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COMMUNITY PLANNING PARTNERSHIP
A meeting of the **CPP MANAGEMENT COMMITTEE**
will take place on the Wednesday, 6 February 2013 at Committee Room 1, Kilmory, Lochgilphead
VC facilities will be available from Helensburgh, Dunoon and Oban.

PLEASE NOTE SIZE OF DOCPAC PRIOR TO PRINTING

*Times are indicative

Agenda Items	Time *	Item Titles	Expected Outcome
1.	10.00	WELCOME/APOLOGIES	Apologies Noted
2.	10.05	MINUTES OF PREVIOUS MANAGEMENT COMMITTEE MEETING HELD ON 12TH DECEMBER 2012 (Pages 1 - 10) 2(a) – Matters Arising	Minute to be approved
3.	10.15	SOA SCORECARD - FQ1,2 AND 3 - THEME LEADS (Pages 11 - 24) 3a) Economy – Douglas Cowan 3b) Social Affairs – Cleland Sneddon 3c) Environment – Andrew Campbell 3d) Third Sector and Communities – Margaret Fyfe	Item deferred from Management Committee meeting held on 12th December
4.	10.45	SOA ANNUAL REPORT - JANE FOWLER	Report requires approval prior to submission to Scottish Government
5.	10.50	THIS PLACE MATTERS - RETHINKING LOCAL LEADERSHIP - JANE FOWLER	Agreement to participate in Local Leadership workshops Nominations from Partner organisations
6.	11.00	HEALTH INEQUALITIES IN SCOTLAND - AUDIT SCOTLAND REPORT - EILEEN WILSON (Pages 61 - 116) 6a) Audit Scotland Report 6b) Draft Discussion Paper	Report and recommendations noted. Proposed response agreed.
7.	11.20	PARTNER PLANS (Pages 117 - 132) 7a) - NHS Highland – Argyll and Bute CHP Local Operational Plan – **To Follow**	Plans discussed and noted.

Agenda Items	Time	Item Titles	Expected Outcome
		7b) POLICE – DEVELOPMENT OF LOCAL POLICE PLAN – Barry McEwan, Chief Superintendent 7c) FIRE REFORM – DEVELOPMENT OF FIRE AND RESCUE PLAN – Jim Scott, Area Commander – Argyll and Bute	
8.	11.50	NEW COMMUNITY PLAN - BRUCE WEST - UPDATE (Pages 133 - 154) 8a) Draft Outcomes for Decision	Agreement on format, outcomes and progress route for further comments and wider circulation.
9.	12.20	DRAFT TERMS OF REFERENCE FOR NEW GOVERNANCE ARRANGEMENTS - BRUCE WEST Proposed New Governance arrangements – covering report 9a – Draft Terms of Reference 9b – Draft Meeting Dates	Agreement sought on New Governance, Terms of Reference and Meeting Schedule
10.	12.30	INSPECTION OF CHILDRENS SERVICE UPDATE - LOUISE LONG	Report noted.
11.	12.40	EARLY YEARS COLLABORATIVE UPDATE - LOUISE LONG	Report noted.
12.	12.50	OPPORTUNITIES FOR ALL - ARGYLL AND BUTE COUNCIL PAPER ON SKILLS PIPELINE AND YOUTH PIPELINE AND YOUTH EMPLOYMENT ACTION PLAN - VERBAL UPDATE - CLELAND SNEDDON	Update and progress noted.
13.	13.00	ARGYLL AND BUTE LOCAL SERVICES INITIATIVE - JANE FOWLER	Agree to support event, cascade information to wider audience and forward contact details of those within their organisations to invite.
14.	13.05	REVISED MEETING DATES - BRUCE WEST	Management Committee to note new meeting dates, and advise of any changes to be made.
15.	13.10	AOCB	
16.	13.10	AREA COMMUNITY PLANNING GROUPS - UPDATE REPORT - JANUARY 2013 - SHIRLEY MACLEOD	Report noted.

Agenda Item 2

ARGYLL AND BUTE COMMUNITY PLANNING PARTNERSHIP

MINUTES of CPP MANAGEMENT COMMITTEE MEETING held in the COUNCIL CHAMBERS, KILMORY, LOCHGILPHEAD on WEDNESDAY 12th DECEMBER 2012

Present

Sally Loudon	Argyll and Bute Council
Eileen Wilson	Argyll and Bute Council
Joyce Cameron (Minutes)	Argyll and Bute Council
Derek Leslie	NHS Highland
Andrew Campbell	Scottish Natural Heritage
Glenn Heritage	Third Sector Partnership/Argyll Voluntary Action
Graham Whitefield	Argyll and Bute Council
Jane Fowler	Argyll and Bute Council
Aileen Goodall	Argyll and Bute Council
Louise Long	Argyll and Bute Council
Douglas Cowan	Highlands and Islands Enterprise
Anne Paterson	Argyll and Bute Council
Chris Carr	Argyll and Bute Council
Shirley MacLeod	Argyll and Bute Council
Donald Henderson	Scottish Government
Katriona Carmichael	Scottish Government
Bruce West	Argyll and Bute Council
David Pettigrew	Strathclyde Police
Fergus Byrne	Strathclyde Police
Jim Scott	Strathclyde Fire & Rescue
Moya Ingram	Argyll and Bute Council
Cleland Sneddon	Argyll and Bute Council

Apologies:

Eileen Wilson	Argyll and Bute Council

ITEM	DETAILS	ACTIONS
1.	**WELCOME AND APOLOGIES** Derek Leslie welcomed everyone to the meeting and intimated apologies.	
2.	**MINUTES OF THE MANAGEMENT COMMITTEE MEETING HELD ON 10th OCTOBER 2012** The minutes of 10th October were approved as an accurate record.	

	Matters Arising:- No matters arising.	
3.	**INSPECTION OF CHILDREN'S SERVICES** Louise Long, Head of Children and Families at Argyll and Bute Council updated partners on the forthcoming children's services joint inspection. She highlighted the important role that CPP have strategic lead for the Children's Service Inspection. It was noted that Inspectors want to meet with the CPP partners on 21st January. Prior to the meeting Louise Long is happy to meet to answer any questions with regard to challenges facing young people in Argyll and Bute. ***Action Points:-*** **Cross section of participants to be identified for a sub group of Community Planning Partners to meet inspectors on 21 January– Louise Long** **Jim Scott of Strathclyde Fire & Rescue to advise a representative.** **Glenn Heritage to represent third sector.** **Cleland Sneddon to liaise with Housing Associations re a representative** **Carol Evans to represent education.** **Andrew Campbell to represent SNH** **It was agreed that each partner would prepare a Corporate Parenting Statement including the Third Sector forum, which is due to meet in early January. Louise Long to meet with Glenn Heritage.** **Community Planning statements will be issued to the CPP for comments once it is endorsed at the Young People Forum.** **Louise Long to provide an update report to Management Committee on 6 February on progress for inspection.** **Cleland Sneddon – Dates to be identified for sub groups to meet.**	**Louise Long** **All Partners** **Louise Long** **Cleland Sneddon**

4.	**SCOTTISH GOVERNMENT REVIEW OF COMMUNITY PLANNING AND SINGLE OUTCOME AGREEMENTS** This report updates the CPP with progress made to date and in particular the newly established National Group. Scottish Government have published guidance for the next SOA. Statement of Ambition was agreed on 15 March 2012, when the National Group agreed set of priorities and considered approaches on Cultural Leadership, policy priorities. Approaches are very important and very clear guidance has been given. Community Planning to look at a 10 year programme of outcomes. It was agreed that good examples of co-production are being carried out and they should be promoted in order to improve and develop partnership working. The timescale of the SOA is April 2013, and we are well within timescale. Douglas Cowan suggested that we should look at the 10 year horizon as we develop the plan. Andrew Campbell advised that statistics around population are on a 20 year horizon and we should take this into consideration and find the gaps.	
5.	**NEW COMMUNITY PLAN** Bruce West advised that feedback from the exercise that has been taking place over the last month. Chris Carr took the partners through the presentation, she advised that the headings were not necessarily the ones that would be used. Key priorities have been detailed as the plan has developed. For each return that was received, information was sorted by range of criteria. Each of the key priorities had been coloured differently on the diagram presented for ease of interpretation. Emphasis was on partnerships, co-production, models of service delivery and align housing with health and social services. It was advised that there was very positive feedback with regards to police presence. Andrew Campbell intimated that there were very positive outcomes in the environment theme. Protecting and enhancing the environment that we have, remains a long term priority.	

	Sally Loudon pointed out that the survey is only as good as the data that's been input but if it doesn't reflect this, how do we as a partnership look at the challenges we have collectively? Bruce West intimated that the first stage in this exercise is to identify people that we need to have discussions with to enhance the information and ensure that we have identified the challenges. **Action Points:-** **Draft proposals to February Management Committee to include Issues from consultation and any final partner comments.** **Sally Loudon urged partners to attend the February meeting.** b) – **Report and Presentation on Consultation** Bruce West will be developing some questions to put forward to the Area Community Planning Group meetings. Plans will be distributed to partners' offices. Document to be put on the CPP website and local tv. Bruce West is also planning to carry out webchat session and to have some form of webcast where a representative can access the CPP website. Glenn Heritage agreed to carry out consultation with harder to reach groups. If partners have any key messages, it would be helpful if they could be received as soon as possible. It was agreed that the plan should be promoted/consulted on via partners intranet sites. **Action Points:-** **Bruce West will bring feedback back to Management Committee on 6th February 2013**.	**Bruce West** **Bruce West**
5.	**MEDI VAC FACILITIES ON COLL/COLONSAY** Moya Ingram advised that issues had been raised regarding the local aerodrome be utilised. Derek Leslie thanked Moya for her attendance.	

	I **Action Points:-** **It was agreed that the Scottish Ambulance Service, NHS and the Coll Local Voluntary Fire Service would work in partnership to agree suitable protocols for medical air evacuations on Coll and investigate potential funding streams for any infrastructure upgrades that are required.**	**Scottish Ambulance Service, Strathclyde Fire & Rescue**
6.	**FUTURE GOVERNANCE ARRANGEMENTS** This update builds on a report that went to Management Committee in October. In future the Full Partnership would meet once a year, looking at mid- year progress. The Meeting would take place in Sept/Oct. Chief Officers Group will report to the Full Partnership. Councillors and Non-Exec members would be invited to future meetings of the Full Partnership. The Community Planning Partnership considered the issue raised by Shirley MacLeod relating to MAKI and recognised that with a new administration in place at the Council, a further discussion will need to take place. In the meantime the Management Committee endorsed the current position. **Action Point:-** **Bruce West to draft a set of terms of reference for each group, outline agendas, structures, more detailed plan for each of the meetings.**	**Bruce West**
7.	**OUTCOME PLANNING** Report noted.	
8.	**OPPORTUNTIES FOR ALL – ARGYLL AND BUTE COUNCIL PAPER ON SKILLS PIPELINE AND YOUTH PIPELINE AND YOUTH EMPLOYMENT ACTION PLAN** Aileen Goodall updated partners on the work being done on youth employment. Organisations came together through Employability group to tackle this issue. The aim is to try to improve opportunities for young	

	people. 2010/11 figures show that almost 10% are in a negative position due to unemployment not being in further education. Skills pipelining has been put together in 5 stages. It is a working document so feedback on any gaps was invited. Partners welcomed the initiative, discussed the plan and made some comments. Cleland Sneddon had a meeting with ACHA on 11th December, and was advised that they require 9 individual work experiences. Derek Leslie advised that he will take proposals back to NHS. **Action Point:-** **Individual Community Planning Partnership organisation to consider how they could contribute to work experience.** **Item to come back to Management Committee on 6th February.**	**All** **CPP Admin**
9.	**EARLY YEARS COLLABORATIVE NOMINATION OF EARLY YEARS CHAMPION FOR ARGYLL AND BUTE** Anne Paterson was delighted to hear Early Years being mentioned throughout the morning as we want Scotland to be the best place for our children to be brought up in. Anne Paterson took the partners through the Early Years presentation. Early Years is very much on a journey in each local authority, and partnership working with Community Planning Partnership is essential to get the best deal in our communities for our children. Sally Loudon proposed Louse Long as the Early Years Champion, all partners were happy to endorse. **Action Point: –** **Similar to the list that Louise provided early. Provide nominations to Anne/Louise week commencing 17 January.** **Most senior representation requested.** **Cleland Sneddon advised that partners should be appointed for 21/22.**	**All Partners**

10.	**ARGYLL AND BUTE COUNCIL BUDGET 2013-14 – PRESENTATION ON COUNCIL BUDGET CONSULTATION** Bruce West advised that there are proposed savings from the Council's budget. The consultation this year will be based on general views around expenditure on services. It was intimated that information can be accessed on the Council's website. **Action Point** **Presentation to be circulated to partners.**	**CPP Admin**
11.	**ARGYLL AND BUTE LOCAL SERVICES INITIATIVE** A project that has been joint funded built on better relationships with third sector and Carnegie. It was proposed and agreed by the partners that we have an event in March to launch the findings of this collaborative project. **Action Point** **Paper to come back to Management Committee on 6th February.**	**CPP Admin**
12.	**STRATHCLYDE POLICE AND STRATHCLYDE FIRE & RESCUE** a) **PATHFINDER UPDATE** b) **STRATEGIC POLICE PRIORITIES CONSULTATION** Pathfinder event had been recently held in Edinburgh. There is no change proposed in front facing service and same policing plans will be in place across 32 councils. Jim Scott advised that he was attending the next pathfinder event in Edinburgh and would update partners in due course. **Action Point:-** **The Council has a paper in next Council meeting – once papers become public. Argyll and Bute Council to circulate around partners advising any comments to chair.**	**CPP Admin**

13.	**PLUGGED IN PLACES – ELECTRIC VEHICLES** Report was noted. **Action Point** **David Pettigrew has not yet got a response but will chase up.**	**David Pettigrew**
14.	**EMERGENCY RESPONDERS UPDATED POSTAL CODES AND ADDRESSES** Graham Whitefield raised an issue regarding emergency services, postcodes and addresses in rural areas. **Action Point** **Invite to go to Scottish Ambulance Service for Management Committee attendance on 6th February.** **Joint letter to go to Scottish Ambulance Service with a copy of letter to be sent to Donald Henderson.** **Graham Whitefield to liase with Jim Scott, Strathclyde Fire & Rescue.**	**Jane Fowler/Eileen Wilson** **Graham Whitefield/Jim Scott, SFR**
15.	**CITIZEN'S PANEL** Survey was carried out in September and the report from Hexagon. If anyone requires a copy of the report please advise Chris Carr – Chris.Carr@argyll-bute.gov.uk All partners were asked to provide questions/themes for the Spring Citizen's Panel Survey. **Action Point:-** **Questions for Spring to come back to Chris Carr.**	**All Partners**

16	**ACPG UPDATES** It was noted that extra meetings had been put in place for all of the groups for January to carry out consultation on the Council's budget and on the new Community Plan. **Bute & Cowal** Concerns had been raised about "projectitis" and the need for mainstreaming of work by the Third Sector rather than short term projects/contracts. Concern had also been raised about lack of consultation with communities over health and social care integration. 23 half hours presentation went to B & C. **MAKI** There was concerns that the report on future governance of Community Planning Partnership does not fully address how this would be taken forward within the MAKI context. **H & L** There was no concerns raised. **OLI** No concerns raised. All groups had focussed on agenda items on Health Screening Programmes, Economic Development Activity and the Economic Development Action Plan, and on the local issues including Broadband/mobile coverage in the MAKI area, key partnership groups in Helensburgh and Lomond, and core paths/national cycle paths and the opportunity for these to be key economic/tourism drivers in Oban, Lorn and the Isles. NHS won't be ready to discuss Budget at January meetings.	
17.	**SOA SCORECARD (1ST AND 2ND FQ) – THEME LEADS –** **Action Point:-** **Defer to 6 February and put to top of agenda.**	**CPP Admin**
	a) ECONOMY	
	b) SOCIAL AFFAIRS	
	c) ENVIRONMENT	
	d) THIRD SECTOR AND COMMUNITIES	

18.	**CPP BUDGET** It was agreed that the partners would remain the same as in previous years. Police/Strathclyde Fire and Rescue/Argyll and Bute Council and NHS happy to contribute. A more detailed budget proposal would be tabled at the next meeting. **Action Point:-** **Paper to go to Management Committee on 6 February**	**CPP Admin**
19.	**REVISED MEETING DATES FOR 2013** Paper Noted. The meetings on 6th March and 11th March are subject to change.	
20.	**AOCB** Health Inequalities in Scotland – CPP short presentation to a MC in 2013 Jane Fowler advised that the Communications Team have been involved in the feature on Oban Airport to be televised in the BBC Landward programme on Friday, 14 December 2012. Operation Archer – attendance – 23 January	
21.	**DATE OF NEXT MEETING** Wednesday 6th February, 2013	

Argyll and Bute Community Planning Partnership

Management Committee
Date: 22 January 2013

Title: SOA SCORECARD - ECONOMY

1. SUMMARY

1.1 The purpose of this paper is to report and provide comment exceptionally on performance against a number of SOA success measures for the third quarter of 2012/13. With the demise of the Thematic Group, the value in monitoring economic data through the scorecard is somewhat diminished.

