

# **Further advice note on the role of voluntary sector members of Community Health Partnerships**

**June 2007**



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## Introduction

The Community Health Partnership (CHP) advice note, *Involving the voluntary sector*<sup>1</sup>, issued in December 2004, explained the make-up of the voluntary and community sector (VCS) and outlined some of the benefits of involving the sector in Community Health Partnerships. CHPs are now a reality and their structures and operational arrangements are being developed. This advice note has been developed to address development issues which have arisen over the 2 years since CHPs were introduced in April 2005.

These include:

- ensuring that the voluntary and community sector has a full role to play in the development, planning and delivery of local services
- supporting the voluntary and community sector to engage fully with CHPs
- assisting CHPs to get the best from their relationships with the voluntary and community sector

This advice note will support the organisational role which the voluntary and community sector can play in a CHP. Public involvement is dealt with in a separate advice note, *Community Health Partnerships: Involving People*<sup>2</sup>.

The advice note will be of interest to anyone who is working within a CHP, at whatever level and for whichever organisation or sector they may work for, to assist them in supporting the service planning and delivery partnership.

It is a chance to put "stakes in the ground" and to develop the future planning and development of partnerships which will benefit all service users.

Feedback has been received through the Voluntary Health Scotland *CHP discussion forum*<sup>3</sup> and from personal contacts throughout Scotland.

This guidance has been developed partly from this feedback and also from issues raised at the training and development day for VCS members of CHP

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committees, which VHS held in February 2006. The day highlighted areas which the delegates felt needed further exploration. These were:

1. Issues of representation
2. Issues around resources
3. Concerns over VCS relationships with CHPs
4. Understanding CHP structures and the roles of representatives

Ten subsequent local workshops and discussions were held around the country to further develop the ideas from the day. A list of the workshops can be found in Appendix Two.

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## What is a Community Health Partnership?

Community Health Partnerships were first described in the 2003 Scottish Health White Paper *Partnership for Care*<sup>4</sup>. There were a number of measures contained in the White Paper relating to NHS services that required legislation and these were addressed in *the NHS Reform (Scotland) Act 2004*<sup>5</sup>. One of these measures was the establishment of CHPs.

The original aims of CHPs were to build on the achievements of Local Health Care Co-operatives (LHCCs), to make a measurable improvement in local population health and to provide higher quality, accessible, joined- up services for local communities.

They were concerned with strengthening primary and community based service planning and delivery and developing joint working with local authorities, the voluntary and community sector and other partners. To do this effectively CHPs required status in law and as such are now committees or sub-committees of NHS Boards, with full delegated functions and resources for primary and community based services.

The *statutory guidance*<sup>6</sup> for CHPs, published in 2004, defines them as:

*“...key building blocks in the modernisation of the NHS and joint services, with a vital role in partnership, integration and service design”*

It can be difficult to visualise actual structures as the guidance was understandably not prescriptive. However all CHPs are designed to deliver on two key policy areas:

- A shifting of the balance of care to more local settings and
- Improvement in the health of local people.

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Within this overall agenda, the specific priority areas are:-

1. Better access to Primary Care Services
2. Taking a systematic approach to long term conditions
3. Anticipatory care
4. Supporting people at home
5. Preventing avoidable hospital admissions
6. More local diagnosis and treatment
7. Enabling discharge and rehabilitation
8. Improving specific health outcomes
9. Improving health and tackling inequalities

It is however accepted that every CHP will be slightly different in its makeup. This difference is down to the combination of many local factors but is mainly operational in nature as the actual outcomes for CHPs are intended to be broadly similar.

This is well demonstrated in the paper from Audit Scotland, *How the NHS works – Governance in Community Health Partnerships – Self Assessment Tool*<sup>7</sup>, which notes:

*“Early indications are that CHPs will operate differently across Scotland to reflect local circumstances. The schemes of establishment differ in the proposed governance, leadership and reporting structures, as well as in levels of devolved responsibility. But there are key standards of governance that should be in place regardless of how each CHP is operating”.*

CHPs are actually a broad partnership of many complementary partnerships, or to use a more familiar voluntary and community sector description, a network of networks. These networks will be at many different levels and will be integrated both horizontally and vertically throughout the CHP.

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## ***Why involve the voluntary and community sector in CHPs?***

In relation to voluntary and community sector involvement in CHPs, the *Community Health Partnerships (Scotland) Regulations 2004* were more prescriptive than the statutory guidance in the requirements they placed upon CHPs, and ensured that, as far as practicable, CHP Committees included:

“...a member of the public partnership forum”

Community Health Partnerships (Scotland) Regulations 2004 – 3(1)(i)

The original guidance envisaged the public partnership forum (PPF) would be a network of existing local user and carer groups, voluntary organisations, interested individuals and others with the key role of considering and informing the CHP on specific issues.

As well as:

“...a member of a voluntary organisation whose activities include the provision of a service similar or related to a service provided by the Board under or by virtue of the Act”

Community Health Partnerships (Scotland) Regulations 2004 – 3(1)(j)

The VCS members' committee position and the PPF members' committee position have separate and distinct roles although some NHS Boards have sought to merge the two. This unfortunately somewhat blurs the distinction between the service delivery and development role of the voluntary and community sector's involvement in a CHP and the public involvement role of the PPF.

