Community Health Exchange (CHEX)

A Strategic Review

March 2008

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Summary

Introduction. NHS Health Scotland commissioned this strategic review of CHEX to help inform decisions on its future direction, positioning and sustainability. It is a review of the factors affecting the future of community development work in health improvement, rather than a full evaluation of the work of CHEX.

The approach taken has sought to allow the maximum potential for the participation of stakeholders, and feedback during the process. As a result this report can only summarise the material collected.

The review process. The review has involved analysis of CHEX and policy documents, consultations with CHEX's Advisory Group and staff, a survey of and a consultation event aimed at CHEX's network of contacts, and a variety of individual and group discussions with contacts in local partnerships around Scotland and with national stakeholders.

The work of CHEX. CHEX's overall aims commit it to a community development approach to health improvement. Its Business Plan defines its target population, which includes community health projects and community health organisations with a health focus as the key elements, but also other staff involved in community health work or policy. Survey responses suggest that CHEX works with a balance of people from across this range.

The key objectives set out in the Business Plan are to:

- provide a resource for this target population
- facilitate networks and exchanges
- inform and contribute to policy debate
- meet the training and development needs of community health projects and community organisations with a health focus.

These are recognised as giving CHEX an 'intermediary' role.

The implications of the unusual position of CHEX as an integral part of the Scottish Community Development Centre, and the fact that the status of that organisation is under review, are outlined. The very close relationship between CHEX and its main funder, NHS Health Scotland, is described.

Perhaps the two most crucial elements affecting the development of CHEX have been the expansion of the community health sector, followed by a risk of significant contraction, and the increased opportunities for engagement in national policy development.

The great majority of contacts receive both printed and e-mail bulletins. Less than half use each of the other specific CHEX services, but according to survey results two thirds do use at least one. These direct services are concentrated on the 'core constituency'. More than half of the organisations in this had received individual advice and support.

The ability of CHEX to plan effectively and to deliver on its plans is well established, and substantial progress has been made on all the substantive objectives of the Business Plan. However some points at which monitoring and evaluation might be improved are noted.

The interviews, discussions and survey overwhelmingly show CHEX as being held in high regard, though some people in local partnerships had a limited awareness of it. Highest ratings were given to CHEX's information and advice functions, and to individual contacts. Slightly lower, but still very positive ratings were given to influencing policy and practice, particularly at local level and supporting sustainability, things which ultimately depend upon others.

A wide range of aspects of the support given to the sector were commented upon positively. However, the most persistent theme in comments from all sectors is that CHEX's special role and value is to act as a link or bridge between the levels of national policy and local practice.

Limits to which actual influence on the health improvement agenda can be achieved, especially at a local practice level, are recognised.

There is a demand for CHEX to take a more actively representative role on behalf of the sector than its position and approach allow.

CHEX, and perhaps the community health sector in general, needs to aim for a wider degree of recognition of its name and nature in future.

Most contacts were clear in their belief that the role of CHEX is distinct from that of other intermediary bodies. However it was widely agreed that there is a need to communicate clearly what these roles are and who different bodies work with or represent.

People sometimes equate both CHEX's area of work and 'community-led' health work generally with the 'third sector' contribution to health improvement. But CHEX provides expertise that is specific to health improvement, not basic organisational and individual capacity building for the voluntary sector. It is also a key agency for promoting community development approaches in the NHS and other health improvement partners.

The policy and practice environment. The long term policy context for the work of community health initiatives (CHIs) is the growing emphasis on the importance of public and preventative health. The work of the Community-led Supporting and Developing Healthy Communities Task Group, the subsequent Implementation Group and the ensuing national capacity building programme are of crucial importance. The 2007 'Better Health: Better Care' Action Plan reaffirms these principles.

Changes to the way government is organised and objectives are set at national and local levels will be of fundamental significance. Local Single Outcome Agreements

are creating uncertainty and risks for community health initiatives, but also the potential for more flexible approaches to health improvement.

New systems for Health Improvement Performance Management may place a greater emphasis on shared outcomes and also on mental health and well-being.

At local level, different practices and understandings lead to very different accounts of how partnerships are engaging communities in addressing local health issues, and how the community-led health sector can contribute to achieving broader health improvement outcomes.

Some commissioners and funders talk purely in terms of engagement in services, without showing any awareness of community-led activity. Others clearly saw the work of initiatives as important to their overall approach. Integrating the contribution of community-led health into high level strategies can make a difference.

Fundamental issues of attitudes and professional culture were raised. No-one expects to turn large numbers of NHS staff into community development workers, but many felt that wider understanding was needed.

The public sector will in future be working to national outcomes around set topics. The community-led health sector will need to be able to articulate clearly and demonstrate how it can deliver a significant contribution to these outcomes.

There is a fear that future work may be tied more closely to targets for changing lifestyles. CHIs will need to develop and communicate an understanding of the logic and processes by which their actions can have an impact on the determinants of health related behaviour and in which different types of outcome are connected.

The community health sector. During the period of this study the sector was facing a crisis of confidence. CHEX contacts considered the position facing community-led health initiatives to be less than ‘adequate’ on every aspect that is external to CHIs themselves. Funding and sustainability were generally considered ‘poor’.

A lot of emphasis was given to the intrinsic strengths of CHIs that arise from their community base and community development approach. This allows them to make a distinctive contribution to reaching and involving people in health improvement. However there is scope for some CHIs to gain a better understanding of community development and to define more clearly how their role combines with that of others in addressing broader social issues related to health improvement and health inequalities.

Short term funding is inappropriate for approaches that seek to achieve long term change. As a result the sector faces erosion, within projects and by the loss of many projects and their accumulated experience and goodwill within communities.

Many felt that the sector still suffers from a lack of clarity of what it is attempting to achieve and struggles to provide evidence of the broad benefits and impact of its work. Others felt that it was getting quite good at this, but not being listened to.

The need to relate outcomes from local work to regional and national outcomes was widely recognised, though there was concern about discrepancies between the community-led approach and the type of outcomes that were assessed or valued. Proper recognition of outcomes and the contributions that all parties make to these is easier to achieve when each sector is recognised and respected as a partner who is able to contribute to outcomes.

The need for action to spread the awareness and recognition of what community-led health work is and can do more widely, especially amongst decision makers, was widely discussed.

A 'SWOT' analysis for the sector as a whole is presented, looking at its intrinsic strengths and weaknesses, and the opportunities and threats that arise from the environment in which it currently works.

When we asked stakeholders to consider possible future scenarios for the sector, they saw the chances of very good and bad overall outcomes occurring as balanced, but an uneven development around the country arising from differing priorities or understandings as most likely.

More 'community leadership' in partnerships was unanimously viewed as desirable. There was also a significant degree of optimism about the likelihood of it occurring. The spread of community development approaches to health improvement amongst NHS and partner staff was viewed as desirable on balance, but only marginally likely to occur.

A shift to funding mainly linked to lifestyle change outcomes was viewed as quite likely to occur and only marginally undesirable. At least some stakeholders have confidence in the sector's ability to deliver in these circumstances.

A move towards a 'social economy' model of delivery was viewed as marginally unlikely to occur. There were significant differences of view about its desirability.

CHEX's future role and position. A SWOT analysis summarising CHEX's strategic position, based on the evidence on its progress and its environment, is presented.

Stakeholders' beliefs about the options for its future role and activities are presented. All the suggested areas of work were on average considered important, with a relatively small amount of variation between them. The most highly rated was 'influencing national policy'.

Two points that command general assent are:

- the need to remain specific to community health and community development
- the need to retain autonomy.

The key role for CHEX was that of a link or bridge between policy and practice. There was also a general consensus that CHEX needs to retain a practice development role.

There is a tension between the demand from many in CHIs for CHEX to play a representative role and its belief that it should build their own capacity to meet this need.

Several people expressed concerns that CHEX might "spread itself too thinly", and must decide on its priorities.

The idea that attracted most discussion was that understanding and decision at local level will be crucial to the future of community-led work, and that CHEX must have a role to play in influencing these. There is a lot of work to be done in determining the correct approach, in order to prevent CHEX from being overwhelmed with unrealistic expectations. Its role has to be seen principally as a supporter or perhaps catalyst for work by local initiatives, rather than one of offering direct support to individual local partnerships.

The Meeting the Shared Challenge programme and Health Issues in the Community training (including training for staff) will be key resources.

Stakeholders did not propose any alternatives to the relationship with NHS Health Scotland. Other financial options were only suggested as marginal contributions. Funding from local areas would mean that activities would have to be concentrated in those areas.

Strategic options and recommendations. It is generally agreed that CHEX should:

- retain its focus on community development approaches to health improvement
- retain a very close relationship with NHS Health Scotland
- show how its own work serves national priorities, and help others to show how community development work in health does so
- act as a bridge between local initiatives and national policy makers and agencies
- retain a strong focus on supporting practice
- focus on 'rebuilding' the community-led sector after the inevitable damage caused by current crises.

Since it is possible that the status of SCDC itself may change early in the new Business Plan period, the possibility of a change in the status of CHEX as an organisation will have to be kept under review.

If it is agreed that continuing core funding from NHS Health Scotland should provide the basis for CHEX, there is still a choice of how far to pursue diversification. Given the lack of obvious options, it is not a short-term priority.

There are in our view significant unresolved issues about the nature of the network(s) that CHEX serves and its relationships with them. Any of the options would require wide consultation and is not for immediate decision. However it is suggested that the best option might be a gradual widening of the existing HLC Alliance, if it is willing, coupled with a clear recognition that CHEX also works with a wider network.

Two areas require strategic choices: the extent to which CHEX should work with 'mainstream' staff and what role it should have at local level. The practical priority is likely to be building capability and understanding in partnerships, especially Community Planning Partnerships and Community Health Partnerships, about how to work with communities on health issues and how to assess outcomes, rather than widespread community development training for staff of public sector health improvement agencies.

Within CHEX's overall priorities, a wide range of possible activities could be pursued and must be prioritised. A list of desirable support measures to ensure an effective and sustainable community-led health sector is presented, with an indication of who might take the lead on each and who else they might need to work in partnership with. CHEX appears to be the likely lead agency for at least half and the need for further choices of priorities will be a major feature of the business planning process.

Some specific recommendations are presented on priorities, networks and partnerships and the governance and funding of CHEX.

These are based on the belief that CHEX has not only served and supported the community development approach to health effectively, but has helped a whole sector to find its identity and its voice.

List of Abbreviations

BEMIS	Black and Ethnic Minority Infrastructure Scotland
BLF	Big Lottery Fund
BME	black and ethnic minority
CDF	Community Development Foundation
CHEX	Community Health Exchange
CHI	community health initiative
CHP	Community Health Partnership
CLDP	Community Learning and Development Partnership
CLTG	Community-Led: Supporting and Developing Healthy Communities Task Group
COSLA	Convention of Scottish Local Authorities
CPD	Continuing Professional Development
CPP	Community Planning Partnership
CVS	Council of voluntary service/ for the voluntary sector
HEAT	Health Improvement, Efficiency, Access, and Treatment (targets).
HEBS	Health Education Board for Scotland
HIIC	Health Issues in the Community
HIPM	Health Improvement Performance Management
HLC	Healthy Living Centre
JHIP	Joint Health Improvement Plan
LEAP	Learning, Evaluation and Planning
NES	NHS Education Scotland
NHSHS	NHS Health Scotland
PFPI	patient focus and public involvement
PPF	Public Partnership Forum
SCDC	Scottish Community Development Centre
SCR	Scottish Centre for Regeneration
SCVO	Scottish Council for Voluntary Organisations
SHC	Scottish Health Council
SURF	Scottish Urban Regeneration Forum
SWOT	strengths, weaknesses, opportunities and threats
VDS	Volunteer Development Scotland
VHS	Voluntary Health Scotland

1. Introduction

NHS Health Scotland has funded the Community Health Exchange (CHEX) since its establishment in 1999 within the Scottish Community Development Centre (SCDC). Since then CHEX has operated as the leading agency in Scotland that supports community development approaches to health improvement and challenging health inequalities. These approaches can be applied in a variety of ways – for example, by community-run organisations, in the practice of health improvement staff or in the ways in which partnerships and agencies relate to the public. CHEX has worked across this range, but has particularly worked to support a network of community health initiatives in developing good practice and influencing health and social policies.

NHS Health Scotland commissioned this strategic review to help inform decisions on the future direction, positioning and sustainability of CHEX. Its current funding runs to August 2008, and it has recently launched its own internal review of its Business Plan. It is expected that this strategic review will also inform a range of other decision making processes. The Community-Led Supporting and Developing Healthy Communities Task Group (see section 4.1.1) called for improved recognition of the role of and the resourcing for national intermediary bodies, such as CHEX (Recommendation 8). More broadly, the Scottish Government has recently announced a review of the sustainability of community-led health initiatives.

The environment within which health improvement work takes place is changing, especially the public sector landscape. Funding streams that have been important to the development of community health initiatives are nearing their end (the Big Lottery Fund's Healthy Living Centres programme) or are changing and under pressure (e.g. the transformation of the Community Regeneration Fund into the Fairer Scotland Fund). New structures for partnership working are beginning to find their feet. Community-led health initiatives will increasingly have to seek support for their work from local decision makers and justify it by its contribution to the achievement of shared outcomes, in partnership with others.

This review is as much, or more, a review of the factors affecting the future of community development work in health improvement as it is a review of the internal workings of CHEX. The needs and opportunities that changes in this environment create will be the key determinants of what a national intermediary body such as CHEX is required and able to do. In particular this is not a full evaluation of the past work of CHEX. We consider its own records of performance and the views of stakeholders on its effectiveness (Sections 3.2-3.3), but our overall conclusion is that the ability of CHEX to plan effectively and to deliver on its plans is well established. That is therefore not be the principal focus of this review, which will instead concentrate on how CHEX and its partners should respond to a changing environment.

In particular CHEX and NHS Health Scotland wished to:

- Be assured that CHEX has achieved the outcomes of its current business plan and is performing well against its current targets, and in particular:

  - has provided effective support to the community health network
  - has enhanced the ability of community-led health initiatives to contribute to wider health improvement outcomes,

- Be confident that key stakeholders, at a national level, understand and value the services and support CHEX provides or might provide in future

- Be assured that CHEX is relevant to the needs of and valued by key local stakeholder groups, particularly Community Planning Partnerships and Community Health Partnerships and assess their future expectations

- Take into account the changing policy and practice climate for community-led health in Scotland and gain a clear understanding of the actual and potential extent to which CHEX's activities contribute to national objectives, not only for health improvement, but also for equality, public involvement and community engagement

- Be certain that CHEX does provide added value to broader health improvement outcomes when other organisations could be seen to be operating on parts of the same territory

- Participate in arriving at recommendations about:

  - the future role of CHEX and the outcomes that it could potentially achieve
  - how it might define its position with respect to other national and regional intermediary bodies and develop strategic partnerships with them
  - the future governance and funding arrangements that help to plan for and ensure CHEX's sustainability beyond August 2008.

The review is based principally on a wide range of contacts with CHEX and its stakeholders, as described in the next section, over the period from October 2007 to February 2008. Our approach involved allowing the maximum potential for the active participation of community health projects, CHEX staff and other stakeholders during the process.

These contacts and the feedback that we have been able to give about them have, we trust, already contributed to the development of thinking about the future direction of CHEX. In trying to fulfil all the above objectives within a manageable span, we shall not attempt to provide a detailed summary of the wealth of material that we have gathered. It has allowed us to build up a rich and generally consistent picture of the issues facing CHEX and the community health sector as a whole. Our findings are based on this material throughout. It will be used to illustrate them, but it will not be quoted in detail to substantiate every point.

2. The review process

The review has involved regular dialogue with a small review management group and in addition the following processes. Appendix 1 gives details of the people and organisations who took part in them.

Documentary analysis

We have reviewed documentary evidence including a previous internal evaluation, the external evaluation of the Health Issues in the Community training programme, the analysis of stakeholder views completed by Margaret Lindsay in late 2006, reports to the Advisory Committee and NHS Health Scotland and other planning and monitoring documents, along with CHEX publications, supplemented with informal consultation with CHEX staff:

We have updated our understanding of the changing policy and strategic context by scanning documents and informal contacts, and considered related studies such as the strategic review of Voluntary Health Scotland (Stevenson & Watson, 2007) and the evaluation of the Scottish Healthy Living Centres programme (Platt *et al*, 2007).

Working with CHEX Advisory Group

We held a series of consultations with CHEX's Advisory Group:

- we conducted short initial telephone interviews with Group members
- we held an interim workshop with the group during the review and explored its views of the issues facing CHEX and the sector as a whole
- we fed findings and ideas back through a Development Day that the Advisory Group and CHEX staff were holding to begin the process of reviewing the Business Plan.

Working with CHEX staff

In addition to informal contacts, we held a rapid appraisal session early in the review with CHEX staff to look at the main features of CHEX's development to date and its current strategic position.

Survey of CHEX Network

In order to give everyone in CHEX's network of contacts the chance to contribute, we circulated a short questionnaire to everyone on its contacts list, after CHEX staff had completed an exercise in updating the contact list.

The questionnaire (reproduced in Appendix 2) asked them for their summary evaluations of aspects of CHEX's work, their views on the position of the sector as a whole, and their priorities for future work; it also provided opportunities for open-ended comment.

After we had eliminated multiple representatives of single organisations[1], 535 contacts were identified. Where an e-mail address was available, contacts were sent an e-mail inviting them to complete the survey on-line. The rest were sent a copy by post. Reply paid envelopes were enclosed. Subsequent reminders were sent to e-mail contacts only.

Over 20% of the e-mail addresses supplied turned out to be invalid, illustrating the difficulty of and lack of priority given to updating this aspect of the database. In the majority of cases we were able to substitute a postal questionnaire. The effective form of contact was therefore: e-mail, 334; post 201. However a further 21 e-mails 'bounced back' at later dates.

The effective sample size for the survey was therefore 514. The total number of responses received was 71, a response rate of 14%. Whilst this may appear somewhat disappointing, it should be noted that the list contained a large number of organisations who receive information from CHEX, some probably with limited involvement in community health work, and some, especially amongst those with postal addresses only, that were added to the list some considerable time ago. As we shall see (Section 3.2.2), the respondents included organisations with a wide range of different levels of contact with CHEX.

Consultation event with CHEX Network

With the help of CHEX and NHS Health Scotland staff, we organised and facilitated a day-long consultation event attended by 37 members of the CHEX Network. Invitations to this were included in the survey letters, emails and reminders, and CHEX staff also publicised it directly. NHS Health Scotland paid travelling and other participation costs for those attending where required.

The primary purpose of the event was to focus on future potential rather than evaluation of CHEX's performance.

Contacts with local partnerships

We identified a lead 'health improvement' contact in each Community Health Partnership (CHP) and each Community Planning Partnership (CPP) in Scotland from lists supplied by CHEX and NHS Health Scotland. We invited those in the areas most accessible to Glasgow and to Stirling to a focus group style discussion in each city. A total of six people from six different organisations attended.

A 50% sample was taken of the contact list for the rest of Scotland, and contact was made by telephone. It was notable that in every single case either the name of the appropriate contact and/or their telephone number was not the same as that originally identified. Nevertheless, telephone interviews with contacts were completed in every case, a total of 21 interviews.

[1] Counting branches of national bodies as separate organisations

The discussion in these focus groups and interviews centred on the following questions:

- How can the community-led health sector contribute to achieving broader health improvement outcomes?
- What challenges face the community health sector in doing so?
- What should the role of your organisation/partnership and others like it be?
- What is your understanding/perceptions of CHEX and its performance so far?
- In what ways might the CPPs/CHPs support CHEX?

Contacts with national stakeholders

We met 13 key stakeholders for semi-structured face to face interviews, including:

- NHS Health Scotland and Scottish Government staff
- Senior staff of CHEX and the Scottish Community Development Centre
- Other national and regional intermediary bodies
- Other organisations active in the Implementation Steering Group of the former Task Group on community-led health improvement.

An additional two people who could not be present for interviews or group discussions were interviewed by telephone.

These interviews explored:

- perceptions of CHEX and its performance
- the emerging policy and practice agenda and the contribution of community-led health to this
- priorities for future action
- opportunities for partnership working with, funding and support for CHEX.

An additional group discussion was held for some further national stakeholders, of whom only two were able to attend.

Symposium for national stakeholders

Near the end of the review we organised and facilitated a “Symposium” for a mixed group of national stakeholders, including some less directly involved but in positions of considerable relevance to future policy and practice, and of people from community health initiatives (members of the CHEX Advisory Group). Seven people attended (one by video link from the Western Isles). The ‘national stakeholders’ who actually participated were from either the Scottish Government or NHS Health Scotland.

Preliminary findings were presented and participants discussed possible future scenarios for the community health sector and possible roles for CHEX and others.

3. The work of CHEX

3.1 Structure and objectives

3.1.1 Overall aims

The key features of CHEX's organisational structure and values are summarised in a diagram which we have reproduced, with some updating, from CHEX's Business Plan 2005-2008 (Figure 3.1).

The overall aim of CHEX is to:

> "Provide a strategic framework and overview for community development and health work, maintaining a clear agenda which promotes the methods and values of community development" (Business Plan 2005-2008).

Specifically:

> "CHEX strives to ensure that the service is underpinned with values reflecting personal empowerment, equity, social justice, sustainable development and a right to good health".

Health is understood within a social model, which follows the World Health Organisation's definition, that health is "a state of physical, social and mental well-being and not merely the absence of disease or infirmity".