2. RECOMMENDATIONS

2.1 That Management Committee notes progress on the SOA Economy success measures for Q.3 2012/13.

3. BACKGROUND

3.1 The economy thematic scorecard incorporates a variety of success measures based both upon partner activity and also on a range of economic data sets that were intended to help the economy thematic group to monitor economic activity across the area and focus attention or direct resources accordingly.

3.2 The economy of Argyll & Bute is highly seasonal and many of the success measures are “annual” targets. It is therefore to be expected that performance in Q3 may be less than 75% of the annual target, particularly for those measures dependant upon private sector input.

3.3 Trading conditions in many sectors have been challenging and unemployment figures are now reflecting this. Similar patterns are consistent across the Highlands and Islands. The effect of public sector cutbacks may not be fully reflected in the figures.

4. CONCLUSION

4.1 Overall performance to end December 2012 is considered to be satisfactory. Performance against CPP / SOA Economy Success measures for the third quarter of 2012/13 appears satisfactory.

For further information contact: Douglas Cowan, Area Manager, Highlands & Islands Enterprise
Telephone 01546 605402

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argyll and bute community planning partnership

CPP Economy Theme

CPP01 A&B has more new businesses ... creating more jobs

A ⇒

Growth in the number of business start ups supported	Actual	92
	Target	107
	Benchmark	96
Growth in the number of existing businesses supported	Actual	204
	Target	200
	Benchmark	
Work Programme - No of job outcomes	Actual	575
	Target	575
	Benchmark	
Work Programme total referrals	Actual	2,753
	Target	2,753
	Benchmark	
CPP 01.05 Account managed businesses supported	Actual	
	Target	30
	Benchmark	
CPP 01.06 Social enterprises supported	Actual	
	Target	11
	Benchmark	
CPP 01.07 Jobs created within fragile areas	Actual	
	Target	15
	Benchmark	11

CPP02 We have a skilled ... workforce ... attracting employment to A&B

CC11 No of adults achieving accredited learning outcomes through CBAL	Actual	
	Target	26
	Benchmark	25
CPP 02.02 Third sector staff upskilled	Actual	168
	Target	140
	Benchmark	75
CPP 02.03 Delivery of CBT based courses	Actual	67
	Target	30
	Benchmark	22
CPP 02.04 Volunteers/course participants finding employment	Actual	
	Target	7
	Benchmark	6
CPP 02.05 Deliver 8 accredited courses	Actual	
	Target	2
	Benchmark	9
CPP 02.06 Deliver 28 unaccredited courses	Actual	
	Target	16
	Benchmark	19
CPP 02.07a Number of people in employment	Actual	
	Target	
	Benchmark	40,300
CPP 02.07b - Self employment rate	Actual	
	Target	
	Benchmark	13.0 %
CPP 02.08a Number of unemployed	Actual	1,826
	Target	1,996
	Benchmark	1,834
CPP 02.08b Long term unemployed	Actual	720
	Target	785
	Benchmark	710
CPP 02.09 No of employability customers securing employment >6 mths	Actual	575
	Target	575
	Benchmark	

CPP03 We contribute to an environment where ... businesses can succeed

% of ALL Planning Applications processed within statutory timescales	Actual	75.1 %
	Target	68.0 %
	Benchmark	
Grants to LEADER projects in rural areas of Argyll & Islands	Actual	
	Target	£ 7,884,379
	Benchmark	
No of CHORD full business cases approved	Actual	8
	Target	8
	Benchmark	

CPP04 Transport infrastructure ... develops to meet social/economic needs

% Cat 1 road defects repaired by the end of next working day	Actual	
	Target	90 %
	Benchmark	
% overall street cleanliness	Actual	79 %
	Target	74 %
	Benchmark	73 %
Average response time for planned pre-salting	Actual	1.55 Hours
	Target	2.50 Hours
	Benchmark	2.52 Hours
Planned road repairs as % of revenue budget	Actual	
	Target	70 %
	Benchmark	72.82 %
Street lighting - % faults repaired within 7 days	Actual	94 %
	Target	88 %
	Benchmark	92 %
CPP 02.10 Increase in Youth Employment	Actual	Completed
	Target	Completed
	Benchmark	Completed
CPP 02.11 Open new engineering centre	Actual	
	Target	Complete
	Benchmark	

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ECONOMY THEME

Element	Latest Target	FQ1 12/13	FQ2 12/13	FQ3 12/13	FQ4 12/13	Owner
CPP 02.07a Number of people in employment	FY 10/11					Douglas Cowan
CPP 02.07b - Self employment rate	FY 12/13					Douglas Cowan
CC11 No of adults achieving accredited learning outcomes through CBAL	FQ2 12/13 26	96	9			Nasreen Kharegat
CPP 01.05 Account managed businesses supported	FQ2 12/13 20	10	14			Douglas Cowan
Growth in the number of business start ups supported	FQ3 12/13 107	53	83	92		Ishabel Bremner
Planned road repairs as % of revenue budget	FQ2 12/13 70 %	80.22	94.8			Graham Brown
% Cat 1 road defects repaired by the end of next working day	FQ2 12/13 90 %	90.47619048	96.66666667			Graham Brown
CPP 02.09 No of employability customers securing employment >6 mths	FQ3 12/13 575	265	390	575		Ishabel Bremner
% of ALL Planning Applications processed within statutory timescales	FQ3 12/13 68.0 %	56.22895623	67.20257235	75.0798722		Ross McLaughlin
Average response time for planned pre-salting	Nov 12 2.50 Hours			1.55		Callum Robertson
No of CHORD full business cases approved	FQ3 12/13 8	8	8	8		Helen Ford
Work Programme total referrals	Dec 12 2,753	2027	2252	2753		Ishabel Bremner
Grants to LEADER projects in rural areas of Argyll & Islands	FQ2 12/13 £ 7,710,152	7817342	8343372			Ishabel Bremner
Growth in the number of existing	FQ3 12/13 200	45	85	204		Ishabel Bremner

businesses supported						
Work Programme - No of job outcomes	Dec 12 575	265	390	575		Ishabel Bremner
CPP 02.08a Number of unemployed	Nov 12 1,900	1657	1652	1826		Douglas Cowan
CPP 02.08b Long term unemployed	Nov 12 725	870	770	720		Douglas Cowan
Street lighting - % faults repaired within 7 days	Dec 12 88 %	95.32951945	95.63880502	93.50604261		Ryan McGlynn
% overall street cleanliness	FQ3 12/13 74 %	75	75	79		Tom Murphy
CPP 01.06 Social enterprises supported	FQ2 12/13 7	6	17			Douglas Cowan
CPP 01.07 Jobs created within fragile areas	FQ2 12/13 10	0	14			Douglas Cowan
CPP 02.02 Third sector staff upskilled	FQ3 12/13 140	67	94	168		Glenn Heritage
CPP 02.03 Delivery of CBT based courses	FQ3 12/13 30	28	44	67		Glenn Heritage
CPP 02.04 Volunteers/course participants finding employment	FQ2 12/13 3	9	18			Glenn Heritage
CPP 02.05 Deliver 8 accredited courses	FQ2 12/13 1	8	8			Glenn Heritage
CPP 02.06 Deliver 28 unaccredited courses	FQ2 12/13 9	11	22			Glenn Heritage
CPP 02.11 Open new engineering centre	FQ2 12/13 On track	On track	On track			Argyll College
CPP 02.10 Increase in Youth Employment	FQ3 12/13	Delayed and rescheduled	Delayed and rescheduled	Completed		Douglas Cowan

Argyll and Bute Community Planning Partnership

Management Committee
Date: 7th February 2013

Title: Social Affairs Performance Update –FQ3 2012 / 2013

1. SUMMARY

1.1 This report highlights performance across the Social Affairs Community Planning Partnership for FQ3 – 1st October to 31st December 2012.

2. RECOMMENDATIONS

2.1 The Management Committee note good and improving performance across community planning partners and acknowledge the reasons given for off track performance.

3. BACKGROUND

3.1 The Social Affairs Thematic Group worked together to produce a suite of performance measures for the new Community Plan / Single Outcome Agreement over the first few months of last year.

3.2 Agreed measures were then incorporated into a performance scorecard which is monitored within the Council's Performance Management system, Pyramid.

4. MAIN REPORT

4.1 Key Successes for the period include;

- 100% of care leavers with a pathway plan
- 100% of children on the Child Protection Register (CPR) with a current risk assessment
- Zero child protection repeat registrations
- 258 visits to council pools per 1,000 population
- Zero clients awaiting free personal care within their homes longer than 4 weeks.
- Curriculum for excellence (basket of measures) exceeding target of 95% and on an upwards trend
- 473 adults participating in activities that improve literacy and numeracy

- 100% homeless priority need determinations
- Increase in the number of people accessing housing advice and information

4.2 Key areas for improvement identified;

- Balance of care – failure to meet target this quarter, however this measure is showing an improving trend and although off target, this is only by 1%
- 19% of new unpaid work orders failed to commence within 7 days (due to supervisor ill health, no available cover due to geography)
- Failure to obtain permanent housing for priority needs households within 37 weeks (however figure did improve by 7 weeks from last quarter)
- Drop in the number of pupils accessing youth services (due to problems recruiting and retaining staff, particularly in Kintyre and Islay).

5. CONCLUSION

5.1 Performance over the period shows a good mixture of 'on track' and improving outcomes. Where performance is 'off track', responsible managers have been contacted and actions to remedy this are being put in place.

Cleland Sneddon
Executive Director
22 January 2013

For further information contact:
Helen Thornton
Executive Support Officer
Community Services
Telephone: 01546 604127

CPP performance report for **Environment Theme**	period **October - December 2012**

Key Successes

- Measurable outcomes are generally proceeding positively.
-
-
-

Key Challenges

1. To select more meaningful and challenging targets
2. To ensure our environmental targets reflect Argyll and Bute's "sense of place"
3.
4.
5.

Action Points to address the Challenges

1. To review what has been selected in this plan and ensure the new plan in preparation reflects what we have learned about targets and relevant outcomes
2.
3.
4.

Changes to the Corporate Plan, Service Plans or Scorecards

Plan	Changes required	Lead	Date of change

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Argyll and Bute Community Planning Partnership

Management Committee
6 February 2013

argyll and bute
communityplanningpartnership

Third Sector and Communities CPP Sub-group

1. SUMMARY

1.1 The Third Sector and Communities CPP Sub-group continues to develop its Plan as part of the SOA/Community Plan.

2. RECOMMENDATION

2.1 To note the contents of the report and the progress of the Third Sector and Communities CPP sub-group.

3. DETAIL

3.1 The Third Sector and Communities CPP Sub-group met on 15 November 2012, attended by representatives from Third Sector Partnership, Strathclyde Police, Argyll College, and Argyll and Bute Council.

3.2 It was agreed to discuss links between Youth Services and Community Planning at the next meeting, in order to ensure that young people are able to participate in the community planning process.

3.3 The sub-group established to consider Events and Training is leading in the organisation of a conference on Saturday 2 March "Planning and Delivering Successful Events". A programme has been drawn up, and speakers and workshop facilitators identified to provide a range of useful sessions to help groups further develop their organisational and funding skills, as well as to measure the economic and social impact of events to the local community. In addition 3 -4 local groups from Argyll and Bute will showcase some positive experiences in delivering events locally. Further information and registration is through the Council's Community Development team.

3.4 A presentation on the recently approved Asset Transfer Process was given by the Social Enterprise Team.

3.5 Partner updates were considered, including reports submitted by partners who were unable to attend.

3.5 The Third Sector and Communities Plan was discussed and a number of measures were highlighted for further discussion and potential amendment. See Appendix 1 (Scorecard FQ3) and Appendix 2 (Quarterly performance report)

4. CONCLUSION

4.1 The Third Sector and Communities Sub-group continues to develop its plan, and also to organise a coordinated programme of training and events to support our communities.

5. IMPLICATIONS

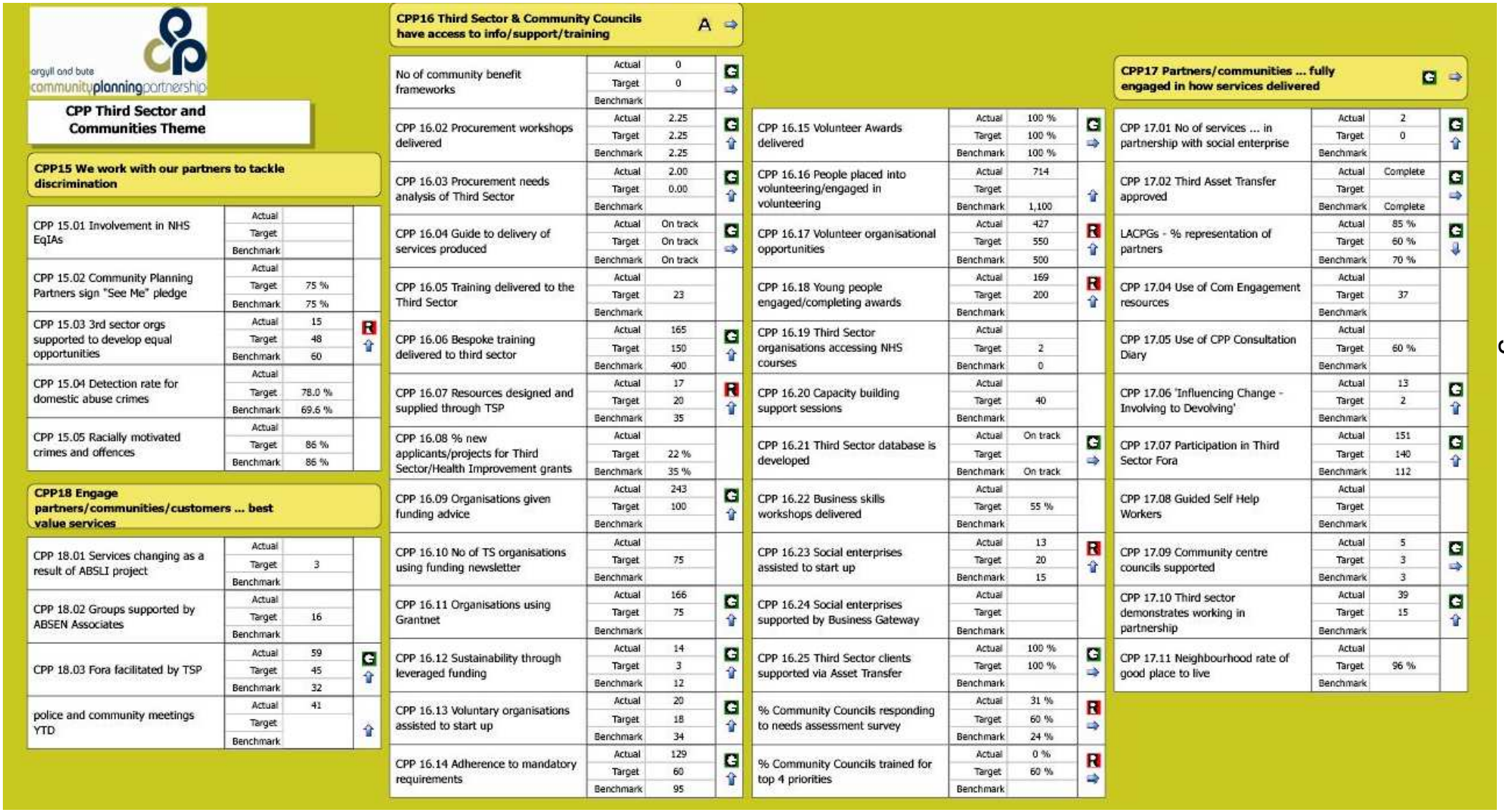
Policy: In line with Community Plan/SOA developments
Finance: None
Personnel: None
Legal: None
Equal Opportunities: None

Margaret Fyfe
Community Development Manager
25 January 2013

For further information please contact:
Margaret Fyfe
Community Development Manager

