COMMUNITY HEALTH PARTNERSHIPS

INVOLVING THE VOLUNTARY SECTOR

ADVICE NOTE

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Introduction

1. This paper offers guidance on the contribution that the voluntary sector can bring to the work of Community Health Partnerships (CHPs). It is set within the context of national policy and identifies possible ways to involve the sector as partners. This should help CHPs to develop strong partnerships with the voluntary sector that are focused on improving health and addressing the health and social care needs of the local population.

The Scottish voluntary and community sector

2. The voluntary and community sector is a major force in Scotland, comprising a very broad range of activities, from social care to disaster relief, arts and heritage to environmental preservation and financial services.

3. Voluntary organisations are sometimes referred to as "social economy organisations" and can be of any size; turnovers can range from £50 to £50M, and they are usually supported by a mixture of paid staff and volunteers. They include amongst their number many patient interest/support groups as well as large service providing organisations.

4. Community-based groups are usually active at community or neighbourhood level and frequently depend on volunteers and community activists. Their agendas usually respond to local people's priorities rather than national strategies and policy directives. They normally work developmentally rather than strategically.

5. Many smaller voluntary organisations could not exist without the support of many volunteers but many larger organisations will use only paid staff. Volunteering is simply any activity pursued by individuals without expectation of payment. There is an extensive programme of volunteering within the NHS.

6. Some community organisations will be naturally drawn to working within the parameters of the Public Partnership Forum[1] and thus supporting the Patient Focus Public Involvement agenda, whilst service provider organisations may be more likely to interact directly with the

[1] http://www.show.scot.nhs.uk/sehd/chpdg/Pages/PWI01908AdNote.pdf

CHP committee through local thematic voluntary sector forums.

7. Within this diversity of organisations lie a multitude of differing capacities and abilities and a host of differing visions and internal structures. It has been justifiably compared to looking into a kaleidoscope.

8. However all voluntary and community organisations share the same ethos i.e. **they are non-profit driven, non-statutory and autonomous and are run by management committees who do not get paid for managing the organisation.** Roughly half of Scottish voluntary organisations are also recognised by the Inland Revenue as charities.

9. Both voluntary and community organisations contribute greatly to the health improvement agenda, through their inter-agency working within Community Planning Partnerships, especially with education, housing, leisure and recreation services. Because they are close to communities and understand their needs and priorities, they are able to put forward innovative ideas and muster support from different local authority services. Examples include local food co-operatives, promoting sexual health services for young people in disadvantaged areas and walking groups.

10. At the same time, the many patient interest/support groups within the voluntary sector often provide services on a contractual basis with the local authority or NHS Board to, for example, people affected by dementia, people with mental health difficulties or people with specific conditions such as diabetes or epilepsy.

11. Such groups and organisations will often engage in campaigning on behalf of their members, seeking improvements in the way in which services are provided. Some agencies and groups provide a specific advocacy service, for example acting for individual clients with mental health difficulties or alcohol problems, assisting them in gaining equality of access to health services.

12. Patient interest/support groups will be key players in Public Partnership Forums, articulating the concerns and interests of their membership whilst supporting the CHP in engaging local service users, carers and the public in discussion about how to improve health services.

13. It is important to note that many voluntary and community organisations engage with both campaigning and service provision simultaneously while those areas may be led quite separately by different programmes within the NHS, both nationally and locally.

14. Individual organisations within the voluntary sector have great pride in their independence and their own unique identity. Whilst many may wish to align themselves closely with CHPs it must be remembered

that they are independent organisations and the work that they will undertake may only be one part of their own work plan and accountability framework.

15. As CHPs develop deeper partnerships with their local voluntary sector there will come a greater understanding between the sectors of their respective capabilities. The CHP should actively promote the value in for example joint training and continuing professional development and secondment opportunities between the partners, regardless of sectoral boundaries.

16. Many voluntary sector intermediary organisations exist which work at a strategic level with the Scottish Executive and which are available as supports to local organisations, both voluntary and statutory. Examples of these would be Voluntary Health Scotland[2] and the Community Health Exchange[3], Community Care Providers Scotland[4] as well as the Scottish Council for Voluntary Organisations[5] itself.

17. Voluntary organisations provide specialist information and data which could enhance communication between professionals and patients as well as informing the redesign of services. Organisations could support the work of primary and secondary specialists, for example physiotherapists and pharmacists as well as supporting individuals in the self management of chronic conditions or supporting them through the stress of initial diagnosis.