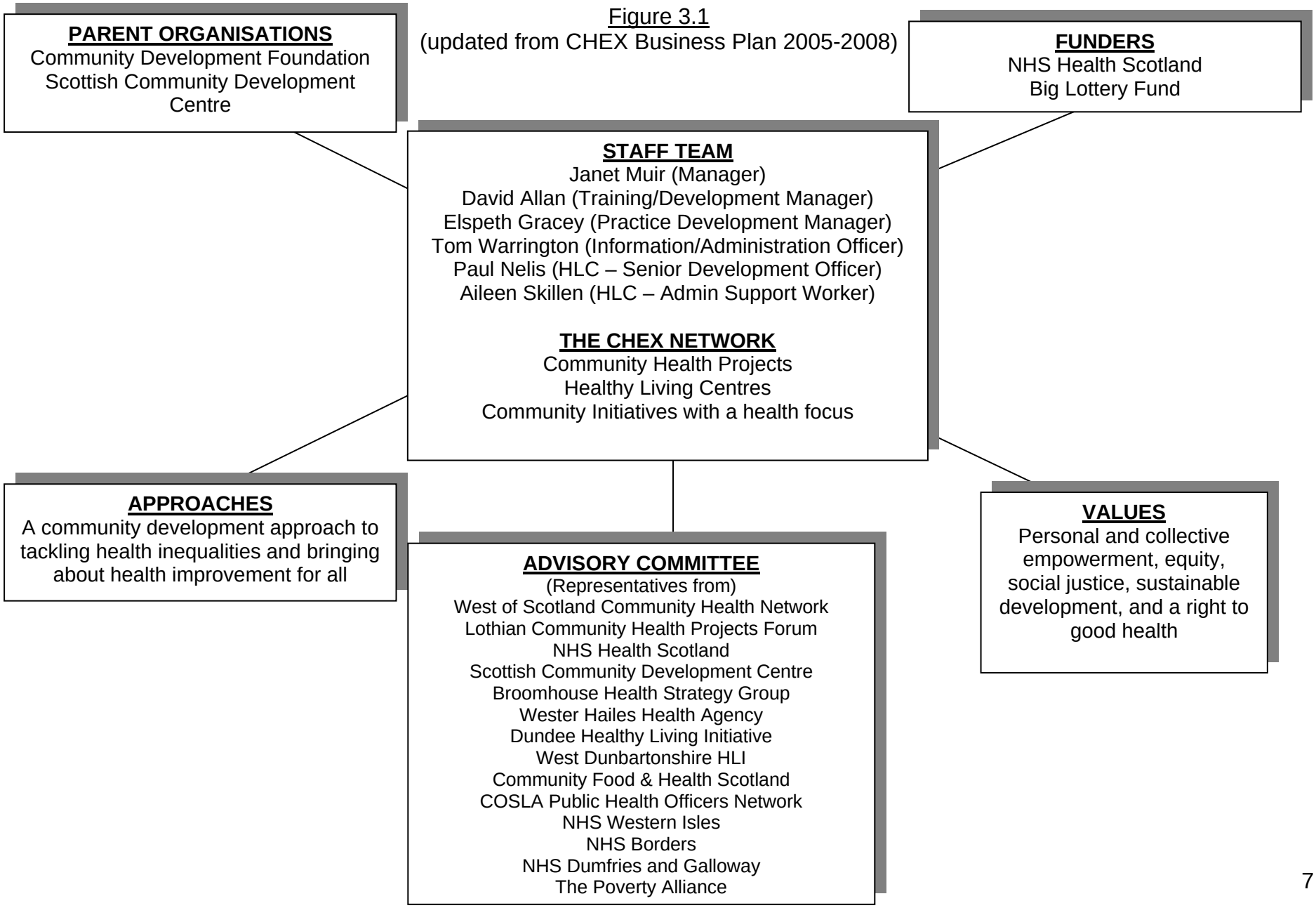
Taken on their own, the statements of overall aims and values, whilst committing the organisation to a community development approach, give little clue as to what type of organisation it is.

3.1.2 Target population

In particular they do not contain any commitment on who CHEX should work with. The Business Plan goes on to define the 'target population' as:

- Community Health Projects
- Healthy Living Centres
- Community Organisations with a health focus
- Community health workers
- Health Promotion Specialists, Public Health Practitioners and Local Authority Public Health Officers
- Community health volunteer workers
- Community health networks
- Policy makers in local and national agencies.

Figure 3.1
(updated from CHEX Business Plan 2005-2008)



It goes on to clarify that the first three are "its key constituents". [We shall refer to these throughout, rather loosely, as 'Community Health Initiatives' (CHIs), leaving open for the time being the issue of how strong a health focus a community organisation must have to count as a CHI]. This commitment is fairly clear[2]. Community Health Initiatives are the core constituency, though it should be noted at once that these are not necessarily 'Third Sector' organisations – many work within statutory agencies.

Beyond this, CHEX also has a commitment to work with various professional and volunteer workers, mainly in the NHS and local authorities, who have a specific responsibility for 'community health' work. This could be interpreted narrowly, to refer mainly to the types of post specifically mentioned in the above list, or more broadly to refer to a wide range of, in particular, primary health care staff. The importance of working with policy makers is also noted.

The responses to our survey give some indication of the range of organisations with which CHEX is actually actively involved (Figure 3.2). We have not attempted to classify the entire contact list on which the survey was based, but we assume that the responses are broadly representative of those contacts that feel they have an active relationship with CHEX. These are respondents' own accounts of who they are, based on the alternatives we suggested.

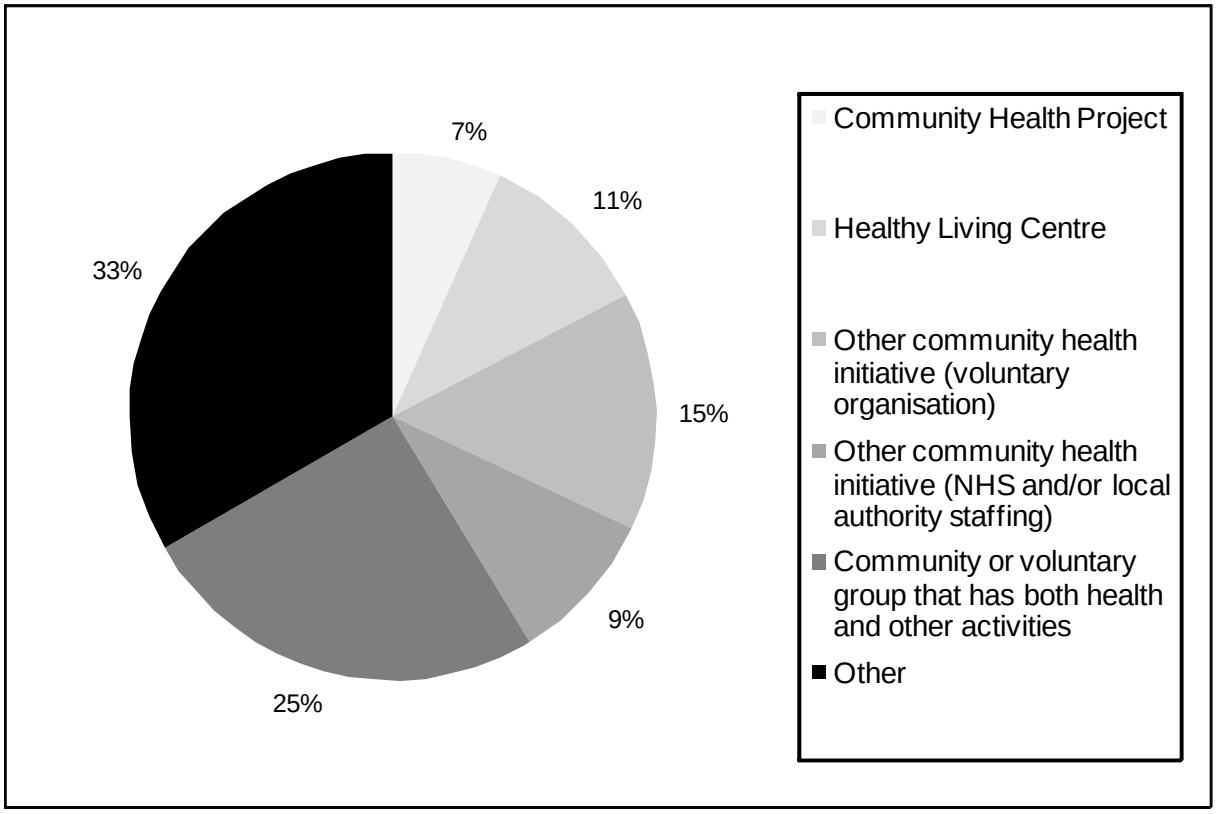
The designation 'Community Health Project' was believed to be a core one, but turned out not to be particularly popular. However 42% of these people were from organisations that fell within that designation or one of the three other types of organisation listed that clearly represent the core constituency of CHIs. 25% were in other community and voluntary groups (some of which would no doubt consider themselves to have a primary 'health focus', others not). One third of respondents fell outwith these sectors, and described themselves in such terms as:

- 'statutory organisation'
- 'national intermediary organisation'
- 'Council for Voluntary Service'
- 'community development organisation'
- 'Community Health Partnership'
- 'NHS'.

In broad terms, it does appear that CHEX works with a balance of people from the range set out in its plans.

[2] Although terminology changes and will continue to do so: the term 'Healthy Living Centres' may or may not survive the ending of BLF funding, and the designations of specialist public health posts change.

Figure 3.2 Types of organisation responding to network survey



N=71

3.1.3 Objectives

CHEX's Business Plan for 2005 – 2008, was based on work identifying outcomes, targets and timescales that had been identified through use of the Learning, Evaluation and Planning (LEAP) model. Table 3.1 sets out the five overall objectives that it specifies. These were either the same as or reworked from objectives in the previous Business Plan. Table 3.1 also gives an indication of the main types of activities to be undertaken in pursuit of the plan, not necessarily in the words that it uses.

The elements derived from the LEAP model are not all set out in the Plan itself. A review of Operational Objectives completed in March 2007 provides more specific definitions of intermediate objectives and indicators.

Within the overall aims, the key objectives set out in the Business Plan are to:

- Provide a resource for community projects and health workers.
- Facilitate networks and exchanges between community health projects, healthy living centres, community health initiatives and policy makers.
- Inform and contribute to policy debate.
- Meet the training and development needs of community health projects, healthy living centres, and community organisations with a health focus

Table 3.1 Summary of CHEX Business Plan 2005/08

	Overall objective	**Examples of activities**
1	Community Development is influential in Health Improvement	Participate in national Task Group & Implementation Group Support CHIs to engage nationally Participate in National Working Groups etc Develop and deliver opportunities for CHIs to engage locally Develop joined-up working between national networks Produce briefings on policies
2	Community health sector develops effective practice and inclusive shared learning	Roll out & develop Health Issues in the Community (HIIC) training & build stakeholder network Support & disseminate lessons from Exemplar Projects within the National Programme for Mental Health Healthy Living Centre Support Programme Support West of Scotland & Lothian CHI networks
3	Community health sector is equipped to apply theoretical models of community development to assist in development of effective practice	Support for use of LEAP for Health (with SCDC) General support, training and development for CHIs
4	CHEX has a clear sense of identity and direction and community health sector has a clear expectation of CHEX's services	Update and develop contacts database Newsletters, E-mail snippets, upgrade of website Joint work with other intermediaries
5	Community health sector has an inclusive and accessible infrastructure	Development of training and practice opportunities, which reflect diversity of the sector Target the inclusion of CHIs representing the interests of minority groups

This clarifies a number of things:

- though training was apparently intended to be focused on CHIs and community organisations, in other respects CHEX is a resource for both 'projects' and other health workers
- CHEX is 'a resource' – it is not a membership organisation or the representative of one specific network of organisations, though it can support those, and has developed the Healthy Living Centres Alliance for that particular group of organisations.

The objectives emphasise exchanges between sectors and contributions to policy debates, without spelling out what is now commonly understood: that CHEX is an 'intermediary organisation'. It acts as a link between its core constituency at local level and the national policy and practice level (in fact an 'Exchange').

We asked CHEX staff to sketch their ideas of the position of the organisation within its wider environment. These sketches typically showed the organisation sitting in between organisations involved in community health work on the one hand and NHS Health Scotland (and separately, the Scottish Government) on the other. A relationship with local partnerships such as Community Health Partnerships (CHPs)[3] and Community Planning Partnerships (CPPs) might also be indicated.

We shall see many other indications of how this 'intermediary' role is recognised and valued. In section 3.4 we shall look at relations with other ''intermediary organisations'.

3.1.4 Organisation and structure

In addition to its status as a resource serving one or more networks but without any closely defined membership or network of its own, there are some other distinctive features to the organisation and funding of CHEX.

It is based within the Scottish Community Development Centre (SCDC). A number of aspects of this position are both unusual and of strategic significance:

- SCDC is a partnership between the Community Development Foundation (CDF) the University of Glasgow. However CHEX staff, like almost all others working at SCDC, are employed by CDF
- CHEX is not a separate legal entity – its Manager is line managed by the CDF Co-Director for Scotland. Yet it projects itself as a distinct entity – with, for example a separate website. It has an Advisory Group (but not management board) of its own
- CDF is a non-departmental public body, operating in all four UK nations but receiving some core funding from the Department of Communities and Local Government. However the great bulk of SCDC's income is nowadays obtained from Scottish sources.

[3] This term will be used throughout. In some areas these organisations are known as Community Health and Care Partnerships or Community Health and Social Care Partnerships

A review of the status of SCDC has commenced, which is expected to look at some degree of autonomy for the Scottish organisation, and might possibly result in a shift in its status from a public body to some form of independently constituted organisation. However initial decisions on the future priorities and funding of CHEX will require to be taken before this review is complete.

CHEX has no formal accountability to its Advisory Group, which consists of representatives of CHIs and networks, NHS Health Scotland, SCDC and other intermediary organisations (Fig. 3.1). But it acts as a sounding board and reference point on the activities of CHEX and the way in which these respond to the needs of the people it works with.

The distinction between CHEX and SCDC work is complicated by the extent of joint and overlapping work that has been undertaken. The LEAP model has been an influence on and focus of much CHEX work. This was developed and supported by SCDC in both its generic and 'LEAP for Health' versions. The additional funding (see below in this section) for the Healthy Living Centres Support Programme in CHEX also funded a LEAP Support Officer in SCDC (and a Strategic Development Manager in NHS Health Scotland). Now in 2008 a national capacity building programme for community health, 'Meeting the Shared Challenge', is being planned and delivered which has distinctive CHEX and SCDC components.

Less unique, but still a crucial factor in determining potential strategic options for CHEX, is its very close relationship with its main funder, NHS Health Scotland, and particularly with the community and voluntary sector programme which is part of the Healthy Settings Team within the Programme Design and Delivery Directorate.

NHS Health Scotland gives CHEX its core budget, £214,977 in 2007/08, which covers staffing costs for four staff (the first four listed in Figure 3.1), training and development work, general running costs, a contribution to evaluation and the distribution of a quarterly newsletter. This funding is currently committed to August 2008.

NHS Health Scotland also contributes separately to the Healthy Living Centres Support Programme, funded for three years to 2007/08 by the Big Lottery Fund (BLF), which supports the other two staff. CHEX's Business Plan covers the work of the Support Programme as well as core funded activities. CHEX charges to cover costs for some events and for Health Issues in the Community (HIIC) training, but these charges represent a very small proportion of its income.

In addition, NHS Health Scotland has funded a number of projects such as the 'Understanding the Policy Maze' guide, which may or may not pass through CHEX's, or rather CDF's, accounts, but are known as CHEX activities and contribute to its reputation.

This close link between a small unit in NHS Health Scotland and the larger (in staffing terms) body CHEX can be justified by the nature of that Unit's responsibilities. To reach out into and support people working in the community and voluntary sector, and to enable a dialogue between them and policy makers, are tasks which by general consensus are better achieved by an intermediary body

rather than directly by the government agency concerned. NHS Health Scotland has consistently accessed the CHEX Network for direct routes into communities related to its work on community-led approaches and consultations on community health.

CHEX has collaborated with other sections of NHS Health Scotland, for example on Mental Health and Wellbeing, Physical Activity, Workforce Development, and Health Improvement in Community Health Partnerships. Several representatives of other sections have contributed actively to this Review. But the principal relationship, which is a close and trusting one in both directions, is with the community and voluntary sector team, and we observed that levels of awareness of CHEX's work decline fairly rapidly within the organisation in line with distance from that team.

3.2 Progress towards objectives

This study is not a systematic evaluation of the work of CHEX. In this section we shall outline the development of the organisation and its current activities, and look at what assessments have previously been made of their effectiveness. In the next section we move on to summarise our main source of information – the views of stakeholders on the work of CHEX and its effectiveness.

3.2.1 Development of CHEX

CHEX was first established in November 1999 by NHS Health Scotland's predecessor, the Health Education Board for Scotland (HEBS), following a positive evaluation of a pilot Community Health Network Project. Working with CHEX staff we created a timeline of significant internal changes and external events that have since affected its development. Table 3.2 is an adapted version of that timeline, with some detail omitted.

Perhaps the two most crucial elements for the development of CHEX have been:

- the expansion of the community health sector through the creation of Healthy Living Centres, followed by a risk of significant contraction
- increased opportunities for engagement in national policy development, especially through the work of the Community-Led: Supporting and Developing Healthy Communities Task Group (CLTG) and since.

The growth of the capabilities of the staff team, the increasingly wide range of activity in support of HIIC training, and the widespread adoption of and desire for support in implementing LEAP for Health could also be singled out from amongst many as amongst the most important factors.

Table 3.2 Timeline of significant events in development of CHEX

CHEX organisational development & milestones	**Date**	**Significant external environmental factors**
First CHEX Business Plan, 2001-03 Appointment of Training & Development Manager Establishment of HIIC partnership Production of first edition of the Policy Maze	2001	
Appointment of Practice Development Manager Review of Admin post and introduction of Information/Admin post First Seminar with West of Scotland Community Health Network on Sustainability Establishment of CHEXPOINT Newsletter Editorial Group Policy Seminars in Lothian & Stirling Introduction of HIIC Annual Conferences	2002	Policy document on 'Closing the Opportunity Gap' Local Government Bill on Community Planning White Paper on Partnership and Care – proposing Community Health Partnerships
CHEX Business Plan, 2003-05 Member of National Advisory Mental Health Group Initiation of CHEX Seminar Programme on Community Planning & Community Health Partnerships	2003	Policy document on 'Improving Scotland's Health: The Challenge' Community-led Health Task Group begins work
Practice Development Seminars in association with SCDC Training links with other providers – e.g. Strathclyde and Glasgow Caledonian Universities	2004	Development of National Standards for Community Engagement

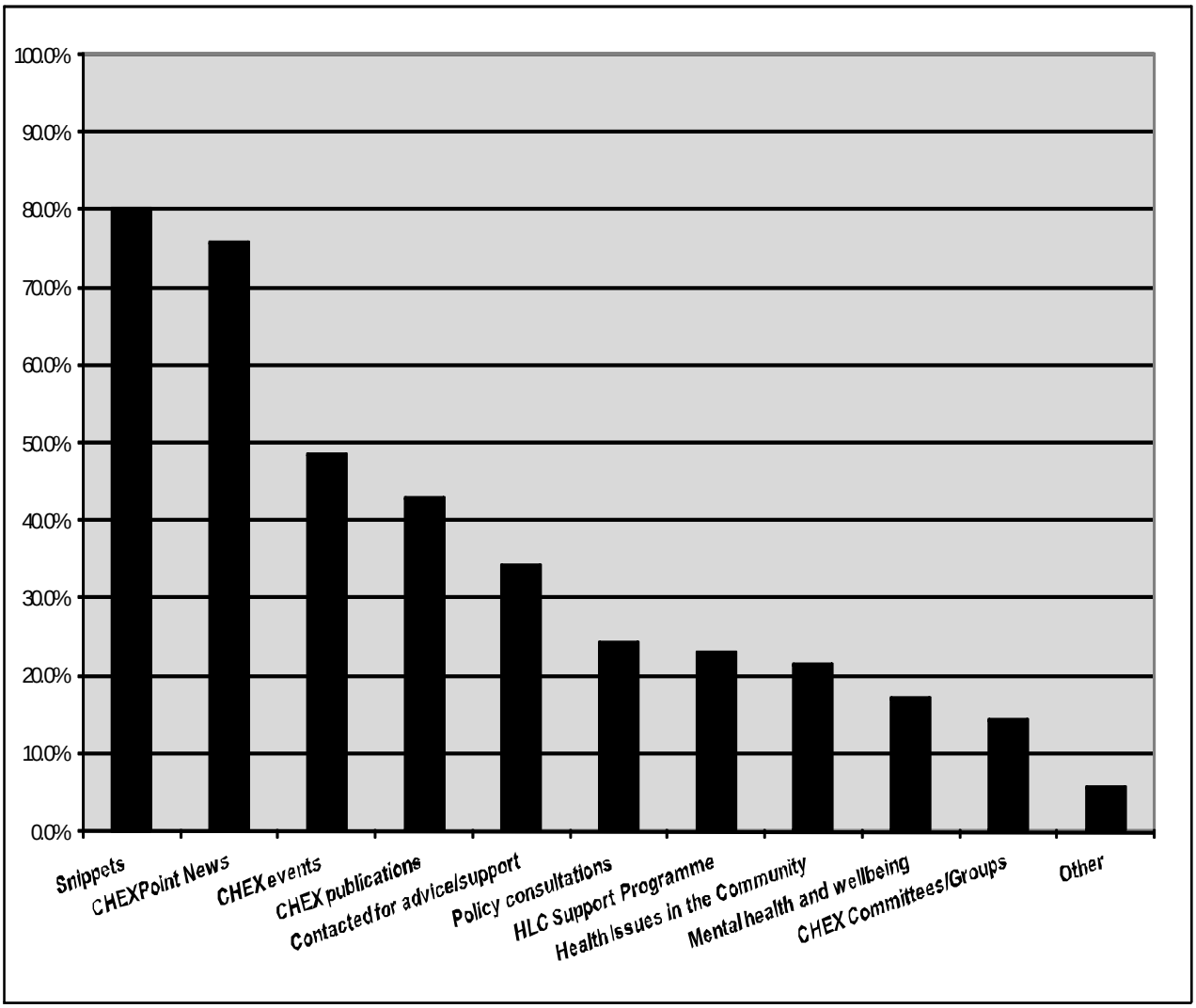
CHEX organisational development & milestones	**Date**	**Significant external environmental factors**
CHEX Business Plan 2005-08 Development of Training Handbook Responding to training and learning needs in the field – Collection of ideas, theory and tools Launch of HLC Support Programme Development of HLC Network Monitoring and evaluation data base of CHEX work CHEX Snippets fortnightly schedule	2005	Appointment of new supervisory contact for CHEX within NHS Health Scotland New LEAP Support Unit in SCDC
Launch of redesigned CHEX Website Training and support sessions for the use of the Training Handbook HIIC Part I Accreditation First HLCs Conference Involvement Public Health Workforce sub group	2006	Community-led Health Task Group Report and Event Funding crisis for Community Health Projects Increased focus on Anticipatory Care in health policy Community-led Health Parliamentary Debate – Briefing paper for MSPs
Increased focus on marketing CHEX information and services Healthy Living Centre Alliance Discussions and support for sustainability options Introduction of HIIC Administration post HIIC national networking events	2007	'Community-led' Implementation Group – recommendations for support programme Better Health Better Care – Consultation Document and Action Plan Integration of LEAP Support Unit into SCDC
Launch of national capacity building programme with SCDC Strategic Review and start of work on future Business Plan	2008	Further funding crisis for Community Health Projects SCDC work on 'logic model' Ministerial Task Group on health inequalities Review of future organisation of SCDC

3.2.2 Contacts' involvement with CHEX

We shall make no attempt to list the full range of activities that CHEX has undertaken. Our survey results give us an idea of which are most used by organisations in CHEX's informal network of contacts, and by whom. Figure 3.3

shows the percentage of respondents who said that they had been involved in each of a range of suggested types of contacts with CHEX. Since very few took the option of listing 'other' types[4], the list is presumably reasonably comprehensive.

