



**The role of the third sector in health
improvement within Community
Health Partnerships: a sector
perspective**

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Abbreviations

CHP	Community Health Partnership
CPP	Community Planning Partnership
CVS	Council for Voluntary Services
GP	General Practitioner
JHIP	Joint Health Improvement Plan
NHS HS	NHS Health Scotland
PPF	Public Partnership Forum
VHS	Voluntary Health Scotland

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Executive Summary

In recent years, health legislation and policy development in Scotland has reflected the drive for health improvement and the aim to tackle health inequalities. In an attempt to modernise the health sector and establish opportunities for joint partnership, Community Health Partnerships (CHPs) were created in 2004 to act as a vehicle for partnership working for health between agencies and sectors including the NHS, local authorities and the voluntary and community or third sector.

This enquiry seeks to clarify the planning and delivery contribution of the third sector to health improvement within CHPs and articulate the unique value brought to health improvement by the sector. In doing so, this paper also seeks to review the progress of CHPs in taking forward an integrative approach to health improvement, offer suggestions for good practice and identify action points to enable CHPs and the third sector working within them to improve their ability to deliver the health improvement services crucial for maintaining the health of the nation.

The results of our enquiry are based on responses from 33 senior members of third sector organisations from across Scotland, who participated in a 20-minute telephone questionnaire.

Approximately one quarter of respondents believe that the partnerships in their CHP(s) are working well; health improvement in CHPs is facilitated through networking opportunities, capacity building and acceptance of the third sector as a contributing member. It would appear that while the third sector places the community at the forefront of the work which they take forward, CHPs as a whole are struggling to deliver on their remit to act as a channel for the community to voice their health improvement and health care needs.

The third sector makes an indispensable contribution to health improvement. The unique value which it brings to the CHP stems from a localised approach, the ability to meet community and user needs, and the application of practical community knowledge. Significantly, the breadth of services offered by the third sector appears to avert community reliance away from NHS acute services.

Points for future action are highlighted that will assist the third sector to better meet its service capacity and help CHPs to improve their integrated delivery of health improvement services. Intermediary bodies will take on a strategic role in ensuring that the potential of the third sector is met.

1. Introduction

Voluntary Health Scotland (VHS) is the national intermediary body for the voluntary health sector. Established in 2000, and supported by the Scottish Government Health and Wellbeing Directorate and NHS Health Scotland, VHS is a membership organisation, linking together over 300 national and local groups and organisations in the third sector. The purpose of VHS is to support members and the wider third sector to maximise its impact on health improvement and health care in Scotland.

The third sector is now fully recognised as a significant force in improving health in Scotland and as a key partner of government in the planning and delivery of services designed to achieve this. VHS is committed to the challenge of developing strategic partnerships with health services so that the sector's work can bring its unique value to health outcomes in Scotland.

For the last four years, Voluntary Health Scotland has worked extensively to support sustainable partnership working between the third sector, the NHS and local authorities through the development of Community Health Partnerships (CHPs) and Community Planning partnerships (CPPs).

Particular efforts have been focused on the role of individual third sector members in the governance arrangements for CHPs and on the health improvement and public participation agendas, the latter through Public Participation Forums (PPFs). This work has been carried forward within the developing policy context for the local delivery of health improvement and health care in Scotland.

2. Policy Context

2.1 Community Health Partnerships

In recent years, health legislation and policy development in Scotland has increasingly recognised the gains to be made through working with the third sector. The *Local Government in Scotland Act (2003)*¹ obliged local authorities to engage with NHS Boards and other partners, including third organisations, to advance their powers to promote well-being through community planning arrangements.

In 2004, the *NHS Reform (Scotland) Act*² made provision for setting up Community Health Partnerships and their associated Public Partnership Forums as the vehicle for public participation. Incorporated in the act is the duty of NHS Boards and their CHPs to achieve health improvement in co-operation with others.

A number of pieces of guidance and advice ancillary to the regulations for setting up CHPs laid out a clear role for the third sector. The *Community Health Partnerships Statutory Guidance (2004)*³ made clear the expectation that CHPs would discuss and agree the inclusion of their national and local third sector partners in their governance arrangements and in the planning and delivery of services.

Advice Notes on achieving public participation and health improvement within CHPs were prepared by the last Scottish Executive administration (*Community Health Partnerships: Involving People (2004)*⁴ and *Community Health Partnerships and Health Improvement (2004)*⁵ and Voluntary Health Scotland has itself prepared two Advice Notes on achieving sustainable partnerships with the VCS in CHPs – *Community Health Partnerships – Involving the Voluntary Sector (2005)* and *Further advice note on the role of voluntary sector members of Community Health Partnerships (2007)*.

2.2 Health improvement in Scotland – partnership working with the third sector

The drive for health improvement and tackling health inequalities has accelerated since 2000 in a series of policy statements. *Improving health in Scotland: The Challenge* (March 2003) identified four 'pillars' of health improvement activity, one of which would be 'community-led', subtitled *Supporting & Developing Healthy Communities*. A Task Group was set up in 2004 to investigate and recommend ways in which community-led activity could be strengthened and supported, its work culminating in December 2006 with *Healthy Communities: a shared challenge*.

The shared responsibility for taking forward the report's recommendations was assigned to the partners who contributed to the outcomes of the Group. In particular, VHS and the Community Health Exchange (CHEX) undertook to share the responsibility for particular recommendations for improving the sustainability of the third sector, strengthening planning opportunities and establishing evidence for the effectiveness of community-led action for health improvement.

Ongoing support for action in communities is now being provided through the extensive programme developed by the Scottish Community Development Centres (SCDC) and CHEX – *Healthy Communities: meeting the challenge – promoting community-led health improvement*, in which VHS is partner. A variety of support mechanisms are being built through twelve regional groupings.

Building on the analysis of health care need in Scotland into the 21st Century (*Building a health service fit for the future – The Kerr Report - (2005)*), the health action plan of the last Labour administration (*Delivering for Health, December 2005*) and the current SNP Government's *Better Health, Better Care*, momentum has been maintained in the local partnership delivery of health improvement.

3. Aim and Objectives of Research

The aim of this research was to explore the third sector's role in health improvement within Community Health Partnerships, as perceived by local third sector organisations. This is defined as third sector service providers playing a significant planning and / or delivery role in health improvement. Within these parameters, the objectives of this strategic enquiry were to:

- Explore the effectiveness of the joint working partnerships between the NHS, third sector and other partners, including local authorities, within CHPs;
- Investigate the contribution of the third sector to health improvement, with specific focus on the added value brought by the third sector;
- Ascertain the primary sources of funding support for the third sector;
- Identify and propose action points to improve local and national support for the development and delivery of third sector service provision for health improvement.