If we accept that CHPs are actually a network of networks then true VCS involvement means being involved throughout these networks and being a part of the way in which the networks evolve and develop for the good of the people receiving services. This is where the committee member from a service

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providing organisation can be invaluable to the support and development of the VCS involvement in CHPs.

Anecdotal evidence suggests that health improvement activity is split roughly equally between the VCS, the NHS and local authorities. Given that this activity is one of the key policy areas for CHPs and that the voluntary and community sectors are recognised as being the sector often working closest to people and communities, their importance in CHPs cannot be understated. It is imperative that VCS organisations have the appropriate input as full partners when services are being reviewed or developed and that their input is used as appropriate.

While full integration of all sectors in service development and provision may as yet be aspirational, it is important to have the voluntary and community sector involved in as many of the areas of a CHP as is practicable. This should include ensuring the expert involvement of appropriate groups and organisations when services are being planned and developed as well as in service delivery itself.

The importance of involving the voluntary and community sector in the planning, development and delivery of services is summed up in the Kerr Report, *Building a Health Service Fit for the Future*<sup>8</sup>, published in May 2005.

*“Partnership with the voluntary sector must be an inbuilt element of the development of Community Health Partnerships (CHPs). The voluntary sector presence in CHPs will encompass a range of roles including service provision, patient advocacy and involvement in service planning.”*

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## **What is the role of VCS members of CHPs?**

There are distinct roles for individuals, for organisations and for the voluntary and community sector collectively. There are also considerations which need to be taken into account when embarking upon and developing local partnerships between the statutory and voluntary and community sectors. This section gives guidance on those areas which were identified during the workshops as needing further clarification.

### ***Choosing the VCS member of CHP committees***

In deciding who should be a member of the CHP committee or sub committee, it is recommended that the Health Board should discuss and agree with the relevant professions/groups and partner organisations an appropriate way of choosing that person. Each member will have a responsibility to work corporately to achieve the objectives of the CHP. They should also be able to put forward any views that their profession or group has on how to improve health and services.

There are different ways currently being used to choose the VCS committee member and all have their pros and cons but how the committee member is selected will have implications for their standing at the committee meetings. There are also differing numbers of VCS committee members, with some CHPs having up to three VCS committee members and some having the statutory minimum of one.

A strong role description, agreed between the CHP and the VCS, which supports the member to fulfil their partnership development obligations will ease the selection and appointments process by ensuring that all parties are clear on the expectations placed upon the candidate. This and a process of governance agreed at CHP level and within the local voluntary and community sector will give a great deal of support to any VCS committee member.

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Appendix Three contains the role profile from NHS Highland against which their VCS committee members were interviewed for their positions. This gave each candidate a valuable sense of the purpose of the position they were applying for and allowed the four CHPs to gain the support of very competent members of the voluntary and community sector at committee level.

The selection process also needs to be carefully managed to ensure that there is no discrimination against suitable candidates from smaller organisations. Such candidates are less likely to have parent organisations which can give the required levels of support previously noted due to their scale.

No single way of choosing the committee member will please everyone but the importance of the chosen method being fit for purpose has to be the overriding concern to ensure the best service for local populations. The implication inherent in this is that to appoint an appropriate candidate will require the local voluntary and community sector and the CHP to work in partnership during the selection process. The original guidance suggested working with the local Council for Voluntary Service (CVS) or similar infrastructure body to facilitate this partnership approach. Interestingly, within the current VCS committee membership around half are from a CVS although some of these class themselves as temporary or “interim” as they do not feel they have the mandate from their local sector as yet.

The regulations state that all appointments to a CHP committee will be made by the NHS Board. This is a formal process which should be treated accordingly. An informal approach does not convey the gravity of the appointment or the responsibilities inherent in becoming a committee member of a CHP. Given the importance and the responsibilities of these committee positions, the appointments cannot be entered into lightly.

An excellent example of how the value of the position was clearly shown is in Fife where one of the CHPs insisted that the VCS committee member was issued an official NHS Fife badge, with the reasoning that it would allow her unrestricted access to any area or member of staff she required to see.

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### ***Responsibilities of the VCS committee member***

The role and responsibility of all CHP committee members is to collectively drive service improvement locally and to ensure the effective delivery of the functions devolved to the CHP as described in the scheme of establishment. It is important for Health Boards and their key stakeholders to be confident that all members of the CHP committee will work together, and with relevant professions/agencies, in the interests of the CHP and the people they serve. In this respect the VCS committee member will be expected to be as effective a committee member as those from statutory agencies.

As well as the generic roles and responsibilities of any CHP committee member, such as financial and clinical governance issues, the VCS committee member will have responsibilities which are specific to their own committee positions.

It has been argued by some in the voluntary and community sector that the most important part of the committee member's role profile is that they do an effective job in ensuring the facilitation of appropriate voluntary and community organisations in the strategic planning, development and delivery of services. This cannot be done in isolation or by a "control and command" mechanism, for reasons outlined in the original advice note. Members of the local voluntary and community sector must actively support the VCS committee member in their role to ensure this facilitation can happen.