Figure 3.3 Survey respondents' contacts with CHEX



N=71

Given the nature of the network listings used for the survey, these people certainly ought to have been in contact with CHEX, either through receiving its e-mail bulletins or its printed newsletters. In fact the great majority received both.

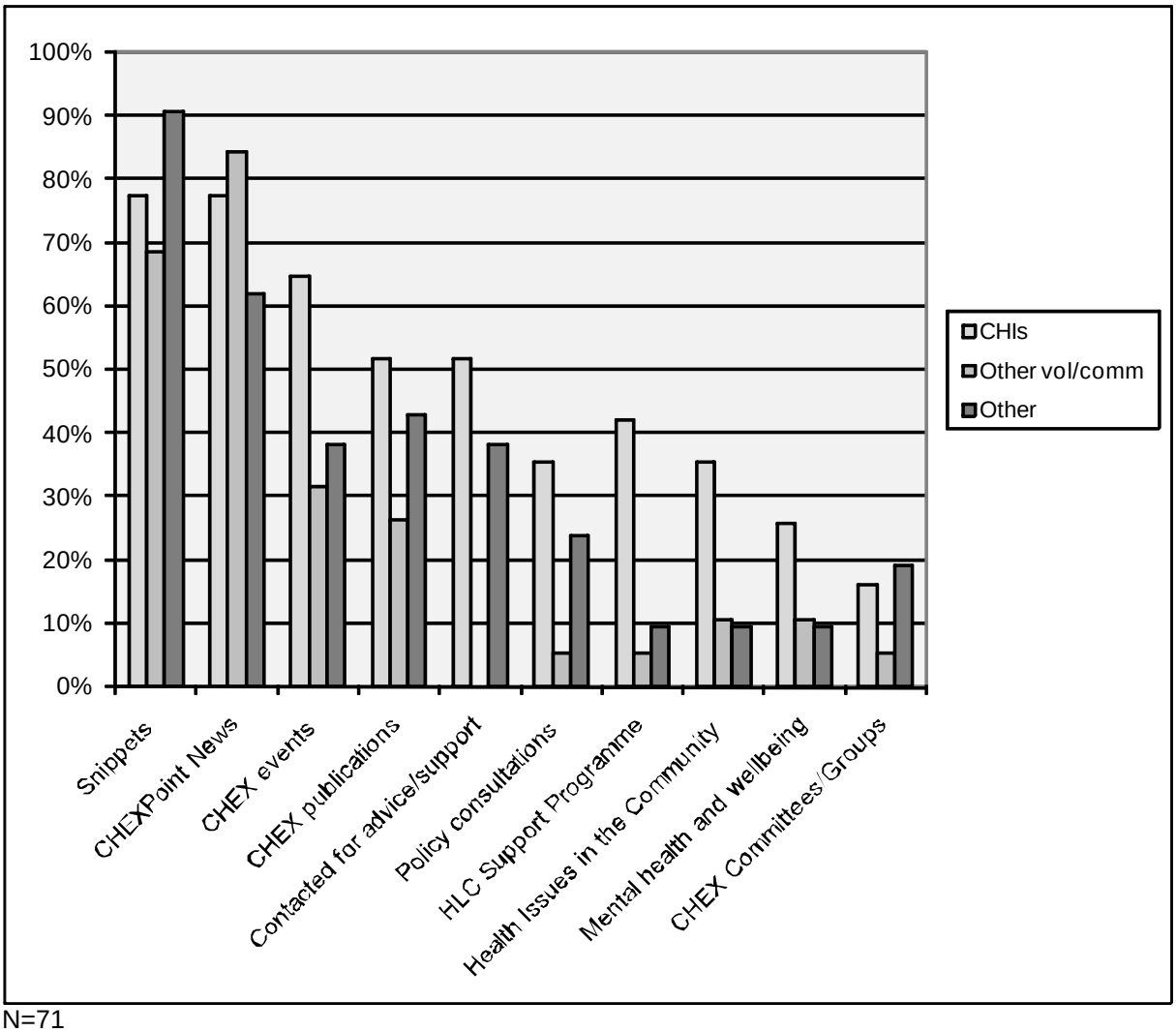
All other specific forms of contact had been experienced by less than half, though almost 50% had attended CHEX events. However, further analysis shows that 66% of these respondents had had at least one form of 'direct' contact with CHEX (usually more). Only a third were 'information only' service users (including the reading of publications). This does not imply two thirds of the entire live mailing list of 514 organisations has had direct contact – we would guess that the vast majority of 'information only' service users did not respond to the survey. But the number of

[4] Only one such response clearly identifies a different type of activity from those listed– support for Regional networks of CHIs

participants in direct contacts must be well into three figures (there may also be others who have attended events etc. who are not still on the mailing list).

It is notable that after 'information only' contacts and events, the next most common type of contact was for individual advice or support to an organisation or worker, which one third of respondents had experienced. For a relatively small national resource it is encouraging to see that so many local organisations reported having had this type of direct support.

Figure 3.4 Contacts with CHEX by type of organisation



N=71

The nature of this support is clarified if we look at what type of organisations reported each type of contact (Figure 3.4). We have grouped respondents, on the basis of their own descriptions, into CHIs (the first four categories in Figure 3.2), other community and voluntary organisations involved in health, and 'other' organisations

The great majority in all categories received both printed and e-mail information, with some variation in which medium was most popular. But what is striking is that the level of contact then 'drops off' much less sharply for CHIs than for the other two

categories. This confirms that CHEX does indeed concentrate its efforts on its 'core constituency'.

More than half of CHIs had received individual advice and support. None of the 'other voluntary and community' groups had done so. Very few had done anything other than receive information or attend events. 'Other' contacts, who are frequently in the statutory sector, were quite unlikely to have experienced some activities, such as HIIC training, but significant minorities had taken part in others, such as policy consultations, and strikingly almost 40% had received direct advice or support.

It should be noted that there is a considerable grey area in determining who represents CHIs, which are by no means always independent voluntary organisations. Although we have not quantified this, we noted that it was not uncommon for us to send a questionnaire to an individual listed in the database as a representative of a named project or group and receive a reply in which they described themselves by their position in (usually) the NHS. Amongst the 46 Healthy Living Centres in Scotland, only 39% were led by a voluntary or community organisation (Hills et al, 2007:21).

3.2.3 Monitoring and evaluation

NHS Health Scotland believes that CHEX has used the discipline of its Business Plan throughout its development to clearly state the objectives and targets of the organisation and plan for the best delivery of its services and responsibilities within the resources available.

It has certainly devoted significant resources to developing, monitoring and reviewing its plans. There have been several reviews or development days involving NHS Health Scotland and other Advisory Group members. Bi-monthly staff activity reports are presented to the Advisory Group. Quarterly reports on the HLC Support Programme are presented to NHS Health Scotland and the BLF. Participation in the Advisory Group obviously varies, but members are obviously engaged with and committed to their role in monitoring the progress of the organisation.

Our overall conclusion is that the ability of CHEX to plan effectively and to deliver on its plans is well established and will therefore not be the principal focus of this review, which will instead concentrate on how to respond to a changing environment.

A small number of process and substantive points can however be made from our own analysis and evaluation, and more will emerge from the views of stakeholders.

In terms of planning, monitoring and evaluation processes:

- More formal reporting on progress on Business Plan targets to NHS Health Scotland or other stakeholders appears somewhat sporadic. No such report has been submitted since November 2006. This gives an overview of which targets had been 'Completed', 'Partially Complete' or 'Ongoing' which is not available in activity reports to the Advisory Group. The closeness of the relationship may have overtaken the perceived need for more formal reporting procedures, but there are risks attached to this.

- CHEX's awareness of and commitment to monitoring and evaluation is so great that it has perhaps become overambitious. The 2007 operational review in particular identified a wide variety of indicators and specified that 'evidence will be collected on an ongoing basis by the staff team'. The result has been an overflowing 'evidence cupboard' whose effective usefulness is not immediately apparent.

- No full evaluation of CHEX has ever been completed. It seems to have been the victim of circumstances in this respect. An external evaluation in the previous Business Plan period submitted an interim report but was never properly completed. Another external evaluation of the HLC Support Programme has also to date only presented a progress report, in early 2007. A full report by the University of Edinburgh is due by summer 2008. A full evaluation of Health Issues in the Community was completed in 2006 (Hall Aitken, 2006) and Margaret Lindsay carried out a small scale survey of national stakeholders' and network members' evaluations of CHEX in late 2006. Some key points from these two pieces of work are noted below.

On the substantive objectives of the Business Plan, we are happy to record that substantial progress has been made in every respect. Two points can be commented on at this stage:

- Objective 5 (Table 3.1) relates essentially to ensuring that CHEX's work promotes inclusion and equality. Efforts have been and continue to be devoted to this, for example ensuring the participation of disability organisations in the network and activities. Work to involve ethnic minorities has perhaps proved more difficult, in spite of former work with a Community Development Network of BME organisations, and active contacts with those ethnic minority based CHIs that do exist. The most recent report to NHS Health Scotland that we have seen records no 'completed' tasks in relation to Objective 5 (unlike all the others) and more 'ongoing' than 'partially completed' ones. Recent work with BEMIS to adapt HIIC to work with ethnic minorities may however prove to be an effective approach.

- The growing need to carry out urgent work to assist the sector to survive in a sustainable fashion has become a major priority, which was perhaps not fully stated in the Plan, even though the ending of BLF funding in particular was entirely foreseeable[5]. CHEX has been making an active and effective response, but some feel that this has got in the way of other priorities. The views of CHEX staff however suggest that there is still an essential strength to the Business Plan framework:

  "The critical nature of what is happening to the sector at the moment has blown our Business Plan off course ... Staff all feel they do wee bits of everything. (The CHEX Manager) uses the Business Plan to combat this - it gives us a rationale." (comments recorded at rapid appraisal session with CHEX Staff)

[5] The sections on 'Community Health Networks and CHIs develop and consolidate their work' and "Consolidate and develop the HItC Initiative across Scotland' do raise the issue, but undoubtedly it would have been given greater emphasis if the Plan was being written now.

Findings from 2006 Stakeholder analysis

CHEX in future should:

- Provide an overview of/market better its organisational structure and functions
- Be more explicit about/show more evidence of policy influencing role
- Produce qualitative information/evidence of daily realities of service users
- Provide more grass roots/local focus to training and networking activities

Future roles for CHEX:

- Supporting implementation of the Community-led Task Group recommendations
- Supporting the inclusion of health/community health in the regeneration agenda
- Developing more systematic and collaborative links with other national partners
- Need for more explicit profiling and promotion of CHEX as an organisation

Findings from 'Health Issues in the Community' Evaluation

The vast majority of courses that are delivered are either individual modules or short thematic courses using modules from the first part of the course. Only 14% of courses delivered are full courses.

Health workers and people from health promotion are the most commonly trained as tutors. But tutors from these backgrounds are less likely to have delivered any courses. Tutors from community development backgrounds or who had taken the course as students were much more likely to have run training courses.

HIIC has had impacts on all three areas of individuals; communities; and organisations.

Individuals have seen improved confidence and acquired the skills and motivation to go onto further learning or into work. Students have become engaged in local health projects both as volunteers and in paid work.

Communities have benefited from greater social cohesion and from the impetus which HIIC gives individuals and groups in jointly taking forward local health projects. The community benefits are most clearly linked to those completing the full HIIC course.

Recommendations focus on:

- aligning HIIC more closely with local strategies;
- developing strong partnerships and clear aims for the initiative locally;
- prioritising action based on community need and wider strategy;
- targeting tutor training at those with delivery capacity;
- promoting dedicated funding for developing the initiative locally;
- developing and supporting local networks of tutors to co-deliver training;
- looking at streamlining the wide range of HIIC courses into more definable 'products'; and
- more consistent monitoring including short and thematic courses and impacts on tutors. (Hall Aitken, 2006)

3.3 Perceptions of stakeholders

3.3.1 Overall awareness and attitudes

We have gathered a considerable amount of material on the views of stakeholders about the effectiveness of CHEX and on other matters. Much of this informs and is summarised in the 'SWOT' analysis presented in section 5.2 (which also incorporates the environmental factors that we report on in following sections).

Some stakeholders had a limited knowledge of CHEX and were unable to contribute evaluative judgements. This applied to a minority of the contacts who answered the survey.

> "I have had very little involvement with CHEX apart from reading newsletter/ snippets etc. and feel unable to answer the above"
> "Can't comment as [area] doesn't have any specific CHIs, only health promotion" (survey respondents)

A limited awareness was most noticeable amongst the contacts in CPPs and CHPs. Unlike our other participants, these people were not contacted on the basis of any known likely involvement with CHEX. Almost half of these interviewees were not very aware of CHEX as wider organisation. It was known to them if at all as a source of information or of training resources for community projects.

On the other hand some of the randomly selected telephone interviewees did have substantial experience of working with CHEX and a high regard for it. Those people who were motivated enough to take part in our regional Focus Groups not only valued it but saw it as having a direct contribution to make to people like them. Points recorded included:

- CHEX is very supportive to the role of Health Practitioners (through consultancy advice, input in terms of service delivery and future planning, HIIC training)
- CHEX is a champion and ally for our way of working and sharing good practice
- There has been a real contribution from CHEX in supporting the case for local recognition of the value of the community development approach and the benefit of the community health sector (Stirling Focus Group)
- CHEX is important to keep the profile of community-led health to the fore at a national level
- A real champion for the community development approach
- CHEX is for community based organisations - not a resource for local authorities as such. But it is there as a support for wider network/ partnership initiatives involving public sector bodies
- Health Improvement Officers and colleagues have used CHEX to support an understanding of community development work (Glasgow Focus Group).

It was also clear, particularly, in later interviews, that several people were becoming aware of the new national capacity building programme and saw it as having a positive potential.

Our interviews, discussions and survey overwhelmingly show CHEX as being held in high regard. General points of recurring positive comment included:

- The expertise and commitment of the staff team
- Openness and generosity as an organisation
- Recognition and respect both at local and national levels
- Adaptability and response to change
- Understanding of the field and practice in CHIs
- Commitment to and promotion of community development.

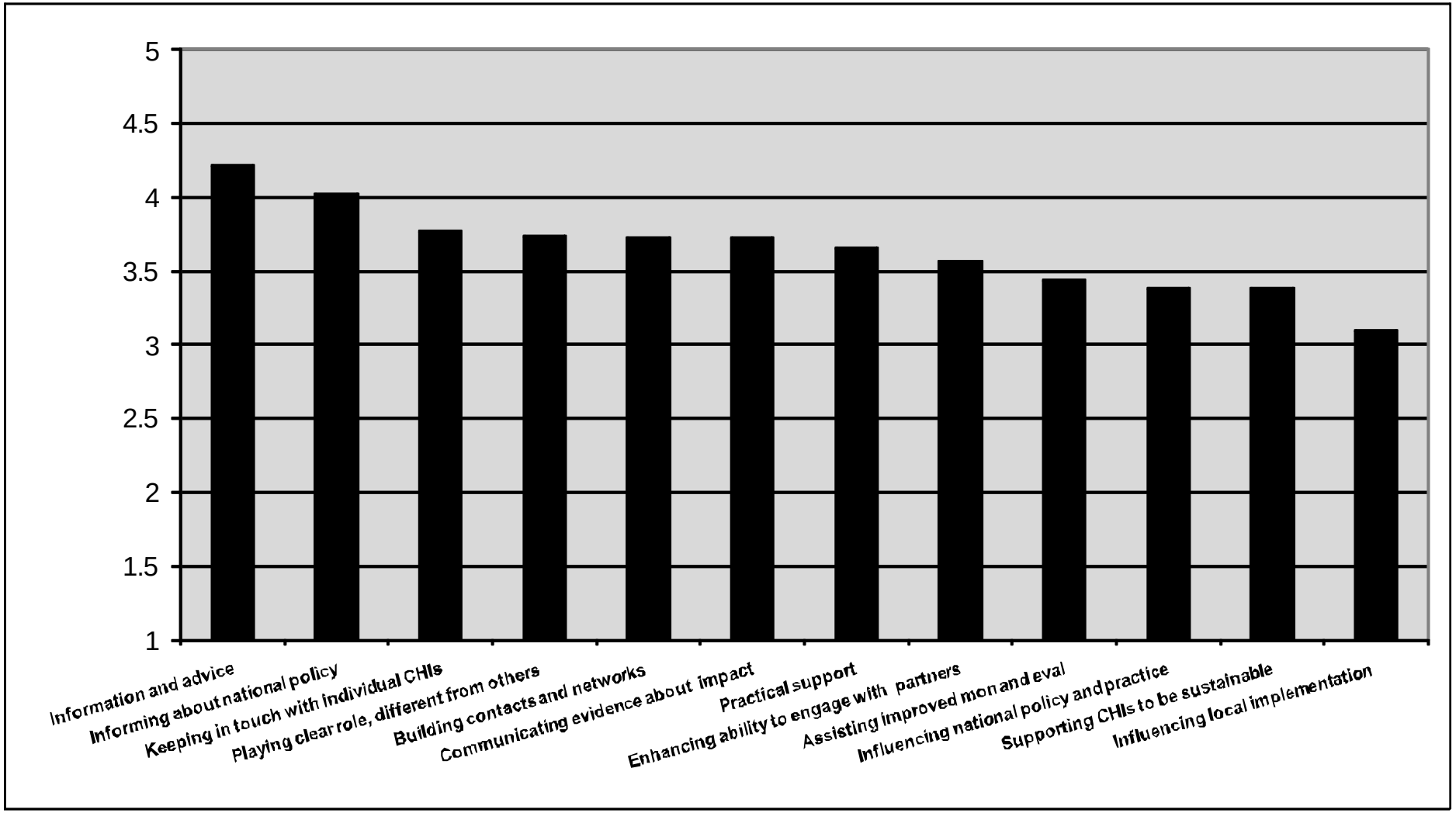
> "Provides an excellent service at every level"
> "A very professionally led organisation with dedicated, professional staff, dedicated to the sustainability of health initiatives"
> "The work of CHEX is recognised and valued by the voluntary sector – based on trust in the integrity and reliability of the organisation" (CHIs)
>
> "The credibility of the organisation is strong – the stakeholders are involved in the organisation at all stages of its operation"
> "People like working with CHEX – it is a good and reliable partner" (National partners)

Perhaps the only reservation of a very general nature was a feeling, particularly expressed by some at the network event, that CHEX was now experiencing capacity issues and might be a 'victim of its own success'.