4. Research methodology

4.1 Questionnaire

A questionnaire was developed in the context of outlined policy and with an informed contribution from VHS Board members. The questions were designed to meet the research objectives and therefore inform topical issues relating to the third sector contribution to health improvement. The questionnaire was piloted with VHS Board members prior to the official enquiry being initiated with service providers. Typically, the questionnaire took 20 minutes to complete as a telephone interview.

4.2 Research scope

It was anticipated that the research would be carried out over a period of five weeks. At the time of the research, 42 CHPs were in establishment. Given that all CHPs were within the sampling framework of the research, the target was to recruit research participants from as many CHPs as possible, in order to offer an accurate national picture. In total, 33 respondents contributed to the research.

Unless otherwise stated, research findings are discussed as a whole, rather than with reference to a particular health improvement topic area (e.g. smoking or physical activity), geographic location, or organisation. To preserve the integrity of our enquiry, direct quotations are offered when applicable; however, because interviews were held in confidence, names and organisations have not been identified.

4.3 Participant and topic selection criteria

Senior members of organisations engaged in or with an appreciation of CHP partnership working were invited to participate in an interview. Individual third sector organisations with a remit for health improvement were identified through the VHS membership list, referrals from local CVS and web-based research. The inclusion criteria for health improvement topics for the purpose of this study reflects the thematic programmes put forth by the Scottish Government in *Improving health in Scotland: The Challenge*⁶. Health improvement topic areas included in this study were thus physical activity promotion, healthy eating advice, quit smoking advice, drugs and alcohol support, promotion of positive mental health and well-being, support for health and homelessness, sexual health advice, and immunisation and screening provision.

Contact via email or telephone was made with third sector organisations and on agreement to participate, interviews were arranged at the participants' convenience. Interviews were primarily conducted over the telephone (85%), the remainder being conducted by email.

CHPs are at different stages of development across Scotland. The awareness of the CHP's role in health improvement and the extent to which the third sector is integrated within the CHP varies very considerably in the perception of third sector providers. Because of this, third sector participation in this research was more limited than anticipated - a level of awareness of the partnerships at the level of the CHP was required to make an informed contribution.

Participating organisations are listed in Appendix 1. It should be noted that this list is not exhaustive, as some organisations made an anonymous contribution to the research.

5. Overview of responses

The enquiry included third sector organisations from a range of CHPs. These organisations contribute to a broad scope of health improvement topic areas and offer a range of services.

5.1 Distribution of respondents

The geographical distribution of respondents is shown in Figure 1. The work taken forward by the organisations represented by the respondents covered 27 of Scotland's 42 CHPs* (Table 1).

* This excludes one national organisation that relates to all CHPs.

Geographical distribution of participating third sector organisations

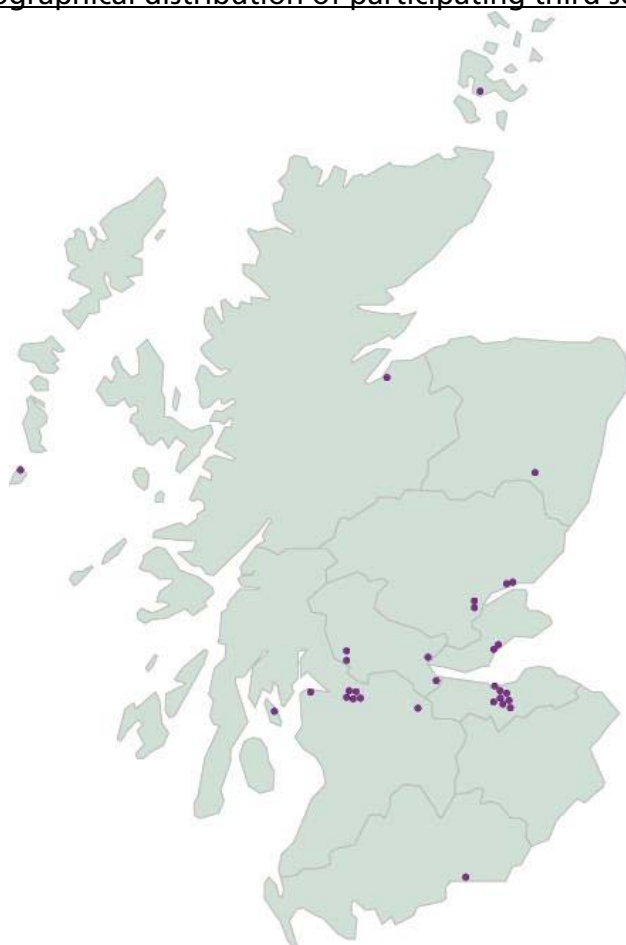


Figure 1. Distribution of respondents.

Table 1. Respondent distribution: CHPs covered by the enquiry.

Aberdeen City	Aberdeenshire	✓	Angus
Argyll and Bute	✓	Borders	Clackmannanshire
Dumfries & Galloway	✓	Dundee City	✓
			Dunfermline & West Fife
East Ayrshire	East Dunbartonshire	✓	East Glasgow
East Lothian	East Renfrewshire		Edinburgh North
Edinburgh South	✓	Falkirk	✓
			Glenrothes & North East Fife

Inverclyde	✓	Kirkcaldy Levenmouth	&	✓	Mid Highland
Midlothian	✓	Moray		✓	North Ayrshire
North Glasgow	✓	North Highland			North Lanarkshire ✓
Orkney	✓	Perth and Kinross		✓	Renfrewshire
Shetland	✓	South Ayrshire			South East Glasgow ✓
South East Highland	✓	South Lanarkshire			South West Glasgow ✓
Stirling	✓	West Dunbartonshire			West Glasgow ✓
West Lothian	✓	Western Isles		✓	

5.2 Health improvement topic areas covered

Many organisations contribute to several health improvement topic areas, as shown in Figure 2.