18. Voluntary and community organisations can support the growing self help agenda within the NHS, especially in the area of self-management of chronic conditions. This could be where national and local organisations, such as Arthritis Care or Asthma UK Scotland, and their local branches, can work in true partnership with the NHS as a part of, for example, a managed clinical network which could span CHP boundaries.

Resources and Sustainability

19. Public sector funding forms an essential part of the voluntary sector's income, currently at 38%[6], but research has shown that public sector funding is open to more volatility and sudden withdrawal than any other source.

20. Research from SCVO suggests that 9% of all public sector funding to the sector goes to voluntary organisations working in the health field, a sizeable share of total public sector funding.

[2] http://www.vhscotland.org.uk/
[3] http://www.chex.org.uk/
[4] http://www.ccpscotland.org
[5] http://www.scvo.org.uk/
[6] http://www.scvo.org.uk/almanac/default.htm

21. However research into funding for the voluntary sector under the NHS Section 16B arrangements[7] has shown that only some £1.7m is disbursed at national level and that less than 1% of Health Boards' overall budget is made available through this funding stream to the voluntary sector locally, while funding levels and practice vary greatly across Scotland.

22. Voluntary organisations are primarily funded for direct service provision and as such most will not have the costs of partnership development work within their current budgets. The hidden costs of active inclusion may be prohibitive for small organisations whose primary function is service provision and whose current funding does not have the principle of "full cost recovery"[8] built into it.

23. Similarly any representatives from the voluntary sector who sit upon a CHP committee will be unlikely to have this work funded as a part of their grant allocation and this may discourage many good candidates from applying for the positions. The CHP will have to consider how resources can be allocated to ensure that the committee positions are accessible to all candidates from the voluntary sector and not just those who can afford the time to participate.

24. A CHP has the potential to encourage voluntary sector growth and sustainability through the contracting of services from its partners within the sector and the opportunity to move away from grant funding into more service level agreements and "mainstreaming" which take into account all of the costs of the partner organisations. As a CHP evolves and knowledge of needs and service availability become clearer then resources will follow need, regardless of which partner is actually providing the service

25. CHPs as multi disciplinary and multi agency partnerships will be fully involved in strategic planning of services across the NHS Board area and in decisions on the use of all NHS Board resources. Therefore the voluntary sector has an opportunity to be part of that process through their involvement as key partners within every CHP.

Building local voluntary sector capacity

26. The Scottish voluntary and community sector is a major employer with an estimated 107,000 paid staff in 2001[9]. The Scottish Executive is committed to growing the contribution of the voluntary sector to public sector delivery and to develop further partnerships between the sectors.

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[7] DR Coid, IK Crombie and MD Murray, Sept 2000, Grant funding of health voluntary organizations by Scottish health boards. *Public Health 114, 5*

[8] http://www.thirdsector.co.uk/charity_news/full_news.cfm?ID=8546

[9] http://www.scvo.org.uk/almanac/snapshot_of_the_sector/summary.htm

27. The Scottish Executive's review of its policies to promote the social economy[10], notes the following among its main findings;

    "social economy organisations can bring added value to the delivery of public services in terms of their capacity to innovate, their closeness to and ability to engage effectively with and meet the needs of their customers/clients and the communities in which they operate, and their access to resources such as volunteer effort and charitable donations"

    And also;

    "there is a case for the Executive to encourage the growth and sustainability of such organisations, so as to increase the range and supply of organisations able to effectively deliver public services;"

28. The recently announced Futurebuilders fund[11], launched on 22 August 2004, is an £18 million investment in the social economy to run over the financial years 2004-05 and 2005-06. Its purpose is to extend and strengthen the role of the social economy sector in delivering better public services whilst encouraging financial sustainability in the sector.

29. Futurebuilders Scotland consists of a £16 million Direct Investment Fund, which is underpinned by £1 million training fund and a £1 million support programme.

30. The Direct Investment Fund will be split into two sections:

    - A £12 million Investment Fund which will award grants to medium to large sized social economy organisations that have established a reputation as service providers. This is designed to encourage capital investment and to encourage them to operate in a more business-like fashion, helping them to develop their financial sustainability; and

    - A £4 million Seedcorn Fund which will award grants to emerging organisations to develop new ideas and enlarge existing schemes that will contribute to their growth and sustainability. It will include a programme of small grants which will encourage new social entrepreneurs to turn local ideas into live projects.

