deal of suspicion from some gatekeepers: "The NHS might be baffled but could see you are trying to help. A care agency will treat you like scum, 'what are you trying to sell?'. I spent the best part of a week, going to care homes and providers". The lesson is that access was "entirely to do with individual personal relationships". For example with the "manager in A&E - we got referrals once we had struck up relationship".

Engaging with target groups directly was not always consistently effective: "We found how difficult it is to get people to come forward for support. Delivering flyers to hospital. Delivered flyers to a hospital, got load of bookings that day, next day, hardly any, then none".

The organisation attempted to build engagement and acceptance by showing what the work was: "We started doing group work in hospitals and care homes. That meant that people who wouldn't [otherwise] come would see what it looked like and that would build up trust" (Body and Soul).

Case Study Two – Recovery and resilience

This example illustrates the importance of flexibility when delivering work to whole teams and also the value of a whole team approach as a way of reaching people across all target groups.

"We were asked if we could do something for the whole team as sometimes people were not feeling like a team, others were feeling too dependent on their team and so they were not attending to their home life".

The aim was to "reach whole teams not individuals; working across pay bands including nurses and HCAs … Something that puts teams in touch with each other".

"Often there was poor communication and hostility to senior management. There are benefits of helping them to 'see each other' and to begin to have a more open dialogue about how they are going to share the problems".

Time is an important issue to manage when considering whole team interventions. Some things were not practical, "People wanted face to face and we could not take time to do that for a couple of days in a hotel away" so ways to use others spaces and online were needed.

Lesson: This sort of work takes a lot of time to set up as there are a lot of people that need to agree to be involved and to find time to do so: "People are really busy – and there are so many people need to agree. Often a team member gets in touch, then refers us to their manager. [It is an] Unusual offer [so people need to] walk people through the exercises. There are lots of [preparatory] meetings".

The outcome is that whole "teams have more effective functioning. We suspect there is an improvement to staff retention. There is likely to be better working environment. Helping people to be compassionate to each other. Teams report benefitting in this way" (CNWL Foundation Trust).

Case Study Three - Funder-funded relationships that support delivery

This example illustrates how the behaviour and processes of the funder supported more effective delivery. In this case the funded organisation needed to make changes during the delivery phase.

The positive and open approach of the Grants Officer during the application phase appears to have set the tone for the rest of the relationship "The Grants Officer was phenomenally supportive. We talked through it … Share an idea and get feedback on idea … and encouragement. Lovely to be encouraged and you feel you can trust them". "Because there was a dedicated [Grants Officer] who worked hard to create peer group of those who had received grants we were able to make connections. It made an immense difference. Made it more a relationship experience. Part of a community of charities who cared about the workforce and learning from one another. A supportive community seeking to make a difference at a time of extraordinary pressure and crisis. The [Grants Officer] did that well".

On delivery matters: "There was good accountability. Also felt supportive - a light touch … it felt relational. Are you ok? How are things? Been fine. Felt measured and appropriate".

When there were difficulties this good relationship meant that issues were shared quickly with the Funder and not hidden: "[Some delivery] things weren't quite as we envisioned". A change was needed and they felt an adult focused conversation was had about maintaining focus on CHSA objectives: "There was a supportive reciprocal response, well if you do that slightly differently that is fine – so long as in line with original aim. Very supportive unlike other grants who may ask more".

The care was appreciated when the organisation's staff team were affected by Covid, "the [CHSA] were good to slip deadline slightly – to go longer than intended. Very straightforward to do".

Appendix B: What worked; Dos and Don'ts - Summary

Outlined below are summarised pointers from the positive delivery lessons learned in each of the three work areas.

Psychological support

Often people are directed to their employer's assistance programmes whereas maybe this is not always the best approach to provide psychological support to a workforce. Peer to peer, volunteer support (separate from employer offered support) was seen as acceptable to the Nurse Community.

Offers of psychological support to NHS and Social Care organisations can be met with suspicion and lack of understanding. Substantial investments of time may be needed to develop new relationships with key gatekeepers that are critical to ensuring staff access.