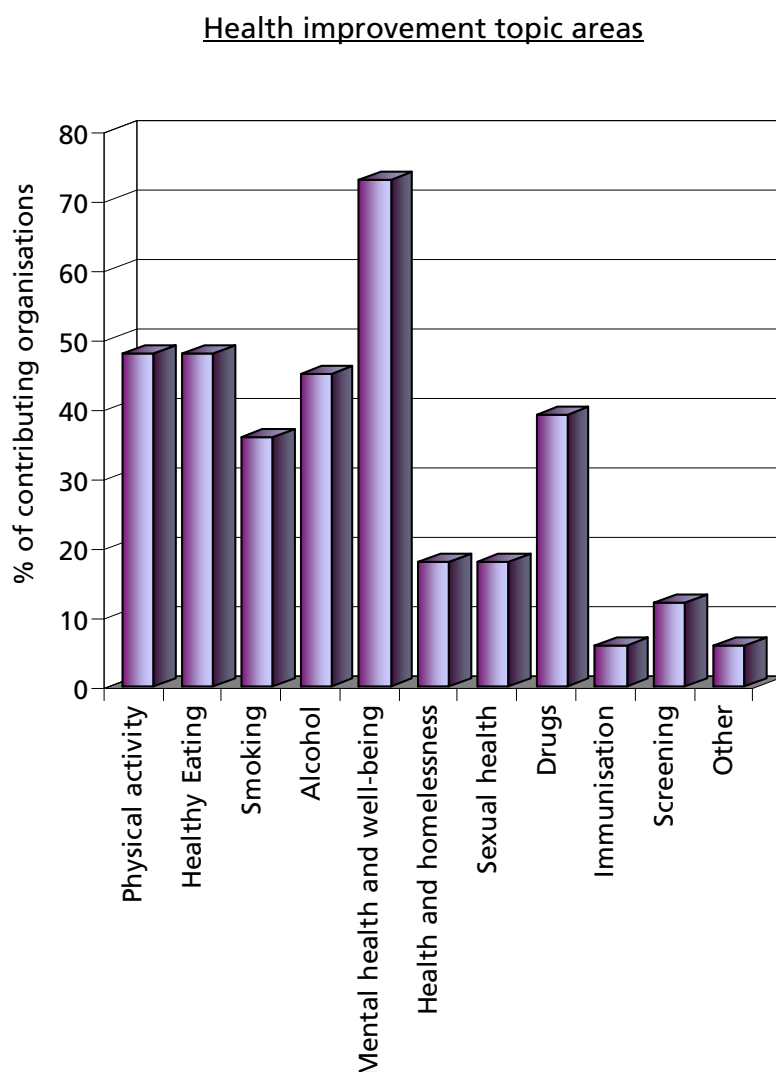


Figure 2. Health improvement topic areas addressed by third sector organisations surveyed

5.2 Range of third sector services

The quality and range of services offered by the third sector married with its characteristic holistic approach often enables organisations in the sector to make a simultaneous contribution to several health improvement topic areas. The services offered by respondents are diverse and therefore offer a fitting glimpse into the third sector health improvement contribution as a whole. Examples of services offered by the third sector organisations surveyed include:

- Befriending / buddying
- Practical / emotional support
- Complementary therapies
- Counselling
- Drugs and alcohol support
- Events / seminars
- Information provision
- Food and nutrition advice

- Networking
- Physical activity promotion
- Policy / research
- Pregnancy advice
- Self-help / support groups
- Sexual health advice
- Smoking advice
- Volunteering
- Transport provision
- Telephone helplines
- Training
- Advocacy
- Weight reduction courses
- Home / day care
- Cooking classes
- Literacy promotion
- Art therapy
- Street work projects
- Signposting to other agencies

5.3 Main priority groups

The local community is placed at the heart of the work taken forward by the third sector. "The local community" was identified by 61% of respondents when they were asked, "*Who are your main priority / client groups?*". Further to this, the key groups which our surveyed third sector organisations aim to reach are children and families (36%), young people and teenagers (33%), older people (27%), carers (18%), drug users (12%), befrienders / buddies (9%) and people with mental health problems (21%) and physical disabilities (15%). Services also reach alcohol users, LGBT (lesbian, gay, bi- and trans-sexual) groups, homeless people, black / minority ethnic groups, and people with learning and sensory disabilities.

Research findings: the third sector contribution to health improvement

Our enquiry was designed to gain insight, from the perspective of third sector service providers, into the role of the sector in health improvement within CHPs.

6. Community Health Partnerships at work

6.1 Community Health Partnerships – the third sector perspective

The 2004 Scottish Executive Statutory Guidance⁷ defines CHPs as “...key building blocks in the modernisation of the NHS and joint services, with a vital role in partnership, integration and service design”. CHPs are still at varying stages of development across Scotland. Two important objectives of this enquiry were firstly to characterise how the CHP strengthens and / or supports the third sector contribution to health improvement, and secondly to reveal ways in which to build upon the partnership networks that have developed within CHPs across Scotland.

Our research revealed that the partnerships within CHPs remain at vastly different stages of integration across Scotland. Service providers were asked to rate the working partnerships in their CHP area on a scale ranging from poor to very good. It is clear from the results that some CHPs still have a lot of work to do to better integrate all stakeholders (Figure 3).

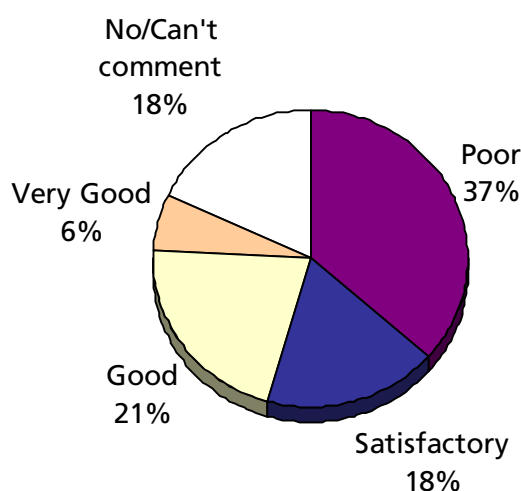


Figure 3. Third sector appraisal of the working partnerships within CHPs.

✦ **How does the CHP strengthen and support the third sector contribution to health improvement?**

Respondents were encouraged to speak to the role of the CHP in supporting the third sector contribution to health improvement. While 18% of respondents believed it was too early in CHP development to reply directly to this question, 30% decisively replied, “It doesn’t”. Within this group, one respondent claimed “The CHP is paying lip service to the voluntary sector”.

Not all responses however were bleak in nature. It is clear that CHPs are supporting the third sector contribution to health improvement in many ways,

for example through integrating the sector into partnerships with the statutory sector. The CHP also supports the third sector through opportunities for strategic involvement, professional networking, capacity building and acceptance of the third sector. Examples of these support mechanisms are listed in Table 2.

Table 2. Ways in which the CHP strengthens and supports the third sector

CHP support mechanism	Examples
Strategic Involvement	<ul style="list-style-type: none"> • Membership in a strategic partnership such as the healthy living committee council, PPF, and / or local public health network • Third sector involvement in drug and alcohol policy development • Opportunities to contribute to planning agenda
Networking	<ul style="list-style-type: none"> • CHP meetings • Established community planning structures • Referrals between GPs, Community Psychiatric Nurses, other health and social care staff • Signposting • Information provision
Capacity building	<ul style="list-style-type: none"> • Provided funding for pursuit of certification, qualification • Commitment to growth of local planning partnerships
Third sector acceptance	<ul style="list-style-type: none"> • CHP has embraced newness of some third sector organisations • Encouraged acceptance of third sector with other sectors • Aided third sector involvement in local health improvement • Included third sector as “full partners” in networks and on consultations

➤ **What might facilitate better working partnerships?**

Despite detailed guidance and Advice Notes on Community Health Partnerships prepared for the third sector, it is the experience of some respondents that CHPs have not adequately engaged the third sector in partnership working.

