Community Health Exchange (CHEX)

A Strategic Review

Summary Report

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NHS Health Scotland commissioned the strategic review of Community Health Exchange (CHEX) in September 2007 to help inform decisions on its future direction, positioning and sustainability. This Report summarises the findings and highlights the recommendations. The consultancy work was carried out by Margaret Lindsay and Peter Taylor.

Some of the opinions expressed in this publication are those of the authors and do not necessarily reflect those of the commissioning body.

Introduction

CHEX

CHEX was first established in November 1999. It is based within the Scottish Community Development Centre (SCDC). It has a very close relationship with its main funder, NHS Health Scotland, and particularly with that organisation's community and voluntary sector programme (which is part of the Healthy Settings Team within the Programme Design and Delivery Directorate).

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. …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".

Its overall objectives, according to its Business Plan 2005-08, are to ensure that:

- Community Development is influential in health improvement
- The community health sector develops effective practice and inclusive shared learning
- The community health sector is equipped to apply theoretical models of community development to assist in development of effective practice
- CHEX has a clear sense of identity and direction and the community health sector has a clear expectation of CHEX's services
- The community health sector has an inclusive and accessible infrastructure.

The community health sector

CHEX works with:

- 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.

The first three categories are considered to be CHEX's 'core constituency'; the first two are referred to as Community Health Initiatives (CHIs).

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 approach taken has sought to allow the maximum potential for the participation of stakeholders, and feedback during the process.

Purpose of Review

The strategic review was commissioned to help inform decisions on the future direction, positioning and sustainability of CHEX. 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.

Strategic Options

Status A decision must be taken, consciously or by default, on the status of CHEX as an organisation – whether it remains independent of NHS Health Scotland and within SCDC. There is no demand from any quarter for an immediate change. But since it is likely that the status of SCDC itself may change early in the new Business Plan period, the implications for CHEX will have to be kept under review.

Funding 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. But given a lack of obvious options, diversification is not a short-term priority.

Networks There are 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 the best option might be a gradual widening of the existing Healthy Living Centres Alliance, if it is willing, coupled with a clear recognition that CHEX also works with a wider network of groups, agencies and individuals.

Priorities 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.

Two areas require strategic choices:

- to what extent should CHEX work with 'mainstream' staff
- what role should it have at local level.

For these areas, 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.

Activities Within CHEX's overall priorities, a wide range of possible activities could be pursued and must be prioritised. Appendix B gives a list of support measures that would be desirable to ensure an effective and sustainable community-led health sector. An indication of who might take the lead on each and who else they might need to work in partnership with is given.

CHEX appears to be the likely lead agency for at least half of these activities. The need for further choices of priorities will be a major feature of the business planning process.

Specific recommendations on priorities, networks and partnerships and the governance and funding of CHEX are given in Appendix C.

Main findings

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.

The work of CHEX

The key objectives set out in CHEX's Business Plan are to:

- provide a resource for the community health sector
- 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.

Perhaps the two most crucial elements affecting the development of CHEX were:

- the expansion of the community health sector, followed by a risk of significant contraction
- the increased opportunities for engagement in national policy development.

Survey responses suggest that CHEX works with a balance of people from across the range of the community health sector.

The great majority of contacts receive both printed and e-mail bulletins. Less than half use each of the other specific CHEX services but 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 there are some ways in which monitoring and evaluation might be improved.

Interviews, discussions and survey overwhelmingly showed 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 for their success.

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 was that CHEX's special role and value is to act as a link or bridge between the levels of national policy and local practice.

Some areas of reservation were expressed:

- 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 CHEX's role 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 'Meeting the Shared Challenge' are of crucial importance. The 2007 'Better Health: Better Care' Action Plan reaffirms these principles.

Changes to the way government works and objectives drive action and spend 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 should create greater understanding of the contributions of different sectors to achieving shared outcomes

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 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.

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.

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

A group of stakeholders was asked 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 was most likely
- more ‘community leadership’ in partnerships was unanimously viewed as desirable
- there was also a significant degree of optimism about the likelihood of this 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.

A 'SWOT' analysis, for the sector as a whole (Annex D), looks at its intrinsic strengths and weaknesses, and the opportunities and threats that arise from the environment in which it currently works.

CHEX's future role and position.

Stakeholders' beliefs about the options for CHEX's future role and activities were examined. 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 ideas that attracted most discussion were 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 to determine the correct approach to take to working at a local level, 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 support 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.

A SWOT analysis summarises CHEX's strategic position, based on the evidence on its progress and its environment (Annex E).

Annex A: Abbreviations

CHEX	Community Health Exchange
CHP	Community Health Partnership
CLDP	Community Learning and Development Partnership
COSLA	Convention of Scottish Local Authorities
CPP	Community Planning Partnership
CVS	Council of voluntary service/ for the voluntary sector
HLC	Healthy Living Centre
NES	NHS Education Scotland
NHSHS	NHS Health Scotland
PPF	Public Partnership Forum
SCDC	Scottish Community Development Centre
SCR	Scottish Centre for Regeneration
SWOT	strengths, weaknesses, opportunities and threats
VDS	Volunteer Development Scotland
VHS	Voluntary Health Scotland

Annex B: Support measures to ensure an 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; Association of 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 Government 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 Government
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 Government, 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

Annex C: Recommendations

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 Annex B, 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.

Networks and partnerships

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.

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 Equality 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

Annex D: Community-led health sector

Strengths

- Access to disadvantaged or ‘hard to reach’ people
- Based on a fundamental human need – health
- Commitment and value base of participants
- Accessible locations, non-threatening approaches
- Ability to fill gaps that statutory services cannot
- Innovative and creative
- Flexibility in response to community wishes and needs
- Support from communities
- Attracts volunteers
- Ability to respond to the individual, take ‘holistic’ approaches
- Ability to address mental health and wellbeing
- Harnesses power of collective action
- Relevant to wide range of issues
- Increasing evidence of impact
- Growing ability to gather and explain this evidence
- Willingness to network and exchange experience
- Wide range of links and partnerships with groups and agencies
- Allows funders to lever additional resources through working with community-led organizations
- Strong support from CHEX

Weaknesses

- Inflexibility when constrained by criteria set by funders
- Relatively small scale
- Locally focussed – not seeing wood for trees
- Diffuse and varied, difficult to retain clear profile and public understanding
- Not a consistent presence across Scotland
- Can be lack of clear definitions of purposes and approaches
- Small weak organisations, with limited management and governance capacity and skills
- Short term funding prevalent
- No clear identity and role in wider partnerships
- Weakness of community partners in partnerships
- Difficult to promise predefined outcomes when responding to community issues
- Lack of collective voice
- Still struggling to give evidence of many outcomes
- Scale in relation to health and social problems means impacts are long term and hard to demonstrate
- Not always consistent in applying community development approaches
- Talks about life circumstances but often works mainly on life style issues
- Rather demoralised by funding situation

Community-led health sector

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 <u>might</u> 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

Annex E: 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 current 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

CHEX

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)
- 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