Voluntary and community sector members of CHPs cannot be experts in all areas of health and will not be expected to be so by the other partners in the CHP. Neither will the other committee members be experts in all areas. The members of CHP committees will not directly deliver services nor will they be expected to develop detailed service plans. Instead, they will be expected to contribute their experience and knowledge to support the overall management and direction of CHPs.

CHPs will probably have a strategy to involve the appropriate people from all agencies and organisations around the correct "planning tables", not just those from the voluntary and community sector. This will be to ensure that all partners know that their experience is best placed to positively influence service and

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policy development. This needs to be done to ensure that those involved do not receive negative impressions of partnership from becoming involved in areas which they cannot add to or benefit from. The VCS committee member will need to actively support and contribute to any such strategy at committee level and be able to sell the vision of involvement at a local level.

It is likely that a great deal of service development and delivery will be delegated to expert groups within the partnership which will be given a set of clear objectives and be expected to deliver policy and service developments which will meet the expectations placed upon them.

Sub-committees, working groups, sounding boards - there are many different names but these will be the expert groups which may be tasked with developing some of the operational policies of a CHP. These are the groups where individual and organisational expertise from the wider partnerships, including the voluntary and community sector, will be best invested in terms of time and expertise and ultimately where individual returns will be noted. There will be differing levels and networks at work and it will be important to choose the most appropriate places for each organisation or individual to be involved.

For example a youth club may have an interest in specific alcohol issues whereas a local council for alcohol would have much wider interest in the topic. Any service development or delivery would ideally include both of these partners but the council for alcohol would likely be involved at a more strategic level.

Committee members need to know how to gather the intelligence required from the sector to be representative when necessary, for example performing a collective advocacy role on such issues as inter-sector relationships and the policies which affect the sector. This will be aided by the commitment from the network of Councils for Voluntary Service (CVS) to map and paint a clearer picture of their local voluntary and community sector. This, however, should be in situations where they cannot actively involve the sector itself, rather than as the norm.

Committee members from the voluntary and community sectors will need to find out how much support they can rely on from their own sector and how

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many organisations will rally to the call to support service development. As previously mentioned, without the knowledge that their input will positively influence service design and implementation, many voluntary and community organisations will question the value of expending resources on supporting CHPs.

VCS committee members need to believe in and be able to see the *bigger picture* of what is happening in their area, and they need to be able to sell this integrated vision to all of the partners in the delivery of services.

It is a complicated role but the committee member needs to be able to balance the expectations of the sector with the accountability required of a CHP committee member.

A working example of this need for both information and support can be seen in Fife where each CHP has a corresponding voluntary sector health and wellbeing network. These networks both support and direct the work of the VCS committee members on the three CHPs.

There are already very good models of partnership working between the NHS and the voluntary and community sector and, as a great many of these are in primary care settings, it is likely they will quickly be integrated into CHPs. These range from support and advice- providing organisations which might be a part of a Managed Clinical or Care Network to services such as NHS Forth Valley's substance misuse services, which is given at point of delivery by the local voluntary and community sector.

Those organisations already working closely with the NHS will likely continue to do so under the CHP arrangements. The challenge will be in enticing and supporting new organisations to become and remain involved with the CHP.

Positive change is usually achieved through the will and creativity of pioneers, who share their experience with others. In many areas CHP committee members will have the opportunity to be these pioneers.

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## ***Representation verses Facilitation***

Many voluntary and community sector areas are no longer asking the VCS committee member to be representative, instead they are asking for a facilitative role to be played by the CHP committee member. Similarly, many CHP General Managers are not asking for representatives. They are instead looking for someone who can give a “*reality check*” and who can bring a good working knowledge of their own area. They require someone who can help to ensure that strategic development includes sustainability of services. Only by all committee members being realistic about the strengths and weaknesses, threats and opportunities within their sphere of influence will true sustainability be built into CHP development.

There are differences between representative and facilitative models which need to be considered when deciding what is wanted from involvement in community health partnerships. Neither is actually right or wrong, but there will be times when a committee member has to be representative of the ways of the sector, its politics or its funding for example, and other times when a committee member has to be facilitative.

As noted in the original *Involving the voluntary sector: Advice notes*<sup>1</sup>, a committee member cannot represent all of the organisations in a geographical area. Neither can they instruct organisations or individuals over whom they have no direct management control to participate in the development of services.

For the process of service development or review the committee member will not be expected to be an expert in specific areas. As previously noted, individual CHP committee members will probably not perform the actual hands-on review or development of services. Their expertise will lie in facilitating the involvement of the appropriate organisations in the groups which are developing or reviewing services.

At developmental levels, within the groups which are tasked with developing and delivering services, members from the voluntary and community sector will

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directly represent their organisations and the contribution they can bring to service planning and delivery.

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## ***Involving the VCS as a proxy for involving the public***

Voluntary and community sector members are primarily on the CHP committee to support the overall management and direction of CHPs just as any other committee member. They have an extended role to ensure that this development includes a role for the sector in the provision of services. This role can be seen as supporting the partnership element of the CHP.