This is particularly problematic for the third sector, which strongly believes that leadership and collaborative working must be at the forefront of service delivery for health improvement. Research carried out by NHS Health Scotland into the Health improvement workforce development⁸ confirmed that the voluntary sector rated the importance of these competency areas higher than all other sectors.

According to one respondent, the third sector is not treated as an equal partner in CHPs because of “a lack of confidence within the CHP that anyone can deliver health improvement apart from the NHS”. It was suggested that third sector strategic involvement in CHPs is hampered by the sector having no authority at CHP level and being inhibited at CHP meetings by “NHS speak”.

This survey has revealed that partnership building might be aided by collaboration between CHPs; struggling partnerships may profit from the experience and advice of well-established CHPs. If models of good practice are established, it is hopeful that CHPs less positively rated by the third sector might be able to resolve some of their issues and improve upon their partnerships. Table 3 contrasts suggestions for improved partnership with statements of positive collaboration from CHPs that might be looked upon as models of good practice.

Table 3. Suggestions for facilitating better CHP partnerships

<i>Suggested actions required to improve partnerships from CHPs rated poorly</i>	<i>Potential models of good practice: factors identified as contributing to effective partnerships from CHPs rated positively</i>
Greater consultation with the third sector on policy and decision making	Decisions are made collectively; there is consultation and collaboration with the third sector
Improved recognition of the value of the third sector	The CHP increases the visibility of the voluntary and community sector
More referrals and signposting to the third sector by statutory partners	Referral systems between partners identify people who will benefit from services; client databases are shared

One central Scotland CHP stood out as “working incredibly well” and as having excelled in establishing good service partnerships among all service providers. Another CHP in Highland offered encouraging feedback: the CHP “offers an immediate idea of who you need to go to” and you are “never struggling with where to go or who to contact”.

➤ ***Do CHPs have a shared vision, of which the third sector is aware?***

It is a pre-requisite for CHP success that all members are united by a common vision of health improvement and care. Yet around only half of our respondents stated that their CHP shared a collective vision of health improvement across its partners. Where they did, the vision was expressed as a collective working towards partnership health care. Where the vision was undeveloped, descriptors of the position in relation to a vision varied and included “emerging”, “a bit boxed”, “very clinically focused”, and existing only “in theory”.

When asked to comment on ways in which their third sector organisation contributed to that vision, respondents were vague. One respondent exclaimed, “There is a vision - it’s *not* shared! It as presented at a CHP meeting... and the community was not at the heart of the structure”.

6.2 CHPs and the community

The remit of CHPs includes a commitment to meeting the expressed health needs of the community; therefore our enquiry pointedly explored the role of the CHP in lending the community a voice.

➤ ***How does the CHP act as a vehicle for community expression of health care needs and community development?***

The responses by the third sector organisations to this question were mixed (Figure 4). In many CHPs, engagement with Public Partnership Forums (PPFs), the vehicle for local engagement with the NHS, and other community forums appeared to be facilitating a good level of community involvement in local health improvement action. In some instances, the PPF representatives had created a two-way channel for information to be passed between the community and the health improvement agencies. Other CHPs gives voice to their community through open invitation to community events. One CHP commissioned a survey designed to capture the community perspective on ways in which services had improved or changed since the CHP was set up.

A number of CHPs have been slow to set up a PPF, and thus many of these forums are still in their infancy - it will take time before their impact can be assessed. As one respondent stated, "In six months time, we may see better the impact [of the PPF]... the PPF is a simple idea for a complex community therefore it is very difficult to implement in a real way".

Nearly half the third sector service providers considered the impact of CHP engagement with the community to be negligible or were unsure what, if any, contribution it was making to community involvement. Barriers to CHP community inclusion in health improvement cited included:

- CHP is "not fast enough to respond to the community";
- CHP is "too far removed from the community";
- Complete lack of awareness by the community of the existence, structure, or function of the CHP;
- Unawareness of CHP meetings by community members;
- CHP meetings not "open to public".

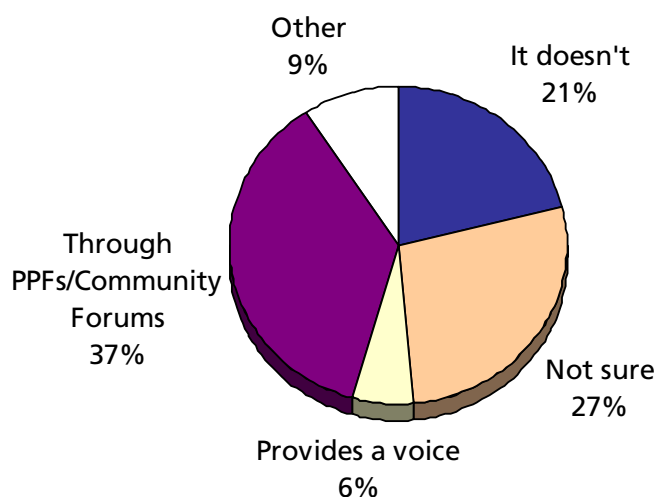


Figure 4. Ways in which CHPs enable community involvement in localised health improvement and community development.

6.3 Communication between CHPs and the third sector

Each CHP structure is slightly different in its organisational structure; however, each CHP committee should have at least one third sector member who acts as a representative for the sector locally. As stated in the VHS *'Further advice on the role of voluntary and community sector members of Community Health*

Partnerships' (2007)⁹, a key task of the 'third sector rep' is to ensure the inclusion of appropriate voluntary and community organisations in the strategic planning, development and delivery of services. It is also understood that the third sector representative acts "to put forward any views that their profession or group has on how to improve health services". In order to fulfil this obligation, the 'rep' must enable two-way communication between the third sector service providers and the whole of the CHP.

Only 52% of third sector organisations surveyed stated there was a system in place to facilitate information-sharing with their representative on the CHP committee. The remainder of respondents claimed they were "not informed at all" of the CHP communiqué. It would seem that while it is the responsibility of the third sector 'rep' to keep the sector informed, this two-way communication is difficult to establish and / or maintain because the 'rep' is largely under-resourced to take on this onerous role.

Examples of ways in which the third sector is kept informed by their 'rep' include:

- E-mail correspondence;
- Distribution of CHP meeting minutes;
- Posting of CHP minutes on the web;
- Receipt of quarterly newsletter;
- Through informal meetings between "core" third sector organisations;
- Through health forum meetings;
- Through an established "voluntary sector health network".

It would appear that a communication strategy between the third sector CHP 'rep' is of crucial significance to the way in which the third sector rates the working partnerships of the CHP. Only one organisation with an established means of communication characterised the working partnerships of their CHP as "poor".