When we asked contacts in our survey to rate the effectiveness of various aspects of CHEX activities, the result was a general level of positive approval across the range (Figure 3.5).

It is interesting that the highest scores (averages of responses on a 1-5 scale), after those for information and advice functions, were for individual contact – keeping in touch with individual CHIs and building contacts and networks. Slightly lower ratings were given for aspects whose successful implementation ultimately depends upon others – influencing policy and practice, particularly at local level and supporting sustainability. Differences in ratings between sectors (not shown) were not large.

Figure 3.5 How effective has CHEX been? (survey respondents)



N=71

3.3.2 Support to sector

Various aspects of the support given to the sector were widely commented on, including:

- shares information, ideas and experience
- information role highly valued – on policy developments, and good practice
- strong links with the world of practice development
- supports grass roots and development of best practice
- comprehensive understanding of sector and able to respond to its needs
- creating an active network that brings people together across the sector
- links projects with others going through similar challenges
- provides practical resources and support – information, networking, training and HIIC training
- signposting resource and funding opportunities
- support for systematic participatory evaluation and planning
- part of wider community development movement
- supporter and promoter of change

> "Through our relationship to CHEX we got an early idea of ways into the CHPs; it has also been very helpful over sustainability"
> "At a time of crisis, CHEX has been able to link projects with activity in other areas that have gone through similar experiences ... CHEX staff have encouraged us to work together and develop a stronger voice as a sector and succeeded in supporting individual projects to feel less isolated and under valued." (CHIs)

> "B is almost like a colleague in the support [s/he] gives. You can phone and say 'I'm writing a report on x, what do you think?'" (NHS staff)

> "CHEX is good at making things seem doable' (national agency)

> "CHEX has ... given me the confidence to continue investing time with local people instead of running around after other people's priorities" (survey respondent).

The only area where a number of reservations were expressed was the ability of a small team to get to know projects in depth and in particular to cover the whole of Scotland to the same degree.

> "No-one has actually been to [our project]. So some of my colleagues say 'that's nothing to do with me'. However I understand the difficulties of them getting around"
> "Though CHEX is careful to try to avoid it, there is perhaps a slight West Coast bias. This is because there are more community health projects there". (CHIs)

The indeterminate and relatively weak nature of the network, as CHEX staff perceive it, may also help to explain such reactions:

> "There is a plethora of CHIs. We send out information. Some reaches them, some misses. Less make contact back" (Comments from staff rapid appraisal session).

3.3.3 Linking policy and practice

But the most striking and persistent theme in evaluative comments from all sectors is that CHEX's special role and value is that it can act as a link or bridge between the levels of national policy and local practice.

People refer to:

- providing a link for the mainstream agencies with the voluntary sector, especially in policy consultations
- contributing to increased awareness of national policy
- credibility from its practice development role
- authority with Scottish Government – comes from connections with the field
- speaking with authority on the views and perspectives of the community health sector
- contributing to national policy but also supporting local interpretation of national agenda.

> "CHEX plays a valuable role to support grass roots activity and the development of best practice; and to reflect and champion the sector and its perspective at a strategic level" (CHI)
>
> "I see added value in the ability of CHEX to reflect and reinforce the local level community-led health sector experience at a national level "
> "CHEX is able to unite different voices and bring a comprehensive overview to national agendas - contributing issues and experiences that might not otherwise be heard" (local authority staff)
>
> "CHEX brings realism to the table when dealing with mainstream agencies" (NHS staff)
>
> "A real strength is the different ways in which CHEX is able to focus and respond as an organisation: nationally, to central government; regionally, supporting effective partnership working; and locally" (national agency)
>
> "[The CHEX Manager] is on everything I go to. [She] is often the only person at meetings who can put across relevant issues" (civil servant).

There are perhaps two main areas of reservation expressed. Firstly, a recognition of the limits to which actual influence on the health improvement agenda is being or can be achieved, especially at a local, practice level.

> "Probably a stronger relationship is needed with NHS services, which is not an easy one"
> "Community development is a key approach to health improvement but is not yet sufficiently recognised within health services practice" (NHS staff)

Secondly, CHEX is well aware that there is often a demand for it to take a more actively representative role on behalf of the sector and a stronger stance on issues, especially at national level, than it feels able to do. This is not possible because of:

- Its community development approach, which leads to the desire to enable and support people, in this case CHIs, to make their own case
- Its status as part of a public body, even if it is one that has little or no profile as such in Scotland.

"CHEX is always clear that it does not speak directly on behalf of its stakeholders – or on behalf of communities. There are times at a national level when this representative stance would be useful" (intermediary body)

Its role as a resource is sometimes not clearly perceived or understood:

> "It is almost a lobby group, or at least one that gathers information for Ministers" (NHS staff).
>
> "CHEX is a conduit for a collective voice on behalf of Community Health Initiatives" (local authority staff).

The difficulty is compounded by the lack of any specific forum for expressing the interests of CHIs, except for the HLC Alliance, whose membership is restricted by the vagaries of former funding. There is perhaps a need to develop more formal mechanisms, probably supported and resourced by CHEX, to communicate the community-led health perspective to policy makers, agencies and partnerships.

Finally there is one other area about which a number of people have concerns, namely the degree of general recognition and profile that CHEX has achieved as an organisation. We noted examples of people amongst our contacts who knew about activities such as HIIC without linking them to CHEX.

Factors such as the ambiguity we have noted over 'representation' and the complicated relationship with SCDC may be involved, and a low profile can often be an integral component of a community development approach. But there is some feeling that this has gone too far and that CHEX, and perhaps through it the community health sector, needs to aim for a wider degree of recognition of its name and nature in future.

> "The name of CHEX should be a bit more high profile. This would pull in new groups." (NHS staff)
>
> "Pulling all the aspects together – promoting and selling the organisation – needs to be looked at"
> "It still goes about its work too quietly. It is not promoting the extent and success of its range of activities" (national agencies).

There is a related concern that CHEX could perhaps help the community health sector to 'sell' itself better, not just in terms of evidence of outcomes and impacts, important as this is, but of raising basic awareness of what the sector is and what it does, and publicising good practice.

3.4 Relationship to other organisations

We were asked to consider the relationship between CHEX and other intermediary bodies. There were suggestions that there might be pressure from policy makers or funders to rationalise the intermediary agencies. These were not expressed directly to us, except in terms of the need for raising and clarifying CHEX's profile. One civil servant felt that:

> "It is difficult to know how the various intermediary bodies relate to each other and hang together, and what their unique contribution is. If it is not immediately obvious to people like me with access, then it must be very difficult for people to know who to approach: SHC, local CVS, VDS, VHS, etc. Could something be done to make this more explicit?"

Another civil servant reported that "I had some concerns at one time about overlap, but these have been largely resolved. I recognise the unique role of CHEX".

Most of our contacts were clear in their belief that the role of CHEX is distinctive. Figure 3.5 shows that survey respondents gave CHEX a relatively high score for 'playing a clear role, different from others'.

> "It is important to appreciate that the intermediary bodies do not represent one sector. It would not be an advantage to amalgamate these different organisations – they work to different target groups and different networks. The perceived 'confusion of the landscape' is in the eyes of the funders, not within the community health sector" (CHI).

It was suggested that other policy areas, such as social enterprise, are much 'busier', with many different national bodies in operation. However it was widely agreed that there is a need for CHEX and others to be clear about what their respective distinctive roles are, who they work with or represent, and to ensure that these messages are given out clearly.

The question most raised is probably that of the relationship between CHEX and Voluntary Health Scotland (VHS), the two main agencies that help NHS Health Scotland to deliver its community and voluntary sector programme. The survey carried out as part of the recent Strategic Review of VHS (Stevenson & Watson, 2007*)* found that it was not always clear to external stakeholders how VHS is positioned in relation to CHEX, and also the Scottish Council for Voluntary Organisations (SCVO).

Close observers report that the two organisations have "worked out their roles reasonably well", and the organisations themselves are clear that they play distinct roles. The VHS review reports that only 20% of the voluntary organisations active in health who form its membership are also "CHEX members" (though that, as we have seen, is not a clearly defined status). The priority may therefore be communicating the distinct roles to others, and initiatives like the March 2008 joint display in the Scottish Parliament (along with Community Food and Health Scotland and the UK Public Health Association) show that this is being addressed.

However defining the distinctive roles of these two organisations does raise some fundamental issues which will not go away, and which suggest the need for close co-operation.

One dimension is that VHS members tend to be mainly concerned with the treatment and care of people with identified health conditions, whilst the activities that CHEX supports are clearly concerned with promoting improved health and well-being in wider populations. But there can be areas of overlap here, particularly perhaps in work with people with mild mental health or addiction problems. More importantly, treatment and care groups can have an important potential to contribute to wider health improvement, and this is one that they should no doubt be encouraged to develop – an area perhaps for joint action by CHEX and VHS.

Perhaps the most fundamental issue is the differences and overlaps between the 'community' and 'voluntary' perspectives. CHEX would say that community development is central to its approach. VHS makes no claim to work in a community development way. However we observed that people sometimes equate both CHEX's area of work and 'community-led' health work generally with the 'third sector' contribution to health improvement.

Strong community activity typically does involve the existence or creation of independent voluntary organisations. But CHEX is not part of the 'voluntary sector infrastructure'. General support for organisational management and development should come perhaps from VHS for some, from bodies such as Volunteer Development Scotland (VDS) and especially from local bodies, particularly Councils of Voluntary Service/ for the Voluntary Sector (CVSs).

From within that sector we were told that CVSs were becoming aware of the health improvement agenda, partly because of the emergence of CHPs, though still learning how to respond. However there was also a clear recognition that, whilst CVSs are there to give generic support to groups, CHEX provides a body of expertise that is specific to health improvement. Evaluation and impact assessment were mentioned, but links to policy and practice also could have been. CHEX can and does help to make this distinction clear to its network:

> "CHEX has encouraged [us] to make use of other intermediary organisations and helped our understanding of how they work – for example VHS, [local CVS] and SCVO. We still find it quite baffling getting a grasp on these other players" (CHI).

Another particularly tricky aspect of the 'community/ voluntary' distinction is that, as we have seen, a significant number of initiatives that are recognised as CHIs are co-ordinated by statutory services (whatever specific self-managed groups may spin off from them). CHEX is clearly a key agency for promoting community development approaches in the NHS and other health improvement partners. The difficulty will be not so much defining its role vis-à-vis other intermediary bodies as being clear about what initiatives should count as part of the 'core constituency' and how to build a network that includes 'initiatives' that have no specific legal identity of their own.

The other organisation whose relations with CHEX might be particularly at issue is Community Food and Health Scotland. The overlap in 'membership' is probably significantly greater. However, given that organisation's clear specialist role and the close working relations that have been established, this relationship was not specifically raised as an issue.

There are clearly many other actual and potential partnerships that could be explored – for example with social enterprise support agencies.

One body that has some relationship with CHEX is the Scottish Health Council (SHC). Here, though, the suggestion might be that rather than overlapping, their current work is too far apart. The 'patient focus and public involvement' agenda that the SHC essentially pursues is not the same as community-led health improvement (though a few of our local partnership contacts were prone to equate the two). However groups and individuals involved in health improvement have potentially a lot to contribute to public involvement in health services, and involvement structures such as Public Partnership Forums (PPFs) could take a more active role in pursuing health improvement. Joint work by SHC and CHEX might facilitate such developments. SHC's monitoring framework for PPFs currently does not ask any questions about involvement in health improvement.

We shall look again at the 'positioning' of CHEX (6.2.1 and 7), but in general terms the message from stakeholders on the relationship with other bodies are:

- CHEX should concentrate on its unique capabilities, such as bringing together community based work with policy makers and sharing practice and approaches in community development and health improvement across Scotland
- other services should support basic organisational and individual capacity building
- opportunities for joint working should be identified wherever appropriate
- there should be better information sharing and networking with other national players
- but the purpose of such interaction must be clearly defined - not just getting together for the sake of being seen to have meetings.

3. The work of CHEX – KEY POINTS

- CHEX's overall aims commit it to a community development approach and it works with a balance of people from across the range of community health projects, community health organisations with a health focus and other staff involved in community health work or policy.

- The key objectives are to provide a resource for these people, contribute to policy debate, and play an 'intermediary' role.

- The position of CHEX within the Scottish Community Development Centre and its very close relationship with NHS Health Scotland are crucial to its work.

- The ability of CHEX to plan effectively and to deliver on its plans is well established, and substantial progress has been made on all the substantive objectives of the Business Plan.

- The interviews, discussions and survey show CHEX as being held in high regard, though some people in local partnerships had a limited awareness of it.

- Highest ratings were given to CHEX's information and advice functions, and to individual contacts. Very positive ratings were given to influencing policy and practice and supporting sustainability, which ultimately depend upon others.

- A wide range of aspects of the support given to the sector were commented upon positively. The most persistent theme in comments from all sectors is that CHEX's special role and value is to act as a link or bridge between the levels of national policy and local practice.

- Limits to which actual influence on the health improvement agenda can be achieved, especially at a local practice level, are recognised.

- There is a demand for CHEX to take a more actively representative role on behalf of the sector than its position and approach allow.

- CHEX, and perhaps the community health sector in general, needs to aim for a wider degree of recognition of its name and nature in future.

- Most contacts were clear that the role of CHEX is distinct from other intermediary bodies. It was widely agreed that there is a need to communicate clearly what these roles are and who different bodies work with or represent.

- People sometimes equate CHEX's area of work and 'community-led' health work generally with the 'third sector' contribution to health improvement. But CHEX provides expertise that is specific to health improvement, not basic capacity building for the voluntary sector. It is also a key agency for promoting community development approaches in the NHS and other health improvement partners.

4. The policy and practice environment

4.1 Policy context

4.1.1 Background

The longer term policy context for the work of community health initiatives is the growing emphasis on the importance of public and preventative health from the Green Paper 'Working Together for a Healthier Scotland' (The Scottish Office, 1998) onwards, and on 'patient focus and public involvement' (PFPI) in planning and service delivery in health and other areas. There is no need to rehearse this long term context in detail, since CHEX and its stakeholders are very familiar with it.

Policy has also emphasised 'shifting the balance of care', which is often interpreted to mean shifting care and treatment where possible from acute to primary services, but is also intended to be not just about where services are located but about getting people to take ownership of the solutions to issues.

In 'Improving Health in Scotland - the challenge' (Scottish Executive, 2003), there was a clear and challenging recognition of the relevance of work on social and economic factors to health improvement, and the designation of 'community-led' approaches as one of its key 'pillars'.

Other important trends over the same period have been the growth and statutory recognition of Community Planning as both a key mechanism for partnership working between agencies to agree and address common priorities, and more equivocally for community engagement in this process.

All Scottish Community Planning Partnerships (CPPs) would recognise health improvement as being one of their priorities in some form. The principal joint approach to the health improvement aspects of the Community Plan is supposed to be the Joint Health Improvement Plan (JHIP). The local authority is recognised as the lead body for developing a JHIP with its partners.

The development of Community Health Partnerships (CHPs) is also seen as a focus for partnership working and community engagement, as well as for the delivery of much health improvement work. There is arguably an ambiguity in the language used to describe CHPs. They are clearly partnerships, between acute and primary care services within the NHS and with local authorities, voluntary organisations and local communities, through the Public Partnership Forums, in hopefully equal roles within the partnership. Yet they are also frequently treated as organisations within the NHS with particular responsibility for primary care and health improvement, and responsible for a specific group of staff.

Other initiatives with a specific importance for community-led work include:

- The Equality and Diversity Strategy for NHS Scotland, with six partner 'Fair for All' initiatives focusing on specific equality groups, and the creation of the new Directorate of Equalities and Planning of NHS Health Scotland.
- The 'Keep Well' programme of health checks, screening and advice on cardiovascular disease and its main risk factors is seen as requiring primary

> care staff to deploy potentially new skills in engaging with and motivating people.

Of potentially crucial significance for the future of community-led health work was the work and report of the Community-led Supporting and Developing Healthy Communities Task Group (CLTG) (NHS Health Scotland, 2006) and the subsequent Implementation Group, in all of which CHEX was a key partner.

The key themes on which the Task Group worked and made recommendations were

- building the evidence base for community-led health
- supporting planning and partnership working
- capacity building for community-led health
- the sustainability of community health initiatives.

Our consultees emphasised the significance of this work in

- looking in depth at the community-led approach
- attempting to raise the profile of the community health sector and appreciation for its contribution to health improvement
- beginning to collect evidence on its effectiveness.

The report tended to expose the gaps in existing evidence. One area in which it was arguably weak was that it perhaps did not clearly articulate the connections between the work of CHIs and community engagement in the work of partnerships.

The national capacity building programme stems from a decision by the Implementation Group to commission CHEX and SCDC to take a lead role in delivering several of their priorities.

4.2.2. Current context

Since the Election in May 2007, the Scottish Government has both introduced new policies and reaffirmed some policies from the previous administration. There was some concern that the work of the CLTG might not be sustained and followed up.

The discussion document 'Better Health: Better Care', stated a focus on reducing health inequalities and improving health by harnessing resources across all sectors. Its aim was

> "to help people sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care" (Scottish Government, 2007a)

Yet it initially heightened this concern by its lack of specific attention to community-led health. However, following comments from CHEX amongst others, the resulting Action Plan (Scottish Government, 2007b) states:

> "The Scottish Government is committed to improving the capacity of the third sector to reduce health inequalities. We are continuing to implement the recommendations of the 2006 report of the community-led task group, by

> supporting commissioners and funders on the one hand and community-led services on the other, to work better together in achieving shared outcomes. Throughout the national discussion we heard from people working in, or benefiting from, third sector organisations and initiatives, who were concerned about their ability to provide or receive these services over the longer term. We will therefore establish a national review of the way in which NHS Scotland supports these organisations to explore ways in which we can enhance the sustainability of programmes that demonstrate a clear benefit for patients and their carers."

This 'national review' promises to be a crucial next development for CHIs. The Ministerial Task Force on Health Inequalities which will report in May 2008 is also expected to deal with relevant issues. Other specific areas of policy will continue to develop, for example an action plan on obesity is expected during 2008.

An announcement is expected shortly on a general Scottish Government commitment and approach to supporting increased 'community empowerment', which, if it is not narrowly focused on involving representatives in forums discussing public sector policy and service delivery, should provide opportunities for people working in community health.

Of fundamental significance will be changes to the way government is organised and objectives are set at national and local levels. The Scottish Government has set five strategic objectives, for Scotland to become

- wealthier and fairer
- healthier
- safer and stronger
- smarter
- greener.

Health issues are now dealt with by a Health and Wellbeing Directorate with a broad range of responsibility.

The key link between national and local level is the Concordat between the Scottish Government and COSLA (Scottish Government, 2007c). This sets out fifteen national outcomes, including:

> "We live longer, healthier lives"

and 49 high level outcome indicators, which include a number of lifestyle related health improvement outcomes, an indicator of increased mental wellbeing, and another of reduced health inequality ("Increase healthy life expectancy at birth in the most deprived areas").

Within this framework local authorities are working on local Single Outcome Agreements explaining how they will seek improvements in these and other locally chosen outcome indicators. These will help to determine the future Scottish Government funding for local authorities. Later, the Agreements are intended to

become agreements with all partners in CPPs, and in some areas this will happen immediately on a voluntary basis.

The new system will affect CHIs in many ways, including:

- the need to get better at demonstrating their contribution to the achievement of broader outcomes
- the possible increased competition for resources with the abolition of many previous sources of 'ring-fenced' funding
- the potential for authorities and partnerships to be flexible about how they deliver outcomes, including working with communities
- but equally or more so, the potential for them to use that flexibility to favour statutory services, especially as no national indicators refer directly to the processes of community development (though some areas may develop local ones that do so)
- the virtual inevitability of up to three years of uncertainty in budget allocations as a new and as yet undetermined funding system is brought in.

A pessimistic view is that:

> "Community-led health will only be taken on locally under outcome agreements if there is a national outcome that covers this. Partners won't use the sector to meet other outcomes" (local authority).

In addition the Community Regeneration Fund, which has been important for many projects, especially those outwith the BLF programme, is being merged with other funds into a new Fairer Scotland Fund, which though still ring-fenced for two years will have more flexible criteria and which appears to be resulting in some sharp upward or downward variations in allocations.

At the same time the NHS and partners have been working on new systems for Health Improvement Performance Management (HIPM).

Currently the NHS (including NHS Health Scotland) must work to the HEAT (Health Improvement, Efficiency, Access, and Treatment) targets. The Health Improvement Targets for 2008 are heavily lifestyle based:

- Reduce mortality from Coronary Heart Disease among the under 75s in deprived areas.
- 80% of all three to five year old children to be registered with an NHS dentist by 2010/11.
- Achieve agreed completion rates for child healthy weight intervention programme by 2010/11.
- Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11.
- Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/ suicide prevention training programmes by 2010.

- Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/9 - 2010/11.
- Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.

It is still not clear how the shared national and local outcome agreements will be linked to these or to a revised system of HIPM (nor what role if any JHIPs will play in the new system).

The Scottish Government's Review of Health Improvement Performance Management for Shared Outcomes (NHS and Local Government) is looking at setting outcome targets related to

- Inequalities and health – reducing social, economic and environmental factors that help shape inequalities in health, including educational achievement, work environment, unemployment, and relative poverty.
- Mental Health & Wellbeing.
- Tobacco – reducing the burden of disease, disability and premature death due to tobacco.
- Alcohol – stemming the increasing burden of disease, harm, distress and premature death due to excessive alcohol consumption.
- Obesity/Healthy Weight **–** stemming the increasing burden of disease, disability and premature death due to rising levels of overweight and obesity in children and adults.
- Early Years – improving the healthy development of families, particularly those children most at risk.