Tel: 01369 708668
E-mail: Margaret.fyfe@argyll-bute.gov.uk

Appendix 1



argyll and bute community planning partnership

CPP Third Sector and Communities Theme

CPP15 We work with our partners to tackle discrimination

CPP 15.01 Involvement in NHS EqIAs	Actual		
	Target		
	Benchmark		
CPP 15.02 Community Planning Partners sign "See Me" pledge	Actual		
	Target	75 %	
	Benchmark	75 %	
CPP 15.03 3rd sector orgs supported to develop equal opportunities	Actual	15	R ⇧
	Target	48	
	Benchmark	60	
CPP 15.04 Detection rate for domestic abuse crimes	Actual		
	Target	78.0 %	
	Benchmark	69.6 %	
CPP 15.05 Racially motivated crimes and offences	Actual		
	Target	86 %	
	Benchmark	86 %	

CPP18 Engage partners/communities/customers ... best value services

CPP 18.01 Services changing as a result of ABSLI project	Actual		
	Target	3	
	Benchmark		
CPP 18.02 Groups supported by ABSEN Associates	Actual		
	Target	16	
	Benchmark		
CPP 18.03 Fora facilitated by TSP	Actual	59	G ⇧
	Target	45	
	Benchmark	32	
police and community meetings YTD	Actual	41	⇧
	Target		
	Benchmark		

CPP16 Third Sector & Community Councils have access to info/support/training A ⇨

No of community benefit frameworks	Actual	0	G ⇨
	Target	0	
	Benchmark		
CPP 16.02 Procurement workshops delivered	Actual	2.25	G ⇧
	Target	2.25	
	Benchmark	2.25	
CPP 16.03 Procurement needs analysis of Third Sector	Actual	2.00	G ⇧
	Target	0.00	
	Benchmark		
CPP 16.04 Guide to delivery of services produced	Actual	On track	G ⇨
	Target	On track	
	Benchmark	On track	
CPP 16.05 Training delivered to the Third Sector	Actual		
	Target	23	
	Benchmark		
CPP 16.06 Bespoke training delivered to third sector	Actual	165	G ⇧
	Target	150	
	Benchmark	400	
CPP 16.07 Resources designed and supplied through TSP	Actual	17	R ⇧
	Target	20	
	Benchmark	35	
CPP 16.08 % new applicants/projects for Third Sector/Health Improvement grants	Actual		
	Target	22 %	
	Benchmark	35 %	
CPP 16.09 Organisations given funding advice	Actual	243	G ⇧
	Target	100	
	Benchmark		
CPP 16.10 No of TS organisations using funding newsletter	Actual		
	Target	75	
	Benchmark		
CPP 16.11 Organisations using Grantnet	Actual	166	G ⇧
	Target	75	
	Benchmark		
CPP 16.12 Sustainability through leveraged funding	Actual	14	G ⇧
	Target	3	
	Benchmark	12	
CPP 16.13 Voluntary organisations assisted to start up	Actual	20	G ⇧
	Target	18	
	Benchmark	34	
CPP 16.14 Adherence to mandatory requirements	Actual	129	G ⇧
	Target	60	
	Benchmark	95	

CPP 16.15 Volunteer Awards delivered	Actual	100 %	G ⇨
	Target	100 %	
	Benchmark	100 %	
CPP 16.16 People placed into volunteering/engaged in volunteering	Actual	714	⇧
	Target		
	Benchmark	1,100	
CPP 16.17 Volunteer organisational opportunities	Actual	427	R ⇧
	Target	550	
	Benchmark	500	
CPP 16.18 Young people engaged/completing awards	Actual	169	R ⇧
	Target	200	
	Benchmark		
CPP 16.19 Third Sector organisations accessing NHS courses	Actual		
	Target	2	
	Benchmark	0	
CPP 16.20 Capacity building support sessions	Actual		
	Target	40	
	Benchmark		
CPP 16.21 Third Sector database is developed	Actual	On track	G ⇨
	Target		
	Benchmark	On track	
CPP 16.22 Business skills workshops delivered	Actual		
	Target	55 %	
	Benchmark		
CPP 16.23 Social enterprises assisted to start up	Actual	13	R ⇧
	Target	20	
	Benchmark	15	
CPP 16.24 Social enterprises supported by Business Gateway	Actual		
	Target		
	Benchmark		
CPP 16.25 Third Sector clients supported via Asset Transfer	Actual	100 %	G ⇨
	Target	100 %	
	Benchmark		
% Community Councils responding to needs assessment survey	Actual	31 %	R ⇨
	Target	60 %	
	Benchmark	24 %	
% Community Councils trained for top 4 priorities	Actual	0 %	R ⇨
	Target	60 %	
	Benchmark		

CPP17 Partners/communities ... fully engaged in how services delivered G ⇨

CPP 17.01 No of services ... in partnership with social enterprise	Actual	2	G ⇧
	Target	0	
	Benchmark		
CPP 17.02 Third Asset Transfer approved	Actual	Complete	G ⇨
	Target		
	Benchmark	Complete	
LACPGs - % representation of partners	Actual	85 %	G ⇩
	Target	60 %	
	Benchmark	70 %	
CPP 17.04 Use of Com Engagement resources	Actual		
	Target	37	
	Benchmark		
CPP 17.05 Use of CPP Consultation Diary	Actual		
	Target	60 %	
	Benchmark		
CPP 17.06 'Influencing Change - Involving to Devolving'	Actual	13	G ⇧
	Target	2	
	Benchmark		
CPP 17.07 Participation in Third Sector Fora	Actual	151	G ⇧
	Target	140	
	Benchmark	112	
CPP 17.08 Guided Self Help Workers	Actual		
	Target		
	Benchmark		
CPP 17.09 Community centre councils supported	Actual	5	G ⇨
	Target	3	
	Benchmark	3	
CPP 17.10 Third sector demonstrates working in partnership	Actual	39	G ⇧
	Target	15	
	Benchmark		
CPP 17.11 Neighbourhood rate of good place to live	Actual		
	Target	96 %	
	Benchmark		

Appendix 2

Departmental performance report for **Third Sector and Communities CPP Group**	period **October - December 2012**

Key Successes

- Three measures (16.01, 16.15 and 17.02) have been completed, and many others have exceeded their targets
- Although there are 7 red indicators in FQ3, 5 of these measures have made improvements in performance, based on the trends highlighted in Pyramid.

Key Challenges

1. A number of targets appear to be over-ambitious, and these require to be reviewed by partners.
2. Some targets are measured by two or more partners, and consistency in what is reported needs further discussion between these partners.
3. Two measures reported on by two different partners (16.06 and 16.20) appear to be similar in terms of what is recorded.
4.

Action Points to address the Challenges

1. Review TSC Plan at next TSC meeting.
2. Partners to share detail of records as appropriate
3.
4.

Changes to the Corporate Plan, Service Plans or Scorecards

Plan	Changes required	Lead	Date of change
Third Sector and Communities Plan	Changes to measures 16.01, 16.10, 16.20, and 18.02 to be considered at next meeting.		

ARGYLL AND BUTE COUNCIL CPP MANAGEMENT COMMITTEE

CHIEF EXECUTIVE'S / IMPROVEMENT AND HR 6TH FEBRUARY 2013

SINGLE OUTCOME AGREEMENT ANNUAL REPORT 2011/12

1. SUMMARY

1.1. This report outlines the submission by Community Planning Partnerships (CPP) of Single Outcome Agreement (SOA) annual reports covering 2011/12.

2. RECOMMENDATIONS

It is recommended that the CPP Management Committee:

2.1. Approve the report for submission to the Scottish Government

3. DETAIL

3.1. The approach to SOA reporting this year continues to be loosely based on the same scope as in previous years.

3.2. Previously there has been guidance published by Scottish Government on the key areas to focus on for the annual reports. This year no guidance was issued, but a request for a copy of the annual report was received from Scottish Government in December.

3.3. The 2011/12 report brings to a close the Argyll and Bute Single Outcome Agreement 2009 – 2012, and highlights the progress made towards the national outcomes made by Argyll and Bute CPP. The report contains performance information on 13 of the 15 national outcomes that were included in the SOA. During the period of the SOA, some actions measured have been completed, some removed from partner operating plans and some are measured on a 2 yearly basis. Those that would present repeat information to last year's SOA are not included.

3.4. The SOA was developed against the original 15 national outcomes set by the Scottish Government. A further national outcome was developed in 2011 which was not incorporated into the Argyll and Bute SOA 2009 – 2012 although has been incorporated in the current SOA 2012/13.

3.5. Performance is set out against the success measures which underpin each of the national outcomes. Data and commentary has been provided by community planning partners.

4. CONCLUSION

4.1. The SOA annual report highlights performance by partners against the 13 of the 15 national outcomes which were used in the SOA, where new information is available since last year's SOA Annual Report. Outcomes 11 and 13 have no new information to be reported either due to actions being complete or the cycle for new information being outside the annual report timescales.

5. IMPLICATIONS

HR None

FINANCIAL None

EQUALITY None

LEGAL None

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argyll and bute community planning partnership

The Scottish Government

Argyll and Bute 2009 - 2012 Single Outcome Agreement

Annual Report 2011/12

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Introduction

The Single Outcome Agreement (SOA) is a three year agreement between the partners that make up the Argyll and Bute Community Planning Partnership and the Scottish Government.

Argyll and Bute's SOA has been agreed by all members of the Community Planning Partnership (CPP). This includes elected members, public and private sector organisations and community and voluntary organisations.

The SOA binds partners in a joint agreement to deliver services collectively in the best interests of and in partnership with the communities and individuals in Argyll and Bute.

The Annual SOA report to the Scottish Government sets out how Argyll and Bute CPP has contributed towards the fulfilment of the Government Purpose and the National Outcomes.

This report presents performance information on progress towards the 15 National Outcomes and this is illustrated by a green/red status. The overall performance for each outcome is arrived at by a simple roll-up of success measures. Tolerances set are as follows:

All green = overall green
Majority green = overall amber
Majority red = overall red

- 7 outcomes are green where overall performance has improved from the 2010/11 level
- 6 outcomes are amber where overall performance remains on track against the targets set
- 2 outcomes (National Outcomes 11 and 13) for which Argyll and Bute CPP has no updated success measures for 2011/12

- Of the 41 measures that are in the SOA:
- 34 or 83% are green and have improved from the previous year or are exceeding the targets that have been set.
- 1 or 2.4% are amber which relates to a basket of indicators which is made of success measures which are green and red
- 6 or 14.6% have seen performance fall or have not met the targets that have been set

The report covers factual content on the progress against the national outcomes and details the success measures that have been identified for each outcome. The report also contains narrative information relating to support the performance information for the success measures identified. The report is based on the performance on the available data for the financial year 2011/12.

Summary Table of Progress on Outcomes 2011/12

	National Outcomes	Status
1.	We live in a Scotland that is the most attractive place for doing business in Europe.	Amber
2.	We realise our full economic potential with more and better employment opportunities for our people.	Green
3.	We are better educated, more skilled and more successful, renowned for our research and innovation.	Green
4.	Our young people are successful learners, confident individuals, effective contributors and responsible citizens.	Amber
5.	Our children have the best start in life and are ready to succeed.	Green
6.	We live longer, healthier lives.	Amber
7.	We have tackled the significant inequalities in Scottish society.	Amber
8.	We have improved the life chances for children, young people and families at risk.	Amber
9.	We live our lives safe from crime, disorder and danger.	Green
10.	We live in well-designed, sustainable places where we are able to access the amenities and services we need.	Amber
11.	We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.	
12.	We value and enjoy our built and natural environment and protect it and enhance it for future generations.	Green
13.	We take pride in a strong, fair and inclusive national identity.	
14.	We reduce the local and global environmental impact of our consumption and production.	Green
15.	Our public services are high quality, continually improving, efficient and responsive to local people's needs.	Green

National Outcome 1 – We live in a Scotland that is the most attractive place for doing business in Europe.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
HIE1b	Highlands and Islands Enterprise	Total account managed businesses	Total number of account managed businesses in 2011/12 was 63 against a target of 60.	Green
LPI09	Visit Scotland	Annual visitor numbers to Tourist Information Centres	The annual visitor numbers to Tourist Information Centres decreased to 1,041,957 in 2011/12 from 1,329,728 in 2010/11. The target for 2011/12 was 1,464,564.	Red

National Outcome 2 – We realise our full economic potential with more and better employment opportunities for our people.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
LPI06	Argyll and Bute Council	Percentage of planning applications dealt with in 2 months	At the end of 2011/12 69% of planning applications were dealt with in 2 months which exceeded the set target and is amongst the best performance recorded by Argyll and Bute Council in recent years.	Green
ABC01b	Argyll and Bute Council	Clear objectives for renewables development	The annual review of the REAP has been progressed by lead partners Argyll and Bute Council and HIE. Notable progress included: • The skills sub group have initiated a skills demand mapping exercise, working closely with the industry. • Partners agreed recommendations outlined for a review of the Argyll and Bute Council Policy on Community Benefit from windfarms. A&BC will progress the necessary work required to finalise the proposed update. Partners agreed to ensure alignment of ongoing discussions and work relative to offshore wind. • Tiree Onshore Scenario Mapping:	Green
		Developers signed up to the renewable concordat	A new concordat is being drafted with Scottish Power Renewables with regard to the Bein An Tuirc 2 wind farm and it is hoped that this will be launched towards the end of the year	Green

HIE2	Highlands and Islands Enterprise	Number of account managed social enterprises	20 account managed social enterprises were supported through growth plans in 2011/12 against a target of 16.	Green
LPI05	Scottish Government	Increased levels of net in-migration	There appears to be a continuing trend of outward migration from Argyll and Bute as the population estimates has risen to 89,590 in 2011 compared with 89,200 in 2010.	Green
ABC09a	Argyll and Bute Council	Business start ups supported	In 2011/11 the Business Gateway service achieved 154 business start-ups against a target of 135.	Green
		% supported businesses still operating after 2 years	In 2011/12, actual performance highlighted that 91% of businesses supported were still operating after 2 years against a target of 80%.	Green

National Outcome 3 – We are better educated, more skilled and more successful, renowned for our research and innovation.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
NP07	Scottish Government	School leavers in positive destinations	90.1% of school leavers in Argyll and Bute were in positive destinations in 2011/12 indicating an increase from 89% in 2010/11.	Green

National Outcome 4 – Our young people are successful learners, confident individuals, effective contributors and responsible citizens.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
ABC04a	Argyll and Bute Council	Curriculum for Excellence implemented	**Overall performance for Curriculum for Excellence**	Green
			100% of pupils experienced different teachers in 2011/12 achieving the local authority target as per the requirement of Curriculum for Excellence.	Green
			85% of schools devoting at least 25% of curricular time on interdisciplinary learning by the end of Level 4 against a target of 75%.	Green
			95% of schools meeting their target to reduce the number of teachers in contact with S1-S3 pupils against a target of 85%.	Green
			53% of schools where all teachers are providing appropriate personal support to pupils against a target of 30%.	Green
			80% of schools had a statement of opportunities for personal achievement against a set target of 80%.	Green
			100% of schools providing vocationally orientated curricular experiences against a target of 100%.	Green
			97% of schools with a pupil council against a target of 95%.	Green
ABC04d	Argyll and Bute Council	Attainment levels in national qualifications	**Overall performance in national qualifications**	Amber

			16% of S6 students attaining 1 or more subjects at level 7 or better against the authority target of 15% and the national average of 15%	Green
			36% of S6 students attaining 3 or more subjects at level 6 or better against the authority target of 34% and the national average of 35%.	Green
			13% of S5 students attaining 5 or more subjects at level 6 or better against the authority target of 10% and the national average of 12%.	Green
			22% of S6 students attaining 5 or more subjects at level 6 or better against the authority target of 22% and the national average of 23%.	Green
			93% of S6 students attaining English and Maths at level 3 or better against the authority target of 96% and the national average of 94%.	Red
			27% of S5 students attaining 3 or more subjects at Level 6 against the authority target of 25% and the national average of 26%.	Green
			79% of S4 students attaining 5 or more subjects at Level 4 or better against the authority target of 84% and the national average of 78 %. The current data analysis does not allow for the inclusion of Skills for Work results or other alternative qualifications delivered by external providers.	Red
			37% of S4 students attaining 5 or more subjects at level 5 or better against authority target of 39% and the national average of 35%. The current data analysis does not allow for the inclusion of Skills for Work results or other alternative qualifications delivered by external providers.	Red

National Outcome 5 – Our children have the best start in life and are ready to succeed.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
ABC04b	Argyll and Bute Council	Number of children accessing the Early Years service	The take up of pre-school provision achieved the target of 100%.	Green
ABC04h	Argyll and Bute Council	Uptake of school meals	The uptake of free school meals on survey day increased to 85% in 2011/12 compared with 79% achieved in 2010/11.	Green
NHS-H3	Argyll & Bute CHP	Child healthy weight intervention programme	Argyll and Bute CHP achieved 28 completions for the child healthy weight intervention programme in 2011/12 against a revised HEAT target of 13.	Green