31. Community Health Partnerships will be able to support the growth and sustainability of the voluntary sector by forging strong partnerships with appropriate local organisations and networks to support their continuing development. The drive to co-terminosity with local authority boundaries and the new Futurebuilders Fund will aid the development of these partnerships.

[10] Scottish Executive; A Review Of The Scottish Executive's Policies To Promote The Social Economy, January 2003
[11] http://www.scotland.gov.uk/about/UNASS/UNASS/00015300/Futurebuilders.aspx

The sector as a partner on the CHP Committee

32. The committee of a CHP will have at least two members of the voluntary sector amongst its membership, one of whom will be a member of the PPF and most likely from a patient interest/advocacy organisation. The other should be drawn from a voluntary sector organisation which provides services within the area of the CHP.

33. The voluntary sector, as opposed to individual voluntary organisations, has no obvious hierarchy and is complex in its makeup, whereas in statutory organisations there is a hierarchy and the level of representation is usually defined by seniority and level of responsibility.

34. As a result the national and local voluntary sector networks and structures supporting health, social care and wellbeing will not claim to fully represent the sector; instead they will identify and articulate the priorities that the sector has in common.

35. Councils of Voluntary Service (CVS) is the generic name for the local infrastructure bodies for the voluntary sector in Scotland. They strengthen the contribution local voluntary organisations make to the economic, social and cultural development of the community and provide a bridge between the sector and key public agencies at a local level. The CVS network is currently exploring its potential to contribute further to the wider health agenda.

36. In addition to CVS there may also be appropriate local health networks, such as Community Care Forums, mental health networks and Community Health Projects who may have many years experience of partnership working and who can act as an effective vehicle for voluntary sector involvement. CHPs should actively seek out and support all local voluntary health networks. This needs to be done both as support for individual networks and as part of developing a local infrastructure which is fully inclusive.

37. The actual process of choosing which individuals from the voluntary and community sector sit on the committee of a CHP will be different for each CHP. Not just because the sector is different in each area but also because each CHP will have unique needs and governance structures. However the process is determined it will need to be open, accountable and democratic. The process must be accessible to everyone in the sector and must be recordable and evidenced so that it will stand up to rigorous scrutiny.

38. One way might be an elective process whereby candidates could put themselves forward for nomination and people and organisations within the sector could be balloted on their choices. This could be a way of ensuring that the successful candidate has a mandate from the sector as they will have voting rights on behalf of the sector so should be able

to present the sectors view rather than their own.

39. Any network or individual who participates in working groups or committees cannot be expected to represent organisations over which they have no direct control. Members of these groups require to be chosen for their *experience and knowledge* of the sector in general, for their *abilities to relate sector issues to the subject they are discussing,* and not be expected to be representative of the whole sector.

40. Any person who sits upon the CHP committee may, from time to time, find themselves with a potential conflict of interest in matters which will be discussed, for example if they are from an organisation providing support for people with mental health difficulties and the mental health strategy is being developed.

41. The Community Health Partnerships Regulations (Scotland) 2004 outline the matters to be included in standing orders regulating meetings and proceedings of a community health partnership including procedures for dealing with potential conflicts of interest by members of the CHP committee.

42. At the moment the local voluntary health and social care sector often does not have a recognised strategic officer to work with partners in the statutory agencies. However, by working with and actively supporting their local network organisations, CHPs should be able to identify, support and develop knowledgeable and appropriate people from the voluntary health sector who can clearly articulate the interests of the whole sector locally.

43. It is important that these networks and individuals have support from within the voluntary sector and by partners to develop the infrastructure required which will allow the entire local voluntary sector to feel they have the opportunity to input to the working of the CHP and to give credibility and a “mandate” where required.

Communication

44. In the current fast moving policy landscape local voluntary organisations have to put disproportionate resources into keeping up with policy changes so that they can contribute fully to the crosscutting implications of many agendas. They are assisted in this by national intermediaries who provide information and support to the local voluntary sector.

45. The voluntary sector will have to develop the capacity and capability which will allow national policy to be interpreted effectively and disseminated locally The CHP will be the catalyst for the joining up of the existing forums around health which will support infrastructure development and communication flows.

46. CHPs will wish to have assurances that there are effective communication systems in place to enable continuous information flow between the sectors. A CHP should encourage the continuous development and evolution of effective and innovative communication tools, this could include supporting and encouraging the development of local managed information networks which could be used to disseminate policy as it applies to local CHP priorities and ways of working.