7. The third sector: committed to health improvement within CHPs

7.1 The third sector contribution to collective CHP health improvement

The third sector is recognised as working closest to people and communities, and thus its role in the delivery of CHP health improvement cannot be understated¹⁰. As testament to this, recent exploration into health improvement workforce development¹¹ revealed that the third sector ranked the importance of “working with and for communities” more highly than all other sectors¹². This focus strengthens the third sector contribution to health improvement in a manner less plausibly attained by the other sectors.

When we asked, “How do you rate your third sector service contribution to health improvement in your CHP?”, the majority of responses were favourable (Figure 5).

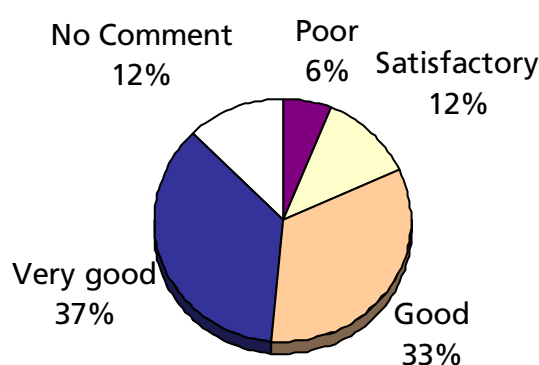


Figure 5. Third sector-rated contribution to CHP health improvement

7.2 Bringing unique value to health improvement

The services provided by the third sector offer significant value to health improvement programmes. This contribution enables CHPs to deliver on the following two key policy areas:

- A shifting of the balance of care to more local settings; and
- Improvement in the health of local people¹³.

➔ ***How does the third sector add value to health improvement programmes?***

Table 4 summarises the unparalleled ways in which the third sector believes it brings unique value to health improvement. The discussion that follows reviews recurring themes that emerged in response to this question.

Table 4. Perceived unique value brought to community health improvement by the third sector

Value-adding function	%¹
Localised approach	70
Practical knowledge of the community	64
Ability to reach unusual, minority, or low income groups	61
Good user perspective	61
Tailored services	61
Community outreach	58
Intimate connection with community	55
Service innovation	52
Flexible hours	52
Relate to stigmatised groups	48
Community-led / integrated service	48
Attitudes / values to cater to service users	45
Loyalty to topic area	39
Tailored information provision	36
Speed of service response	36
Reduce reluctance to access established health services	36
Reach people who wouldn't otherwise engage in health services	30
Link community and clinical services	27
Provide a service not otherwise offered	24

¹ *Percentage (%) of third sector service providers interviewed who report to offer unique value to health improvement through particular service function(s).*

Meeting user and community needs

The drive of the third sector to meet user and community needs was explicit in many interview responses, which included statements such as: “we’re there”, “people see us as more approachable” and “our agency is seen as a trusted, reliable, accessible service”. This localised community approach appears to be critical to the work taken forward by the third sector in part because it helps to tailor services to reach people who would not otherwise engage in primary care.

Filling the gaps

Respondents suggested that the community opts to engage in third sector services over statutory services because of the sector’s ability to “see people where they are” (and in areas not reached by statutory services). Additionally, the sector is able to “fill gaps” left by the statutory sectors (i.e. to provide services complementary to or not offered by the statutory sector or offered in a way that makes them inaccessible to the greater community. Examples include counselling, massage sessions and healthy eating advice).

Integrating service users

The ability to integrate users into project services also holds a unique and valued position in the eyes of the third sector. Opportunities for the “helped to become the helpers” are prevalent throughout the sector. For example, training and employment opportunities exist which encourage service users to become volunteers and even project workers / leaders, building social integration and social capital within the greater community.

Social networking opportunities – a holistic approach

It was revealed that a direct consequence of many third sector services is the building of social networks between service users. The holistic third sector approach, which works beyond the scope of treatment, links service users to opportunities for personal growth. While social integration does not always feature overtly on the third sector agenda, many organisations see this ability as unique to the sector and an integral part of the health improvement work which they take forward.

Increasing the capacity of service users

Third sector workers believe that they add value to health improvement through indirectly increasing the capacity, self-motivation and self-esteem of their service users. This is accomplished, in part, through the social networking opportunities described above. Consequently, service users are empowered to engage more appropriately in statutory health services, whilst experiencing significant improvement in health and well-being.

Levering in funding

Lastly, the third sector believes it brings value to health improvement due to the funding which it can lever into the CHP through funders such as the Big Lottery. In the eyes of the third sector, this contribution is significant and, as one interviewee stated, "Without us, the CHP would really struggle to deliver on NHS [health improvement] targets!"

7.3 Decreased reliance on acute NHS health care

In order to fully appreciate the contribution of the third sector to health improvement, the impact of third sector services on reliance on acute NHS health care services must be considered.

➤ *In what ways do third sector services help to avert reliance on acute NHS health care?*

There was resounding agreement among respondents that the third sector averts reliance away from acute care in a significant, yet under-recognised, manner. Of those interviewed, 70% believed that the health improvement work of the third sector diverts the need for acute care through primary prevention or the ability to "work upstream". This takes place through activities that increase mental health and well-being and encourage involvement in healthier lifestyle choices. Additionally, over 30% of respondents believed that the work of the third sector directly decreases admissions to acute care through enabling people to live at home, providing anticipatory care, and / or reaching more people with recovery services. As two respondents eloquently stated, third sector services "deal with the root causes of problems that prevent acute health problems from developing further down the line" and avoid acute care "by supporting individuals to take more responsibility for themselves and providing supportive networks".

The ways in which the third sector averts reliance from acute NHS services through primary prevention / health improvement were identified as being numerous. Examples include:

- Offer health promoting activities;
- Decrease stress;
- Increase well-being;
- Promote positive healthy living;
- Decrease weight, BMI;
- Distribute information of local non-acute service providers;
- Take forward “pre-crisis”, “upstream” work;
- Offer self-help training;
- Improve self-motivation;
- Through encouraging behavioural change;
- Involve families in care and support;
- Dissipation of homelessness;
- Increase fruit and vegetable consumption;
- Put clients directly in touch with more appropriate services;
- Through social inclusion;
- Involving youth in sport;
- Reduce GP time spent on counselling;
- Decreased drug use / prescription drug.

➔ ***Is the third sector contribution to decreased reliance on acute care recognised?***

It is clear that third sector service providers feel that their ability to reduce reliance on acute NHS services is not recognised by the CHP (as indicated by 42% of respondents). Concern was voiced that CHP awareness of the relative value of input from different service providers to health improvement outcomes is not clear and that CHP recognition of the third sector contribution is slow to come. Commonly, respondents felt that patchy and insecure funding for the third sector was indicative of the lack of appreciation for the sector’s contribution to health improvement. Third sector workers aver that they are “battling to have [the third sector] value seen”.

In some instances, respondents believed that their contribution, while not recognised by the CHP, was recognised by the NHS. On the other hand, one respondent stated, “The NHS does not ever appreciate how much the voluntary sector does to save them money”.