The inclusion of mental health and well being is a particularly significant step for community health work.

People close to the process gave us fairly positive views of the implications. The aim is to include "shared outcomes that say people must co-operate", and which will play into the hands of good community projects who are used to working in partnership.

"Over the next few years you should see that there are:
- things that the NHS is expected to deliver, but with other contributions
- things that the NHS is expected to contribute to" (civil servant).

In addition to the national policy drivers, CHEX will need to relate its work closely to the priorities in NHS Health Scotland's Business Plan, which identifies community health as a specific area of work to deliver on.

Significantly, the agency has also introduced an ethical framework (Figure 4.1), which requires decision-making to be underpinned with specific principles and values including:

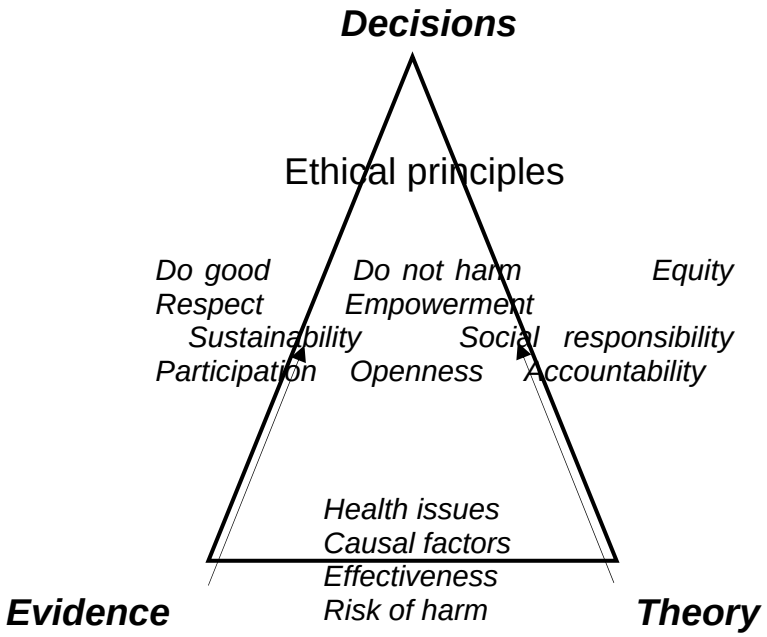
- do good
- do not harm

- equity
- respect
- empowerment
- sustainability
- social responsibility
- participation
- openness
- accountability

All are values that CHEX would subscribe to, and some are defined in particularly relevant ways.

> 'Empowerment': is described as "about helping individuals, families, other groups, communities and populations to have more control over their health. It includes promoting life circumstances, individual and collective knowledge and skills, and opportunities conducive to good health".
>
> "Participation" is explained by "a cardinal principle of health promotion is that of doing things with people, not just for them or to them. As far as possible, people should be involved in identifying health issues and solutions, and in taking action for better health".

Figure: 4.1 NHS Health Scotland's ethical principles and decision making triangle



Source: NHS Health Scotland (2008)

The aim is to achieve "evidence-informed, rather than purely evidence-based, decision making". It is recognised that a strong theoretical account of how actions can be expected to work is important, and that "comprehensive packages of actions can generally be expected to have more impact than a narrower approach".

4.2 Practice environment

The environment in which people involved in community health work relate to their local partners is clearly influenced by policy changes. As we have seen CHIs during the period of this review were acutely aware of an actual or potential funding crisis caused by a variety of factors, including the ending of BLF funding, delays to local authority commitments caused by the delayed national Spending Review, and uncertainties around the change from the Community Regeneration Fund to the Fairer Scotland Fund.

Some stakeholders felt that a discrepancy between rhetoric and reality had been exposed, not only in national policy but also at a local level where according to one account "in the main, authorities and services have been making the right noises without necessarily offering any guidance, support or funding".

It has also been a period of change in structures, with areas in varying degrees reporting:

- friction caused between CPPs and CHPs
- lack of full implementation of Community Planning structures
- links between Community Planning and the JHIP not clear
- local authorities inward looking as a result of political change.

The relationship between and understanding of the role of structures such as CPPs, CHPs and PPFs varies greatly across Scotland. The opportunities for co-ordinated working are clearly enhanced in those areas where they share the same boundaries. One local authority also argued that where joint working has already been set up and supported in the past, particularly through the Social Inclusion Partnerships, these approaches are being adopted fairly quickly in Community Planning work, but in areas without this background it was proving a more difficult and slower process.

But the specifics of funding and reorganisation did not dominate our discussions with CHP and CPP representatives. Generally speaking they reveal a more fundamental and diverse range of issues concerned with approaches to and understandings of working with communities that determine the very different environments within which CHIs must operate.

4.2.1 Local approaches

Asking people from CHPs and CPPs to what extent their partnership was engaging communities in addressing local health issues, and how the community-led health sector could contribute to achieving broader health improvement outcomes, yields a wide variety of responses, depending both on different practices and different understandings.

Approaches described, not mutually exclusive, include:

- Multi-agency forums at different levels which involve community – or voluntary sector - representatives
    - Community Planning mechanisms at different levels

  - Corporate structures in Councils
  - Area forums and partnerships

- Consultation mechanisms
  - Public Partnership Forums
  - lay representatives on health committees, strategy groups, or local service delivery group
  - shared consultation arrangements and databases with partners
  - informal networks, and through local groups and small projects
  - Community Councils (mentioned in rural areas)

- Service delivery or health promotion initiatives
  - one stop shops,
  - outreach work, including youth work and schools
  - mobile information bus

- Capacity building activities
  - HIIC with staff, or in one case PPF members
  - Seminars for elected members
  - Potentially, the national capacity building programme

- Specific staff roles
  - Public Health Practitioners (said by one area to "use a community development approach to inform and support their work")
  - Health promotion and health improvement staff
  - Community engagement staff (in CHPs mostly involved in supporting the PPF)

- Community managed initiatives and projects
  - Healthy Living Initiatives
  - Specific projects involving food, drugs, young people, alcohol etc.

Some also talked about other related service areas where there was scope for community involvement, including:

- the Joint Futures agenda and the planning and delivery of health and social care
- planning services for older people
- managing and commissioning children's services.

CHEX would argue that there is a clear difference between the work of community-led health and patient focus and public involvement activity, but recognises that it has often been difficult for health services to distinguish these two areas.

Some of our interviewees certainly manage to talk about the subject purely in terms of engagement in services, without showing any awareness of community-led activity, making declarations such as:

> "The NHS view of CHPs is that there should be a strong focus on community engagement and involvement in the development of services" (CHP).

Others described their structures for engagement without describing any link to the work of community-led initiatives, but did mention these as additional ways of working (after heavy prompting, in at least one case).

But others clearly saw the work of initiatives as important to their overall approach:

> "A lot of good engagement work is carried on through the Local Healthy Living Project"
> "At a more operational level, health improvement relies heavily on the work of other agencies, including the community and voluntary sectors" (CHPs)

In one area the use of the national standards for community engagement was described as an integral part of how they planned their health improvement work.

Clearly, integrating the contribution of community-led health into high level strategies can make a difference, and the extent to which this has been done varied greatly, but is often limited.

> "People in Health Boards just don't know what's out there. Planning Frameworks need to show the role and funding of the community and voluntary sector – not just that they sit on PPFs" (local authority).

> "A high commitment is reflected in the strategic documents of the local authority and the CHP for the involvement of the community – and recognition of the need to support knowledge, understanding and skills to allow that to happen" (CHP)

> "In terms of where the community-led sector can complement and contribute to health improvement outcomes there is a very uneven understanding across the country. There are no clear guidelines or consistency in developing and strengthening the community health infrastructure" (intermediary body).

4.2.2 Attitudes and culture

A good deal of discussion at both national and local level was about fundamental issues of attitudes and professional culture.

Points discussed included:

- the NHS is used to working with problems that patients present on a one to one basis – community-led work involves a significant shift in the relationship
- a degree of suspicion is still part of the culture
- officers and managers in statutory services can find consultation challenging - they need to recognise the purpose and benefits of engagement (CHPs)
- there is a need to do more to convince clinicians and health care professions to look at whole lifestyles and social pressures
- there is a limited understanding of the central role of community development in community health improvement (Focus Group)

- there is a need to get people to understand that community development is not whatever goes on in communities, or all of regeneration (national Symposium)
- even when there is support for the principles behind working in this way, staff still feel too pressured by other service priorities and demands (CHP)
- a community development approach encourages workers to meet people as equals – it is not about taking charge and having the answers. This can be quite daunting and challenging to staff used to more conservative and traditional service delivery (CHI)
- the NHS has a requirement "to evaluate everything to death" and this can be problematic for a small organization (discussion at network event).

Whilst no-one expects to turn large numbers of NHS staff into community development workers, there are differing emphases on how far the community development approach needs to spread. One CHI felt that:

> "We are now requiring a range of front line practitioners to engage and work with patients and communities in a very different way ... Lack of understanding of the community development process is a major issue".

But when this point was discussed at our national Symposium, it was argued that:

- we may not really want NHS staff to take community development approaches themselves – "they could be square pegs in round holes"
- they perhaps need education about community development, rather than skills in it
- there will be some NHS staff that do need to use community development approaches
- managers also need to understand them.

Symposium participants concluded that:

> "We need to do more to harness the opportunities of the community health sector:
>
> - by promoting and supporting a better understanding of community development approaches for mainstream health services and staff
> - by encouraging health services and staff to appreciate and be knowledgeable about what is going on in local communities
> - by actively linking the potential of community health to anticipatory care and supporting a more pro-active approach to mental health and wellbeing".

There was some evidence that these attitude and awareness issues are being addressed. This can involve harnessing the expertise of people already working in the field. In one area it was argued that the fact that there <u>are</u> people employed within the health service with a remit to ensure that the community voice is heard has been beneficial and helped raise others' awareness.

Angus CPP has worked with Dundee University on developing an innovative training package around the community engagement standards and competences. 150 managers from across the local partnerships are currently going through this training programme to strengthen and develop community engagement practice in health.

Provision of training is not enough by itself. One Focus Group described opportunities for health and primary care staff to participate in community development training being available, but a lack of follow up support to help them implement this.

High level support may be crucial, including from Health Board members and local elected members. Their awareness may also need raising.

> "The Director of Public Health has been very supportive. Without the high commitment at this level community-led health activity would not have survived after the period of Big Lottery funding" (CHP)

4.2.3 Outcomes and targets

Those who are committed to community-led health believe that it could come to be considered as an important part of policy and services, built into mainstream thinking and planning.

Achieving this will involve not only some of the attitudinal or cultural changes discussed, but an ability for community-led health initiatives to adapt to the new public sector environment. The public sector will be working to national outcomes around set topics. The community-led health sector will need to be able to articulate clearly how it can deliver a significant contribution to these outcomes.

Although there is a potential for outcome targets to encourage shared approaches, many obstacles to this happening were referred to:

- smaller projects may struggle to cope with contracts and service level agreements with the statutory sector
- many funders are still looking for basic information on inputs and outputs in their monitoring, rather than outcomes and impact information
- the HEAT targets guide all the thinking of Health Boards, though they are not supposed to (civil servant)
- there are strong preferences from mainstream services and funders for quantitative evidence, but the value and benefits of the community health approach are better appreciated when there is a better understanding of the complementary use of qualitative evidence
- people are still struggling to look at 'programmes' holistically rather than establishing 'projects'.

There is a fear that future work may be tied more closely to targets for changing lifestyles, preventing it from responding flexibly to the needs of communities and achieving often unexpected larger benefits as a result.

> "If funding was only specifically provided for smoking cessation groups the innovative work on the wider determinants which get people closer to

> attending the cessation groups would not be able to go ahead." (Discussion at network event.)

To overcome this, CHIs must overcome fears in some quarters:

> "The biggest problem, from a health point of view, is smoking. But when [CHIs] try to tackle this people want to bring up other issues such as safety or dog dirt" (national agency)

This cannot be addressed by downplaying the health importance of factors such as smoking, nor simply by rhetoric or even evidence about the social determinants of health and health related behaviour. It also requires CHIs to develop and communicate an understanding of how, by what logic and processes, their actions can have a worthwhile impact on such determinants and in which different types of outcome are connected.

A subtler danger is that a focus on lifestyle outcomes may mean that organisations which provide the end point services, e.g. smoking cessation classes, get all the credit and the role of community-led work in getting people there is not recognised.

Possible shifts of focus towards mental health and wellbeing outcomes, or towards outcomes for vulnerable groups such as those experiencing homelessness or young people at risk would also carry risks for community-led work but also perhaps present clearer opportunities.

4. The Policy and practice environment- KEY POINTS

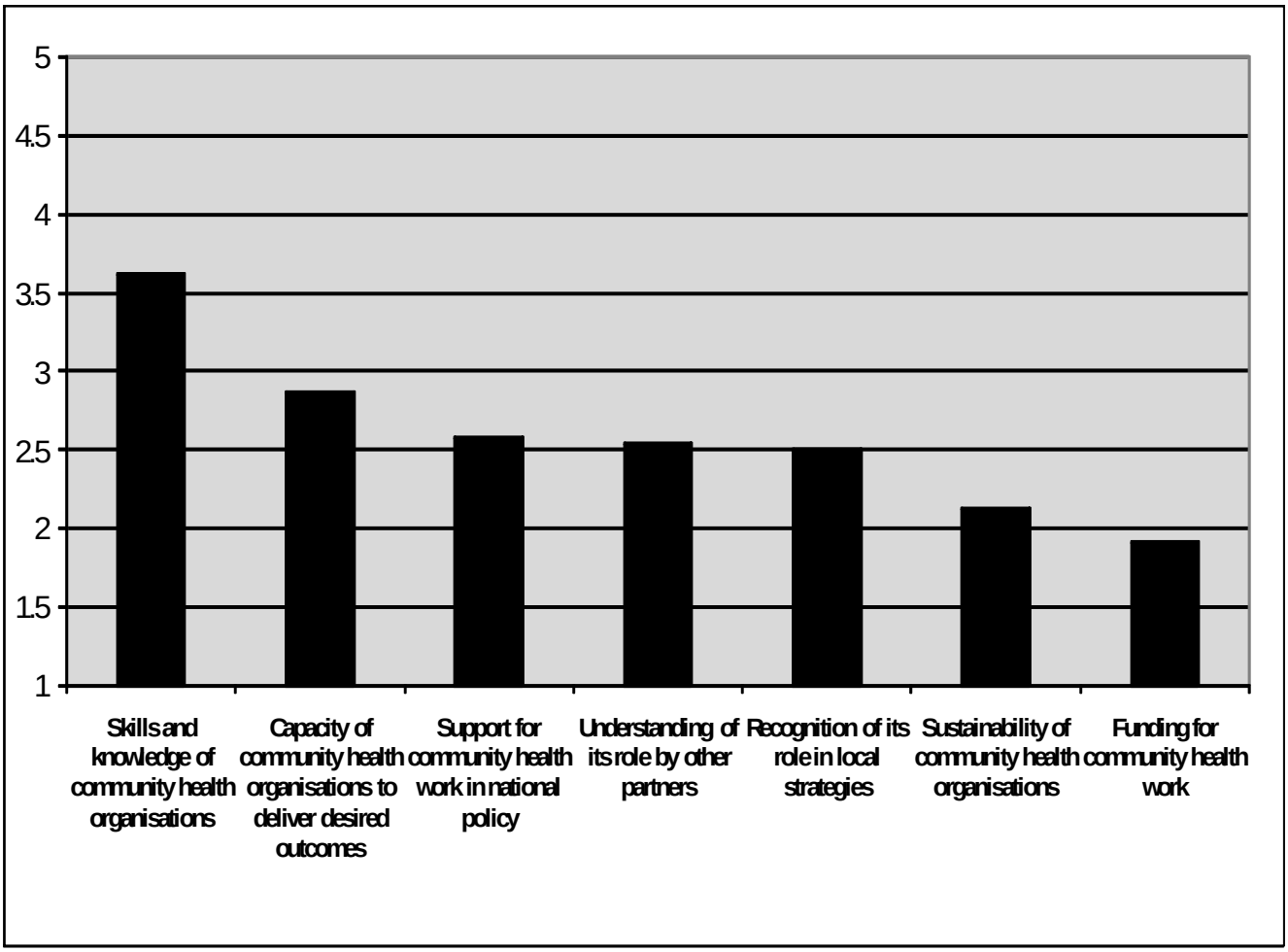
- The long term policy context for the work of community health initiatives is the growing emphasis on the importance of public and preventative health. The 2007 'Better Health: Better Care' Action Plan reaffirms these principles.
- The public sector will be in future working to national outcomes around set topics. The community-led health sector will need to be able to articulate clearly and demonstrate how it can deliver a significant contribution to these outcomes
- At local level, some talk purely in terms of engagement in services, without showing any awareness of community-led activity. Others clearly see the work of initiatives as important to their overall approach. Integrating the contribution of community-led health into high level strategies can make a difference.
- Fundamental issues of attitudes and professional culture were raised. No-one expects to turn large numbers of NHS staff into community development workers, but many felt that wider understanding was needed.
- There is a fear that future work may be tied more closely to targets for changing lifestyles. CHIs will need to develop and communicate an understanding of the logic and processes by which their actions can have an impact on the determinants of health related behaviour and in which different types of outcome are connected.

5. The community health sector

5.1 Views of stakeholders

In this section we shall focus specifically on what appear to be the challenges and opportunities for community-led health initiatives. We asked CHEX contacts in our survey how good they saw the position that 'community-led health initiatives and community development approaches to health' face in each of a number of aspects. The results (Figure 5.1) illustrate the crisis of confidence that the sector was facing in the period that we were carrying out this study. On every aspect that is wholly or partly external to CHIs themselves – policy, understanding, funding – on average the position was considered to be less than 'adequate' (3 on our 1-5 scale). Funding and sustainability were generally considered 'poor'. Only CHIs' own skills and knowledge receive a higher rating – though these are still seen on average as less than 'good'.

Table 5.1 How good is position of CHIs? Views from survey



N=71

Respondents added a large number of comments that we shall not quote from in any depth. A very high proportion of them include a mention of funding. The issues raised are similar to those raised in our other forums, which we shall review in the rest of this section (the emphasis on funding was perhaps particularly dominant in the survey responses).

5.1.1. Capabilities of CHIs

In discussions, a lot of emphasis was given to the intrinsic strengths of CHIs that arise from their community base and community development approach. They were seen variously as:

- sensitive to local needs
- user friendly, approachable and flexible
- 'part and parcel' of communities
- having links with community networks
- having an understanding about how people and communities function, how they develop and how they can change
- better placed for reaching priority groups
- having a people centred approach that empowers and skills people
- engaging people; helping them make changes in their lives
- helping local communities to identify their own issues, express their views, have a voice and engage in collective action
- getting communities involved in tackling their needs
- building confidence and self esteem in communities
- building capacity and strengthening local leadership
- working across community issues, not exclusively those seen as health issues.

"The statutory sector needs to recognise that they can't do it all themselves. They need community workers engaging with communities. They need this ... to help people move to a position where they can start using support services" (discussion at network event)

"The strengths of the approach are that it:

- Seeks to be complementary to the work of the statutory sector – recognises the different strengths of the different sectors
- Develops and invests in connections with communities
- Encourages and develops individual confidence and skills and group cohesion
- Works towards empowerment and sustainability
- Has a vision of social and cultural change for individuals and communities" (Discussion at Stirling CHP/CPP Focus Group).

Few reservations were expressed about the strengths of the sector in these respects. Very few people mentioned the well-known issues about how widespread the engagement that can be achieved within a community really is, and the fragmentation of community life that can cause difficulties in getting consistency and focus. A few comments suggested that work with black and ethnic minority communities needed to be more 'proactive', more 'embedded in the mainstream'. Dispersed rural populations could be difficult to reach.

There is perhaps a hint of complacency, or perhaps defensiveness, in the sector's account of itself. The language of community development is widely used, and any

CHI will almost certainly have a way of working in a community that is different from that of mainstream service. Yet some CHEX staff suggested that, contrary to their own expectations, they had found that surprisingly few CHIs were actively practicing community development. This presumably implies that they are concentrating on 'service delivery' and that work on new issues and approaches might be limited.

Closely linked to discussions of the strong community base of CHIs were discussions of the distinctive contribution that this allows them to make to health improvement. They were described as:

- involving the hardest to reach
- providing a first step into the formal health system
- involving people through their own interests and concerns
- working in a way that empowers and skills those involved
- encouraging people to take ownership of health issues
- building relationships between community and voluntary organisations and health professionals
- helping to identify where and how mainstream services get it wrong and provide ideas about alternative approaches for delivering services
- acknowledging where individuals and communities experience huge problems affecting their quality of life, family relationships or employability
- working across community issues, not just those badged as health, such as housing, unemployment, lack of access to services, safety
- working to achieve long term, lasting change.

  "There is a huge potential in community-led initiatives – largely untapped by mainstream services:

  - Getting at the causes of the problem
  - Building understanding
  - Developing skills
  - Keeping well in the first place" (Discussion at Glasgow CHP/CPP Focus Group).