47. National policies require to be translated into local needs and priorities. A CHP will be well positioned to disseminate its thinking to the wider voluntary sector particularly in relation to planning and service quality issues. This is an area where it is vitally important that the appropriate people are appointed to the CHP committee and effective communication pathways are put in place.

Professionalism and accountability

48. As previously noted, the differences between the voluntary and statutory sectors are vast. Understandably this can give rise to mutual misunderstandings of each other's roles, responsibilities, work practices, and lines of accountability.

49. Voluntary sector providers can often be accountable to many differing grant providers and be expected to work to the standards of quality and accountability they require. Membership organisations also have an additional degree of accountability to their own membership.

50. Operational managers within statutory organisations should seek to understand the voluntary sector's structures, functions and ways of working which will allow them to comfortably rely on the sector as fully accountable partners. Similarly the voluntary sector will require to develop knowledge of their partners in a CHP to minimise any misunderstandings which may occur.

51. Voluntary organisations are generally mature, independent organisations that take responsibility for the contractual agreements they sign up to. As independent organisations they have the flexibility to provide adaptable and highly innovative approaches to service delivery and user involvement.

52. Voluntary organisations are already working in partnership with the NHS in many areas, both as direct service providers and in an advocacy/safeguarding role. It is important to remember that, as service providers, they will often engage in campaigning, seeking change and improvement in the way that services for their clients are configured.

Organisational development

53. The organisational development of CHPs has already begun and it is vitally important that voluntary sector support for the planning and development of new CHPs is sought as soon as is practically possible.

54. In many cases CHP structures may resemble voluntary sector organisations or forums and consequently voluntary sector leaders, with their abilities to lead a group of organisations over whom they have no direct management responsibility, will be ideally placed to support the development of emerging CHPs.

Training

55. Within the statutory organisations there is a co-ordinated programme of training, designed to promote organisational as well as personal development.

56. However, within the voluntary health sector there is currently little evidence of such co-ordination and this can result in an imbalanced approach to sector development, with some organisations giving greater emphasis to training than others for a number of reasons. Every opportunity should be taken to work across agencies and organisational boundaries to co-ordinate training and development utilising the skills of all to further develop the CHP.

57. The voluntary sector is also a provider of training as well as being a receiver, and as partners in a CHP, they can provide training and support to agencies who may be working in developmental ways which are new to themselves and to CHPs.

Next steps

58. NHS Boards should examine their current practice in partnership working with their local voluntary sector and identify networks and organisations which they currently engage with and others which would be able to contribute to the development of a CHP.

59. NHS Boards must include the contribution of their local voluntary sector in developing their Schemes of Establishment to ensure that the partnerships proposed are realistic and will help achieve the aims of the CHP.

60. Local voluntary sector infrastructure bodies should begin to develop a locally appropriate, democratic process for the selection of an appointee to the CHP committee.

Appendix One

The Scottish Compact and local compacts for health

1. The *Scottish Compact*[12] lays down a framework of principles covering the working relationship between central government and its agencies in Scotland and the voluntary sector and volunteering interests, including community organisations. It describes commitments by Government and the voluntary sector under the five headings of Recognition, Representation, Partnership, Resources and Implementation.

2. Margaret Curran, MSP, Minister for Communities launched the newly updated *Scottish Compact* between the Scottish Executive and the voluntary sector at the end of February 2004.

3. It takes into account some of the latest legislation by, for example referring to Best Value within the context of the Local Government Act 2003.

4. The aim of the Compact remains the same, which is to develop robust relationships for the wider public good and within its remit it describes the benefits it will deliver, this time specifically including NHS Boards within its parameters.

5. The new Compact also aims to promote an understanding of the value of voluntary sector activity to all public sector bodies and stakeholders and will ensure clear and accessible channels of communication.

6. The updated Compact has a specific implementation strategy, allowing monitoring and evaluation to be carried out. This is a major step forward in that it will allow tracking of any partnership development or changes in ways of working that will arise directly from its implementation.

7. By the end of 2004 Voluntary Health Scotland will have developed a guide to building local compacts for health which every NHS Board can adopt as formal recognition of the agreement between them and their local voluntary sector on the principles of partnership working.

Bill Weir
For Voluntary Health Scotland
January 2005

[12] Scottish Compact: The Principles underpinning the relationship between Government and the Voluntary Sector in Scotland, The Scottish Office, 1998