Only 12% of respondents stated that their contribution to relieve reliance on acute care was recognised by the CHP, with a further 15% feeling that their contribution was “somewhat recognised”. The remainder of respondents were not able or unwilling to comment.

8. The third sector - funding and development

8.1 Funding the third sector

The third sector is reliant on numerous sources of funding. Most often, funding is received in the form of a grant, a service level agreement, or a contract. There is also a small, but growing, number of social enterprises working in the health improvement service. One objective of this enquiry was to identify the funding sources that make third sector services viable, and explore the role of the local NHS in offering financial support.

Speaking on the issue of funding allocation between CHP partners, a few respondents preceded their discussion with the statement that the CHP was “not a level playing field” for funding opportunities. One interviewee commented that something of a power struggle exists between statutory and third sector organisations because of limited funding: in order for the CHP “to support one organisation inevitably means to divert resources away from another”.

➤ *From whom does the third sector receive funding? What is the nature of the agreement?*

It became obvious that this question broached a sensitive topic with third sector service providers. The discussion that evolved around the question was insightful: plainly and simply - the funding situation for the third sector is dire.

Multiple funding arrangements

Most third sector organisations are forced to secure multiple funding arrangements. The majority of funding is sourced externally to the CHP, for example, through the Big Lottery, local authorities, the NHS Health Improvement Fund, and Community Regeneration Project funds.

Dependency on grant funding

There was a clear dependence on grant funding within the organisations we surveyed (60% of all organisations had grant agreements). Grants typically contributed from 10% to 50% of the third sector organisation’s total funding. This is an unsettling reality for many respondents, because, as one respondent stated, “It’s not sustainable...we have to apply year after year”.

Only 24% of the organisations surveyed were engaged in service level agreements (ranging from 1- to 5-year agreements). There is a hopeful feeling within the third sector that, not too far in the future, a shift away from grants and towards service level agreements may take place.

A small percentage (9%) of the third sector organisations surveyed said that they subsidised their work through income generation, trusts, personal donations, beneficiaries and social enterprise.

It was clear that organisations believe that, as a consequence of unstable and sometimes marginal funding, they are not able to meet their full service capacity, the ability to plan for the future is impeded and the work taken forward by the sector is unsustainable.

8.2 Third sector service feedback

We hoped that this research would help to clarify from whom and in what ways the third sector receive input on their contribution to health improvement.

Most organisations receive feedback from multiple sources including health practitioners (21% of respondents), funders (15%) and other stakeholders, such as management committees and/or the CVS (42%). Input received from service users was the most predominant source of feedback (73%), which is consistently sought by the third sector.

➤ *In what ways does feedback support the work taken forward by the third sector?*

The responses to this question were relatively uniform, and can be described under four headings. The third sector mainly uses feedback to: secure funding; establish measurable outcomes; inform on-going work; and improve services.

Of the 27% of respondents who stated that feedback informs their work, a few felt it was an “integral” aspect of their development in that it reveals emerging needs and confirms the need for, and the value of, their service.

The majority of respondents integrate user feedback into their programmes, allowing them to further prioritise and tailor their services to users and proceed with a “client- led” approach. User feedback also helps develop new programme areas, new techniques, and “answer the question: is there a better way?” Speaking to the adaptive, user-led service approach that her organisation has made a top priority, one respondent stated, “It may be unpalatable or unpopular [with other stakeholders], but it’s our approach and it’s what we feel the people want and need”.

8.3 Intermediate indicators of health improvement in the third sector

The need to develop and deploy measurable health improvement process indicators is a topical issue across Scotland’s health improvement agenda.

➤ *Does the third sector have established health improvement process indicators?*

This research revealed that intermediate indicators of health improvement are not broadly established in the third sector. This is evidenced by the fact that that 55% of the third service providers surveyed either did not have established health improvement indicators or were unaware of how these indicators might be defined.

Of the 45% of organisations with process indicators, 40% were in line with national targets for specific topic areas. This was particularly true for organisations providing services with a specific focus on drugs and alcohol.

By and large, the indicators most employed by third sector organisations were those which measured service user adoption of healthy behaviours. These indicators included:

- Measures of fruit and vegetable consumption;
- Physical measures of BMI, waist circumference, or weight;
- Changes in lifestyle (such as the percentage of users breastfeeding);
- Time spent engaged in physical activities.

There is evidence that some organisations measure changes in self-confidence and self-efficacy, mainly through indicators of healthy lifestyle choices. These are used as markers of mental health and well-being.

Most organisations collect feedback through pre- and post-service questionnaires. As an example, one organisation with a particular focus on mental health and well-being uses “happiness scales” as a health improvement indicator of their influence on health and well-being pre- and post-service use.

In order for the third sector to gain the credibility and recognition it aspires to achieve, the extensive use of process indicators must be encouraged. These indicators can consequently be used as benchmarks to accurately define the third sector contribution to health improvement. It is a challenge for the sector and intermediary bodies such as VHS to help establish shared process indicators that can be implemented across the third sector working for health improvement.

8.4 NHS health improvement workforce development programmes

The NHS runs programmes such as Leadership for Health Improvement which aim to increase the capacity of NHS staff and others working for health improvement. All members of the health improvement workforce should have access to opportunities that help to develop their organisation.

The majority (85%) of third sector organisations surveyed said they had not been included in NHS workforce development programmes. Of the few who had attended a programme, only one organisation was invited not only to attend, but to contribute to the programme. Statements from two respondents who had attended programmes spoke to the feeling of the third sector as to how their contribution is regarded:

- “We are invited to attend... yet, the NHS will pick the brains of the voluntary sector without a reverse contribution”;
- We are “not put in the position to contribute... The statutory sector doesn’t seem interested in how [our organisation] maintains its effectiveness”.

Responses to this question lead to the observation that, in general, despite CHP partnerships, the third sector is not included as an equal party in organisational development programmes, nor is the contribution of the sector recognised as having merit transferable to the statutory sector.

9 Conclusions and Proposed Actions

9.1 Developing the third sector contribution to health improvement within CHPs: next steps

While the third sector is making a vital contribution to health improvement, there are actions that can be taken by national and local intermediary bodies such as Voluntary Health Scotland (VHS) and local Councils for Voluntary Service (CVS), as well as by CHPs, to provide further opportunities for the third sector to demonstrate the unique value which it brings to health improvement within CHPs.

Three main propositions and related action areas were put by the third sector respondents to our enquiry which they considered would support their contribution to health improvement in CHPs. These are discussed below, with supporting statements from the third sector respondents, quoted directly as indicated.

Voluntary Health Scotland has considered the next steps that can be taken to address the concerns and needs of both the third sector and CHPs themselves in relation to partnership working for health improvement. As a result, VHS has been able to identify areas where it can progress action and support.

