

# **Towards voluntary and community sector engagement in Community Health Partnerships – a baseline mapping exercise**

## **1. Introduction**

The Community Health Partnerships Regulations (Scotland) 2004<sup>1</sup> came into force on 1 October 2004 with the intention that Community Health Partnerships (CHPs) would be “live” by 1<sup>st</sup> of April 2005. This short mapping exercise looks at the involvement of the voluntary sector in the development and implementation of CHPs since the beginning of 2005.

## **2. The mapping exercise**

During the summer of 2005, Voluntary Health Scotland carried out an initial mapping exercise on the engagement of the local voluntary and community sector in CHP development.

Of the 36 CHPs which so far have gained Ministerial approval VHS has managed to elicit a response from 35. Of these 35 CHPs, 2 have joint management, Edinburgh North and South, and have been considered for our purposes to be a single CHP.

It should be noted that CHPs gave a mix of responses in that not all General Managers responded nor did all voluntary sector leads, therefore some information is given from a voluntary sector view, some from a statutory view and some from both.

The mapping was done through telephone, e-mail and in-person discussions with CVS and other voluntary sector network managers and co-ordinators and with CHP general managers or development leads, seeking answers to the following three questions.

- 1. Is there a member of the local voluntary/community sector on the CHP Committee?*
- 2. How was the member chosen, i.e. was it an elective process, a selective process (interview style) or was someone chosen because of their position or job title?*
- 3. How the member is supported, both by other committee members and their local voluntary sector colleagues, to ensure their contribution is valid and appropriate?*

## **3. The responses**

### **3.1 Is there a member of the local voluntary sector on the CHP Committee?**

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<sup>1</sup> Link: <http://www.opsi.gov.uk/legislation/scotland/ssi2004/20040386.htm>

Almost unanimously those CHPs (or NHS Boards where the CHP was not yet functioning) which responded stated that there was a place for the voluntary sector identified as a committee member. This is in addition to any member from the Public Partnership Forum (PPF).

2 CHPs have no identified voluntary sector contact person as yet and 4 have 2 or more representatives.

Of the 33 individual representatives so far identified 25 are from CVS. One of these is the temporary rep for 5 CHPs with a further 3 stating that their positions were also temporary. A further 2 are from Community Care Fora, with 1 of these representing the voluntary sector on 2 CHPs. The other 6 representatives are from independent organisations although one of these is employed by a CVS to represent the sector on the 2 Edinburgh CHPs.

Currently, the issue of deputies remains to be clarified in some CHP areas.

***3.2 How was the member chosen, i.e. was it an elective process, a selective process with an interview or was someone chosen because their position or job title made them appear the most appropriate person?***

### **3.2.1 Elective process**

In Fife, an elective process has been adopted which has been supplemented by a detailed job specification and person profile. This has provided a clear mandate from the local sector as well as ensuring that the members have a clear description of their responsibilities and boundaries.

### **3.2.2 Selective process**

In two areas, Edinburgh and Aberdeenshire, the benefits of having a salaried representative who has been chosen through a selection interview are being explored.

### **3.2.3 Member chosen from existing fora or networks**

In many areas the members have been selected from existing committees, members of fora or CVS, although the exact nature of the selection process has not always been identified. Some of these members stressed the "temporary" nature of their appointment, pointing out that they wished either to find or select/elect a more appropriate person who would have a mandate from the local voluntary sector or seek a clear mandate for themselves.

Aberdeenshire CHP funded Bridge CVS to consult with its local sector on involvement and from this the CVS has been nominated to the seat on the committee but it still feels that further mandate should be sought, interestingly enough through a selection interview process.

**3.3 How the member is supported, both by other committee members and their local voluntary sector colleagues, to ensure that their contribution is valid and appropriate?**

NHS replies to the question of ongoing support have consisted mainly one of two responses. Either: *"We will have structures in place to ensure support to all members of the committee, including the voluntary sector member."*, or: *"The CVS/for a local Community Care Provider network will provide the support necessary for the member..."* These are opposite sides of the same issue in that in that members will need ongoing NHS support as an integral part of their contribution to CHP development but will also require assistance from their own local voluntary sector to develop their own external structures and networks with which to validate and support their place on the CHP committee. Therefore both approaches will need to be taken to fully support the voluntary and community committee members in their role.