Community-led health is undoubtedly "rooted in a social model ... not just a 'health badge' but addresses a range of issues such as literacy, employment, social isolation" (national agency). But there is perhaps relatively little discussion or clarity about how far it is the role of CHIs to address such issues directly, rather than recognising them as crucial factors in the lives of the people they work with, and enabling them to take action at a personal level to deal with them, and /or to take advantage of other services or activities that have a specific focus on these other issues.

One CHP that has a track record of active support for community-led initiatives stressed that "the potential is huge, but we must recognise that a lot of what is going on is broader and does not necessarily need NHS input" – other services, community development workers or community groups without an explicit health focus will also be dealing with relevant issues.

The social model of heath does not necessarily imply that it is organisations with a 'health' label that will be the key agencies responsible for trying to deliver the necessary changes in social and economic factors.

It is interesting to hear CHEX arguing that it 'strives to integrate the social and medical models of health' and that CHIs can 'demonstrate how to get the best from both models'.

We heard relatively little about organisational, skills and similar issues that might affect the capacity of CHIs to deliver. Issues raised include:

- Lack of CPD development of staff
- No recognised skills framework and linked pay scales for staff
- Need for proper resourcing and support to enable community management groups to fulfil high expectations
- Need to share information and good practice
- Need to build capacity of community groups for partnership working.

The 'Sustainability' survey carried out for the CLTG (Reid Howie Associates, 2006) found that CHIs had a range of organisational development and support needs similar to those of much of the voluntary sector. The fact that these were little mentioned in our consultations probably reflects some combination of:

- a focus on the immediate external challenges facing the sector
- an understanding that general organisational capacity building is not a primary role for CHEX.

The Glasgow Council for the Voluntary Sector 'Healthy Organisations' programme, which offers a tailored package of organisational support and development services to meet the needs of health-oriented organisations in the voluntary sector, was praised and offers a model of support that both recognises the health dimension and is delivered at an appropriate, local level.

However, CHEX should perhaps not lose sight of a long term need to monitor the capacity of the sector, identify need and assist in mobilising resources to meet that need.

5.1.2 Environment for CHIs

The great majority of stakeholders' discussions of the challenges and issues facing community-led health work referred to the effects of the environment in which it must work.

Some referred to the longstanding difficulties (mostly) of achieving effective partnership working, and especially the effective engagement of communities in this. Issues raised include:

- community groups feel they are treated like second-class citizens instead of being viewed as equal partners
- mainstream agencies struggle to understand how the community-led sector works or can enhance their work

- projects and services working separately – not sharing experience or trying to plan and deliver in a complementary way
- competitiveness and duplication e.g. in smoking cessation work
- difficulty of getting effective partnership working amongst the mainstream agencies themselves
- disruptive impact of changes in public bodies
- need for greater management support
- insufficient information and advice.

But the most discussed challenges were those of funding and the related issues of how to demonstrate and communicate impact. Many different comments referred to the problems associated with a constant reliance on short term funding and the lack of core funding and support for CHIs, or any strategic approach to this. Some felt that there is a constant drive for the new and innovative rather than supporting known good practice. Short term funding was intrinsically inappropriate for approaches that sought to achieve long term change.

As a result the sector faces erosion within projects (e.g. through high staff turnover, insecurity in planning work or applying for funding tied to low priority objectives) and by the loss of many projects and their accumulated experience and goodwill within communities. There was a feeling that funders are generally unaware of the implications for communities in loosing a community-led health organization.

> "[They are] little candles of light in the darkness – but not enough to light the whole place up. They flicker and die without much coming from the activity" (national agency).
>
> "There is a real dilemma for voluntary and community groups trying to establish long term working relationship with statutory sector services through short term funded projects" (discussion at Stirling CHP/CPP Focus Group).
>
> "Because of the investment of time, commitment and ownership from community members, closure of an organization can have significant detrimental health effects on individuals and the wider community. It can also result in communities turning in on themselves with soured relationships, thus creating major barriers for any future involvement" (discussion at network event).

Some areas of Scotland were said to have achieved robust relationships with local funders. In CHEX's view, initiatives have survived largely where they have worked closely with existing structures and been recognised as playing a strategic role.

Probably even more comment was devoted to the challenges of demonstrating impact in order to win that recognition as a strategic contributor**.**

In general many felt that the sector suffers from a lack of clarity of what it is attempting to achieve and struggles to provide evidence of the broad benefits and impact of its work (though others felt that it was getting quite good at this, but not being listened to).

There were also comments from many different types of source about the need to relate outcomes from local work to regional and national outcomes and in particular to help the community-led sector to engage with the new context of Single Outcome Agreements.

> "The community and voluntary sector needs to increase its bargaining power, it needs to get funders to recognise what it can do for them, and this could best be done by focusing on funders' priorities and illustrating how it can deliver" (discussion at network event)
>
> "Community projects operate at the soft end of the health spectrum. The trick is to convert the importance of that work into evidence of contribution to more traditionally recognised indicators of health improvement" (national agency)

There were, however, also many warnings that learning to communicate in these terms would not be an automatic or cost-free route to success. Some of the concerns were about how decisions are taken:

- There was concern that CHIs might be asked to justify themselves and evidence impact in ways that other public organisations are not, often with little support to allow them to do so.
- Some reported that, even when carried out, impact evaluations did not seem to make any difference to the understanding and decision making of funders.
- They could describe their contribution to certain outcomes, but public bodies might still prefer to fund their existing services or create new ones that target the same outcomes.

There was also concern about intrinsic, or at least deeply entrenched, discrepancies between the community-led approach and the type of outcomes that were assessed or valued:

- government priorities are focused on lifestyles, but CHIs work with communities on issues they feel are important, which may be different
- groups have been forced to change the focus of their work away from community development because of the type of funding they receive, and a lack of understanding about community development by others
- some work undertaken by the sector is and has to be speculative and experimental without measured outcomes
- partners are looking to deliver outcomes in three years – when the type of changes being sought are long term ones in people's lives
- the evidence that is required to show changes in health inequalities should not just be the responsibility of community projects
- the involvement of the community in identifying their needs is a key contribution of CHIs (in addition to evidence).

"From a Community Planning perspective, we have access to information on local needs and existing service provision. What needs to be added to that is the community perspective – their experience of living conditions and relevance of the

existing services. Only with that partnership can we successfully go forward together to agree priorities and address gaps". (CPP)

The aim must therefore be not to assemble the perfect body of evidence but to create the conditions for dialogue. To suggest an example, CHIs should accept that a community in which smoking levels are not being reduced is not likely to be progressing towards being healthier; whilst partners should accept that community-led work may be helping them to progress towards that without necessarily running any visible anti-smoking services.

> "CHIs should talk, for example, to transport agencies first of all about a transport agenda, but then go on to say that this will also help to achieve health. They must sell themselves on what they can do that the statutory sector can't." (Discussion at national Symposium.)

Again, as with sustainable funding, proper recognition of outcomes and the contributions that all parties make to these is easier to achieve when the sector is recognised and respected as a partner.

As well as talking about specific areas of tension or misunderstanding about targets and outcomes, our contacts also raised the type of more general issues about 'cultural' differences that we looked at in section 4.2.2.

- professionals feeling threatened by community activities
- helping NHS staff understand and value community-led / development approaches
- consultation being seen as challenging.

We did not gain from our discussions much guidance about the directions in which community-led health work might move in future, again perhaps because the current focus is so much on defending what it already does. One main area is clearly the work on evidence and outcomes implied by the perspectives described above.

There were some, though relatively few, who wanted to discuss other aspects that might be related to achieving greater sustainability:

- integrating projects and sharing resources (discussed in Glasgow, where this has been pursued)
- developing sustainable community activities, spreading expertise through 'training the trainers', etc.
- learning to cope better with contractual arrangements, Service Level Agreements, etc.
- widening partnerships, working more closely with agencies in related fields e.g. employability initiatives
- looking at alternative structures such as Development Trusts or Social Enterprises, though there were few if any suggestions about what markets these might trade in.

Perhaps the main 'area for further' work that was widely discussed is the need for action to spread the awareness and recognition of what community-led health work is and can do more widely, and especially amongst decision makers.

Possible action at a wide variety of levels was referred to:

- better engagement of CHIs with local primary care health services, particularly GPs.
- greater promotion of CHIs with and through local authority and health planning and delivery structures
- support for those wishing to speak to the media
- lobbying Parliament, especially new MSPs
- building networks or an Alliance.

5.2 SWOT analysis of sector

In order to summarise the views and perceptions on the community-led health sector that we have described (and a great deal more, largely covering the same ground) we have carried out two strategic analyses.

Firstly we present a 'SWOT' analysis for the sector as a whole, looking at its intrinsic strengths and weaknesses, and the opportunities and threats that arise from the environment in which it currently works.

The network event and the CHEX Advisory Group carried out exercises which have informed this, but it draws upon all of our consultations and investigations. Issues are not presented in any particular order of priority.

Community-led health sector

Strengths	Weaknesses
Access to disadvantaged or 'hard to reach' people	Inflexibility when constrained by criteria set by funders
Based on a fundamental human need – health	Relatively small scale
Commitment and value base of participants	Locally focussed – not seeing wood for trees
Accessible locations, non-threatening approaches	Diffuse and varied, difficult to retain clear profile and public understanding
Ability to fill gaps that statutory services cannot	Not a consistent presence across Scotland
Innovative and creative	Can be lack of clear definitions of purposes and approaches
Flexibility in response to community wishes and needs	Small weak organisations, with limited management and governance capacity and skills
Support from communities	
Attracts volunteers	Short term funding prevalent
Ability to respond to the individual, take 'holistic' approaches	No clear identity and role in wider partnerships
Ability to address mental health and wellbeing	Weakness of community partners in partnerships
Harnesses power of collective action	Difficult to promise predefined outcomes when responding to community issues
Relevant to wide range of issues	
Increasing evidence of impact	Lack of collective voice
Growing ability to gather and explain this evidence	Still struggling to give evidence of many outcomes
Willingness to network and exchange experience	Scale in relation to health and social problems means impacts are long term and hard to demonstrate
Wide range of links and partnerships with groups and agencies	Not always consistent in applying community development approaches
Allows funders to lever additional resources through working with community-led organizations.	Talks about life circumstances but often works mainly on life style issues
Strong support from CHEX	Rather demoralised by funding situation

Threats

Termination of several short term funding streams

Need to 'reinvent the wheel' after project closures; loss of skills and experience

Public sector finances getting tighter

Uncertainty over degree of recognition in current Scottish Government policy

Pressures on NHS to deliver care and treatment targets

Local decision makers may use freedom of funding to divert resources from voluntary/ community sector

Lack of understanding of community development in NHS

Narrow 'clinical' definitions of health improvement

Potential loss of flexibility if only funded to achieve, e.g. lifestyle change outcomes

Patchiness of commitment to community-led approaches across different CHPs, etc.

Lack of interest by PPFs etc in health improvement as opposed to service issues

Opportunities

Support in national health policy frameworks

Relation to national policy on social justice, community empowerment, equalities, sustainability etc

New Government – new allies?

Fairer Scotland Fund

Ministerial Task Force on health inequality

Growing interest in public health issues

Potential to link with developments such as Keep Well, anticipatory care

Growing awareness of importance of mental health and wellbeing

Work on health workforce identifying skill needs of NHS staff in relating to communities; also skill needs of voluntary sector

Government focus on public involvement in health

Growing role of Community Planning Partnerships, leading to awareness of cross-cutting issues

New focus on funding outcomes might lead to openness about ways of achieving these

PPFs may be finding their feet and taking an interest

Growth of and support for social enterprise options

Mainstream funding may offer longer term agreements, support for core staffing, etc.

Health a springboard for community development and involvement

5.3 Possible scenarios

We felt that, although some of the contributions on the issues facing the sector were not specifically forward-looking, much of the discussion could be distilled into a number of possible scenarios for its future.

We put these initially to the national stakeholders' Symposium that we held. Three of them express different possible overall pathways for the growth or decline of the sector.

A. Independent community health initiatives and healthy living centres largely disappear as national funding dries up and is not replaced at local level. Some health improvement workers continue to try to take community development approaches and some other community groups continue to be involved in health issues.

This is intended to represent the worst possible outcome, from the point of view of the sector, of the current period of anxiety about funding and sustainability. Even if specific projects dedicated to community health work ended, it would not disappear as an approach.

B. After a bumpy period in 2008, funders, principally in local partnerships, continue to support independent initiatives on a long term basis. These grow in confidence and ultimately numbers as a result of national recognition and a clearer shared understanding of their role and impact.

This is by contrast the best possible outcome. Though there would inevitably be some loss of current initiatives, since this is already happening, this would be only a temporary setback.

C. In some parts of the country community-led initiatives are recognised as key contributors to achieving health outcomes, are supported and flourish. In others, they disappear or fail to develop, and local funding is directed to agency led programmes tightly targeted on achieving individual outcome indicators.

This is not intended to express purely an 'intermediate' position. One stakeholder criticised it on the grounds that on any scenario, local decisions would inevitably lead to different levels of support for activity in different parts of the country. However this scenario is intended to suggest the possibility that an uneven development of community-led work might result not just from differing priorities, but from a lack of knowledge or understanding about it in some areas or amongst some decision makers, and in particular from a lack of understanding of how it might contribute to desired or required outcomes.

The other suggested scenarios emphasised different possible directions of change which were not necessarily mutually exclusive with each other or with scenarios A-C.

D. Led by national policy and growing evidence of effectiveness, health improvement and anticipatory care become increasing priorities for NHS

services and partners, and their staff are increasingly encouraged and equipped to take community development approaches to delivering these priorities.

This shifts the emphasis from the future of specific community health initiatives to the possibility of community development approaches becoming more widespread within NHS and other agencies

E. Community health workers and initiatives are increasingly only employed or funded to work on programmes to deliver specific lifestyle changes. Voluntary and community groups are supported mainly through contracts to deliver specific services.

F. Community health organisations are increasingly able to operate as independent social enterprises, combining trading income, contracts and funding from a variety of sources.

E and F express in effect what might be either negative or positive aspects of a possible shift away from the availability of or dependence upon generic funding for the core community development work of community health organisations.

G. Local health and Community Planning partnerships respond to priorities expressed by local people and increasingly focus on health improvement, prevention etc as well as service delivery. They recognise the need to work in and with communities to decide how to deliver these things effectively

G is intended to highlight possible development of another aspect of the way in which health improvement might become more 'community-led'. Recognising that, as we have seen, health improvement is currently often a less important focus of public involvement in partnerships than is service delivery, it suggests that this might begin to change with positive results.

5.2.1 Stakeholders' ratings of scenarios

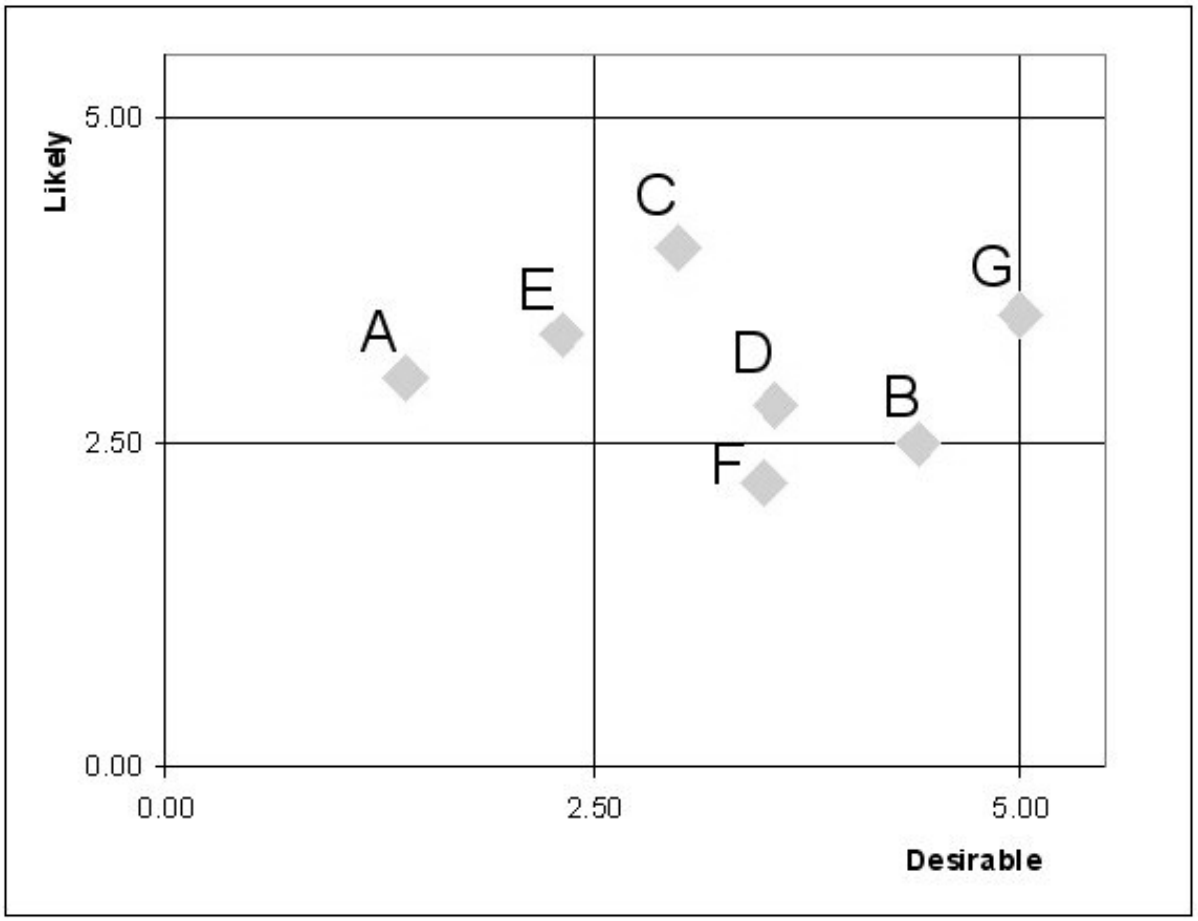
We asked the mixed group of stakeholders at our Symposium to rate individually (on scales of 1 to 5) how desirable they thought each of these scenarios is and how likely it is to be realised. Figure 5.1 shows the average ratings given for each scenario. Whilst the numbers involved were small and the precise ratings should not be taken too seriously, the results are instructive.

As intended, scenario A is viewed as highly undesirable and scenario B as highly desirable, with mixed views on scenario C. More interestingly, stakeholders viewed the chances of the 'best' scenario B actually occurring as evenly balanced, with similar results for the 'worst' scenario A, though this was on average seen as fractionally more likely. The mixed picture C was seen as much more likely to occur. Though expressing a significant level of pessimism about the future for community health initiatives, these perhaps represent more balanced judgements than the fears that were expressed, as we have seen, by our survey respondents.

Of the other scenarios G, involving more 'community leadership' and awareness in partnerships, was unanimously viewed as 100% desirable. There was also a

significant degree of optimism about the likelihood of it occurring. The spread of community development approaches to health improvement amongst NHS and partner staff (D) was viewed as desirable on balance, but only marginally likely to occur.

Figure 5.1 Stakeholders' average judgements on possible scenarios



Of the scenarios expressing different aspects of a possible shift away from the availability of or dependence upon generic funding, E which focuses on a shift to funding mainly linked to lifestyle change outcomes was viewed as quite likely to occur and only marginally on average undesirable, which suggests that at least some stakeholders may have confidence in the sector's ability to deliver in such circumstances.

Scenario E, essentially about a move towards a 'social economy' model of delivery, was viewed as marginally unlikely to occur, though on balance desirable. Discussion however suggested that there were significant differences of view about this.

Overall, this exercise suggests that there is still an underlying level of confidence in the sector – most suggested scenarios are both desirable and at least not unlikely. It also suggest that CHEX and its partners should be prepared to work in almost all of these possible situations, since they are considered more likely than not. It might also suggest a need to promote the development of all the 'desirable' possibilities, including the relatively less 'likely' social economy model.

5. The community health sector – KEY POINTS

- During the period of this study the sector was facing a crisis of confidence. Contacts considered its position to be less than 'adequate' on almost every aspect. Funding and sustainability were generally considered 'poor'.

- The intrinsic strengths of CHIs that arise from their community base and community development approach were emphasised. However there is scope for some CHIs to gain a better understanding of community development and to define more clearly how their role combines with that of others in addressing broader social issues.

- As a result of short term funding the sector faces erosion, within projects and by the loss of many projects and their accumulated experience and goodwill within communities.

- Many felt that the sector still suffers from a lack of clarity of what it is attempting to achieve and struggles to provide evidence of the broad benefits and impact of its work. Others felt that it was getting quite good at this, but not being listened to.

- The need to relate outcomes from local work to regional and national outcomes was widely recognised, though there was concern about discrepancies between the community-led approach and the type of outcomes that were assessed or valued.

- The need for action to spread the awareness and recognition of what community-led health work is and can do more widely, especially amongst decision makers, was widely discussed.

- When we asked stakeholders to consider possible future scenarios for the sector, they saw the chances of very good and bad overall outcomes occurring as balanced, but an uneven development around the country arising from differing priorities or understandings as most likely.

- A move towards a 'social economy' model of delivery was viewed as marginally unlikely to occur. There were significant differences of view about its desirability.

6. CHEX's future role and position

6.1 SWOT analysis of CHEX

We have already looked at the progress of CHEX and some of its strengths and weaknesses have emerged. The policy and practice environments and the issues facing the community-led sector as a whole form the environment to which CHEX must respond and from which threats to and opportunities for the organisation will emerge.