At the beginning of July 2006 a report was published in England by the Third Sector Commissioning Taskforce entitled *No Excuses. Embrace partnership now. Step towards change!*<sup>9</sup> It is the result of a year's working between the third (voluntary and community) and statutory sectors. The Task Force set out to establish what barriers existed to the VCS providing health services and to look for ways to overcome these, to promote a sound commercial partnership between the sectors and to promote equality of access for VCS organisations in the development and provision of health services.

The report sets this out in the context of the vision for reform of health and social care in England

The report of the Third Sector Commissioning Taskforce notes that:

*“Many third sector organisations will have clear and well-grounded views on how best to achieve the outcomes for service users sought by commissioners, and how resources can be used most effectively. They should systematically be involved in needs assessment, priority setting and service design – **although commissioners and the sector also need to recognise that involving third sector organisations is not a proxy for engaging local communities and service users themselves.**”*

They note a clear distinction between a dialogue with **groups of users** and a dialogue with **groups for users**.

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The guidance, *Informing, Engaging and Consulting the Public in Developing Health and Community Care Policies and Services*<sup>10</sup>, issued by the Scottish Executive in 2003 in draft form, requires NHS Boards to inform, engage, consult and provide feedback to patients, service users and their representatives including carers, on **all** proposals for service change. This is one area where voluntary and community organisations will support public involvement by facilitating dialogue with groups of service users.

One major distinction between involving the public and involving the voluntary and community sector is over the issue of representation. In order to involve large groups of the public, there needs to be a mechanism by which the public can be represented. The *National Standards for Community Engagement*<sup>11</sup> aim to ensure effective engagement of communities and as a working definition of community engagement uses the following:

*“Developing and sustaining a working relationship between one or more public bodies and one or more community groups, to help both to understand and act on the needs or issues that the community experiences.”*

This definition describes the gathering of intelligence and the development of relationships within communities. Although it establishes the groundwork for working together it does not fully cover the integration of service providing organisations within the structure of a CHP. Involving the voluntary and community sector is about developing organisational partnerships. It is about ensuring that people with appropriate knowledge from appropriate organisations are engaged within the planning, developing and delivery of services, taking into account the relationships and intelligence from within the communities.

Effective voluntary and community organisational involvement cannot be dealt with through the Public Partnership Forum on its own. Although the PPF will have voluntary and community organisations within its membership and will be supported by the voluntary and community sector it cannot be used as a proxy for the true engagement of organisational knowledge and expertise in the development, planning and delivery of services.

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Voluntary Health Scotland is currently working to develop supports for voluntary and community organisations which will allow them to play a fuller part in the public involvement agenda at a local level.

### ***Resources for partnership***

CHP resources will inevitably be focused on service delivery through the partnership and, as all sectors are aiming to maximise their resource value, a joined up approach allows everyone to work smarter rather than harder. It is generally accepted that no one sector can deliver population health improvement in isolation and therefore the partnership approach is particularly important. One of the values of the partnership approach will be the aligning of complementary services and the joint working practices which can assist each partner in meeting and possibly exceeding their individual targets.

The supports which are required for partnership working are not necessarily monetary. Indeed the experience in Edinburgh, where the CHP committee member has been advertised as a salaried position for one day a week but Edinburgh Voluntary Organisations Council (EVOC) has had difficulties in filling the position, shows that finances is possibly not the barrier it was expected to be.

Committee members require the resources and the time to do all that is asked of them. The guidelines for non-executive NHS Board members suggest that up to eight hours a week should be allocated to do an effective job but realistically, with CHPs being as embryonic as they currently are, this is likely to be much more at the present time for the CHP committee member. It is unlikely that anyone without the support of their organisation will manage to find this amount of time within their working week and the need for this level of commitment requires to be made clear to anyone wishing to take on the position, as well as the supports they can expect to receive.

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A promising example of partnership development support is in Aberdeenshire, where the CHP has given development monies to the CVS for a two year period to develop the local voluntary sector capacity for involvement.

Voluntary and community organisations recognise that they cannot currently be financially remunerated by the CHP for participating in the actual design of services unless they are specifically commissioned to take part. Therefore organisations which take the time to become involved in planning and developing services need to be confident that in giving their support it will be effectively used, it will be enthusiastically welcomed and that their knowledge and experience will be listened to and accepted.

The converse of the above statement is, of course, that voluntary and community organisations who do become actively involved in the workings of a CHP need to be able to listen to partners and learn from their collective experiences and knowledge sets. In this way the CHP, and by proxy the local populous, will benefit from the sharing of knowledge and resources which true partnership working will bring.

Whilst the provision of an improved service is of paramount importance, it is the joint delivery of services and the sustainability this can bring which will inevitably draw in voluntary and community sector partners to the planning and delivery of those services.

When the intelligence and the networks from the voluntary and community sector are combined with the intelligence gathered from other areas, such as the PPF, it can only improve the health planning for a particular area. The true value of investing resources in developing the mechanisms to support this intelligence gathering through appropriate support for the voluntary and community sector will be difficult to quantify in any short period of time, but could be tracked by CHPs and the voluntary and community sector to allow appropriate justification of investment and resource usage.