National Outcome 6 – We live longer, healthier lives.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
ABC05c	Argyll and Bute Council	Waiting list for home care adults	No client was awaiting Free Personal Care within their home as part of a Community Care package in Argyll and Bute in 2011/12. This was an improvement on the 1 person who was waiting in 2011/12.	Green
ABC05d	Argyll and Bute Council	Waiting list for residential care adults	No client was awaiting a Care Home Placement in 2011/12 which was an improvement in the 6 people waiting in 2011/12.	Green
ABC05b	Argyll and Bute Council	Decrease the % of older people receiving services cared for in care home	The percentage of people in institutional care in March 2012 was 33% showing improved performance against 34% in March 2011 but still greater than the target of no more than 30%.	Red
NHS-STANDARD	Argyll & Bute CHP	Diagnostic tests: 6 weeks	Argyll and Bute CHP achieved their target of having no patients waiting over 4 weeks at the end of 2011/12.	Green
NHS-H7	Argyll & Bute CHP	Proportion of new born children breastfed	At the end of 2011/12, 28.6% of children in Argyll and Bute were breastfed. This was below the target set of 36%.	Red
NHS-T9	Argyll & Bute CHP	Improve management of dementia patients	Figures in 2011/12 shows a favourable level of performance in the early diagnosis and management of dementia patients. In 2011/12, 759 per 100,000 people had been diagnosed early achieving the target set.	Green

National Outcome 7 – We have tackled the significant inequalities in Scottish society.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
ABC05a	Argyll and Bute Council	Community based support for children affected by disability	At the end of 2011/12, 77% of children with a disability received community based support against a local authority target of 80%.	Red
	Argyll and Bute Council	Proportion of looked after and accommodated children in a residential setting	In 2011/12, 17% of Looked After Accommodated Children were in a residential placement against a target of no more than 27%.	Green
ABC05b	Argyll and Bute Council	Resource centre placement for learning disability clients. (Resource Centre only)	3% of Learning Disability service users attend resource centres against a target of no more than 10% for 2011/12.	Green
ABC06a	Argyll and Bute Council	Completions on shared equity and social rented houses	A total of 80 completions were achieved in 2011/12 against a target of 60.	Green
		Proportion of homeless households assessed in priority need	Performance for 2011/12 was recorded at 92% which exceeded the target set of 90%.	Green
		Repeat homelessness within 12 months of case being completed	The overall repeat percentage for 2011/12 is 4.5% which is within the national average of 5%.	Green

National Outcome 8 – We have improved the life chances for children, young people and families at risk.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
ABC04c	Argyll and Bute Council	Attainment of looked after children: Number and percentage attaining at least one SCQF level 3 (any subject)	After a level of performance of 70% in 2010/11 academic attainment decreased to 55.2% in 2011/12. However, this fluctuation relates to a relatively small cohort of pupils.	Red
		Attainment of looked after children: Number and percentage attaining at least one SCQF level 3 in English AND Maths	After a level of performance of 36.8% in 2009/10, academic attainment of looked after children attaining at least one SCQF level 3 in English and Maths increased to 50% in 2010/11 against a target of 40%.	Green

National Outcome 9 – We live our lives safe from crime, disorder and danger.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
LTS01	Strathclyde Police provides data to Argyll and Bute Council	Road accidents: fatal and serious injuries	The number of fatal and serious injuries on Argyll and Bute roads in 2011 was 63 which was a reduction from 81 in 2010.	Green
LTS02	Strathclyde Police provides data to Argyll and Bute Council	Road accidents: slight injury casualties	The number of slight injury casualties in 2011 was 252 which was a reduction from 316 in 2010.	Green
LTS03	Strathclyde Police provides data to Argyll and Bute Council	Road accidents: child killed or seriously injured	There was 1 child killed or seriously injured in 2011 against the target figure of 1. There has been continued improvement made over the past 5 years.	Green
SP1a	Strathclyde Police	Violent crime: Crimes of Violence (Group 1)	The number of crimes of violence has decreased to 12/10,000 population which is below the 4 year rolling average of 13/10,000 population.	Green
SP2a	Strathclyde Police	Substance misuse: Detections of anti-social offences (Consumption of alcohol in public and Urinating in Public)	The number of anti social offences was 85/10,000 population in 2011/12 which is significantly higher than the performance for 2010/11, the 2011/12 target and the baseline figure. This shows continued improvement against the baseline figure of 33 in 2007/08	Green

SP2b	Strathclyde Police	Substance misuse: Number of persons detected for drug supply crimes	There has been a sharp increase in the number of persons detected for drug supply. In 2011/12, Strathclyde Police detected 98 persons compared with 62 in 2010/11. This shows continued improvement against the baseline figure of 50 in 2007/08.	Green

National Outcome 10 – We live in well-designed, sustainable places where we are able to access the amenities and services we need.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
LPI01	Argyll and Bute Council receives data as per Scottish Roads Maintenance Condition Survey (SRMCS)	Network road condition indicator (excludes trunk roads)	In 2011/12 58.9% of the road network in Argyll and Bute was in either the red or amber band for condition, according to Road Condition Index (RCI) against a target of 56%. In 2011 the Council's Roads & Amenity service developed the Roads Asset Management and Maintenance Strategy which set out a 3 year roads recovery programme and a 10 year proposed strategy for roads. The Council committed to a 3 year £21M capital roads reconstruction programme for 2012-15 in its Budget of February 2011	Red
ABC08	Argyll and Bute Council	Waterfront and town centre regeneration - progress on the key projects that comprise the CHORD programme	100% of Full Business Cases were approved achieving the target was set for 2011/12.	Green

National Outcome 11 – We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.
Key success measures
There are no key success measures relating to this national outcome for 2011/12..

National Outcome 12 – We value and enjoy our built and natural environment and protect it and enhance it for future generations.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
SEARS2a	SEARS	Trial reintroduction of beavers to Knapdale	In 2011/12, 96 events and activities were held with a focus on the Beaver Trail in Knapdale. In addition, 3350 people engaged with the project. There was press coverage and the trial and the surrounding area appeared on 4 national TV shows. 3 out of the 4 families of beavers have successfully bred and all are established in the wild. The project was also used a platform to launch the Heart of Argyll Tourism Alliance.	Green

National Outcome 13 – We take pride in a strong, fair and inclusive national identity.
Key success measures
There are no key success measures relating to this national outcome for 2011/12..

National Outcome 14 – We reduce the local and global environmental impact of our consumption and production.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
ABC02a	Argyll and Bute Council	Increased recycling rate for household waste	In 11/12 year combined recycling ,composting and recovered was 40.5% against the target of 40% .	Green
		Reduced Biodegradable Municipal Waste going to landfill	In 2011/12, 21382 tonnes of Biodegradable Municipal Waste was sent to landfill against a target of no more than 21500 tonnes.	Green

National Outcome 15 – Our public services are high quality, continually improving, efficient and responsive to local people's needs.				
Key success measures				
Ref	**Lead Organisation**	**Success measures**	**Commentary**	**Status**
NHS-H6	Argyll & Bute CHP	Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit)	As a result of the smoking cessation services available, there has been an increase in the Community Health Partnership's smoking population successfully quitting. The cumulative figure for 2011/12 was 538 compared with a target of 420.	Green

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Argyll and Bute Community Planning Partnership

Management Committee
6th February 2013

This Place Matters

1. SUMMARY

1.1 The University of Glasgow School of Social and Political Sciences has been carrying out research to explore the importance of local leadership in achieving the sustainable development of localities within Scotland.

1.2 There is an opportunity for the Argyll and Bute Community Planning Partnership to take part in a half day facilitated workshop in March or April, offered by the University, to explore the role of local leadership in shaping places.

2. RECOMMENDATIONS

2.1 The Management Committee agrees to participate in the 'This Place Matters' workshop

2.2 Partners each nominate a participant

3. BACKGROUND

3.1 The Council Leader met with Professor David Adams in December 2012 and discussed the research and development work that the University has been carrying out.

3.2 The focus of the workshop, highlighting the need to examine critically the issues facing the public sector with reduced resource, but increasing demand for services; the focus on a prevention agenda and the context of public sector reform is highly relevant to the Council and to the partnership. The focus on place is one of the key pillars of reform as highlighted by the Christie Commission.

3.4 Professor Adams has offered the Council and partners a complimentary workshop on the basis of the programme that has been developed. Details of this are attached to this paper.

3.5 This presents a positive opportunity for the partnership to benefit from current research and to explore the role of leadership in service delivery at this time of change and ongoing challenge.

4. CONCLUSION

4.1 Participation in this event will provide an opportunity for partners to consider their role in community leadership in relation to place.

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Urbanism Dept. Architecture and Design Scotland

Urban Studies, School of Social and Political Sciences, University of Glasgow

THIS PLACE MATTERS

Re-thinking local leadership

A half-day workshop for leaders of places

University of Glasgow

Architecture+DesignScotland
Ailtearachd is Dealbhadh na h-Alba

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Architecture+Design Scotland
Ailtearachd is Dealbhadh na h-Alba

The proposition

A chasm is opening between demand for public services and the resources to provide them. A dilemma unprecedented in 60 years is unfolding and our current modes of provision are unsustainable. How we resolve this will shape our society.

Scotland already has a sharply divided population which public services, in their present form, have not been able to correct. The negative outcomes of that failure drive current public spending. With the gap between demand and resources growing, our communities and the places they inhabit will be hit hard and a retreat from meeting that demand will seed social distress. New ways will have to be found.

The Christie Commission set out principles that must guide us: a concentration on prevention and outcomes, a focus on place, and the integration of services - all imbued with the idea of 'co-production'. Prevention presses down on service demand. Co-production augments civic resources. Both raise new questions of scale and governance.

A focus on place and its well-being unlocks all those other ideas. New guidance for single outcome agreements requires 'a clear understanding of place'. 'Place' enables necessary attention to outcomes that really matter. It guides investment towards building healthy and supportive communities. It is the key to open the door to thinking collaboratively about prevention and prosperity. It is the lynchpin of local leadership in the years ahead. That's why This Place Matters.

This workshop, provided by the University of Glasgow and Architecture and Design Scotland, explores the centrality of place in addressing these urgent challenges. It spotlights the importance of place distinctiveness and local decision-making. It looks at how the goals and methods of local leadership can, and should, be re-cast.

> If we are not simply to retreat, ignoring demand and cutting services, with all the social risks that entails, the time for re-thinking and new action is now.

The approach

2017 is the critical year when current modes of public service provision begin to fail as resources drain away and demand increases. That's what the government says. If we are not simply to retreat, ignoring demand and cutting services, with all the social risks that entails, the time for re-thinking and new action is now.

The only measure of success is outcomes - not service outputs nor 'deliverables', but outcomes that mark and signal changes of real relevance to family and community life. New paths of prevention must be mapped. The starting point is to recognise that public services alone can't 'deliver' health or well-being or thriving places to live. The journey requires mobilising civic assets, in the widest sense, and working across the divides of institutions and services, markets and communities. Building that new 'relationship ecology' can happen only at the scale and within the governance of the places people inhabit.
Civic assets are in part physical and more of their control will soon vest in the communities in which they sit. As important are the people for whom public services exist. Those individuals and their communities, living in the places they live in, are themselves assets and agents of change, essential co-producers in the design and management of services. Talking to teachers about teaching, children about childhood, and neighbours about their neighbourhoods is more likely to provoke workable solutions supported by the people they are designed to help.

Making this happen means thinking differently about the conversations we have with citizens about public services. It means thinking differently about resources - about making assets, managing assets and cultivating social capital. It means aligning those resources for a common purpose. It means thinking differently about governance, building it on relationships and collaboration.

That is possible only if we work at a scale which is relevant and comprehensible and if we share common understandings, often though stories, of the place we live. Stories convey authenticity. Authenticity and a relevant scale together breed support for change and for collaboration in the pursuit of change.

Collaboration - a new community planning duty for public agencies in one place - stretches beyond those public agencies to all those who participate in the shaping and making of successful places. Collaboration has two indispensable building blocks among others: conversations with citizens and local data. It needs stories from the ground, and rich local data from the ground, user generated and systematically collected. It requires new relationships. And they require authentic leadership

Conversing with citizens and gathering data both require a scale that people can understand and to which they relate, a scale that matters. Change and well-being at the level of place provides the most useful frame for collaboration and the leadership which drives it.

So place stands at the centre. Past failure in concisely creating successful and resilient places helped produce the negative outcomes now driving public spending. If we invest in and strengthen place - and all the human connections, attachments and assets that make it work - then we provide the basis for collaboration and co-production. In turn they are the means to provide the outcomes on which our common future depends. Strong, resilient, connected places promote local prosperity and that prosperity itself provides the foundation for social improvement and reduces pressure on public services.

This all puts larger and different burdens on local leadership. Those leaders need to know that places, successful or unsuccessful, don't just drop from the sky. They are made by our human action, either through thought and deliberate deeds - or through accident. Those that are thoughtfully and deliberately made are likely to carry and embody the values and aspirations of the leaders who helped make them and the professionals who enabled them.

They are also likely to be successful places. And successful places serve better the people that inhabit them.

“ If we invest in and strengthen place - and all the human connections, attachments and assets that make it work - then we provide the basis for collaboration and co-production.

Workshop Outline

The workshop is a starting point. Its intentions are to assist participants:

- acquire understandings, attitudes and mental tools for place leadership
- develop the relationships and common commitments towards collaboration and effective place leadership in this locality
- build a common understanding of the particular issues for this locality
- acquire access to resources for further development in individual and collective place leadership.

The workshop is fast-paced and participative. Over about 3 hours, plus a break, there will be short presentations together with participative workshop sessions in varying forms. Deliberately, it aims to cover substantial ground in a short time by linking the tacit knowledge of experienced participants to the broader concepts of place leadership.

After the workshop, participants will have access to a local information pack and password access to a website of presentations and a report of the event.

The workshop leaders will be:

- Professor David Adams, Ian Mactaggart Chair of Property and Urban Studies in the University of Glasgow
- Professor Trevor Davies, honorary professor of Urban Studies in the University of Glasgow and from 2003-07 Convener of the Planning Committee of the City of Edinburgh Council.
- Diarmaid Lawlor, Head of Urbanism Architecture and Design Scotland

Running order

1st workshop
Place, us, them

1st presentation
Uncertainty to hope - the skills of 'public narrative'.

2nd workshop
The story of your future - part 1

2nd presentation
Founding on Values

3rd presentation
What makes a successful place?

4th presentation
Stories from elsewhere

3rd workshop
The story of your future - part 2

4th workshop
Getting there - assets and actors

5th workshop
Getting there - barriers and blocks

6th workshop
Getting there - building leadership

5th presentation
The tools to lead

Reflections
Participants and presenters

Next Steps

Participation will be small, up to 20, and must of necessity reflect the collaboration of place. Included should be:

- political leaders and professional leaders from local government,
- leaders from other public agencies active in this place,
- leaders from the private sector and
- leaders from the third and community sector.

The follow-up

The University of Glasgow and A+DS are also able to offer follow-up consultancy services, where necessary recruiting others with specialist knowledge or skill. These services, supplied in various possible ways, can help promote informed change and may include:

- Diagnostics programme - understanding your place
- Values, vision and outcomes - devising the outcomes your place really needs
- Development scenarios - alternative physical futures for your place
- State-market analysis - shaping better relationships between commerce and the public interest
- The real economy - sustaining resilient local prosperity in austere times
- Public narrative - a crucial leadership tool for your place
- Relationship mapping - making better use of all assets in your place
- Mentoring - for political and place-making leaders in your place

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Argyll and Bute Community Planning Partnership

Third Sector and Communities
Date: 15th November 2012

Title: AUDIT SCOTLAND – HEALTH INEQUALITIES IN SCOTLAND

1. SUMMARY

1.1 This report is to inform the CPP of the recently published Audit Scotland report on health inequalities in Scotland.

2. RECOMMENDATIONS

2.1 That the Management Committee notes the content of the report and the recommendations for Community Planning Partnerships.
2.2 That the Management Committee considers the proposed response.

3. BACKGROUND

3.1 The audit report aims to assess how well public sector organisations are working together to tackle health inequalities. It focusses on how well organisations are working together to identify need, target resources and monitor performance.

3.2 The report outlines the scale and effects of health inequalities, how much is spent by the public sector on reducing health inequalities and the quality of the evaluations used. The report also looks at whether access to health services is equitable across all groups within the population.