In at least two CHP areas, East Dunbartonshire and Aberdeen City, the voluntary sector has been included in the Leadership Development for CHPs programme, developed by the SEHD. This equality of access to training and support is considered an example of good practice.

Within the voluntary sector networks are being developed at the local level to support the voluntary sector representative and some existing networks are being further developed to include CHP business in their remit.

## **4. Key issues**

### **4.1 Securing inclusion on CHP committee**

CHPs are still at a relatively early stage in their development and this is reflected in the responses to the questions asked in this exercise. All areas except one have plans to include the voluntary sector as a full member of the CHP committee. The CHP in question has informed the voluntary sector representatives that they will be allocated a place on the CHP governance committee instead.

Another CHP stated initially that it had no room on its board for a member of the voluntary sector but pressure from the local sector in pointing out the legislative requirement for a member of the sector to be present has rectified this.

One NHS Board objected to the people nominated by the PPF, noting that they were Office Bearers from organisations to which the NHS gave funding and thereby citing a conflict of interest. Fortunately, this appears to be a rare occurrence, given the concern on this issue in the sector arising from previous experiences, and should be resolved with fresh examination of CHP guidance<sup>2</sup> and the actual legislation itself. The legislation<sup>3</sup> covers actions that require to be taken when a potential conflict arises, adding that:

*“A member shall not be treated as having any interest in any contract or matter if it cannot reasonably be regarded as likely to significantly affect or influence the voting by that member on any question with respect to that contract or matter.”*

From this it should be taken that an honest and mature approach should be adopted to ensure that the potential for future conflict of interest should not be used to exclude good members from the opportunity to contribute to the work of the CHP.

#### **4.2 Identifying and securing representatives**

Many CHPs have worked with either organisations or networks with which their NHS Board already had relationships or sought out new relationships with those infrastructure bodies mentioned in the guidance. This is no criticism, given the kaleidoscopic nature of the voluntary and community sector and the lack of awareness often prevailing in NHS structures of services provided by the voluntary sector. This is a real opportunity for greater partnership working.

Some respondents felt that earlier involvement of the voluntary sector in the CHP development work at locality level may have produced stronger partnerships.

In a considerable number of areas, the local voluntary sector felt that it had not been sufficiently involved in the process of identifying a representative and more than one of the named representatives was unaware of their appointment. It would appear that nomination for one voluntary sector representative had been sought from the local authority rather than approaching the CVS which sponsored a local voluntary sector health improvement network.

Given that the regulations state *“all members shall be appointed by the Board”*, it seems quite extraordinary that the formal appointments process is not coherent enough to inform those who have been chosen of their appointments.

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<sup>2</sup> Link: <http://www.show.scot.nhs.uk/sehd/chp/Pages/CHPfinal%20guidanceOCT2.pdf>

<sup>3</sup> Link: <http://www.opsi.gov.uk/legislation/scotland/ssi2004/20040386.htm>

Voluntary Health Scotland (VHS) is working with Edinburgh Voluntary Organisations Council (EVOOC) on a pilot project which has seen a member of staff employed for an initial period of one year to be the voluntary sector representative on the City of Edinburgh CHP.

This appointee will work one day a week on the business of supporting and representing the voluntary sector on the CHP. The advantage of this model is the strong job description which supports the job holder in developing the local infrastructure whilst remaining independent of any one organisation or community of interest.

In Aberdeenshire these discussions are at an earlier, preliminary stage with the CHP supporting the finding of the pilot project, but it has been noted that geographical and other differences will require a post covering two days per week and a proposal is being developed which takes this into account.

Closer examination of the methods used to select the CHP representatives will be a feature of updates to this mapping exercise.

#### **4.3 Gaining a mandate to represent the voluntary and community sector**

Most representatives of the voluntary sector either already have or are currently seeking a mandate from their local sector to be its representative. One CVS was reportedly seeking “a clear mandate” whilst the related CHP observed that “no-one in the sector seems to have objected” [to the CVS being the representative].

It would appear that realisation of the level of strategic operation at which a CHP committee will be working has dissuaded some of the candidates who wish to represent their own organisation and its concerns rather than the whole sector. The word “representative” or “rep” has therefore been used to describe comfortably the generic role of the voluntary sector member of a CHP committee.

In most instances currently, the actual representation element of the role has not been the main concern. This may become so very shortly as committee structures develop and issues of accountability and governance assume greater importance.