- Peer to peer support through anonymous listening
- Therapist support online or over the phone
- Using mainstream media to gather volunteer resources that could help meet needs
- Developing marketing in line with evolving capacity to deliver
- Developing approaches and marketing using customer relationship data to identify gaps and needs
- Connecting with the wider system
- Developing mental health resources for use by the membership

Communications to engage:

- Some people expanded their work through word of mouth
- Others spent time usefully improving the inclusivity of the messaging in website (language, diversity in images)
- Others used their existing connections with organisations
- Social media played a role and using but "not relying on Twitter – nurses prefer Facebook", (ICS).
- Where funded bodies were targeting their members they reached out directly using existing internal communications routes
- Using their own members to reach non-members
- Using data to identify gaps and needs

Recovery and Resilience

- Using the support, skills and connections of the wider team by having a well connected steering group
- Having a tried and tested methodology
- Doing more to ensure beneficiaries maintained their connections with each other
- Going beyond resource development to ensure beneficiaries received the input
- Providing an offer that was visibly separate from employer offers encouraged engagement
- Delivering whilst not being able to meet face to face
- Building stronger connections to deliver jointly with other charities
- Enabling people to find space for themselves

- Helping teams to care more effectively for each other
- Bringing in peer support to enable ongoing support within teams
- Having time to develop and evolve the offer is important to creating effective, relevant delivery
- Understanding the target group's likely constraints on participation was important in designing the approach offered
- Providing whole team interventions can engage everyone across ethnic groups, pay bands and professional groups
- Being flexible about whole team interventions
- Online delivery can work to enable the inclusion geographically remote participants. Face to face meet ups are valued as part of this
- Key organisational leaders can be important to engage as programme beneficiaries even if they are not initially target group members. They can open doors and help engage others.
- Volunteer facilitators: being flexible in the way the delivery method was deployed enabled new facilitators to engage more readily and become confident in using it in ways that would work with different groups

Emergency Aid and Hardship

- Simplified grant giving methods
- Online application forms were a cornerstone of speedy delivery
- A structure of grant giving was put in place
- Membership organisations felt trusted
- Diverting Hardship resources to Recovery funds as it became clear that is where the demand was
- Stigma: use word of mouth to overcome stigma
- Communication:
- Word of mouth; newsletters to members, online and direct communications using existing channels were effective in reaching target groups.
- Pre-existing special interest groups within one of the organisations provided a clear route to communicate to target groups.
- Branch officers provided phone support to people completing applications.

Appendix C – The scope and its development

The formal scope laid out below was built upon through early exploratory conversations with the Trustees and CHSA's team to understand the priorities for investigation. Once these priorities were understood a research method was agreed with CHSA's team along with reporting dimensions.

The initial scope was offered by CHSA as follows:

The evaluation will be using a mixed methods approach and will be broken down into two parts:

Part 1: Quantitative: Did CHSA meet its original aims?
The evaluation would need to assess each of the priority areas to understand if the objectives were met. The following questions would need to be addressed for each priority area:

o Emergency aid and hardship – did the grants awarded relieve the financial pressures that healthcare workers were experiencing during the pandemic?
o Psychological support – did the grants awarded help to reduce the psychological impact of the pandemic?
o Recovery and resilience – did the grants awarded help to strengthen the workforce, improve leadership and bring about positive change across the sector?
o Did CHSA meet its grant giving targets around:
    a) Countries
    b) Ethnicity
    c) Professions
o What was the grant giving split between the independent sector and the NHS?

Part 2: Qualitative: Lessons learnt
This part of the evaluation would look at the outcomes and impact of the funding and would focus on the following three areas:

1. How successful were grant making processes?
o Were the grants given in the right way?
o Were the grants given in a timely way?
o Lessons learnt around best practice for grant makers

2. How did the grants demonstrate the intended impact across the three priority areas?

We would like the evaluation team to assess the lessons that can be drawn from

the work of CHSA, looking at why there were variances across, different sectors of the workforce (independent and NHS), ethnic groups, and geographical areas. For example:

o Why was there less engagement with the independent sector?
o Why was the take up lower for psychological support for people from an ethnically diverse background?
o What can organisations do better to work with different groups across the healthcare sector?
o What role can a grant making organisation like CHSA play in addressing health inequalities across the sector?
o Using a constant comparative analysis approach, in relation to the combined impact of the grants made to the individual organisations, what were the areas of divergence, convergence and silence in respect of the outputs and outcomes from the organisations to benefit from a grant?
o Which priority area had the greatest impact? Why was this the case?
o Were there any specific threads or themes to be identified across the organisations
o What were the experiences during this time of the organisations who received funding.
o What were the areas of greatest impact across the areas of grant-making? Why was this the case? Is there any indication as to how this impact can be sustained?

3. Overall impact of three priority areas?
We would like the evaluation team to look at the overall impact of CHSA's grant giving.