4. KEY MESSAGES

4.1 The key messages from the report are that:-

- CPPs need to clarify the roles and responsibilities of local organisations in tackling health inequalities.
- Interventions such as the smoking ban have been shown to be effective however other national policies and strategies aiming to improve health and reduce inequalities have so far shown limited evidence of impact.
- CPPs need to take a more systematic approach to assessing the cost effectiveness of actions to reduce health inequalities.
- CPPs' SOA reports are weak in the quality and range of evidence used to track progress in reducing health inequalities.

5. CONCLUSION

5.1 The report contains a number of recommendations for Scottish Government, NHS Boards, Councils, CHPs and CPPs. The key recommendations for CPPs are that they should:-

- ensure that all partners are clear about their respective roles, responsibilities and resources in tackling health inequalities, and take shared ownership and responsibility for actions aimed at reducing health inequalities
- build robust evaluation, using all available data and including outcome measures and associated costs, into local initiatives aimed at reducing health inequalities
- include in SOAs clear outcome measures for reducing health inequalities which demonstrate impact, and improve the transparency of their performance reporting

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Health inequalities in Scotland

AUDIT SCOTLAND

Prepared for the Auditor General for Scotland and the Accounts Commission
December 2012

Auditor General for Scotland

The Auditor General for Scotland is the Parliament's watchdog for helping to ensure propriety and value for money in the spending of public funds.

She is responsible for investigating whether public spending bodies achieve the best possible value for money and adhere to the highest standards of financial management.

She is independent and not subject to the control of any member of the Scottish Government or the Parliament.

The Auditor General is responsible for securing the audit of the Scottish Government and most other public sector bodies except local authorities and fire and police boards.

The following bodies fall within the remit of the Auditor General:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Enterprise.

The Accounts Commission

The Accounts Commission is a statutory, independent body which, through the audit process, requests local authorities in Scotland to achieve the highest standards of financial stewardship and the economic, efficient and effective use of their resources. The Commission has four main responsibilities:

- securing the external audit, including the audit of Best Value and Community Planning
- following up issues of concern identified through the audit, to ensure satisfactory resolutions
- carrying out national performance studies to improve economy, efficiency and effectiveness in local government
- issuing an annual direction to local authorities which sets out the range of performance information they are required to publish.

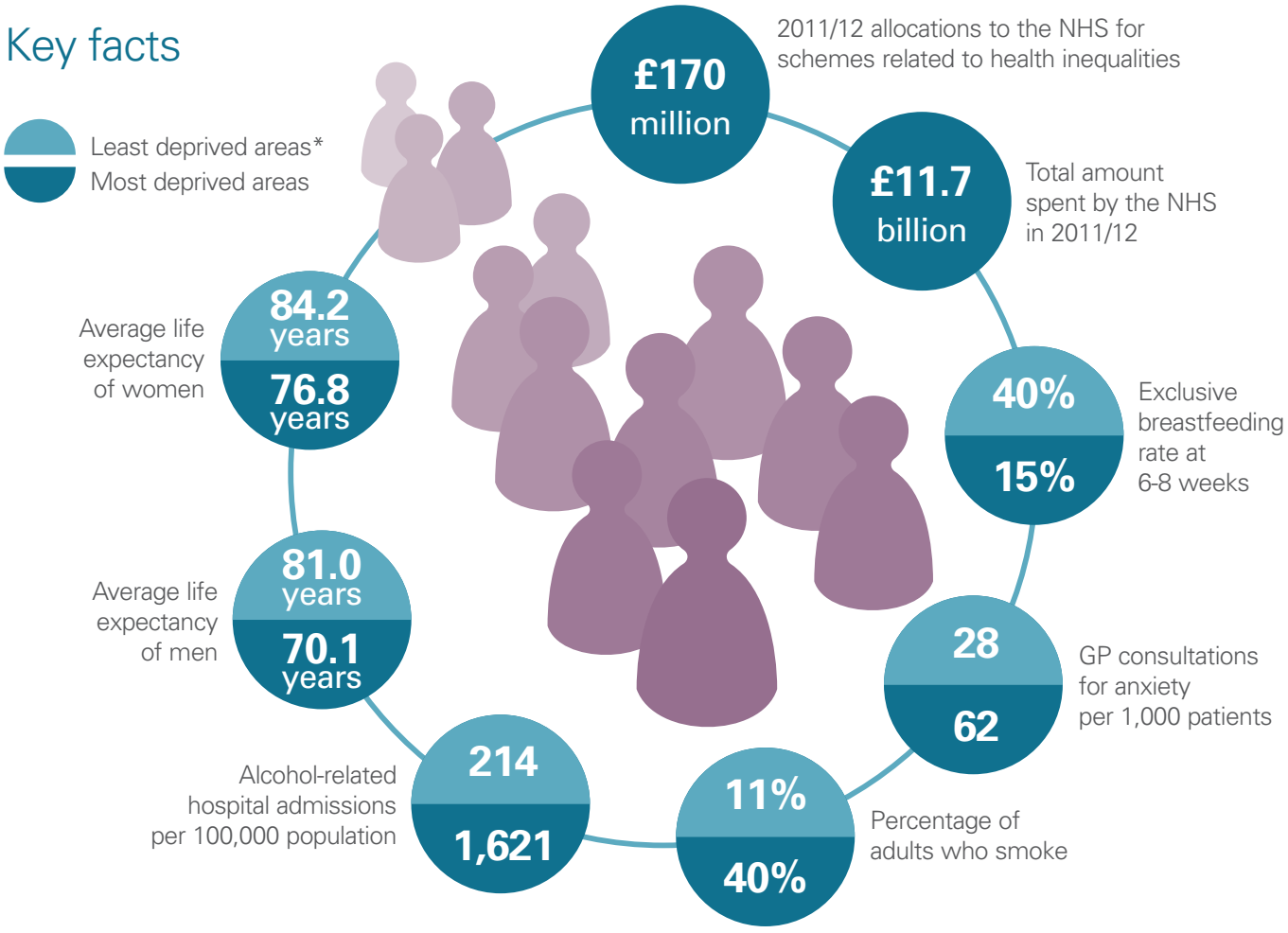
The Commission secures the audit of 32 councils and 45 joint boards and committees (including police and fire and rescue services).

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. It provides services to the Auditor General for Scotland and the Accounts Commission. Together they ensure that the Scottish Government and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.

Contents

Summary

Key facts



* These comparisons refer to people living in the one-fifth most deprived and one-fifth least deprived areas.

There are significant and long-standing health inequalities in Scotland. The public sector can make better use of its resources to address these challenges.

Background

1. Tackling health inequalities is challenging. Health inequalities are influenced by a wide range of factors including access to education, employment and good housing; equitable access to healthcare; individuals' circumstances and behaviours, such as their diet and how much they drink, smoke or exercise; and income levels.[1]

2. Given the complex and long-term nature of health inequalities, no single organisation can address health inequalities on its own. Community Planning Partnerships (CPPs) are responsible for bringing all the relevant organisations together locally and for taking the lead in tackling health inequalities.[2] Many public sector bodies and professionals contribute to reducing health inequalities; it is not just the responsibility of health services. Councils have a major role through their social care, education, housing, leisure and regeneration services. The voluntary sector also has a role in reducing local health inequalities.

3. There have been long-term increases in average life expectancy in Scotland and considerable improvements in overall health. However, there are still significant differences in life expectancy and health depending on deprivation, age, gender, where people live, and ethnic group. More data is available about the links between deprivation and health inequalities so we are able to provide more comment on deprivation in this report.

4. Reducing health inequalities will help increase life expectancy and improve the health of people in disadvantaged groups. It could also bring considerable economic benefits. For example, if the death rate in the most deprived groups in Scotland improved then the estimated average economic gains would be around £10 billion (at 2002 prices); and if the death rate across the whole population fell to the level in the least deprived areas, the estimated economic benefit for Scotland could exceed £20 billion.[3] These are conservative estimates as they relate only to differences in life expectancy and do not include other health inequalities.

5. Tackling the problems most commonly associated with health inequalities would also help to reduce the direct costs to the NHS and wider societal costs. For example, the Scottish Public Health Observatory has estimated that a one per cent reduction in smoking prevalence would save around 540 lives a year; reduce smoking-attributable hospital admissions by around 2,300; and reduce estimated NHS spending on smoking-related illness by between £13 million and £21 million.[4]

6. In 2007, the Scottish Government established a Ministerial Task Force for Health Inequalities to identify and prioritise practical actions to reduce the most significant and widening health inequalities. The Task Force published its report, *Equally Well*, in June 2008. This considered the evidence for health inequalities in Scotland and identified a range of priorities where action is most needed to tackle health inequalities, including: children's early years; tackling poverty and increasing employment; physical environments and transport; and access to health and social care services. The report also included recommendations for the Scottish Government, NHS boards, councils and other public sector bodies. The Task Force published a review of *Equally Well* in 2010 which examined progress since the publication of *Equally Well* and made more recommendations for addressing health inequalities. The Task Force reconvened in November 2012.

7. Reducing health inequalities has been a priority for successive governments in Scotland with the introduction of major legislation supporting this aim, such as the ban on smoking in public places and minimum pricing for alcohol. The Scottish Government's 2012/13 spending review reiterated its commitment to addressing health inequalities, and in 2011/12 it allocated around £170 million to NHS boards to directly address health-related issues associated with inequalities.[5]

8. Shifting resources from dealing with the consequences of health inequalities to effective early intervention and access to preventative services is essential to tackling health inequalities.[6] The Scottish Government's policies prioritise preventing social problems rather than reacting to them but our previous work has highlighted that shifting resources will be challenging for the public sector, particularly in the current financial climate.[7 8 9]

1 *The Spirit Level*, R Wilkinson and K Pickett, Bloomsbury Press, 2009.
2 All council areas have a CPP to lead and manage community planning. CPPs are required to engage with communities, report on progress, and publish information on how they have implemented their duties and how outcomes have improved as a result. CPPs are not statutory committees of a council, or public bodies in their own right. They do not directly employ staff or deliver public services.
3 These estimates are based on a pro-rata comparison with estimates produced for the Marmot Review of health inequalities in England ('The economic benefits of reducing health inequalities in England and Wales', S Mazzucco, S Meggiolaro and M Suhrcke, background paper for the Marmot Review, January 2010).
4 *ScotPHO Smoking Ready Reckoner – 2011 Edition*, Scottish Public Health Observatory, June 2012.
5 *Scottish Spending Review 2011* and *Draft Budget 2012-13*, Scottish Government, September 2011.
6 *Equally Well*, Scottish Government, 2008; *Equally Well Review 2010*, Scottish Government, 2010; *Fair Society, Healthy Lives*, Marmot Review, 2010.
7 *Report on preventative spending*, Scottish Parliament Finance Committee, 2011.
8 *Report of the Commission on the future delivery of public services*, 2011.
9 *Review of Community Health Partnerships*, Audit Scotland, 2011; *Commissioning social care*, Audit Scotland, 2012.

About the audit

9. Our audit aimed to assess how well public sector organisations are working together to tackle health inequalities. Given the scale and complexity of the problem, we have not examined in detail the impact of wider policies such as education, employment and housing on reducing health inequalities. Instead we have focused on how bodies work together to identify need, target resources and monitor their collective performance in reducing health inequalities. In this report, we:

- outline the scale of health inequalities and the effects on specific groups of people
- estimate how much the public sector spends on reducing health inequalities, although information on this was limited
- look at the quality of evaluations
- review how well CPPs ensure that there is a coordinated focus on health inequalities
- look at whether access to health services is equitable for all groups within the population, particularly people living in deprived areas.

10. Evidence for this audit is based on an analysis of national and local strategies and evaluations; finance and performance data; interviews with Scottish Government officials, NHS and council staff, academics and other relevant professionals; a review of CPP annual reports; and focus groups with a range of staff. We also visited five *Equally Well* test sites to review their progress to date. Further details of our methodology are set out in Appendix 1. Appendix 2 lists members of our Project Advisory Group, who gave advice and feedback at key stages of the audit, and Appendix 3 presents a summary of progress against national strategies for improving health and addressing health inequalities.

11. This report is structured into four parts:

- Health inequalities in Scotland (Part 1)
- Spending on reducing health inequalities (Part 2)
- Local health services for reducing health inequalities (Part 3)
- Effectiveness of approaches to reducing health inequalities (Part 4).

12. In addition to this report, we have also published a range of accompanying documents on our website:

- a detailed analysis of the extent of health inequalities across a range of indicators
- a report on our focus groups with CPP managers, Community Health Partnership (CHP) managers and frontline staff
- a checklist for CPPs to help improve their approach to addressing health inequalities
- a checklist for non-executive and elected members to assess how well health inequalities are being addressed in their local areas.[10] [11]

Key messages

- Overall health has improved over the last 50 years but health inequalities remain a significant and long-standing problem in Scotland. Deprivation is a major factor in health inequalities, with people in more affluent areas living longer and having significantly better health. Health inequalities are highly localised and vary widely within individual NHS board and council areas. Children in deprived areas have significantly worse health than those in more affluent areas.
- The Scottish Government takes account of deprivation, rurality and remoteness, and other local needs in allocating funding to NHS boards and councils. However, it is not clear how NHS boards and councils allocate resources to target local areas with the greatest needs.
- The distribution of primary care services across Scotland does not fully reflect the higher levels of ill health and wider needs found in deprived areas, or the need for more preventative healthcare. Patterns of access to hospital services also vary among different groups within the population, with people from more deprived areas tending to have poorer access and outcomes.
- Reducing health inequalities requires effective partnership working across a range of organisations. However, there may be a lack of shared understanding among local organisations about what is meant by 'health inequalities'

10 CHPs are responsible for coordinating a wide range of primary and community health services in the local areas, including GP services, general dental services, community-related health services and mental health services. We use the term CHP in this report to refer to both health-only structures and Community Health and Care Partnerships (CHCPs) which are integrated health and social care structures. The Scottish Government plans to integrate adult health and social care services, and to replace CHPs with Health and Social Care Partnerships.

11 www.audit-scotland.gov.uk

and greater clarity is needed about organisations' roles and responsibilities.

- National policies and strategies which aim to improve health and reduce health inequalities have so far shown limited evidence of impact. Changes will only be apparent in the long term but measures of short-term impact are important to demonstrate progress towards policy goals. Many initiatives to reduce health inequalities have lacked a clear focus from the outset on cost effectiveness and outcome measures. This means that assessing value for money is difficult.

- Current performance measures do not provide a clear picture of progress. CPPs' reports on delivering their Single Outcome Agreements (SOAs) are weak in the quality and range of evidence used to track progress in reducing health inequalities, and differences among SOAs means that a Scotland-wide picture is hard to identify.

Key recommendations

The Scottish Government should:

- introduce national indicators to specifically monitor progress in reducing health inequalities and report on progress.

The Scottish Government and NHS boards should:

- review the distribution of primary care services to ensure that needs associated with higher levels of deprivation are adequately resourced

- include measurable outcomes in the GP contract to monitor progress towards tackling health inequalities, and ensure that the Quality and Outcomes Framework is specifically designed to help reduce health inequalities.

The Scottish Government and CPPs should:

- ensure that cost effectiveness is built into evaluations of initiatives for reducing health inequalities from the start

- align and rationalise the various performance measures to provide a clear indication of progress in reducing health inequalities.

CPPs should:

- ensure that all partners are clear about their respective roles, responsibilities and resources in tackling health inequalities, and take shared ownership and responsibility for actions aimed at reducing health inequalities

- build robust evaluation, using all available data and including outcome measures and associated costs, into local initiatives aimed at reducing health inequalities

- include in SOAs clear outcome measures for reducing health inequalities which demonstrate impact, and improve the transparency of their performance reporting.

NHS boards should:

- monitor the use of primary care, preventative and early detection services by different groups, particularly those from more deprived areas. If this identifies systemic under-representation of particular groups, NHS boards should take a targeted approach to improve uptake

- monitor the use of hospital services by different groups and use this information to identify whether specific action is needed to help particular groups access services.

NHS boards and councils should:

- identify what they collectively spend on reducing health inequalities locally, and work together to ensure that resources are targeted at those with the greatest need.

Part 1. Health inequalities in Scotland

The health of people in Scotland continues to improve but significant inequalities remain.

Key messages

- Overall health has improved over the last 50 years but deep-seated inequalities remain. Deprivation is the key determinant of health inequalities although age, gender and ethnicity are also factors. Health inequalities are highly localised and vary widely within individual NHS board and council areas.
- Children in the most deprived areas have significantly worse health compared to children living in the least deprived areas. They are more likely to have a lower birthweight, poorer dental health, higher obesity levels and higher rates of teenage pregnancy. They are also less likely to be breastfed, which is associated with a healthy start in life.
- There is a mixed picture of progress in tackling health inequalities. For some indicators, such as deaths from coronary heart disease, inequalities have decreased but other indicators, such as healthy life expectancy, mental health, smoking, and alcohol and drug misuse, remain significantly worse in the most deprived parts of Scotland.