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## ***Resources for service delivery***

There are some concerns in the voluntary and community sector about any move away from grant funding for voluntary and community organisations towards service level agreements or contracts. When an organisation receives grant funding for a piece of work around identified needs, it is argued that that organisation is leading on the agenda, whereas a contract is seen to be based upon the contractor's needs or assessments. Some people in the voluntary and community sector have expressed discomfort with this perceived move away from their being seen as *leading* on an agenda towards being seen as *following* the NHS agenda.

This can be reconciled if the voluntary and community sector is an integral part of the strategic planning for health and service delivery for a given area. With this model they have joint ownership of the process of determining local needs and can comfortably develop services to assist in meeting those needs through service level agreements as well as supplementing these with grant-based income should this approach be required.

Each partner will bring resources to service delivery but not all will be in monetary terms. Much has been written about the "added value" which the voluntary and community sector can bring to service delivery and this can include;

- Building social capital
- Meeting special needs or responding to niche interests with significant expertise
- Having an independent voice
- Fully involving their stakeholders
- Being flexible and innovative
- The ability to work across public sector divides

This "added value" can be seen as complimentary working practices which will strengthen the work of the CHP and extend its reach within the community it serves.

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The CHP itself will have its own budget which can be used for service delivery and which will allow it to commission services from the partners within it. Thus the best working practices in terms of value for money, responsiveness and innovative approaches should be supported and developed to ensure the recipient of services gets the best service available to meet their needs.

The Third Sector Commissioning Taskforce sums up the financial advantages of contracting with the voluntary and community sector and the added value it can bring:

*One of the great strengths of commissioning from the voluntary sector is its ability to add value through the access to services. These include engagement and empowerment of service users and groups, the provision of information and advice on needs not directly covered by the contract, and support to access other services. Voluntary organisations often have great potential to further add value to services by working in partnership with other organisations.*

- *Commissioners should engage potential voluntary providers in discussions about added value.*
- *Commissioners should develop a clear understanding of how users and stakeholders are engaged in other aspects of the organisations' work, and explore how these mechanisms could add value to the contract, or other services.*
- *Commissioners should explore with voluntary organisations whether further added value could be achieved by the inclusion of additional organisations in delivery partnerships.*
- *Appropriate remuneration should be paid for quantifiable added value benefits, under the principles of Full Cost Recovery.*

*Report of the Third Sector Commissioning Taskforce Part 2*

Full Cost Recovery (FCR) is an acknowledgement that voluntary and community organisations may need additional funding to cover overheads which would not be appropriate to a profit making company. It applies when statutory organisations or departments procure or fund services delivered by voluntary or

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community sector organisations. HM Treasury first endorsed the principle of Full Cost Recovery in its 2002 cross-cutting review, *The role of the voluntary sector in service delivery*<sup>12</sup>.

### ***Developing a shared understanding***

It is generally accepted that the voluntary and community sector can be difficult to understand and it has been likened to a kaleidoscope due to its myriad of differing organisations.

In the local workshops, it was observed that designated and protected time needed to be given over to develop the understanding and relationships required to take forward partnership working. This was equally to support the voluntary and community sector in developing a greater understanding of the intricacies of the NHS and the NHS in better understanding the voluntary and community sector.

In business this would be a function of marketing but neither the NHS nor the voluntary and community sector has an overt marketing function. However there are ways to go gathering this intelligence but just introducing senior management to each other in the two sectors will do very little to effect change.

It was also brought up that many supposed organisational relationships are actually based on personal contacts. By definition these are personal relationships and do not necessarily foster working relationships between organisations. These personal relationships have no effective terms of engagement and do not currently constitute real service integration. However they do offer the potential to develop the "compact champions", as noted in the key findings of the *Review of Local Compacts in Scotland*<sup>14</sup>, commissioned by the Scottish Executive in March 2005.

*"There was a general view that there is a need for a Compact "champion", in effect a visible figure from either the public or voluntary sector who can act as a focus for promoting the benefits of a Local Compact."*

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The recently updated *Scottish Compact*<sup>15</sup> is an agreement between the Scottish Executive, its Agencies and Non-Departmental Public Bodies and the voluntary and community sector on the principles of working in partnership. It is based on a mutual understanding of the distinctive values and roles of the Executive and the voluntary and community sector. Its aim is to develop robust relationships for the wider public good.

There are two “levels” of compact: “national” compacts and “local” compacts. Local compacts typically involve either a single, or, increasingly, a group of public bodies and representatives of the voluntary and community sector at a local level. An example of a local compact would be the compact between NHS Tayside and its local voluntary and community sector.

In early 2005 Voluntary Health Scotland, working with many other voluntary and community organisations, produced a guide to local compacts for health. This is currently due for revision but original copies can be obtained from VHS. The work also fed into the Scottish Executives *guidance on developing local compacts*<sup>16</sup>, which was published in 2006.

Compacts are not legal documents. Compacts are, in effect, non-binding agreements entered into by the partners.

Many infrastructure bodies in the voluntary and community sector, such as CVS, are currently mapping their localities to ensure that local organisations are known and can be informed of the opportunities which exist within the CHP. This local intelligence gathering will be of great assistance to the VCS committee member in ensuring that the most appropriate organisations are invited to a seat at the appropriate planning and service review tables.

