West Sussex Drug and Alcohol Partnership – An evaluation of a lived experience community fund co-production programme

This briefing note accompanies the full evaluation, and summarises the background, successes, challenges, and learning from the lived experience Community Fund co-production programme, concluding with key learning for system leaders and partners.

Background

Between Autumn 2024 and Spring 2026, the West Sussex Drug and Alcohol Partnership (WS DAP) delivered a co-produced Community Fund programme using national DATRIG funding. The programme was designed to test whether small-scale, community-led projects, co-designed with people with lived and living experience (LLE) of substance use, dependency, and related disadvantage, could be delivered safely, accountably, and in alignment with national and local WS DAP partnership priorities.

The programme funded nine community projects and was underpinned by structured governance arrangements, independent LLE oversight, and a Theory of Change–based application process.

What worked well

1. **Co-production was meaningful, not tokenistic.** Co-production was embedded throughout project design, assessment, delivery, and oversight, ensuring that LLE involvement was meaningful. Participants reported increased confidence, skills, wellbeing, and social connection, underpinned by strong, trusting relationships between statutory partners and the Lived Experience and Recovery Organisation (CAPITAL).
2. **Strong strategic alignment with WS DAP priorities (2024-27).** The programme demonstrated clear alignment, with all priority areas addressed across the portfolio of projects. The most consistently evidenced areas included treatment access, co-occurring need, peer leadership, housing stability, and the development of peer support networks.
3. **Robust governance and financial control enabling safe and effective delivery.** The programme operated within agreed budgets and contractual requirements, supported by structured governance, independent review, monthly oversight, staged funding release, and clear escalation routes. These arrangements enabled risk to be identified and managed effectively, safeguarding public funds while supporting participant growth and wellbeing, and contributing to the achievement of intended project outcomes.

What did not work as intended

1. **Administrative and regulatory barriers delayed or prevented delivery.** Banking, charity registration, and regulatory compliance (e.g. Ofsted) proved prohibitive for at least one project, which could not proceed within funding timescales.
2. **Single-person dependency increased project risk.** Projects relying on one individual were more vulnerable to disruption due to changes in health, housing, recovery, or staffing support.
3. **Short funding cycles limited effectiveness.** Start-up, trust-building, and mobilisation took significant time, leaving short delivery windows and reduced flexibility to recover projects where delays occurred.

What we would do again

1. **Retain a strong lived experience delivery and oversight model.** Continue to use a Lived Experience and Recovery Organisation as the delivery partner, supported by independent LLE review and oversight arrangements, to ensure credible co-production, appropriate challenge, and participant support.
2. **Maintain clarity of purpose and proportionate accountability.** Require all projects to articulate a clear Theory of Change to strengthen clarity of intent, outcome focus, and accountability, while ensuring monitoring arrangements remain proportionate to project scale and risk.
3. **Design for flexible, supportive delivery within clear safeguards.** Build flexibility into programme delivery to accommodate community-led approaches, while retaining robust financial, ethical, and safeguarding controls. Prioritise regular, supportive check-ins over performance-heavy reporting to enable learning, risk management, and participant wellbeing.

What we would build on and enhance

1. **Build on early planning through strengthened readiness and risk assessment.** Enhance application and mobilisation processes through earlier readiness and risk assessment, helping identify and address delivery considerations at an early stage.
2. **Build resilience through partnership and community involvement.** Encourage collaborative delivery models and establish standing lived experience or participatory groups to support rapid mobilisation when funding opportunities arise.
3. **Enhance shared understanding of impact and outcomes.** Develop a shared understanding from the outset of how local activity contributes to programme outcomes, supporting effective monitoring, evidence gathering, and reporting against grant objectives.

Key learning for system leaders and partners

1. **Co-produced community funding is viable and replicable.** Co-designed and co-produced community-funded projects can be delivered safely, accountably, and in alignment with statutory priorities. With appropriate adaptation, this approach is replicable across other complex public health and social policy areas where lived experience is essential to effective innovation and design.
2. **Early investment and deliberate design are critical to managing risk and value.** This model is resource-intensive, particularly in early phases, but delivers both instrumental benefits (delivery, reach, outputs) and intrinsic benefits (empowerment, trust, system insight). Risks are manageable where governance, relationships, and support mechanisms are deliberately designed and resourced from the outset.
3. **Short-term funding constrains impact rather than indicating delivery failure.** Time-limited funding is a structural constraint that limits effectiveness and sustainability, rather than a reflection of delivery capability. Policy, commissioning, and funding models should adjust accordingly to enable mobilisation, trust-building, and meaningful impact.

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