13. Health inequalities are linked to a range of factors that are complex and interrelated. For example, genetic factors and poor housing can have a major effect on an individual's health over time, and these are likely to be exacerbated by harmful behaviours such as smoking, alcohol misuse and a lack of exercise. Public services in Scotland can address some of these factors, for example by improving social housing or access to sports facilities. Broader UK and global factors, such as the current economic downturn, also play a part.

14. Health and life expectancy generally worsen as deprivation levels increase. For example, the incidence of low birthweight and lung diseases are both higher in deprived areas, with the latter linked to higher rates of smoking in more disadvantaged groups. But other conditions such as high blood pressure and high cholesterol are not so directly associated with deprivation although they are risk factors for major illnesses that are strongly linked to deprivation, such as cardiovascular disease.[12] Binge drinking is more common among men living in the most deprived areas, but levels of weekly alcohol consumption vary across the whole population and are not linked to deprivation. There are also gender differences in terms of inequalities; for example, women living in more deprived areas are more likely to be obese, but this pattern is less evident among men.

People in deprived areas have lower life expectancy

15. Overall life expectancy has increased in Scotland in recent years but continues to be closely associated with deprivation (Exhibit 1). Between 1999-2000 and 2009-10, the average

Exhibit 1

Average life expectancy at birth, 1999-2000 to 2009-10

Average life expectancy has increased but people in the least deprived areas still live longer than people living in the most deprived areas, and the gap has increased for women.

Source: Scottish Public Health Observatory, 2012

12 *Inequalities in health in Scotland: what are they and what can we do about them?,* S Macintyre, MRC Social and Public Health Sciences Unit, 2007.

life expectancy of men living in the least deprived areas remained around 11 years higher than in the most deprived areas but the corresponding difference for women increased from around 6.5 years to around 7.5 years. Life expectancy can vary widely within individual NHS board and council areas. For example, between 2006 and 2010, the average life expectancy among males in the most deprived areas of Renfrewshire was around 66 years which was nine years less than in the rest of Renfrewshire.[13]

16. Women tend to live longer than men but have more years living in poorer health. In 2009-10, average healthy life expectancy for women was around 2.5 years higher than for men, although this difference has fallen in recent years.[14] Between 1999-2000 and 2007-08, healthy life expectancy increased by around three years for men (from 65.1 to 68.0) and over two years for women (from 68.2 to 70.5).[15] The average healthy life expectancy of people living in the least deprived areas in 2009-10 was around 18 years higher than people living in the most deprived areas.[16]

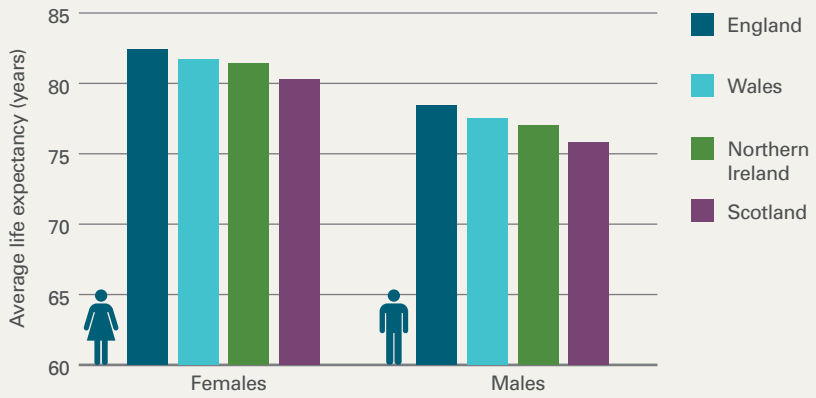
17. People living in rural areas live on average two to three years longer than people in urban areas and can expect to live in good health for an average of six years longer. This may be partly due to rural areas generally having lower levels of deprivation than urban areas.[17]

18. Although average life expectancy and healthy life expectancy in Scotland have increased, average life expectancy is lower than in other parts of the UK (Exhibit 2). Average healthy life expectancy is lower than the UK averages for both men and women.[18] Both life expectancy and healthy life expectancy are lower in Scotland than in many Western European countries.

Exhibit 2

Life expectancy at birth in the UK, 2008–10

Average life expectancy in Scotland is lower than in the other UK countries.



Source: Office for National Statistics, 2012

Deprivation is most concentrated in the west of Scotland

19. All NHS boards and councils in Scotland have areas of deprivation but the west of Scotland, especially Glasgow and its surrounding areas, has high levels of deprivation and consequently accounts for a significant proportion of health inequalities in Scotland.[19] Deprivation and life expectancy vary widely between CHPs in different parts of Scotland, and between CHPs within NHS board areas (Exhibit 3).[20]

Health inequalities vary widely within local areas

20. There are wide variations in both deprivation and health inequalities in smaller geographical areas within individual NHS board or council areas. To assess variation within one council area, we compared deprivation and an indicator of health inequalities (rate of hospital admission for drug misuse) across the 21 electoral wards within the Glasgow City Council area (Exhibit 4, page 10). To further examine the variation within an individual electoral ward, we also compared deprivation and health inequalities within one ward – Glasgow Shettleston (Exhibit 5, page 10). Our analysis shows that both deprivation and health inequalities can vary widely among small local areas.

Children in deprived areas have poorer health

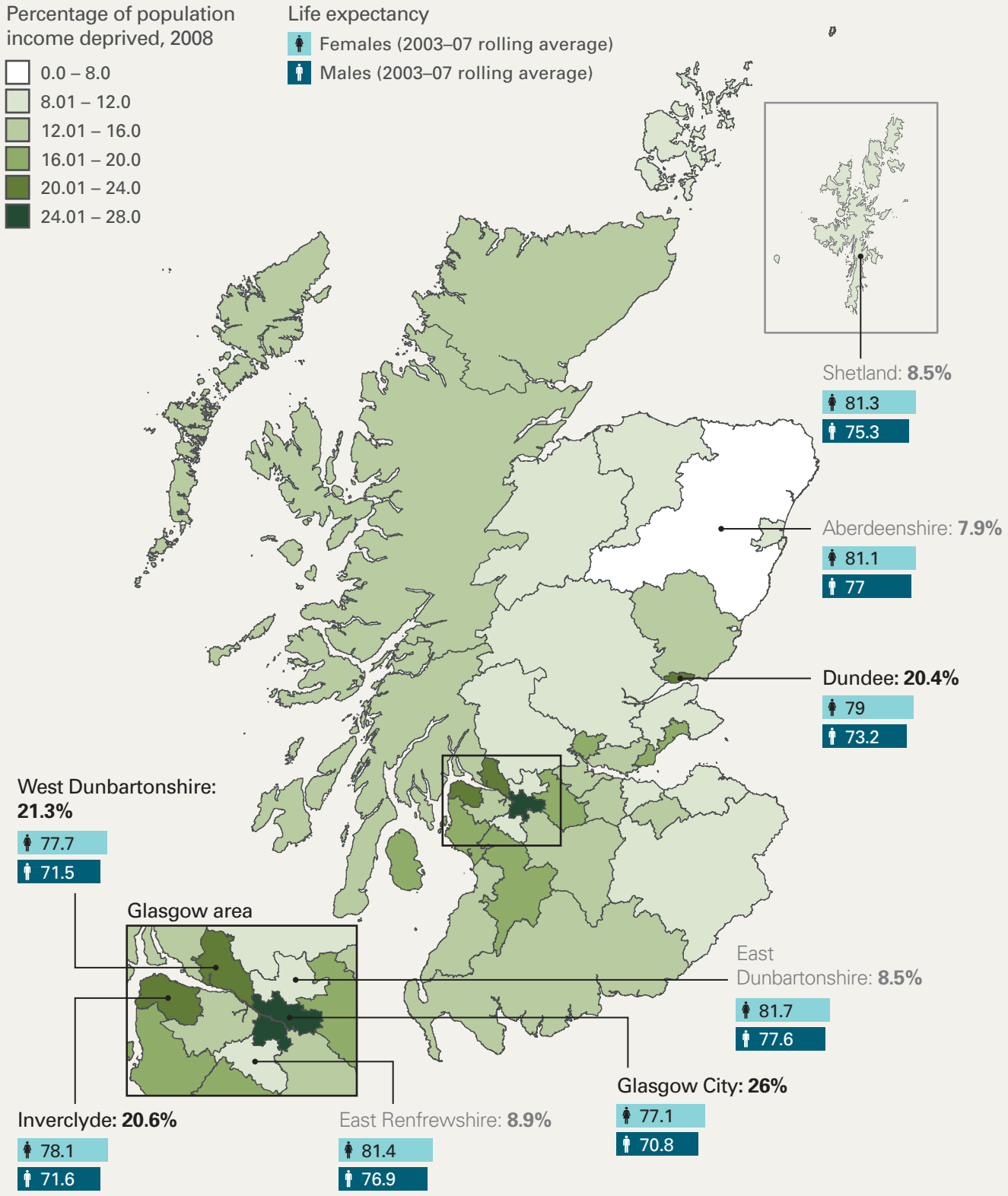
21. Children's early years are a major determinant of their future health.[21] Children living in the most deprived areas of Scotland experience significantly worse health outcomes than children living in the least deprived areas (Exhibit 6, page 11).

13 *Life Expectancy in Scottish Council Areas split by Deprivation, 2005-2010*, National Records of Scotland, October 2011.
14 Healthy life expectancy is the number of years people can expect to live in good health.
15 Healthy life expectancy data from 2009/10 is not comparable with earlier years owing to a major change in methodology.
16 This comparison refers to people living in the one-fifth most deprived and one-fifth least deprived areas.
17 Scottish Public Health Observatory, 2011.
18 *Health Expectancies at birth and at age 65 in the United Kingdom, 2008-2010*, Office for National Statistics, August 2012.
19 Deprivation tends to be concentrated in small local areas and it can be difficult to see the pattern of local deprivation by looking at just the NHS board or council level. In this report, we have used CHP areas where possible to provide a more detailed analysis of the effect of deprivation.
20 We have presented data for CHPs as we present data in Part 2 of this report to compare local deprivation level and indicative funding allocations by CHP.
21 *Early Years Framework*, Scottish Government, 2008. The Scottish Government defined early years as pre-birth to eight years old.

Exhibit 3

Deprivation and life expectancy in CHPs

The west of Scotland experiences higher levels of deprivation and lower life expectancy compared to most other parts of Scotland.



Note: We have presented comparisons for the four most deprived and four least deprived CHPs in Scotland. © Crown copyright and database rights 2012, Ordnance Survey licence number 0100050061.
Source: Audit Scotland, 2012

There is a mixed picture of progress in tackling health inequalities

22. Scotland faces major challenges in tackling a range of deep-rooted health problems, and the inequalities associated with them. We reviewed a range of health indicators to look in detail at the extent of health inequalities related to them and progress made in reducing them (Exhibit 7, page 12). These indicators are all linked to deprivation and some are linked to other factors such as gender and ethnicity. Health inequalities have decreased for some indicators, but they have either remained the same or worsened for others.

23. Since 2008, the Scottish Government has published an annual report setting out progress against a range of long-term indicators of health inequalities.[22] The most recent report, published in 2012, shows that the gap in health inequalities has not narrowed for these indicators apart from indicators for low birthweight and alcohol-related deaths. These measures give an indication of progress but the Scottish Government has not set out timescales or numerical targets to measure progress against these long-term indicators.

Exhibit 4

Variation in deprivation and rate of hospital admissions for drug misuse by electoral ward in Glasgow, 2005

There are higher rates of drug-related hospital admissions among people from more deprived wards.

Source: Audit Scotland analysis of Scottish Neighbourhood Statistics

Exhibit 5

Variation in deprivation and rate of hospital admissions for drug misuse within the Glasgow Shettleston electoral ward, 2005

There are higher rates of drug-related hospital admissions among people from more deprived small areas.

Source: Audit Scotland analysis of Scottish Neighbourhood Statistics

22 *Long-Term Monitoring of Health Inequalities*, Scottish Government, October 2012.

Exhibit 6

Summary of health inequalities among children

Children living in the most deprived areas experience significantly worse health outcomes.

Low birthweight

The percentage of low birthweight babies is over twice as high in the most deprived areas. In 2010, 31 per cent of babies who were born with very low birthweight were born to mothers living in the most deprived areas, compared with 13 per cent of babies born to mothers living in the least deprived areas.

13%
31%

Breastfeeding

Rates are almost three times lower in the most deprived areas. In 2011/12, 15 per cent of mothers in the most deprived areas exclusively breastfed their child at 6-8 weeks compared to 40 per cent of mothers in the least deprived areas.

40%
15%

Dental health

There have been recent overall improvements but children in the most deprived areas did not meet national tooth decay targets of 60 per cent of children with no dental decay. Fifty-four per cent of children in the most deprived areas had no dental decay in 2011, compared to 81 per cent in the least deprived areas.

81%
54%

Obesity/overweight

There is increasing prevalence of obesity among children in the most deprived areas. In 2010/11, 25 per cent of children in the most deprived areas were classified as overweight compared to 18 per cent in the least deprived areas.

18%
25%

Teenage pregnancy

Rates among under-16s are five times higher in the most deprived areas. In 2010, the rate was 14 per 1,000 population in the most deprived areas compared to three per 1,000 population in the least deprived areas.

per 1,000 population

3
14

Note: A more detailed analysis of these indicators is available on Audit Scotland's website: www.audit-scotland.gov.uk
Source: Audit Scotland analysis of published statistics, 2012

Exhibit 7

Summary of significant health challenges and health inequalities in Scotland[1]

Progress in tackling health inequalities is mixed.

Coronary Heart Disease (CHD)	
Overall patterns	• Between 2001 and 2010, the overall rate of death from CHD fell by around 40 per cent, from 202 per 100,000 to 129 in 2010. However, the rate in Scotland remains around a third higher than in England and higher than in most other Western European countries.
Extent of inequalities[2]	• CHD death rates are highest in West Central Scotland and are higher among males than females, with a rate of 90 per 100,000 for women in 2010 compared to 168 for men. Death rates in the most deprived areas are over 1.5 times higher than in the least deprived areas. • South Asians living in Scotland have substantially higher rates of heart attacks than the general population, but they also have higher survival rates.
Change in inequalities	• There is some evidence that health inequalities are narrowing. Between 2001 and 2010, the death rate decreased by a third in the most deprived areas but by less than a fifth in the least deprived areas.
Alcohol misuse	
Overall patterns	• Rates of alcohol-related hospital admissions have decreased in recent years. There was an 11 per cent fall between 2006/07 and 2010/11. • However, there has been a long-term (30-year) increase in alcohol-related problems with alcoholic liver disease increasing fivefold, alcohol-related hospital admissions quadrupling and alcohol-related deaths trebling. • There are higher levels of consumption and more significant health problems in Scotland compared to England and Wales. Alcohol sales are around 20 per cent higher in Scotland than in England while alcohol-related deaths are around twice as high.
Extent of inequalities[2]	• Problems are twice as high among men than among women. One in ten of all hospital discharges for men was estimated to be attributable to alcohol compared to one in 20 for women. In 2011, there were 432 female alcohol-related deaths compared to 815 male deaths - almost twice as many. • Alcohol-related deaths and hospital discharges are around six to seven times higher in the most deprived areas than in the least deprived areas. In 2010/11, the rate of alcohol-related discharges was 214 per 100,000 in the least deprived areas compared to 1,621 per 100,000 in the most deprived areas.
Change in inequalities	• Health inequalities related to alcohol misuse are relatively stable.
Smoking	
Overall patterns	• Just under a quarter of adults currently smoke. This has fallen from over 30 per cent in 1999. Prevalence in Scotland is generally higher than in England and Wales. • The number of pregnant women who smoke has fallen over the past 15 years from 29 per cent in 1995 to 19 per cent in 2010.
Extent of inequalities[2]	• Prevalence is around four times higher in the most deprived areas than in the least deprived areas. Around one in ten people in the least deprived areas smokes, compared with four in ten people in the most deprived areas. • The percentage of women who reported smoking while pregnant is five times higher in the most deprived areas than in the least deprived areas.
Change in inequalities	• Levels of smoking across the whole population are relatively stable with no significant changes between the most and least deprived areas. • Over the past ten years, the largest reduction in the percentage of women who reported smoking while pregnant was in the most deprived areas.