It is also imperative that the organisations which are invited to take part in topic specific development, planning and delivery of services within sub committees and working groups are able to support and contribute fully to the discussions. Any VCS member participating at this level will be representing his or her own organisation and the contribution it can make to changing health locally. For this reason they must be senior enough to commit to the change processes required in this new environment.

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Members of staff from all organisations who are supporting the development of services need to be able to see where such service development fits in with their own organisations' agenda and funding sources. They need to be clear where their organisations can contribute within existing funding streams but also be able to commit to further development through the CHP budget as an active partner, where this is appropriate. The programme *Leadership for Health Improvement in Scotland*, which is currently being delivered by NHS Health Scotland and NHS Education Scotland and is targeted at dispersed leaders who can deliver local change, will support individuals and organisations in this situation.

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## Recommendations for the way forward

### For CHPs

### For the local voluntary and community sector

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CHPs should ensure that they are fulfilling the legislative requirement to have separate VCS and PPF committee members, as per the regulations and the Audit Scotland Governance Toolkit.

Local voluntary and community sectors should ensure they have sufficient infrastructure in place to support the VCS committee members and the PPF committee members.

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CHPs should examine their appointments processes to ensure they are supported by the local voluntary and community sector and that they can support candidates from smaller organisations.

Local voluntary and community sectors should examine their nomination processes and ensure they support the involvement of smaller voluntary and community organisations.

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CHPs should assess their partnership structures to ensure they are equally accessible to all partners, not just the voluntary and community sectors.

Local voluntary and community sectors should ensure they have an understanding of the partnership structure within their CHP and can align themselves with it where applicable.

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CHPs should appraise the role description for committee members and assess its suitability in facilitating the involvement of the voluntary and community sector in service delivery and planning.

Local voluntary and community sectors should ensure they have a clear, written expression of the expectations it places on the VCS committee members of their CHPs.

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**For CHPs****For the local voluntary and community sector**

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CHP committees should review how they are involving voluntary and community sector organisations within the spirit of partnership envisaged in the original guidance.

Local voluntary and community organisations and umbrella bodies should examine their own relationships with CHPs and seek to understand how these can be improved for the benefit of service users.

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CHPs should review how they differentiate between public involvement and involving the sector as a partner in the planning, development and delivery of services.

Local voluntary and community organisations should look to how they can support the public involvement role of CHPs as well as the planning and delivery of services.

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CHPs should take this opportunity to examine how the inherent added value of involving the voluntary and community sector is monitored and quantified.

Local voluntary and community sector leaders should assess how they are promoting, supporting and assessing the value of organisational integration into CHPs

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Developing these relationships will ultimately allow the CHP to be much more effective in its partnership working which in turn will translate into improved health and service outcomes for the local population.

**Bill Weir**

**For Voluntary Health Scotland**

**June 2007**

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## ***Appendix One - Sources of support***

### **Voluntary Health Scotland**

Voluntary Health Scotland (VHS) is the first and only national network of voluntary health organisations of its kind in the UK. Established in 2000, VHS has over 290 members and is recognised as a Scottish charity.

VHS is committed to the challenge of developing strategic partnerships with health services in Scotland so that voluntary and community organisations can maximise their contribution to health improvement and health care.

VHS was a key member of the national Community Health Partnership Development Group and provided a significant input to the development of the statutory guidance for CHPs.

VHS also developed the initial advice note on involving the voluntary and community sector in CHPs, which was adopted by the SEHD and distributed by them.

For further information contact: Helen Tyrrell, Director on [Helen.Tyrrell@VHScotland.org.uk](mailto:Helen.Tyrrell@VHScotland.org.uk)

VHS can be found on the web at <http://www.vhscotland.org.uk>

VHS office number 0131 557 6845

### **The VHS CHP support network**

Voluntary Health Scotland has developed and hosts the national support network for voluntary and community sector members of CHPs.

The network was launched at the training and development day for the VCS committee members of CHPs in February 2006 and is currently working to address the fundamental issues which were identified on the day through a series of regular training and development days and the gathering and publication of evidence.

There are a number of national voluntary and community sector networks in addition to VHS such as SCVO, Community Care Providers Scotland and CHEX already offering specific support to meet the needs of voluntary and community sector members of CHPs. The VHS support network has been developed specifically to address the information, policy, infrastructure and networking needs of the very large number of individuals from groups and organisations engaged in health improvement and health care through CHPs in Scotland.

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The aims and objectives of the VCS CHP members' network are:

- To undertake a learning needs analysis for voluntary and community sector members of CHPs
- To identify and facilitate training and learning opportunities to meet the identified training needs.
- To provide opportunities, most often internet-facilitated, for CHP voluntary and community sector members to engage in networking, peer support and the identification of common issues
- To identify and disseminate examples of good and emerging practice In CHPs

In addressing these issues, the support network will allow the voluntary and community sector to gain the confidence to allow them to fully participate in CHPs and assist them to deliver the health improvement agenda required of them.

### **Voluntary Health Scotland Discussion Forum**

A key feature of the VHS support network is the discussion forum which facilitates communication, peer support and the identification of common issues. This is a web based, interactive discussion forum which is open to everyone who has an interest in CHPs. The forum can be accessed through the Voluntary Health Scotland website.