Proposition 1: Clarify the shared vision of health improvement in CHPs and the third sector role in this activity

- Articulate a clear vision of health improvement in CHPs and “establish a transparent list of expectations for the contribution of the third sector”
- Improve understanding of the scope of CHP – who is involved, topic areas covered, key responsibilities
- Involve the third sector in problem solving and strategic development
- Improve all CHP stakeholders’ knowledge of the challenges and limitations of health improvement work

Action Area 1: Keep third sector informed of health improvement vision and agenda in CHPs

- Create networking opportunities and joint events; establish an open forum for the exchange of good practice
- Provide CHP meeting de-briefs: some organisations are “too small to have time to keep up with CHP communiqué”
- Develop shared databases – contact names and numbers, key services offered
- Develop training opportunities and activities through which the third sector can become better acquainted with *how* to work within their CHP
- Strive to inform the third sector of key strategic policy changes, distribute summarised policy briefings and offer de-briefs of noteworthy meetings
- “Help the statutory sector understand the terminology of the third sector; different NHS understanding of words like ‘access’ and

'advocacy' inhibit appreciation of the work taken forward by third sector service providers

Voluntary Health Scotland therefore intends to:

- Undertake wider dissemination of the VHS Advice Notes and other relevant partnership working advice
- Promote the value of Scottish Compact principles in partnership working
- Set up a national network of third sector CHP representatives and continue to provide regular events which allow for the sharing of practice and experience
- Report on and disseminate early examples of good practice in local partnership working
- Prepare and circulate a dedicated electronic bulleting for CHP representatives and senior managers of CHPs
- Conduct an enquiry into what further supports could be given to CHPs to allow them to develop more effective partnerships for health
- Develop a strategic relationship with the Association of CHPs

Proposition 2: Improve the perceived value of the third sector as a partner within CHPs

- Need "parity and respect for the voluntary sector contribution... professional status would make what is currently an unequal partnership more effective"
- Abolish belief that the third sector serves the statutory sector; change the mentality that "the NHS will contract and commission voluntary sector services"
- Overcome the perception that the volunteers are the "poor cousins" of employees in the health industry

Action point 2: "Promote the work and contribution of the third sector to CHPs

- Challenge the persistent perception that the third sector is lacking in credentials and "contribute to an understanding that [the third sector] is a professional, cost-effective sector with good outcomes"
- Reduce prejudice towards the types services offered: "raise the credibility" and "reduce the stigma" commonly associated with certain topic areas, such as sexual health
- Lobby from the top town to have health improvement tackled from *within* communities

Voluntary Health Scotland therefore intends to:

- Explore both within the third sector and with statutory partners the unique value of services brought by the third sector to health improvement
- Develop intermediate and process health improvement indicators for the third sector which can have take-up within CHPs

- Signpost the third sector to greater opportunities for learning and workforce development

Proposition 3: Achieve a more sustainable funding base for the third sector working in health improvement

- Require better access to sustainable funding opportunities
- Alleviate experiences such as that of one respondent who “has spent seven years trying, without success, to secure public funding”
- Need to secure and sustain staff
- Establish service level agreements
- Improve third sector programmes that “could be so much better with greater resources”

Action point 3: Make the case for more sustainable funding for the third sector

- Where NHS services are being supported or complemented by the third sector, “push for a greater transfer of resources” in the pursuit of shared outcomes
- “Existing and successful local partners should be engaged through service level agreements”
- “Decrease the conflict of interest” between the statutory and voluntary and community sectors when bidding for the same sources of funding
- Assist the third sector in bidding for contractual services

Voluntary Health Scotland therefore undertakes to:

- Contribute to the government-led review of NHS support for third sector organisations
- Explore and disseminate information about funding sources for health improvement to the third sector
- Explore with relevant partners a greater role for social enterprise within health improvement at local level

9.2 Consolidating the findings – General Conclusions

Finally, this enquiry has enabled general some conclusions to be drawn about the position of the third sector in the drive for health improvement at local level.

It proved more difficult than anticipated to identify and locate third sector organisations with direct experience of contributing to health improvement within CHPs and to speak to staff members sufficiently senior to recognise and comment on the issues of concern.

Those third sector organisations engaged in the delivery of health improvement at CHP level are generally not the same as the parent organisations of the CHP committee representatives, which are still, to some considerable extent, Councils of Voluntary Service. This suggests that better communication between the CVS and local third sector organisations on health engagement is required. In few

cases however are the committee representatives funded to work with their local constituents on health issues specifically.

This enquiry also led us to conclude that while the whole national policy context and arrangements for CHPs make it clear that a partnership with the third sector is required for effective health improvement work, this is not necessarily being taken up at local level and that significantly more effort needs to be made by all parties involved.

CHPs are at very different stages of development and yet, not to include the third sector meaningfully at an early stage is to miss an opportunity to bring the unique value attributes of the third sector to the delivery of *Better Health, Better Care* and its attendant programmes.

Finally, the research demonstrated on the part of both the CHPs and the third sector some degree of lack of confidence in progressing real partnership working, due to the insecurity of the third sector and the lack of established measures of the value which it brings to health improvement.

In the coming year, Voluntary Health Scotland will further consider the propositions and action points identified by the respondents in the survey and develop a programme of relevant work, in partnership with key organisations both in the third sector and in the NHS, to address the challenges identified.

Appendix 1

Organisations which assisted with this research*

Advocacy Shetland
Age Concern Scotland
Alcohol Counselling Inverness
Annadale & Eskdale Family Support Group
Annexe Healthy Living Centre
Barnardo's
British Red Cross
Bute Health Living Initiative
Caring Over People's Emotions (COPE)
Community Health Improvement and Regeneration Project (CHIRP)
Crossline Central
Crossroads (Cobhair Bharraigh) Day Care
Cruse Bereavement Care Scotland
Cyrenians
Fife Alcohol Support Services (FASS)
Getting Better Together
Glasgow Association for Mental Health (GAMH)
Health Spot
Home-Start
Inverclyde Community Care Forum
Letham Sports Club
Midlothian Healthy Living Partnership (HELPP)
Midlothian Sure Start
Momentum Scotland
North Glasgow Community Food Initiative
Perth and Kinross Access Group
Pilton Community Health Project
Quit and Save
Time 4 U
Upper Deeside Access Trust

* This list is not exhaustive, as some organisations made an anonymous contribution to the enquiry.

Appendix 2

The research questionnaire



THE THIRD SECTOR'S CONTRIBUTION TO HEALTH IMPROVEMENT WITHIN COMMUNITY HEALTH PARTNERSHIPS: A BRIEF ENQUIRY

The third sector offers significant added value to health improvement within the context of Community Health Partnerships (CHPs). Voluntary Health Scotland aims to better appreciate your organisation's contribution to health improvement. Therefore, your response to the following questions would be greatly appreciated. The questionnaire should take approximately 20 minutes to complete.