Drug misuse	
Overall patterns	• The estimated number of problem drug users in Scotland increased from around 55,000 in 2006 to almost 60,000 in 2009/10.[3] • The number of drug-related deaths in Scotland has been increasing and reached an all-time high in 2011.
Extent of inequalities[2]	• Problems are higher among men than women. In 2011, men accounted for almost three-quarters of drug-related deaths with 429 deaths compared to 155 for women. • Drug taking, drug-related harms and drug deaths are higher in the most deprived areas. In 2010/11, the rate of drug-related hospital discharges was over 16 times higher among people in the most deprived areas. More than half of drug-related deaths in 2010 were among people in the most deprived areas.
Change in inequalities	• The inequalities gap for both drug-related hospital admissions and drug-related deaths are relatively stable.
Cancer	
Overall patterns	• The overall death rate from cancer fell by 12 per cent between 2001 and 2011. • Lung cancer levels in Scotland continue to be among the highest in the world.
Extent of inequalities[2]	• Overall incidence is around a third higher and overall death rates are around 75 per cent higher in the most deprived areas. In 2007–11, the cancer mortality rate per 100,000 was 157 in the least deprived areas compared to 276 per 100,000 in the most deprived areas. • The effect of deprivation on incidence and death rates varies by type of cancer: lung cancer rates are strongly linked to deprivation while breast cancer rates are not.
Change in inequalities	• Inequalities by deprivation in cancer incidence are relatively stable, but the gap between the most and least deprived areas is growing for death rates from cancer.
Mental health	
Overall patterns	• There has been little recent change in the Scottish Government's indicator of mental well-being (the Warwick-Edinburgh Mental Well-being Scale). • The suicide rate in Scotland has been similar to or lower than the EU average since the 1980s. • The suicide rate in Scotland has fallen in recent years but remains higher than in England. • In 2008, the suicide rate among males in Scotland was almost double that in England and Wales, with 24.1 suicides per 100,000 population compared to 12.6 in England and Wales.
Extent of inequalities[2]	• More than twice as many females consulted GPs for depression and anxiety than males in 2010/11. • People in deprived areas have lower overall mental well-being and more GP consultations for depression and anxiety. In 2010/11, those in the most deprived areas had twice as many consultations for anxiety (62 consultations per 1,000 patients compared to 28 per 1,000 patients in the least deprived areas). • Suicide rates are three times higher among men than women and over three times higher in the most deprived areas. Between 2007 and 2011, the suicide rate in Scotland was 26.4 per 100,000 in the most deprived areas compared to 7.1 in the least deprived areas.
Change in inequalities	• The difference in the suicide rate between the least and most deprived areas has remained stable in recent years.

Obesity	
Overall patterns	• Obesity in Scotland has been increasing over recent years. More than a million adults in Scotland – over a quarter of the adult population – are now obese or morbidly obese.
Extent of inequalities[2]	• Obesity increases with age, with the highest level (38 per cent) among people aged 55-64. • Obesity rates are higher in the most deprived areas than in the least deprived areas, especially among women. Around a third of women in the most deprived areas are classified as obese compared with less than a fifth in the least deprived areas.
Change in inequalities	• The gap in obesity rates for women by level of deprivation is stable.
Diabetes	
Overall patterns	• By 2012, around 247,000 people in Scotland had been diagnosed with diabetes, an 18 per cent increase since 2007.
Extent of inequalities[2]	• Type 2 diabetes rates increase with deprivation level. In 2008, incidence was around 2.5 per cent in the least deprived areas compared to over four per cent in the most deprived areas. • Prevalence of type 2 diabetes is higher among some ethnic groups.
Change in inequalities	• GP contact data shows no signs of an increase in the gap in inequalities by deprivation.
Screening	
Overall patterns	• Recent annual uptake rates for breast screening and cervical screening were around 75 per cent. In May 2012, the overall uptake rate for bowel screening was around 55 per cent.
Extent of inequalities[2]	• Uptake for bowel cancer screening is higher among women (58 per cent uptake) compared to among men (51 per cent). • Uptake for both breast and bowel cancer screening is higher among people living in less deprived areas. For bowel cancer screening, uptake is 63 per cent in the least deprived areas compared to 42 per cent in the most deprived areas. For breast cancer screening, the uptake rates are 82 per cent and 64 per cent, respectively.
Change in inequalities	• Differences between the most and least deprived areas in uptake of breast cancer screening are constant over time.
Unintentional injuries	
Overall patterns	• In 2010/11, approximately one in nine adult emergency hospital admissions and one in seven child emergency hospital admissions were due to unintentional injuries.
Extent of inequalities[2]	• Adults and children in the most deprived areas are more than twice as likely to die from an unintentional injury compared with those living in the least deprived areas. Between 2006 and 2010, there were 1,502 adult deaths in the most deprived areas compared to 810 in the least deprived areas.
Change in inequalities	• Trend data is not yet available.

Notes:
1. A more detailed analysis of these indicators is available on Audit Scotland's website: www.audit-scotland.gov.uk
2. These comparisons refer to people living in the one-fifth most deprived and one-fifth least deprived areas.
3. The 2009/10 estimates of problem drug users are for financial year, while earlier estimates were for calendar year. The change to financial year brought the estimates in line with other available information sources on drug misuse in Scotland, and to align them with the reporting format of the other UK administrations.

Source: Audit Scotland analysis of published statistics, 2012

Part 2. Spending

The public sector needs to make better use of resources to help reduce health inequalities.

Key messages

- The Scottish Government takes account of deprivation, rurality and remoteness, and other local needs in allocating funding to NHS boards and councils but it is not clear how NHS boards and councils allocate resources to target local areas with the greatest needs.
- We estimate that the Scottish Government allocated around £170 million to the NHS in 2011/12 – around 1.5 per cent of the overall NHS budget – for specific schemes to improve health and address health inequalities.
- Recent changes in quality payments to GPs have helped to provide more funding to GP practices in deprived areas. These changes mean that deprived areas should receive additional resources to help address problems related to health inequalities.

Overall NHS and council funding formulae take account of deprivation and local needs

24. The Scottish Government's funding formula for the NHS is designed to take account of levels of local deprivation.[23] [24] This formula also takes account of each board area's population size, age and gender distribution, levels of ill health and the additional costs of providing care in rural and remote areas. The Scottish Government is phasing in the introduction of this formula to allow NHS boards to plan for any significant changes to their budgets.[25] There is no timescale for full implementation and some NHS boards are not yet receiving their target share.[26] This may affect boards' capacity to effectively tackle health inequalities in their local areas.

25. In 2010/11, councils in Scotland spent around £18.5 billion. The Scottish Government funds around 85 per cent of council spending through a block grant to each council, with the remainder being funded by council tax and other income streams.[27] The Scottish Government allocates money to councils through Grant-Aided Expenditure (GAE) according to the level of local demand for services. GAE also takes account of factors within each council area, such as the proportion of people living in deprived areas or in rural locations, which may affect the level of required funding.[28]

26. In 2010/11, councils spent around £3.6 billion on social work services, including £155 million on services for adults with mental health problems and £60 million on services for adults with substance misuse problems.[29] However, this does not present a complete picture of all council spending on services to reduce health inequalities.

It is not clear how resources are targeted within local areas

27. The formula for allocating money to each NHS board is built up from information on small geographical areas.[30] Indicative weightings have also been calculated at CHP level.[31] CHPs with the highest indicative weightings are remote and rural areas such as Western Isles, Orkney and Shetland, and areas with high levels of deprivation and ill health such as Glasgow and Dundee (Exhibit 8).

28. It is not clear whether the local distribution of resources is targeted on the areas of greatest need. The Scottish Government allocates funding to NHS boards but there is no national or local information about how NHS boards allocate these resources locally. There is significant variation in the extent to which NHS boards devolve services and budgets to CHPs, and CHPs directly manage only around a quarter of total NHS spending.[32] There is also no published information about how councils allocate resources locally.

Around £170 million was allocated to the NHS in 2011/12 for schemes related specifically to health inequalities

It is difficult to track direct spending by the NHS and councils on addressing health inequalities

29. NHS boards spent around £11.7 billion in 2011/12 and councils spent around £18.5 billion in 2010/11 (Exhibit 9). NHS boards report their spending on a range of clinical and non-clinical services, and councils report their spending on a range of services, including services for adult mental health and substance misuse problems. However, there is no information about specific spending on addressing health inequalities.

23 The Scottish Government uses the NHSScotland Resource Allocation Committee (NRAC) formula to calculate the target percentage share of the health budget each NHS board should receive to provide Hospital and Community Health Services (HCHS) and GP prescribing. HCHS includes acute care, care of the elderly, mental and learning difficulties services, maternity services and community services. NRAC replaced the previous Arbuthnott formula. Both formulae have similar overall approaches but the NRAC formula more accurately accounts for: changes in population; the higher relative needs of the very young and very old; and the need for increased healthcare services due to levels of ill health and deprivation.

24 The Scottish Government uses the NRAC formula to allocate around 70 per cent of its total health budget. It allocates the other 30 per cent to NHS boards to provide Family Health Services (general dental, ophthalmic and pharmaceutical services) and to tackle drugs misuse and blood-borne viruses.

25 This gradual introduction means that all boards receive real-terms increases in funding each year. NHS boards below their NRAC target share will receive more money per head of population than other NHS boards until boards reach their NRAC target share.

26 *NHS financial performance 2011/12*, Audit Scotland, 2012.

27 *Revenue Funding Streams to Local Authorities*, Scottish Government, 2011.

28 *'Green Book' for Grant-Aided Expenditure, Local Government Finance Settlement 2012-2015*, Scottish Government, February 2012.

29 *Scottish Local Government Finance Statistics 2010/11*, Scottish Government, February 2012.

30 The small geographical areas used are intermediate data zones for HCHS and GP practices for GP prescribing. There are 1,235 intermediate data zones in Scotland, each with a population of between 2,500 and 6,000 people.

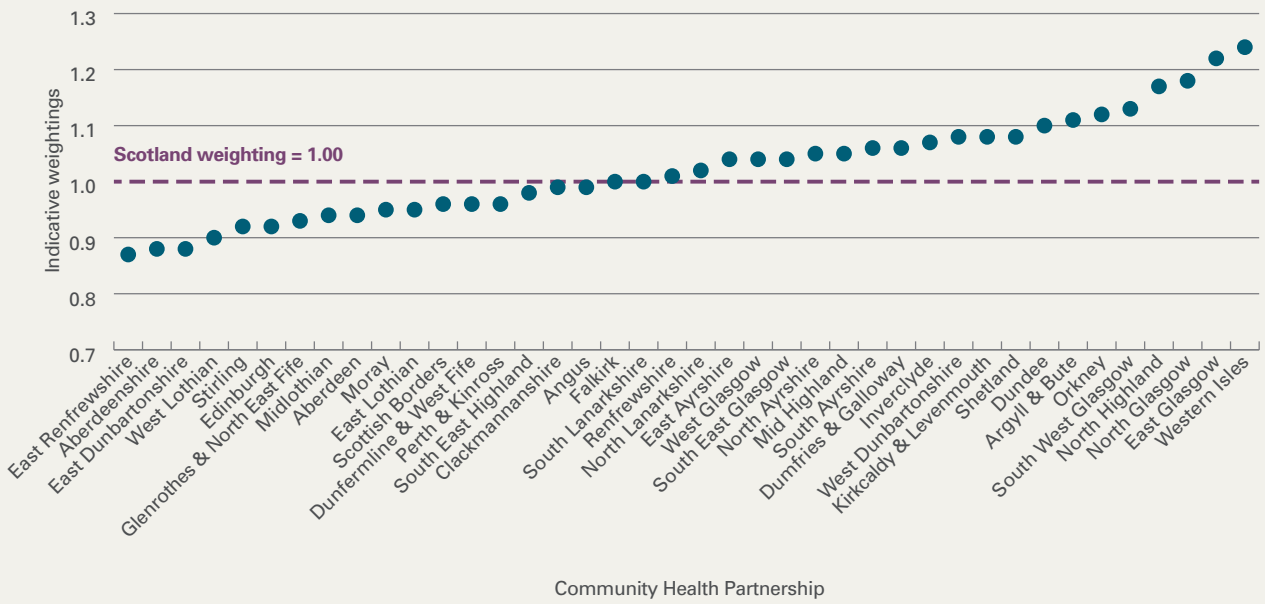
31 *Resource Allocation Formula*, NHS Information Services Division, March 2012.

32 *Review of Community Health Partnerships*, Audit Scotland, 2011.

Exhibit 8

Indicative weightings for funding allocations by CHP, 2012/13

CHPs with higher levels of rurality or deprivation have higher indicative weightings for funding allocations.

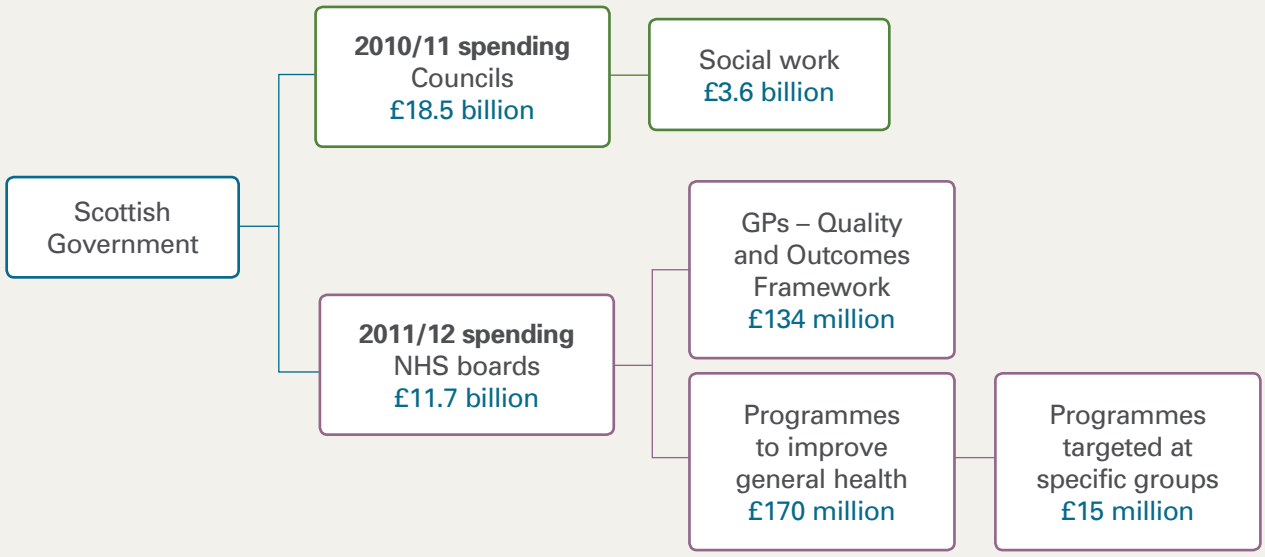


Source: Information Services Division, 2012

Exhibit 9

NHS board spending (2011/12) and selected council spending (2010/11) for programmes related to health inequalities

Information about NHS and council spending makes it difficult to track direct spending on addressing health inequalities.



Source: Scottish Government

30. We estimate that the Scottish Government allocated around £170 million to NHS boards in 2011/12 for programmes related specifically to health inequalities (Exhibit 10). This represents around 1.5 per cent of the total health spending of around £11.7 billion. The Government's allocations included around £15 million for programmes such as *Keep Well* and *Childsmile* which are specifically aimed at reducing health inequalities by targeting specific groups within the population.[33] The remainder of the £170 million is spent on improving the health of the whole population.

31. Funding for the *Keep Well* programme up to 2014/15, and for tackling some of the other problems associated with health inequalities (including smoking, alcohol misuse and obesity) is expected to remain at the same level as 2012/13.[34] This will mean a decrease in real terms.

Exhibit 10

Scottish Government funding allocations to the NHS for tackling health issues associated with inequalities, 2011/12

The Scottish Government directly allocated around £170 million to NHS boards for schemes related to health inequalities.

Notes:
1. This funding is for a range of national initiatives and programmes including support for the Mental Welfare Commission for Scotland, delivery of mental health legislation and NHS targets, and support for organisations such as NHS Health Scotland.
2. The Scottish Enhanced Services Programme includes a range of services which the Scottish Government has identified as national priorities. These include child obesity services, alcohol screening and brief interventions, and flexible GP appointment sessions.
3. Healthy Start helps to provide a nutritional diet for pregnant mothers and young children in the UK, particularly those in low income families. The scheme provides fresh milk, fresh fruit and vegetables and infant formula milk and vitamins as a benefit in kind and is primarily targeted at women and children under four in families in receipt of Income Support.

Source: Audit Scotland analysis of Scottish Government data

The Scottish Government allocated an estimated £1.8 billion from 2008/09 to 2010/11 for issues related to health inequalities

32. In *Equally Well*, the Ministerial Task Force set out the Scottish Government's overall funding allocations to councils and NHS boards for programmes and services which aim to address both the underlying causes and the consequences of health inequalities. The Task Force identified that the Scottish Government had allocated about £1.8 billion between 2008/09 and 2010/11 to tackling health inequalities (Exhibit 11).