We shall therefore now present a SWOT analysis summarising CHEX's strategic position, before moving on to look at what stakeholders believe may be the options for its future role and activities. Like the previous analysis, this draws on all aspects of our work, although there were specifically related exercises undertaken at the network event.

The analysis presents what may appear to be an even balance of 'strengths' and 'weaknesses'. This does not have any evaluative implications, and certainly does not represent the balance of opinion about CHEX's performance among stakeholders, which was strongly positive.

CHEX

Strengths

In touch with almost all relevant initiatives

Wide network, also includes wider range of community organisations and agency staff

Widely used as information source

Makes connections between local and national organisations and policies

Trusted at both national and local levels

Has pursued and delivered on a clear Business Plan

Flexible – offers a range of services and approaches

Seen as effective and expert across range of services

Accumulated credibility and expertise of staff

Specialist expertise in evaluation and impact assessment

Good relations with other intermediary organisations, general agreement on roles

Strong understanding of community development

Makes direct contributions to national policy making

Location in SCDC reduces overheads and allows strong alliances, e.g. capacity building programme

Good response to and wide range of uses for Health Issues in the Community

Weaknesses

Demand for CHEX to have representative role that its position does not allow

Still doubt about role vis-à-vis other organisations in the minds of some

Conflicting demands on small organisation

Role in relation to working with NHS and other statutory sector staff not clearly defined

Dependent on knowledge and contacts of key staff

Tends to be known through individuals

Need to represent sector in many forums spreads resources thinly

Little known outside immediate sector; confusion about relation to SCDC

Perhaps less progress with building work around equalities issues than some other strands?

Can't work directly on the whole range of issues related to health

Difficult for small national organisation to give 100% geographical coverage and retain individual contact

Limited UK and international contacts

Lack of full time administrative support

Threats

Withdrawal of funding from CHIs may leave area of work too diffuse for an effective network

Localisation of decision making may mean it is more difficult for a national organisation to have influence

Possible pressure to merge with other bodies might leave role unclear

Heavy dependence on one funder

End of current funding period approaching

Lack of any clear potential for financial support from members or from partners at local level

Opportunities

Changing position of sector (see Sector SWOT, section 5.2)

Localisation of decision making creates new need for networks and exchange of good practice

National capacity building programme should bring new contacts and identify new needs and opportunities

Chance to agree objectives and terms of possible future funding period

Develop new links and identify new needs through national capacity building programme

Possible growth of regional networks may provide effective channel for work and influence

Wider use of training modules building on ‘Health Issues’ experience

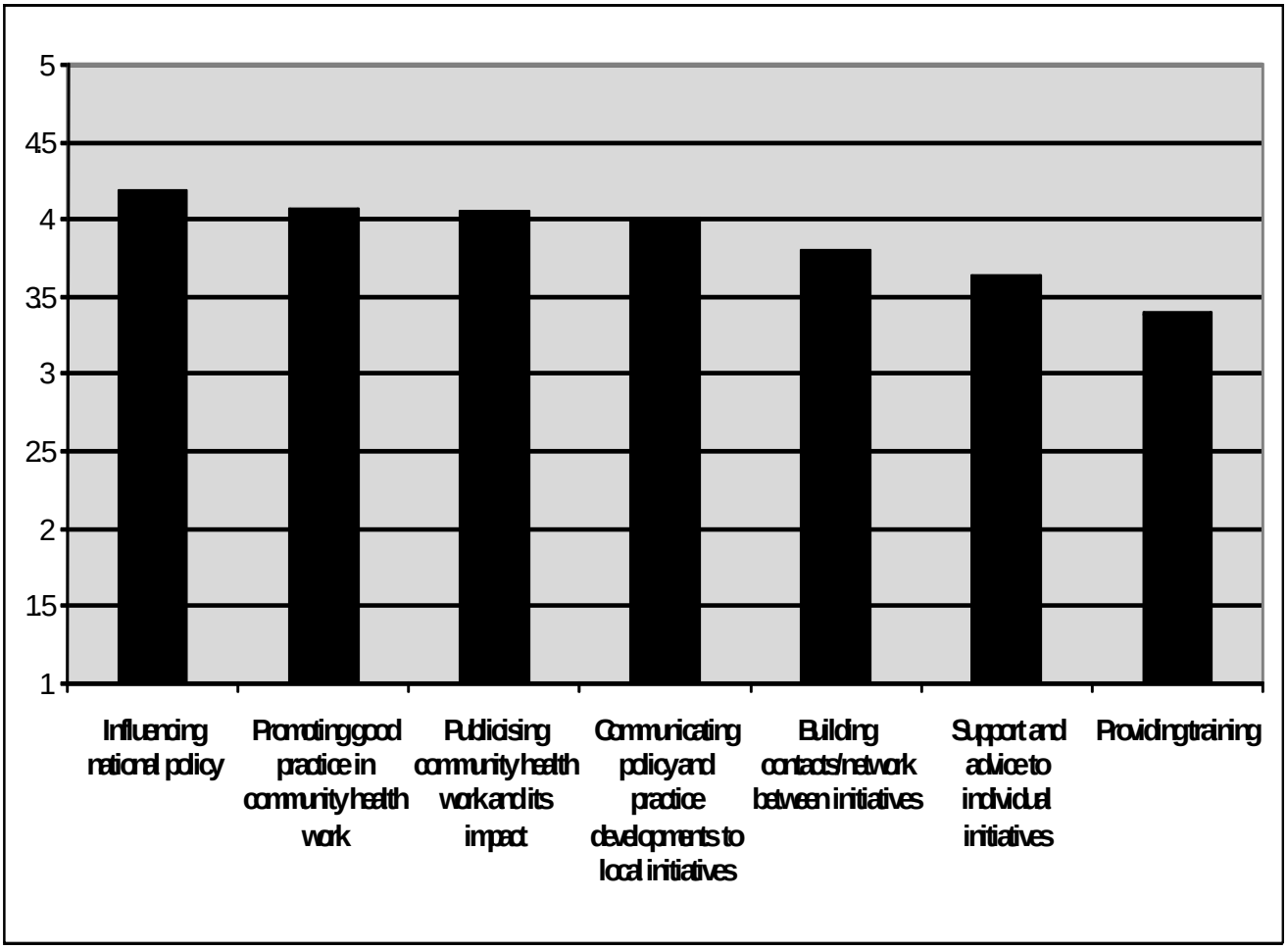
Potential for local support/ consultancy contracts?

Possible reorganisation of SCDC might give freer hand

6.2 Views of stakeholders

We asked survey respondents how important they thought each of a list of types of work should be for CHEX in future (Figure 6.1). The list had been agreed to be a fair representation of CHEX's main areas of work.

Figure 6.1 Views of future role of CHEX in survey



N=71

All areas of work were on average considered important, with a relatively small amount of variation between them. The most highly rated was 'influencing national policy', and aspects of this were well represented in the comments that people wrote in.

Clearly some people had definite views about priorities. For example, one explained:

> "I marked support and advice to individual initiatives as less important. This is partly because CHEX does not really have the capacity to do this, and partly because CHEX should work through network-building and common cause, rather than through providing services to individual initiatives".

But as we saw in section 3, many do feel that they get effective individual support and advice and value this. So any variations in priorities are largely cancelled out in the totals. In any case, no item was seen as less than 'important' by more than 11% (of the people who gave valid responses) (this figure was for 'training').

6.2.1 Overall role and positioning

We discussed the role of and options for CHEX with all stakeholders (though some of the local CHP/CPP contacts had limited knowledge of it). Two points that would probably command general assent are:

- the need to remain specific to community health and community development (rather than other agendas such as PFPI)
- the need to retain autonomy.

> "CHEX must avoid becoming a 'think tank' of the Health Department" (national agency).

From all sectors, the key role for CHEX that was emphasised again and again was that of a link or bridge between policy and practice. The same idea was expressed in a wide variety of ways:

> "CHEX is a messenger, a go-between"
> "there is a real strength in having a foot in both camps"
> "the authority for the policy role comes from the connection with the field "
> "CHEX has a translation role"
> "a two way bridging role between policy and practice"
> "Policy and practice aspects are important and there is great value in CHEX retaining a stake in both of these areas"
>
> "Someone needs to be in touch with what is happening at ground level – the government isn't. But CHEX also keeps an eye on what government is doing and passes information between the two levels – that's their role" (CHI).

There was therefore a general consensus that CHEX needs to retain a practice development role.

> "There would seem to be, even more strongly, the need for an organisation like CHEX to support the community health sector and assist it to restructure to respond to the new policy direction for health improvement of ... government" (intermediary body).

But there is also a strong feeling, particularly from many working in CHIs, that CHEX should have a clearer and more public role in seeking to influence policy on behalf of the sector and acting as a representative voice. CHEX may need to consider how this demand can be accommodated by its own actions or by supporting others, though as we have seen (section 3) there are limitations on its ability to take up positions on behalf of the sector and it is not itself a representative network.

This feeling emerged particularly strongly at the network event, where it was urged that

> "CHEX ... has done good work around power and other issues and so will have to progress next to address a more political role"
> "CHEX has a role to bring together and support community and other groups and act as a representative for many voices"

But it was also argued that

> "The sector needs to organise itself well to advocate on its behalf and lobby national and local decision-makers. CHEX has a role in supporting this type of organization, but not leading it".

CHEX staff themselves are firmly of the view that CHEX should neither aim to become a representative body nor seek to develop a membership organisation of community health initiatives. It should build on its strength of responding to support networks if and when required and should continue to focus on strengthening networking between the organizations interested in or responsible for community-led health at both national and local levels.

Although the relationship with NHS Health Scotland cannot be taken for granted and must be reviewed (the options are discussed in section 7), those stakeholders who considered the matter did not suggest any other options apart from retaining this relationship, whilst remaining an autonomous organisation. As one pointed out, whatever the future relationship or structure, CHEX would always need to demonstrate how it can assist NHS Health Scotland to achieve its objectives.

Some who are familiar with the organisation argue that CHEX should broaden its range of working relationships with NHS Health Scotland, perhaps for example working more often directly with the Healthy Settings Team, and thus perhaps strengthening the potential for a NHS Health Scotland commitment in policy and planning terms.

We have already reviewed the relationship between CHEX and other intermediary bodies (Section 3.4). Other options for the partnerships which CHEX might work in, or the structures it might help to establish were raised, though none were discussed in depth. It was suggested that CHEX:

- should be more involved in 'strategic level committees' (though it is difficult for us to suggest where it is missing out, except at the highest levels of the Scottish Government)
- should be involved in some new national body to replace the recent Implementation Group
- should adopt a regional focus for some professional development activities – as is now beginning to happen through the capacity building programme
- should have representation from CHPs on its Advisory Group
- should work with the Association of CHPs.

One or two did move beyond discussing whether or not CHEX could speak for the sector to government, to suggesting that there is a need for the community health

sector to organise to have a voice and representation in its own right, supported by CHEX. We consider this in section 7.

6.2.2 Priorities and activities

Several people expressed concerns that CHEX might "become 'all things to all people'" or "spread itself too thinly if it tries to do everything", and therefore must decide on its priorities. Unfortunately, as we have seen from the survey results, there are voices arguing for most possible priorities. Examples could be chosen to illustrate most possibilities, including:

- support CHI engagement in local structures
- strategic capacity building role
- inform ministers about what is happening in community health and community development
- lobbying role to inform strategic thinking and shape more effective policy making
- community development training for (NHS) middle managers and practitioners
- more partnership working
- co-ordination, dissemination of information, provide a networking exchange
- get stronger at representing the sector
- build people's capacity to get involved in policy making
- improve the sustainability of projects
- provide information for projects on ways to evaluate and tools to show evidence of making a difference
- continue communication and information role – Snippets, Newsletter, Website
- build on the experience of the LEAP for Health Unit on outcome focused planning and evaluation
- work with management committees to build their capacity and help build business cases
- deliver more training for facilitating Health Issues in Community
- improve the capacity of people who fund evaluations to be realistic about the community-led sector's contribution and timescales.

Two specific areas of work that attracted comment and suggestions were communications and events.

Communications

- make the newsletter and 'snippets' more interactive: focus on local projects to help them promote themselves and learn from others
- extend process of 'trawling through' and reviewing policy into a similar process reviewing outcome indicators, etc.
- prepare papers to start discussions in local partnerships on process, evidence etc., preferably on one side of A4
- 'keep the website alive with useful information, data and reports'

Events

- 'conferences, seminars, interproject learning ... to keep CHEX close to the people it is trying to represent'

- 'events where we can be briefed on the national agenda and opportunities and their application in each CHP area, and how to influence the other way'
- big events at a national level 'such as the ones in Motherwell and Dunfermline' providing opportunities to network, and show that community health work is being recognised at a national level
- 'more practical briefing events like SURF's open forums'
- 'more showcasing and market places'.

6.2.3 Influencing the local level

The area that attracted most discussion was the idea of seeking to influence policy and practice in partnerships and public agencies at local level. There was a general perception, with which we would agree, that understanding and decision making at this level will be crucial to the future of community-led work, and that CHEX must have a role to play. "It needs to do middle down and bottom up work" as well as providing a bridge to national policy.

The discussion of possible approaches and priorities was rather unfocussed. Some of the people in CHPs and CPPs that we spoke to probably only speculated about the role of CHEX because we asked them to. There is clearly still a lot of work to be done in determining the correct approach. In particular there are two difficulties to be overcome:

- CHEX always perceived a potential need to work with professional staff in structures such as CHPs and to support partnership working, but chose from the outset to give its main priority to supporting the community based sector directly. The question now arises of whether the priority for supporting partnership working with a community health dimension and awareness of community development approaches should be a higher priority for CHEX. These aspects are emphasised in the national capacity building programme, but the division of responsibility, in which non CHEX SCDC staff apparently take the lead on such matters, may create confusion in the longer term.

- The extent of support offered and the availability of CHEX as a resource in this area will have to be well thought through and defined, in order to prevent it from being overwhelmed with unrealistic expectations from 32 CPPs and 42 CHPs.

The suggested objectives of working with local partners are also quite various:

- help CPPs/CHPs understand the community health sector and work in partnership with it
- educate health boards and CHPs about the value added by CHIs
- bring partners together to explore common understandings about community development
- promote value of common planning and evaluation frameworks, e.g. LEAP
- capacity building with community health partners
- strengthen community engagement in work of local partnerships
- build capacity of voluntary sector and community representatives to be involved in structures

- support community health initiatives to get involved in structures and partnerships, keep their profile strong and move with new agendas
- help partnerships understand needs for ongoing capacity building
- support partnerships to think through the resources and training that are required
- help support moves towards local level community planning
- share experiences and approaches to working with Single Outcome Agreements
- champion community health at Chief Executive and Senior Officer level.

Apart from the need to choose priorities between such objectives, work will also be required on effective roles for a fairly small national organisation that might allow it to have useful influence at local level. Although it has already offered direct support to local partnerships from time to time, its role has to be seen principally as a supporter, or perhaps a catalyst. Specific suggested roles include:

- disseminating information
- sending material promoting community health to all CHPs
- supporting networks
- sharing good practice and experience
- research
- producing guidelines on
    - principles of good practice
    - joint action planning
    - how to include community-led approaches in Community Planning, JHIPs, CHP operating plans, etc.

One suggested role was as an 'honest broker' between communities and CPPs/CHPs, but CHEX is clear, no doubt correctly, that this could compromise the organisation.

Two aspects of CHEX work emerge as the key resources to deciding and developing its role in working with local partners:

- Firstly the national capacity building programme will clearly be the crucial vehicle for such work over the coming year, and will hopefully lead to the accumulation of experience, both about needs and what is effective. Its potential was already being mentioned by several CHP/CPP contacts interviewed in January/ February 2008.

- The other key resource is Health Issues in the Community, which is already known in many CHP areas. Some saw it as an important community capacity building resource. But others were talking about it as a resource for staff, with a view to strengthening local delivery and better supporting community involvement in health issues. How HIIC is developed and perhaps adapted to meet these differing needs will be crucial.

However one area that several people raised, particularly amongst the local contacts, was the prior need for awareness raising on what CHEX does or could do, before they can be sure about its potential local role.

6.2.4 Funding and sustainability

The fact that CHEX contributes to objectives which appear to be confirmed as long term elements of government policy raised hopes for the sustainability of the organisation. There were some fears about the implications if the sector that it supports were to be substantially reduced in size.

As we have seen, a close relationship with NHS Health Scotland is assumed by everyone to be central to the future of CHEX. They were seen to be natural partners and have "a good healthy relationship" (CHI). The CLTG recommendations assume a central role for CHEX.

CHEX could be seen as vulnerable by being so dependent on a single funder. But observers felt that CHEX has benefited from being funded and supported in a way which has given it space to develop and deliver with a large degree of autonomy. One or two who wanted to see CHEX develop a higher profile lobbying role feared that this could lead to a conflict of interest.

People in NHS Health Scotland and the Scottish Government encouraged us, without commitment, to believe that continued NHS Health Scotland funding is a realistic option.

Not many stakeholders even suggested other financial options, except at the margins. A few suggestions were floated:

- contracts with individual health boards
- income generation through consultancy and training
- 'an element of members themselves contributing something so that they value or increase their role'
- 'CPPs and CHPs ... should be tapping into the skills and experiences of CHEX – and as such contributing to the costs of the organisation'.

The possibility of support from other Scottish Government sources for particular aspects of work was not suggested or discussed.

It may be that options exist, for example through the further development of Health Issues in the Community training, that have not yet been fully explored. But alternative funding sources apart from often being scarcely feasible – CHIs are unlikely to be able to afford to make a significant contribution – could weaken the role that CHEX has played by reducing its flexibility.

Funding from local areas would mean that activities would have to be concentrated in those areas – one CHI, perhaps exaggerating the point, thought that if funded by an area CHEX "would need at least a fulltime worker there to ensure a local impact".

Any move to more varied project based funding could fragment the work of the organisation. Some of those closest to CHEX commented that present funding had already boxed some staff into roles, and that they would ideally want more flexibility

to work as an integrated team (we noticed ourselves a tendency for some contacts to know CHEX only through the work of one particular member of staff).

There would be a serious loss of flexibility – to respond to local issues, to play a representative role in national working groups, etc. - if all staff time were to be prioritised on a costings basis.

6. CHEX's future role and position - KEY POINTS

- Stakeholders considered all the suggested areas of work as important, on average, with a relatively small amount of variation between them. The most highly rated was 'influencing national policy'.

- Two points that command general assent are:

    - the need to remain specific to community health and community development
    - the need to retain autonomy.

- The key role for CHEX was that of a link or bridge between policy and practice. There was also a general consensus that CHEX needs to retain a practice development role.

- There is a tension between the demand from many in CHIs for CHEX to play a representative role and its belief that it should build their own capacity to meet this need.

- Several people expressed concerns that CHEX might "spread itself too thinly", and must decide on its priorities.

- The idea that attracted most discussion was that understanding and decision at local level will be crucial to the future of community-led work, and that CHEX must have a role to play in influencing these.

- There is a lot of work to be done in determining the correct approach to this, in order to prevent CHEX from being overwhelmed with unrealistic expectations. Its role has to be seen principally as a supporter or perhaps catalyst for work by local initiatives, rather than one of offering direct support to individual local partnerships.

- The Meeting the Shared Challenge programme and Health Issues in the Community training (including training for staff) will be key resources.

- Stakeholders did not propose any alternatives to the relationship with NHS Health Scotland. Other financial options were only suggested as marginal contributions. Funding from local areas would mean that activities would have to be concentrated in those areas.

7. Strategic options for CHEX

In this section we try to highlight some of the key strategic choices that CHEX and its partners must make. In the next section we shall make some consequential and additional recommendations.

Some things are generally agreed, including that CHEX should:

- retain its focus on community development approaches to health improvement
- retain a very close relationship with NHS Health Scotland
- show how its own work serves national priorities, and help others to show how community development work in health does so
- act as a bridge between local initiatives and national policy makers and agencies
- retain a strong focus on supporting practice
- focus on 'rebuilding' the community-led sector after the inevitable damage caused by current crises.

The following areas are ones where there is room for some debate, or at least a need for the basis for the choices made to be fully aired and debated.

Status

A decision must be taken, consciously or by default, on the status of CHEX as an organisation. The following appear to be conceivable options.

1. Continue CHEX as unit within SCDC

> PROS – established relations; strong link with SCDC's own aims and approach; some shared administration costs
>
> CONS – can confuse people over CHEX's identity and role; public body status limits ability to speak on behalf of sector.

2. Establish CHEX as an independent organisation and create new Board with stakeholder representation

> PROS – greater profile and visibility; greater influence for stakeholders
>
> CONS – no appetite amongst stakeholders for new body in the sector; could add to confusion about roles of various third sector health bodies; questionable whether creation of new organisation would help it become more sustainable than currently; disruptive to ongoing work.

3. Merge CHEX and Voluntary Health Scotland

> PROS – reduces number of organisations in the field; brings together different but related activities around voluntary projects and community development approaches

CONS – different focus of activity in each organisation; encourages confusion between community-led health activity and third sector activity; merging different approaches might weaken both; much community health work not suitable to join a membership network

4. Set up new unit in NHS Health Scotland to take over CHEX functions

PROS – integrates activity and mainstreams its activities

CONS – removes its independence; compromises its ability to support initiatives and partnerships; reduces credibility with community groups.