1. Which organisation do you work for?

a. Is someone from your organisation a member of the local CHP Committee?

b. In which NHS Board area does your organisation work?

All Health Boards	Ayrshire and Arran	Argyll and Clyde	
Borders	Dumfries & Galloway	Fife	
Forth Valley	Grampian	Greater Glasgow	
Highland	Lanarkshire	Lothian	
Orkney	Shetland	Tayside	
Western Isles			

c. In which Local Authority area does your organisation work?

All Local Authorities	Aberdeen City	Aberdeenshire	
Angus	Argyll and Bute	Scottish Borders	
Clackmannanshire	West Dunbartonshire	Dumfries and Galloway	
Dundee City	East Ayrshire	East Dunbartonshire	
East Lothian	East Renfrewshire	City of Edinburgh	
Falkirk	Fife	Glasgow City	
Highland	Inverclyde	Midlothian	
Moray	North Ayrshire	North Lanarkshire	
Orkney Islands	Perth and Kinross	Renfrewshire	

Shetland Islands		South Ayrshire		South Lanarkshire	
Stirling		West Lothian		Comhairle nan Eilean Siar	

d. In which CHP does your organisation work?

Aberdeen City		Aberdeenshire		Angus	
Argyll and Bute		Borders		Clackmannanshire	
Dumfries & Galloway		Dundee City		Dunfermline & West Fife	
East Ayrshire		East Dunbartonshire		East Glasgow	
East Lothian		East Renfrewshire		Edinburgh North	
Edinburgh South		Falkirk		Glenrothes & North East Fife	
Inverclyde		Kirkcaldy & Levenmouth		Mid Highland	
Midlothian		Moray		North Ayrshire	
North Glasgow		North Highland		North Lanarkshire	
Orkney		Perth and Kinross		Renfrewshire	
Shetland		South Ayrshire		South East Glasgow	
South East Highland		South Lanarkshire		South West Glasgow	
Stirling		West Dunbartonshire		West Glasgow	
West Lothian		Western Isles			

2. The Scottish Government has put forth *The Challenge* to improve health in Scotland. To which Specific Focus Programme(s) or other health improvement programmes does your organisation contribute?

Physical activity		Healthy Eating	
Smoking		Alcohol	
Mental Health and well-being		Health and homelessness	
Sexual health		Drugs	
Immunisation		Screening	

a. What service(s) do you provide to carry out your work? Please indicate from the categories provided, or use the space below to further elaborate:

Adoption / fostering		Befriending / buddying	
Support: practical / emotional		Complementary therapies	
Counselling		Drugs and Alcohol	
Events / Seminars		Food and nutrition	
Information provision		Networking organisation	
Physical activity		Policy / Research	
Pregnancy advice		Self help / support groups	
Sexual health		Smoking advice	
Volunteering		Transport	
Telephone help lines		Training	

3. Who are your main priority / client groups? Please indicate from the categories below:

Alcohol users		Offenders, prisoners	
Asylum seekers / refugees		LGBT groups	
Befrienders / buddies		Men	
Carers		Older people	
Children and Families		Sex workers	
Drug users		Young people / Teenagers	
Homeless people		Women	
Black / minority ethnic groups		The local community	
People with:			
Physical disabilities		Mental health problems	
Learning disabilities		Sensory disabilities	

4. Are you funded by the CHP to carry out your work?

Yes		No	
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If yes, what is the nature of the agreement with CHP (grant; service level agreement; contract)? Does this add sustainability to your organisation?

If no, who funds your work?

5. Do you play a strategic role in the health improvement agenda of your local CHP?

Yes		No	
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Please comment on your role:

a. Prior to the establishment of your CHP, had you already been involved in community planning for health?

6. Do you believe there is a good level of awareness of the range of services offered by the third sector in health improvement among the partners of the CHP?

Yes		No	
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7. How would you characterise the working partnerships of the CHP?

Poor		Satisfactory		Good		Very good	
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- a. Please comment on your experience of how local health services are integrated by the CHP, including what might facilitate better working partnerships:**

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- b. How does the CHP strengthen and support your contribution to health improvement?**

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- c. Do you think an accessible working database with contact names / numbers for health improvement service providers in your local CHP is needed?**

Yes		No	
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- d. Have you been included in NHS health improvement workforce development programmes? e.g. *Leadership for Health***

Yes		No	
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If yes, did you contribute to the programme?

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8. Can you characterise the *unique value* you offer the community health improvement sector?

For example, do you offer a specialised niche understanding of the community, a responsive and flexible approach to the people receiving your service, or other valuable approaches or services? *Please indicate from the options and/or elaborate in the space provided below:*

Localised approach		Intimate connection with community	
Flexible hours		Community outreach	
Tailored services		Relate to stigmatised groups	
Tailored information provision		Speed of service	
Ability to reach unusual / minority groups		Reduce reluctance to access health services	
Service innovation		Good user perspective	
Practical knowledge of community		Attitudes and values to cater to population	
Link community and clinical services		Loyalty to topic area	

a. How does your CHP act as a vehicle for members of the community to voice their ideas of localised health care needs and community development?

b. In what ways do you believe the services you provide help to avert community reliance on acute NHS health care? Is this contribution recognised by the CHP?

9. From whom and how do you receive feedback on your contribution to health improvement?

a. How does this feedback better inform and support the work you take forward?

b. Have you established health improvement process indicators?

Yes		No	
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If yes, please describe briefly:

i. Are these process indicators shared across the CHP?

Yes		No	
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10. It is envisaged that all members of the CHP are united by a common vision of health improvement and care. Does your CHP have a shared vision of which you are aware?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes, please comment on how you contribute to that vision:

a. Is there a system in place to enable communication between your organisation and your third sector CHP committee representative?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes, does this better inform and support the work you take forward?

11. Overall, how would you rate your service provision contribution to health improvement in your CHP:

Poor	<input type="checkbox"/>	Satisfactory	<input type="checkbox"/>	Good	<input type="checkbox"/>	Very good	<input type="checkbox"/>
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a. What might improve your experience of working in health improvement within your CHP?

b. What more can local (i.e. CVS) or national (e.g. VHS) intermediary bodies do to help?

Thank-you very much!

Voluntary Health Scotland (VHS) is the national intermediary body for third sector health organisations and groups in Scotland, founded in 2000 and the first its kind in the UK. Membership comprises over 300 voluntary and community groups and organisations. VHS is supported by NHS Health Scotland and the Scottish Government Health and Wellbeing Directorate.

VHS has been set up to support the third sector to take a full role in health improvement and complement the statutory sector's development and delivery

of health services. Please visit our website for further details of how VHS can be of assistance to your organisation. If you have any suggestions of how VHS might act to further support you in your mission, please do not hesitate to contact to us; we look forward to hearing from you.

For further information contact:

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10. References

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