[WWW.VHscotland.org.uk/BB](http://WWW.VHscotland.org.uk/BB)

The forum continues to be developed and is a growing resource which will enable VHS to map the voluntary and community sector input to CHPs, allow CHP committee members to share emerging practices and to quickly identify common issues arising. It is intended to be a useful knowledge base on all aspects of the voluntary health sector.

### **Community Health Exchange (CHEX)**

The Community Health Exchange (CHEX) is part of the Community Development Foundation and operates within the Scottish Community Development Centre. CHEX is funded by the NHS Health Scotland and its target groups are community health projects and community health initiatives across Scotland.

CHEX's remit is to support community development approaches in health improvement and it has created opportunities for community health initiatives to explore good practice in community engagement and participation with CHPs.

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Along with Voluntary Health Scotland, CHEX has further sought to build capacity through influencing outcomes of the Community-Led: Developing Healthy Communities Task Group.

CHEX provides support at a local level.

For further information contact: Janet Muir, Manager on [Janet@scdc.org.uk](mailto:Janet@scdc.org.uk).

## **SCVO**

The Scottish Council for Voluntary and community Organisations is the national body representing the voluntary and community sector. SCVO seeks to advance the values and shared interests of the voluntary and community sector by fostering co-operation, promoting best practice and delivering sustainable services.

SCVO supports the activities of Scotland's charities and voluntary and community organisations by prioritising its work around five key themes.

- Promoting Equality
- Developing Active Communities
- Growing the Social Economy
- Highlighting the Rural Dimension
- Building Sustainability

SCVO can be found on the web at [www.SCVO.org.uk](http://www.SCVO.org.uk)

## **CVS Network**

The Councils for Voluntary and community Service (CVS) Network was identified in the original CHP guidance as being one of the key ways to engage with the voluntary and community sector at a local level. It consists of 56 independent local intermediary organisations that provide a range of development and support services to the voluntary and community sector in Scotland.

The Network delivers these services via their Core Activities Framework which focuses on 6 key areas:

- Understanding the voluntary and community sector
- Communicating with the voluntary and community sector
- Representing the interests of the voluntary and community sector
- Providing support services
- Promoting good practice
- Growing the sector

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CVS activity is supported by the Scottish Executive and local authorities, as well as by trading income and funding from a wide range of sources.

From April 2004, the Scottish Council for Voluntary Organisations (SCVO) has had direct responsibility for the development and co-ordination of the Network and contacts for all CVS can be found on the SCVO website.

### **Scottish Health Council**

The Scottish Health Council's role is to ensure that people's views are valued and have influence both in their personal relationship with the NHS and as members of communities affected by changes to local services. It will ensure that each Community Health Partnership operates their Public Partnership Forum effectively and in accordance with standards currently being developed by the Scottish Health Council.

The support available from the Scottish Health Council includes opportunities to network and share and record practice together with advice from their local offices across Scotland.

Contact: Rosemary Hill, Development Manager

Telephone: 0141 225 6876

Email: [Rosemary.hill@scottishhealthcouncil.org](mailto:Rosemary.hill@scottishhealthcouncil.org)

Further information on the Scottish Health Council can be found at:  
[www.scottishhealthcouncil.org](http://www.scottishhealthcouncil.org)

### **Scottish Health on the Web (SHOW)**

SHOW is the website of the NHS in Scotland and is a portal to all NHS Boards, both geographical boards and special health boards, such as NHS Health Scotland. It hosts the Scottish Executives Health Department's web site as well as all recent health publications from white papers to official health department letters.

Show also hosts both the Scottish Executive Health Departments' CHP website and the Community Health Partnership Development Group (CHPDG) website.

SHOW can be found on the web at <http://www.show.scot.nhs.uk>

## ***Appendix Two - Timetable of workshops***

| <b>Date</b>           | <b>Working in partnership with:</b>                    | <b>Place</b>           |
|-----------------------|--|------------------------|
| 24 <sup>th</sup> May  | Clackmannanshire CVS                                   | Alloa                  |
| 25 <sup>th</sup> May  | Association of CHPs and Institute of Health Management | Airth Castle, Stirling |
| 6 <sup>th</sup> June  | Perth and Kinross CVS                                  | Perth                  |
| 8 <sup>th</sup> June  | Bridge CVS   | Buchan                 |
| 13 <sup>th</sup> June | Renfrewshire CVS                                       | Paisley                |
| 14 <sup>th</sup> June | Borders Forum of CVS                                   | St Boswells            |
| 16 <sup>th</sup> June | CVS Falkirk and Carers centre                          | Falkirk                |
| 22 <sup>nd</sup> June | Midlothian Voluntary Action                            | Dalkeith               |
| 27 <sup>th</sup> June | Stewartry CVS  | Kirkcudbright          |

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## ***Appendix Three – Role profile from NHS Highland*** **- an example of good practice**

Note – NHS Highland now has four CHPs since Argyle & Bute CHP joined them in April 2006, after this document was written.

This role description applies to members appointed to participate on the main Committee of each of NHS Highland's three CHPs on behalf of the voluntary sector

- North Highland Community Health Partnership
- Mid Highland Community Health Partnership
- South East Highland Community Health Partnership

The voluntary sector members appointed will represent the wider voluntary sector within the area of the CHP; will promote the voluntary sector as a partner in health and care service provision, and will contribute to the achievement of the CHPs objectives in relation to health and wellbeing.