COMMENTS There is in practice no demand from any quarter for an immediate change in status (provided that the relationship with VHS can be clearly agreed and communicated). Any advantages of a change would surely be outweighed by the costs of disruption. But since it is possible that the status of SCDC itself may change early in the new Business Plan period, the possibility of a change of status will have to be kept under review.

Funding

We have reported that few if any alternatives to core funding from NHS Health Scotland were proposed. But there are choices to be made about the degree of diversification of funding that should be sought. Increased diversification might be sought through paid services to network members or local partnerships, project grants from research, government or charitable sources, or conceivably programme grants from other government departments or agencies (though no such possibilities were suggested). The issues arising from greater diversification include:

PROS – reduces dependence on single funder; prepares organisation for range of possible longer term future options; might allow in depth work on priority topics; might strengthen relations with local partners

CONS – leads to pursuit of non-priority work purely because funding is available; ties up staff time in seeking and administering funding; ties staff to specific pieces of work, reducing capacity to respond flexibly to needs; could prevent adoption of a generic, community development approach.

COMMENTS If it is agreed that continuing core funding from NHS Health Scotland should provide the basis, the choice is not an either/or one, but a question of how far to pursue diversification. Given the lack of obvious options, it is not a short-term priority.

Networks

There are in our view significant unresolved issues about the nature of the network(s) that CHEX serves and its relationships with them. Several factors may make these issues even more obvious:

- the decline in the significance of the distinction between HLCs and other CHIs
- the possible absorption of the work of some CHIs into the practice of health improvement teams and partnerships
- the demand from many in the sector for a strong representative voice.

CHEX itself should not become a membership-led network of CHIs (even on status 'option 2') since this would be incompatible with its highly valued 'bridging' role.

It will no doubt always wish to retain, perhaps even expand, a general contacts list of all interested people who are invited to certain events, receive e-mail bulletins, etc. But there are other options to be considered:

- Should CHEX have a 'membership', or at least a more formal list of its core contacts to whom it provides enhanced information, individual support, etc.? If this was free and open, it would not differ much from the current ad hoc system of being on a mailing list. If it is restricted to certain types of member – presumably 'community health projects', however they are defined – who can expect a higher level of support, it might duplicate any other possible network, whilst excluding many key contacts in community development roles in health agencies.

- Should there be a national network or alliance of all community health initiatives? Supporting such an alliance would no doubt be a job for CHEX. Given the demand for a strong representative voice, we feel that this option should be seriously considered. But there are significant problems involved:
    - would this replace or work alongside the existing HLC Alliance?
    - more importantly, how can healthy living initiatives based in the statutory sector be involved and represented?
    - how wide a range of community groups with a partial interest in health, or of voluntary care and treatment groups (the core constituency for VHS) should be involved? Many of these will wish to affirm their commitment to community-led health, but there could be a danger of obscuring the distinctive contribution of CHIs.

COMMENTS Any of these options would require wide consultation and is not for immediate decision. However we suspect that, given the above problems, the best option might be a gradual widening of the existing HLC Alliance, if it is willing, coupled with a clear recognition that CHEX also works with a wider network.

Priorities

Given agreement that CHEX should retain roles both in supporting practice and contributing to policy-making, and also in ensuring two-way communications between these levels, other decisions on its priorities will mainly be about how to select from the wide range of possibly relevant activities and avoid overload. We shall say more about this below.

But there are two closely related areas in which we think strategic choices must first be made.

Does CHEX work with mainstream staff? CHEX already provides advice and information to 'mainstream' NHS and other staff who are not part of any specific community initiative, and some take part in HIIC training. At the outset, it took a decision that this should remain a lower priority than working with community-led initiatives. Some stakeholders now think that its priority should be increased, given the need to support partnership working and spread awareness of community development approaches. But this could open up the possibility of major new competing demands on CHEX. NHS Health Scotland has an overall responsibility for the development of the health improvement workforce. There is also a need to be cautious about assuming that a wide range of NHS and other staff can and should actually practice community development. CHEX staff would prefer to influence mainstream staff principally by helping to build the capacity of CHIs to work in partnership with them. But this option may not be available in areas where CHIs are underdeveloped. In addition some models for 'mainstreaming' community health work may blur the distinction between CHI and other health improvement staff.

What role should CHEX have at local level? Continuing to provide strong support for community health practice implies the need to keep in touch with local initiatives. But there are also, as we have seen, significant levels of expectation that CHEX may be able to assist CPPs, CHPs and others to take effective responsibility for the further development of community health. CHEX needs to plan very carefully, and perhaps seek additional resources, to meet these needs so far as it can. But it clearly cannot provide individually tailored support to every area, and must therefore decide what generic resources and approaches can be developed that will have the desired impact.

COMMENTS In the coming year the national capacity building programme will be the key vehicle for dealing with these issues. The needs expressed through this programme, the effectiveness of the responses, the resources developed and in particular the effectiveness of the new regional groups will be crucial to decisions on a longer term approach. At the end of that programme the division of responsibility between CHEX and other SCDC staff may need to be reviewed.

In general the practical priority is likely to be building capability and understanding in partnerships, especially Community Planning Partnerships and Community Health Partnerships, about how to work with communities on health issues and how to assess outcomes, rather than widespread community development training for staff of public sector health improvement agencies.. However, options for a wider and more diverse use of HIIC can also be explored.

Activities

Within CHEX's overall priorities, a wide range of possible activities could be pursued and must be prioritised. As an initial guide, we have compiled a list of what appear to be desirable support measures to ensure an effective and sustainable community-led health sector (Table 7.1). Although CHEX has an interest in almost all of these, it is neither necessary nor desirable for it to take the lead on all of them. We have indicated who we think might do this, and who else they might need to work in partnership with. These indications are we trust helpful but would no doubt require considerable further discussion and consultation.

CHEX does still appear to be the likely lead agency for at least half of these activities, and the need for further choices of priorities will no doubt be a major feature of the business planning process. Some of our specific recommendations in the next section also touch on these choices.

Table 7.1
Support measures to ensure effective and sustainable community-led health sector

		Lead organisation	**Other partners**
A	Develop guidelines for local partnerships on including and working with the sector	SCDC with CHEX	NHSHS, SCR, other community development agencies; Scott Assoc CHPs?
B	Provide information, training and support on community health issues to local community health projects	CHEX	NHSHS, CHPs, CPPs etc
C	Build the organisational capacity of community health projects	Determined locally: CVSs, CPP, CHP, CLDP etc	CHEX to monitor; VHS, VDS etc
D	Build capacity amongst the sector to engage better with local CPPs and CHPs, and connect with and inform national policy	CHEX: networking via regional forums, CVSs etc	CPPs, CHPs, CLDPs; NHSHS & Scottish Govt re opportunities to connect to policy
E	Build the capacity of the sector to monitor, evaluate and assess outcomes and impacts	CHEX	NHSHS; Evaluation Support Scotland; local support agencies
F	Develop guidelines for all stakeholders on where and how community-led health approaches can contribute to/link with Single Outcome Agreements	CHEX	NHSHS, COSLA, Scottish Govt
G	Carry out research to identify and articulate an evidence base for the outcomes and impact that can be achieved by the sector	NHSHS	National network
H	Develop evaluation tools to demonstrate effectiveness of health improvement interventions	NHSHS	CHEX, SCDC, Evaluation Support Scotland
I	Identify ways and means of improving the sustainability of the sector	National network	CHEX, Scottish Government, local partnerships
J	Undertake capacity building with agency staff to increase their knowledge and understanding of community development approaches and the role of community-led health projects	NHSHS with local partnerships/ SCDC (capacity building project)	NES, Skills for Health, ?Improvement Service, education providers, CHEX

K	As part of Workforce Development Programme, advise NHS and local authorities on commissioning community-led health services and approaches.	NHSHS	CHEX
L	Develop and support a community-led health national network that can promote a coherent “brand” and market its activities to communities, local partnerships and government	CHEX	HLC Alliance
M	Build a knowledge bank of good practice and disseminate it amongst all stakeholders	CHEX	National network
N	Disseminate information about current activities to local projects and partnerships	CHEX	National network
O	Create opportunities that bring policy makers and practitioners together to share lessons and learning	CHEX	National network, NHSHS, Scottish Govt, others e.g. Poverty Alliance
P	Develop clear national policy and guidance on the role of community-led health work	Scottish Government	NHSHS, National network etc
Q	Represent the sector and argue its case to elected members	National network	Supported by CHEX

8. Recommendations

CHEX has not only served and supported the community development approach to health effectively, it has helped a whole sector to find its identity and its voice. At a time when national policy reaffirms the need for community-led action to address health inequalities, but in practice the sustainability of the sector is under severe threat, continuing support and in particular effective dialogue between policy and practice are clearly needed. This can only realistically come by building on the work of CHEX, though it will face choices of priorities as the focus and organisation of community health work shifts.

Priorities

1. The key priorities for CHEX should be:

    - to continue bringing together community based work and policy makers, and sharing practice and approaches in community development and health improvement across Scotland
    - to support the sector to rebuild its strength and thrive in the new public sector environment

2. NHS Health Scotland should take the lead in agreeing the allocation of responsibilities for activities in support of community-led health work. These could be those suggested in table 7.1, after further consultation. More opportunities for joint working should be identified. The Business Plan should indicate priorities in more detail.

3. Information, training and networking should continue to be core activities. Particular attention should be given to the development of evidence gathering and outcome planning capabilities in the sector. But the need for general raising of the profile of the community-led sector through publicity and the exchange of good practice should also be taken into account.

4. CHEX should review how it can become involved in local activities to build the capacity of people in CHPs and CPPs. These should concentrate on supporting them to work in partnership with and understand the value of the community-led sector. National guidance, resources and promotion of good practice should be used to drive this work wherever possible.

5. In particular CHEX should learn lessons from the Meeting the Shared Challenge national capacity building programme and review what its long term role in work with local partnerships might be, in collaboration with SCDC.

6. Although other, principally local, services should support basic organisational and individual capacity building for CHIs, CHEX should retain a long term responsibility to monitor the organisational capacity of the sector, identify need and assist in mobilising resources to meet that need.

7. CHEX should support dialogue on, and the development of logic models that clarify, what part services and initiatives established primarily to improve health can effectively play in addressing broad social and economic issues, and when such issues are best addressed by those other services or activities that have their primary focus on each issue.

Networks and partnerships

8. CHEX should develop its profile and 'brand' more actively and seek to ensure that a wider range of groups and, national and local agencies understand its role and capabilities.

9. Organisations in the sector should be consulted about the desirability of a new or broadened alliance to provide a representative role with CHEX support.

10. CHEX should also review and update its contacts list and consider whether to establish a more formal list of people wishing to be seen as part of its network, and what enhanced level of service they might receive.

11. There should be continuing efforts to ensure information sharing and networking with other intermediary bodies, and joint agreement on how to present and publicise their differing roles. The objectives for such networking activities must be clearly defined.

12. CHEX and the Scottish Government should publish a joint briefing note for CPPs that explains the roles of different health intermediary bodies; describes their own links to and support for them and encourages greater contact by CPPs with them in local service planning and delivery arrangements.

13. NHS Health Scotland and the government should also consider how they can bring together all the main national health intermediaries at least annually to review how policy and practice are developing in relation to community-led approaches to tackling health improvement and inequalities.

Governance and funding

14. CHEX should continue to operate as a unit within SCDC, though this may be reviewed as part of the review of SCDC's own future structure.

15. NHS Health Scotland should continue to be the core funder, based on a new agreement on how CHEX can help it to meet the outcomes that it requires.

16. Diversification of funding should be looked at as a long term objective, but is not the immediate priority. A clear policy may be required on what services CHEX can offer free of charge and those that it will deliver on a paid basis or to contract.

17. CHEX should review the membership of its Advisory Group, specifically representatives from CPPs and CHPs, several sections of NHS Health Scotland and the Scottish Government.

18. CHEX should carry out equalities impact assessments of its plans and work with the new NHS Health Scotland Directorate of Equalities and Planning, the Equalities and Human Rights Commission and organisations active in relevant sectors to ensure that the community health sector is inclusive and accessible.

19. Arrangements for reports specifically recording the degree of progress towards objectives should be considered as part of the implementation of the new Business Plan. These should not replace the existing practice of close dialogue with NHS Health Scotland and other stakeholders.

20. CHEX should seek if possible to build its own capacity for administration, processing evidence on its own and CHIs' impact, publicising good practice and maintaining up to date links with its network.

21. The new Business Plan should continue to be developed in a participative way and the future roles and responsibilities of CHEX should continue to be open to consultation as part of this process.

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Appendix 1 List of consultees

NATIONAL AGENCIES and FUNDING ORGANISATIONS

Face to face interviews:

Laurence Gruer, NHS Health Scotland
Eleanor McKnight, NHS Health Scotland
Emma Witney, NHS Health Scotland
Lizanne Conway, NHS Health Scotland
Rosemary Hill, Scottish Health Council
Mary Castles, North Lanarkshire Council
Helen Tyrell, Voluntary Health Scotland
Bill Gray, Community Food and Health (Scotland)
Eric Samuels, Big Lottery Fund
Stuart Hashagen, SCDC
Catriona Windle, Lothian Community Health Forum
Christine Caldwell, West of Scotland Community Health Network
Janet Muir, CHEX

National Focus Group:

Roddy Duncan, Health Improvement Strategy Division, Scottish Government
Margaret Wilson, SCVO

Telephone Interviews:

Kathleen Bessos, Primary Care, Scottish Government
Allyson McCollam, Scottish Development Centre for Mental Health

Symposium:

Agency Representatives
Russell Bain, Performance and Improvement Division, Scottish Government
David Pattison, Specialist Public Health Adviser, Scottish Government
Wilma Reid, Learning & Workforce Development, NHS Health Scotland
Emma Halliday, NHS Health Scotland

CHEX Advisory Group Members
Sheila McMahon, Dundee Healthy Living Initiative
Christine Caldwell, East End Health Action
Tina Burgess, Health Promotion, Western Isles NHS Board

COMMUNITY PLANNING and COMMUNITY HEALTH PARTNERSHIPS

Focus Groups:

Clackmannanshire CHP
Stirling CHP

North Glasgow Health Improvement Team
South East Glasgow CHCP
North Lanarkshire Council
South Lanarkshire CPP

Telephone Interviews:

CHP
Aberdeenshire CHP
Dumfries & Galloway CHP
Dumfries & Upper Nithsdale LHP[6]
Dumfries and Galloway CHP
East Lothian CHP
Glenrothes & NE Fife CHP
Mid Highland CHP
Midlothian CHP
Moray CHSCP[7]
Shetland CHP
Western Isles CHP

CPP
Aberdeenshire Council
Angus Council
City of Edinburgh Council
East Ayrshire Council
Edinburgh Partnership
Highland Council
Midlothian CPP
Moray Council
Orkney Islands Council
South Ayrshire

CHEX ADVISORY GROUP

Susan Dawson, Argyll & Bute Council
Rohini Kharbanda, City of Edinburgh Council
Geraldine O'Riordan, Community Food and Health (Scotland)
Sheila McMahon, Dundee Healthy Living Initiative
Christine Caldwell, East End Health Action
Lesley Blackmore, Lothian Community Health projects Forum
Catherine Young, NHS Borders
Elaine Lamont, NHS Dumfries & Galloway
Heather Apsley, NHS Health Scotland
Lizanne Conway, NHS Health Scotland
Stuart Hashagen, Scottish Community Development Centre
Linda Newlands, Health Strategy Group
Robin Tennant, Poverty Alliance
Deborah Niven, West Dunbartonshire Healthy Living Initiative

[6] Local Health Partnership (subdivision of CHP)
[7] Community Health and Social Care Partnership

Linda Arthur, Wester Hailes Health Agency
Tina Burgess, Western Isles, NHS Board

NETWORK EVENT

Ali Shire, NHS Health Scotland
Andy Carver, British Heart Foundation
Ann McGhee, Tea In The Pot
Anne Marie McKay
Anne Rennie, Stirling Health & Wellbeing Alliance
Beverley Black, Dundee HLI
Brenda Sowney, SEAL
Brendan Rooney, Cambuslang & Rutherglen Community Health Initiative
Caroline Mockford, Tea In The Pot
Caroline Thomson, Deaf Connections
Carrie Ho, Securing Care for Ethnic Elders in Scotland
Christine Caldwell, East End Healthy Living Centre
D Black, Communicable Health
Dave Allan, CHEX
David Hewitt, Pilton Community Health Project
Della Thomas, NHS Health Scotland
Douglas Guest, Equalities & Human Rights Commission
Elspeth Gracey, CHEX
Frances Bryce, Renfrewshire Community Health Initiative
Gary Smith, CHANGES Community Health Project
Heather Apsley, NHS Health Scotland
Jan Graham
Janet Muir, CHEX
Janette McCormick, North Glasgow HLC
Karina MacDonald, Phoenix Community Health Project
Kate Marshall, West Lothian Council
Laura Harris, NHS Health Scotland
Linda Newlands, Broomhouse Health Strategy Group
Lizanne Conway, NHS Health Scotland
Margaret Ann Prentice, North Lanarkshire Health Project
Margaret Rutherford, SEAL
Martin Coyle, Kingsway Health & Wellbeing Centre
Martin Oliver, North Lanarkshire Health Project
Moira Findlay, Coal Industry Social Welfare Organisation
Nicky Thomson, Good Morning Glasgow Project Ltd
Sheila McMahon, Dundee HLI
Stuart Hashagen, SCDC

SURVEY

Thanks also to all who responded to the e-mail or postal survey.

Appendix 2. Questionnaire to CHEX network

CHEX - STRATEGIC REVIEW 1. Introduction	
This short survey is about the future of the Community Health Exchange (CHEX) and the directions that it should move in the future. It is being carried out on behalf of CHEX and NHS Health Scotland by Margaret Lindsay and Peter Taylor. Please click on the button on the last page to submit your answers. Your answers will remain private to the researchers and will only be quoted anonymously.	
1. Name	
2. Position	
3. Organisation	
4. Status of organisation or project (please choose one)	
Community Health Project	
Healthy Living Centre	
Other community health initiative (voluntary organisation)	
Other community health initiative (NHS and/or local authority staffing)	
Community or voluntary group that has both health and other activities	
Other (please specify)	
5. Which of the following contacts with CHEX have you been involved in? (please tick all that apply)	
Read CHEXPoint News	
Read Snippets e-mail bulletin	
Used CHEX publications	
CHEX events (training, conferences)	
Contacted CHEX for advice/support	
Delivery or development of Health Issues in the Community Training	
CHEX consultations on influencing health improvement policy	
Healthy Living Centre Support Programme	
CHEX's work on mental health and wellbeing	
CHEX Committees/Working & Planning Groups	
Other (please specify)	

CHEX – STRATEGIC REVIEW 2. How well CHEX has been working					
6. In your experience, how effective has CHEX been in the following areas?					
	Not very effective		**Reasonably effective**		**Highly effective**
Providing practical support to community health initiatives (CHIs)	o	o	o	o	o
Publishing information and advice for CHIs (newsletters etc)	o	o	o	o	o
Keeping in touch with individual CHIs	o	o	o	o	o
Building contacts and networks between CHIs	o	o	o	o	o
Enhancing the ability of CHIs to engage with other partners in health improvement	o	o	o	o	o
Informing CHIs about national policy and its implications	o	o	o	o	o
Assisting CHIs to improve their monitoring and evaluation	o	o	o	o	o
Communicating evidence about the impact of community-led health work	o	o	o	o	o
Influencing national policy and practice	o	o	o	o	o
Influencing implementation of policy at local level	o	o	o	o	o
Supporting CHIs to become more sustainable	o	o	o	o	o
Playing a clear role, different from other organisations	o	o	o	o	o

7. Any other comments on how well CHEX has been working?

CHEX - STRATEGIC REVIEW 3. Issues facing community-led health initiatives

These questions are about the overall situation facing community-led health initiatives and community development approaches to health.

8. Judging from your own experience and knowledge, how good is the position that initiatives face in each of the following areas?

	Very poor	**Needs improvement**	**Adequate**	**Good**	**Very Good**
Support for community health work in national policy	o	o	o	o	o
Recognition of its role in local strategies	o	o	o	o	o
Understanding of its role by other partners	o	o	o	o	o
Capacity of community health organisations to deliver desired outcomes	o	o	o	o	o
Skills and knowledge of community health organisations	o	o	o	o	o
Sustainability of community health organisations	o	o	o	o	o
Funding for community health work	o	o	o	o	o

9. What are the main barriers to the success of community health work?

10. What are the main opportunities for helping community health work to make a bigger impact?

CHEX - STRATEGIC REVIEW 4. Future directions for CHEX					
11. How important do you think that each of these types of work should be for CHEX in future?					
	Not essential	**Less important**	**Important**	**Very important**	**Top priority**
Influencing national policy	o	o	o	o	o
Communicating policy and practice developments to local initiatives	o	o	o	o	o
Support and advice to individual initiatives	o	o	o	o	o
Building contacts/network between initiatives	o	o	o	o	o
Providing training	o	o	o	o	o
Publicising community health work and its impact	o	o	o	o	o
Promoting good practice in community health work	o	o	o	o	o

12. Your comments about: What directions CHEX should take in the future?

13. Your comments about: What the relationship between CHEX and local initiatives and partners should be in future?

14. Any other comments about how you would like to see CHEX develop or work with you in future?

[Invitation to event]

THANK YOU VERY MUCH for completing our survey.