#### **4.4 Building supporting structures**

Clearly CHPs are at a very early stage in their development and many of the ongoing supporting structures for members have yet to be defined.

Many areas have either tentative plans in place for their supporting structures or have fledgling support systems but as yet no evidence base for their effectiveness in the policy environment of a CHP.

Voluntary Health Scotland intends to develop a national support network for voluntary and community sector members of CHPs. This was frequently mentioned in the course of interviews and was given wholehearted support by the voluntary sector. A small unresolved issue was that of interaction with local support networks and ways in which this would be best managed.

In some areas NHS Boards have asked or commissioned voluntary sector organisations to support them in designing their framework for community involvement. Greater Glasgow NHS Board, for example, contracted Glasgow Council for Voluntary Service to develop its draft framework whilst Clackmannan CHP worked closely with Clackmannanshire Council for Voluntary Services' Health Development Worker (HDO) to develop their model, a partnership which the CVS HDO described as "extremely positive and equal."

#### **4.4 Increasing resource and building capacity**

There are very real concerns in some areas about the voluntary and community sector's capacity to service the voluntary sector members sufficiently, this concern being expressed by both the NHS and the CVS network, although couched in different terms. However, it is interesting to note that out of almost 150 places on the CHP national leadership development programme only 2 appear to have been allocated to the voluntary sector.

There is further concern on the issue of reimbursable expenses. The legislation states that "*the Board shall pay all reasonable travelling and other expenses properly incurred by members in connection with the performance by them of functions associated with their appointment.*" However which expenses will be counted as "*properly incurred*" is open to interpretation. At present the range of expenses covered should be set by CHPs, but these should follow the principles of full cost recovery and may be an ongoing area of concern for capacity building.

Enthusiastic individuals within some CHPs are looking at ways in which capacity building can be supported. One CHP has a "switched on" finance officer who is supporting its CVS in getting funding to support involvement along the lines of the VHS/EVOC pilot model. The CVS reported being "shocked and delighted" at his response to their support needs.

#### **4.5 Number of representatives on the committee**

Discussion at the national Community Health Partnership Development Group recognised that the PPF should ideally have two members on the CHP committee, one from a community based organisation and one a member of the local general public. Identifying these two distinct

positions plus a separate voluntary sector representative has led to the strong recommendation in the "Guidance on involving the voluntary sector"<sup>4</sup> that "The committee of a CHP will have at least two members of the voluntary sector amongst its membership".

## 5. Conclusion

From the responses to this baseline mapping exercise to date, the general view within the voluntary sector appears to be that of cautious optimism. This is however tempered by the recognition that much work is still to be done. It also appears that there are many different models of engagement, differing levels of commitment and understanding and differing emphasis placed on routes to engagement/participation through either the Public Partnership Fora (PPF) or the CHP committee structure.

Some areas have noted that the representatives who have been identified from the voluntary sector already have experience within a health setting but there will still be a need for their further development in areas such as partnership development and emerging policy.

VHS has received requests from individual NHS staff for support in developing their own structures to ensure inclusion of the voluntary sector at the appropriate level. This is work which can only really be done with the local voluntary sector but VHS is well placed to advise on any such meeting.

It would appear that there is no one right way for community and voluntary sector members of CHPs to be identified and integrated into the CHP management structure, provided they have the support and confidence of their local voluntary sector and their CHP.

In many cases the rhetoric used from the NHS and the voluntary sector has been quite different, but this has not strayed from the fact that both parties appear to be working in the main towards a productive working agreement. In some areas the voluntary sector has expressed a desire to see established a working agreement to *Compact* principles whilst in others it was the NHS which raised the issue of *local compacts for health*.

This initial exercise in mapping the growing engagement of the voluntary and community sector with CHP management structures as they develop has provided Voluntary Health Scotland with a baseline picture six months on from the setting up of Community Health partnerships in Scotland. VHS is committed to following progress, identifying emerging practice and reporting further on issues arising on an ongoing basis.

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<sup>4</sup> Link <http://www.vhscotland.org.uk/>

I should like to thank all those who have given of their time to respond to this short enquiry and update me on local developments. Their assistance has been gratefully received.

Should you wish to contribute your experience to the emerging picture of voluntary sector involvement in CHPs please contact Voluntary Health Scotland.

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**October 2005**