### **The role of the voluntary sector member on the CHP Committee**

1. To promote the profile of local voluntary sector groups and organisations within the CHP as partners in service provision.
2. To contribute to the development and strengthening of positive working relationships across all local partners.
3. To provide or facilitate expert advice to CHP Committee and associated groups on aspects of new policy, funding streams or other national, regional or local initiatives which have an impact on voluntary sector activity in relation to health and wellbeing.
4. To ensure that the decisions and actions of the CHP are informed by the perspectives of local voluntary sector groups and organisations.
5. To promote or facilitate the contribution of the voluntary sector in projects or initiatives aimed at improving the health and wellbeing of local people.
6. To contribute to building community capacity through the effective utilisation of the wide range of skills and expertise within the statutory and voluntary sectors.
7. To contribute to the planning of service change initiatives, and to encourage best practice in informing and involving patients, carers and the wider community.

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8. To take a corporate and supportive approach as a full member of the Committee.

9. To assist in the development of CHP community involvement and other related strategies.

### **Eligibility for appointment to CHP Committee**

You must be employed by or have formal, officer status in a voluntary sector organisation which is a provider of direct services in health care or in the promotion of health improvement and which operates within the area of the CHP.

You will have a wide range of skills – personal and professional – in order to meet the requirements of the role description.

You will have a record of working alongside the NHS, be willing to develop insight into NHS structures and systems, and be able to support NHS colleagues to develop greater understanding of working systems within the voluntary sector.

You will be able to demonstrate an ability to work well with a range of different agencies in the voluntary, statutory, and independent sectors.

You will have a commitment to continuing learning and development, and to use opportunities for joint learning/working with NHS colleagues and other partners.

You will have good communication skills including the ability to communicate on behalf of other organisations/groups, even if you do not share their views. You will have effective communications links in order to feed back responses or highlight issues within the wider voluntary sector.

You will be willing to work in a positive way alongside a wide range of people from within the NHS and partner agencies in the interests of all patients and communities, and to challenge, question and contribute in a constructive manner.

### **Commitments**

#### **Fixed commitments – meetings**

North CHP meetings are held 5 times a year, last approx 3 hours and venues are rotated around the area – (Wick area; Golspie area and Tongue)

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Mid Highland CHP meetings are held four times a year, venues vary throughout the area but may include Fort William, Invergordon, Skye. Meetings start at 10am and normally finish at 1pm.

South East Highland hold four meetings per year, venues rotate throughout the area. Meetings normally start at 2pm and finish around 5pm.

### **Other work/activities**

In order to work effectively on behalf of local voluntary organisations, you may need time for a range of other activities, for example

- involvement in other CHP operational meetings, e.g. management teams, locality meetings
- reading briefings, reports, other documents
- networking with other voluntary sector bodies, both formal and informal, and gathering intelligence to feed in to CHP Committee or other activity
- one to one reviews with CHP General Manager (or other as agreed) to identify and respond to any issues arising in connection with Committee conduct or business.
- working with NHS staff to identify and address your individual learning and development needs, and utilising any support offered for training or development

### **Process for Appointment to CHP Committee**

The 3 existing Highland CHPs have an agreement with Voluntary Action Highland (VAH) who have undertaken to coordinate the appointment process on their behalf.

- A role description and guidance on membership will be circulated widely to all known Voluntary organisations with a health interest by VAH.
- Applicants will be invited to express an interest in membership of the relevant CHP committee on a proforma to be submitted to VAH.
- All applications received on the agreed closing date will be considered for short listing by a panel consisting of:
  - CHP Chairman
  - CHP General Manager
  - Representative of Voluntary Sector (National Level)
  - Representative of Voluntary Sector (neighbouring area [non-Highland])
- Short listed applicants will then be invited to attend an interview with the aforementioned panel.

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## **Period of office**

CHP Committee members from the voluntary sector will be appointed for 2 years initially, followed by a review of arrangements. A further term can be served by agreement. It is expected that members will serve a maximum of three terms in total not exceeding 6 years.

## **Financial support for Voluntary Sector Members**

Members of CHP Committee from the voluntary sector will normally be paid employees of a service provider organisation. Members time will not be repaid by the CHP. If the demands of the CHP result in additional expenses for the voluntary sector member, these must be discussed with the CHP General Manager in advance, and all reasonable expenses incurred directly as a result of CHP activity will be reimbursed at the standard rates and allowances paid by the NHS.

Version 1 – July 2006

Review – July 2007

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3. Voluntary Health Scotland CHP discussion forum  
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4. Scottish Executive (2003) **Partnership for Care: Scotland's Health White Paper**
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9. Department of Health (2006) **No Excuses, Embrace Partnership Now, Step towards change!**
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11. Scottish Executive (2003) **Informing, Engaging and Consulting**
12. HM Treasury (2002) **The role of the Voluntary and Community Sector in Service Delivery: A Cross Cutting Review**
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14. Scottish Executive (2004) **the Scottish Compact**
15. Scottish Executive (2006) **guidance on developing local compacts**