33. The information in *Equally Well* provides an estimate of Scottish Government funding aimed at addressing issues linked to health inequalities as not all of the allocated funding was specifically for this purpose. For example, annual allocations for tackling poverty and fuel poverty accounted for around one-third of the total allocations but these initiatives have only an indirect effect in reducing health inequalities. There was no information about whether these estimated funding allocations were targeted at areas of greatest need.

Changes in payments to GPs have led to more funding to deprived areas

34. GPs make an important contribution to reducing health inequalities by providing advice and primary care services. In 2011/12, the Scottish Government allocated around £710 million to NHS boards to contract services from GP practices.[35]

35. Most GPs in Scotland are paid through the UK-wide General Medical Services (GMS) contract which is made up of the following elements:

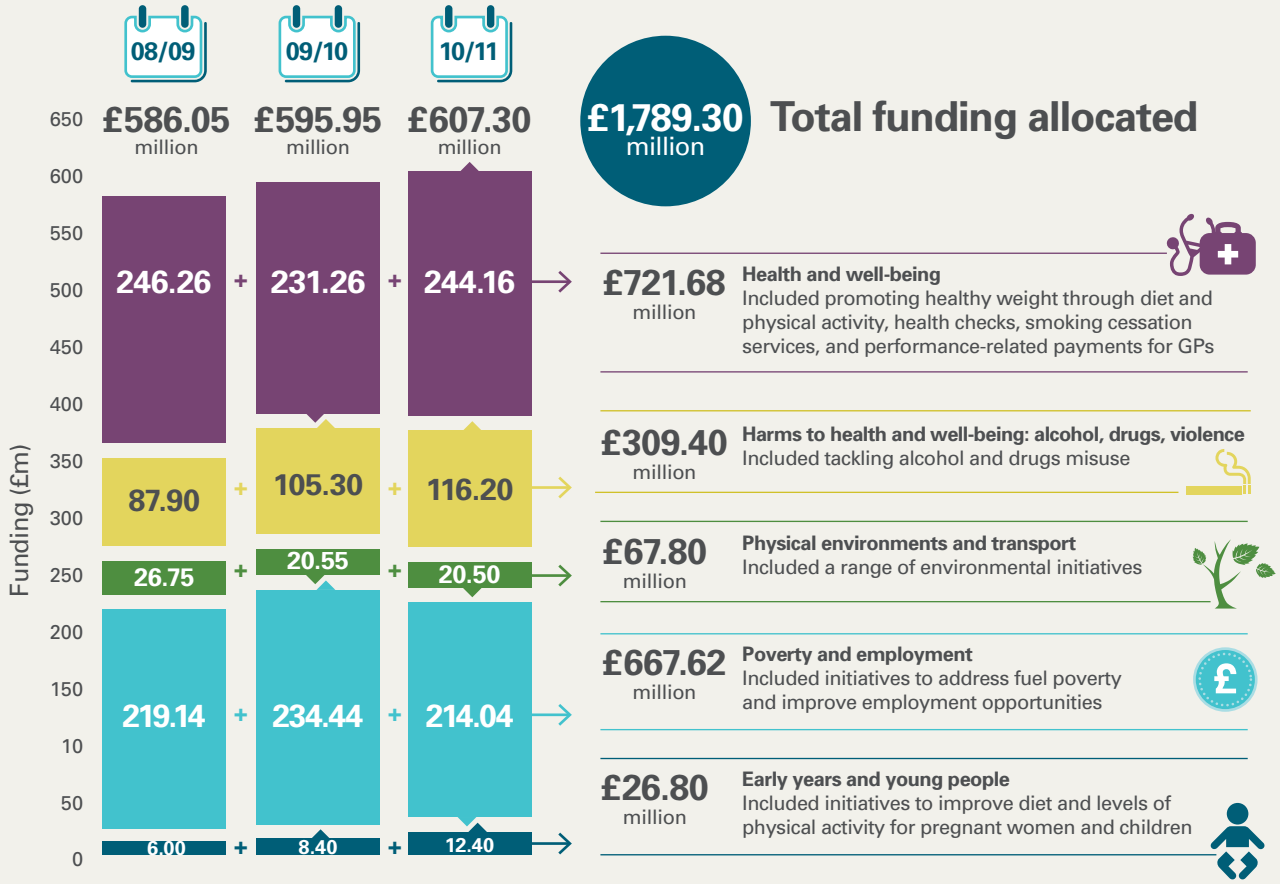
- the global sum which accounts for more than half of the total

33 *Keep Well* is the Scottish Government's principal national programme for tackling health inequalities. It delivers health checks to people in the most deprived areas. *Childsmile* is a national programme designed to improve the dental health of children in Scotland, and reduce inequalities in dental health.
34 *Scottish Draft Budget 2013-14*, Scottish Government, September 2012.
35 *Scottish Spending Review 2011* and *Draft Budget 2012-13*, Scottish Government, September 2011.

Exhibit 11

Scottish Government funding for reducing health inequalities, 2008/09 to 2010/11

The Task Force estimated that the Government allocated around £1.8 billion between 2008/09 and 2010/11 to the public sector to help address issues related to health inequalities.



Source: *Equally Well*, Scottish Government, 2008

funding and which pays for routine services that GPs must provide. Funding for these services takes account of various patient and population characteristics including age, sex, deprivation, and remoteness and rurality

- payments for enhanced services such as health checks and immunisation programmes, which are not part of the routine services provided by GPs

- the Quality and Outcomes Framework (QOF) which provides additional funding to practices that meet a range of quality targets, including improving the management of chronic diseases.

36. In 2011/12, GP practices in Scotland received around £134 million in QOF payments (just under a fifth of the total payments to GPs), and the average QOF payment to a GP practice was around £139,000.[36] The QOF is an important part of the GP contract and has the potential to help reduce health inequalities although it was not explicitly designed to do this. There is evidence that it has helped to reduce the gap between the most and the least deprived areas in the management of chronic disease through better recording and monitoring of health problems. This was shown by a narrowing gap between QOF payments to practices in the most and the least deprived areas, but it is too early to say whether these improvements in management practice have led to reductions in health inequalities.[37]

37. In 2009, the system for calculating QOF payments was adjusted to better reflect the prevalence of long-term conditions in local communities. We compared the QOF payments to the 100 practices serving the most

36 *Quality & Outcomes Framework of the new GMS contract*, Information Services Division, September 2012.
37 *The Quality and Outcomes Framework (QOF): does it reduce health inequalities?*, National Institute for Health Research, April 2011.

deprived areas in Scotland (known as 'Deep End' practices) with other GP practices. In the three years following the change, average QOF payments per patient to Deep End practices increased by around eight per cent while the average payment to non-Deep End practices increased by around four per cent (Exhibit 12).

38. Changes to the GMS contract are negotiated at a UK level, but the Scottish Government has signalled its intention to move to a more Scottish-focused contract to better reflect Scottish health priorities.

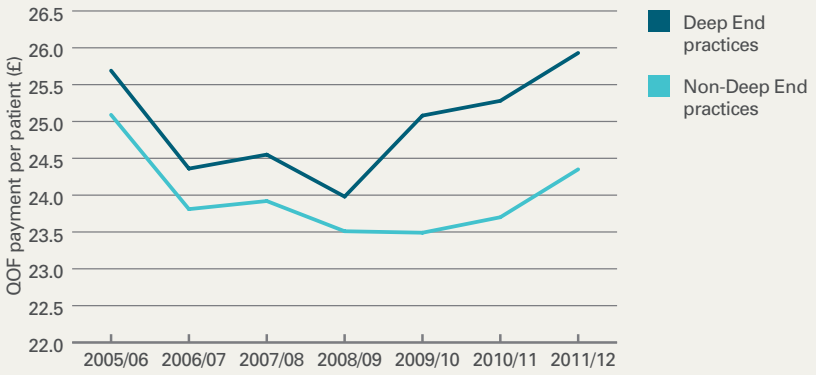
Recommendations

- The Scottish Government and NHS boards should include measurable outcomes in the GP contract to monitor progress towards tackling health inequalities, and ensure that the Quality and Outcomes Framework is specifically designed to help reduce health inequalities.
- NHS boards and councils should identify what they collectively spend on reducing health inequalities locally, and work together to ensure that resources are targeted at those with the greatest need.

Exhibit 12

QOF payments to Deep End and non-Deep End GP practices

Deep End practices received higher increases following a change in funding method in 2009.



Source: Audit Scotland analysis of Information Services Division data, 2012

Part 3. Local health services

The health service can do more to reduce health inequalities by providing better access to services for disadvantaged groups.

Key messages

- Appropriate access to health services is an essential part of reducing health inequalities. GPs have a critical role to play in helping to reduce inequalities and in facilitating access to the whole range of NHS services including hospital care. But the distribution of primary care services across Scotland does not fully reflect the higher levels of ill health and wider needs found in deprived areas, or the need for more preventative health care. The distribution of other primary health care services, such as pharmacies, is more closely matched to need.

- Action taken to improve health can have the unintended consequence of widening inequalities if uptake by those most at risk does not increase. Patterns of access to hospital services vary among different groups within the population and people from more deprived areas tend to have poorer access and outcomes. NHS boards need to ensure that all patients get the services they need, and provide better access to services for disadvantaged communities to help reduce health inequalities.

Better access to health services is needed to reduce health inequalities

39. Appropriate access to healthcare services can contribute to the prevention of poor health and better outcomes from treatment for disadvantaged groups. In May 2010, the Scottish Government published *The Healthcare Quality Strategy for NHSScotland*, which includes a commitment by the NHS to understand the needs of different communities, eliminate discrimination, reduce inequality, protect human rights and build good relations by breaking down barriers that may prevent people from accessing the care and services that they need. However, there is evidence that people from disadvantaged communities may have difficulties accessing these services.

GPs in the most deprived areas face significant challenges in tackling health inequalities

40. For most people, GPs are the initial point of contact with healthcare services. Primary care is the main focus of most efforts to reduce health inequalities, and *Equally Well* stated that: 'NHS action to reduce health inequalities starts with primary care, where more than 90% of patient contacts take place.'

41. The distribution of GPs across Scotland does not fully reflect levels of deprivation (Exhibit 13).[38] The availability of GPs is more accurately measured by whole time equivalent (WTE) rather than headcount. The NHS has published information on the number of WTE GPs in Scotland but this did not include details of the distribution of WTE GPs across the various levels of deprivation and has not been updated since 2009.[39]

42. Recent findings from the Deep End project indicate that GPs working in the most deprived areas of Scotland face significant challenges in tackling health inequalities. For example, GPs in these practices reported that:

- they treat patients with higher levels of multiple health problems than GPs working in less deprived areas[40]

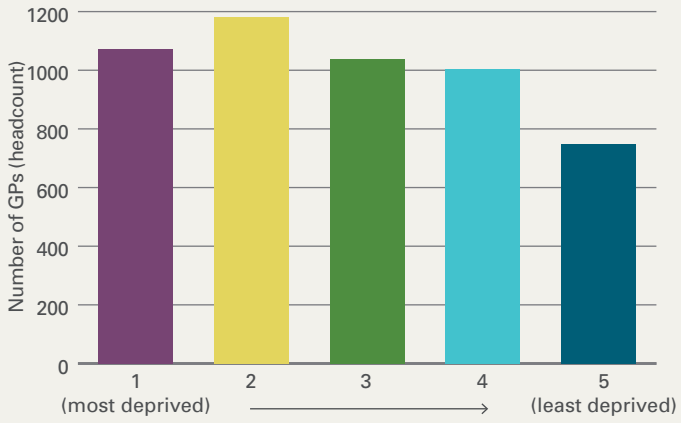
- public sector budget reductions and changes to the benefits system were increasing patients' visits to GPs and having detrimental effects on patients' mental and physical health[41]

- they are constrained by a shortage of consultation time with patients which limits the opportunity to provide appropriate treatment, advice and referral to suitable services.[42]

Exhibit 13

GP numbers by deprivation in Scotland, 2012

The distribution of GPs does not fully reflect the levels of deprivation.



Source: Information Services Division, 2012

38 'GPs at the Deep End', G Watt, *British Journal of General Practice*, January 2011.
39 *National Primary Care Workforce Planning Survey*, Information Services Division, 2009.
40 'Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study', K Barnett, S Mercer, M Norbury, G Watt, S Wyke and B Guthrie, *Lancet*, May 2012.
41 *GP experience of the impact of austerity on patients and general practices in very deprived areas*, Deep End Steering Group, March 2012.
42 'Patient encounters in very deprived areas', G Watt, *British Journal of General Practice*, January 2011.

43. Audit Scotland's 2011 review of CHPs reported variable engagement between CHPs, GPs and other independent contractors owing to a lack of shared vision and priorities. The Deep End project and our focus groups of CPP managers and CHP managers also reported difficulties in getting good engagement between GPs, CHPs and councils.[43]

44. Practice nurses provide an increasingly important role in primary care, often providing services such as immunisations, blood pressure checks and programmes to help people to stop smoking. However, information about the numbers of practice nurses across different areas of deprivation is not available, so it is unclear whether their distribution matches levels of patient demand.

Access to other primary care services reflects higher levels of need in deprived areas

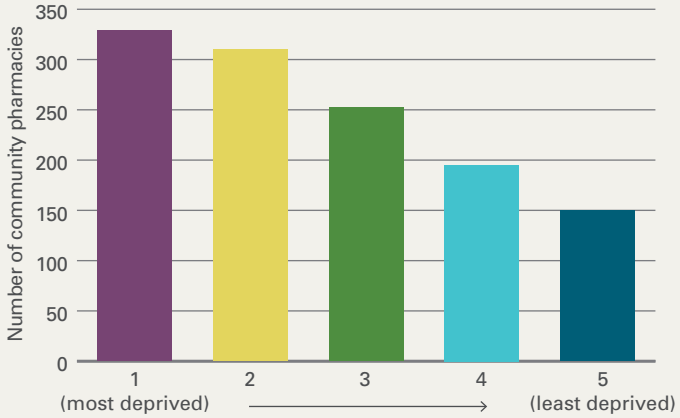
45. In addition to GP practice staff, other staff working in primary and community services make an important contribution to improving public health and reducing health inequalities. Community pharmacists provide a range of services, including advice and treatment for minor ailments. Pharmacists may also deliver health improvement services such as smoking cessation. Our analysis shows that the distribution of community pharmacies across Scotland varies by deprivation levels, with the highest number of pharmacies in the most deprived areas (Exhibit 14).

46. Dentists also have an important role to play in helping to reduce health inequalities. Information on adult oral health is generally poor, but the incidence of oral cancer is higher amongst people from deprived areas, and risk factors for poor oral health such as smoking and poor diet are higher in deprived areas. The distribution of dentists across Scotland varies by deprivation levels, with the highest number of dentists in the most deprived areas (Exhibit 15).

Exhibit 14

Distribution of community pharmacies by deprivation, 2012

There are over twice as many pharmacies in the most deprived areas than in the least deprived areas.

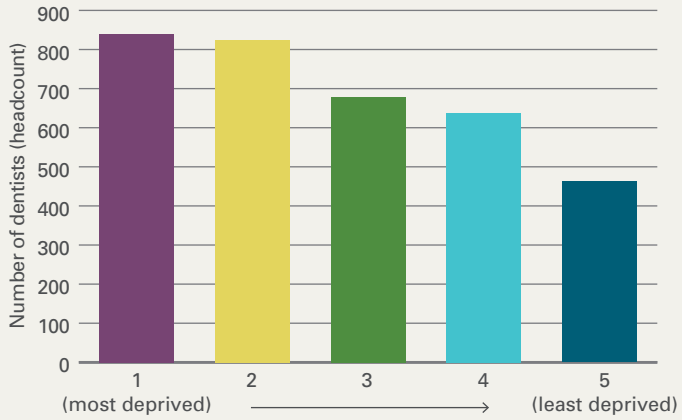


Source: Practitioner Services Division, 2012

Exhibit 15

Distribution of dentists by deprivation, March 2012

There are almost twice as many dentists in the most deprived areas than in the least deprived areas.



Source: Audit Scotland analysis of Information Services Division dental workforce data, 2012

43 *Time To Care: Health Inequalities, Deprivation and General Practice in Scotland*, Royal College of General Practitioners Scotland, 2010.

47. Since 2007, dentists practising in the most deprived areas of Scotland have received a Deprived Areas Allowance of up to £9,000 a year.[44] Between 2007 and 2012, the number of dentists based in the most deprived areas more than doubled, compared to an increase of one-fifth in the least deprived areas (Exhibit 16).[45]

Policies designed to improve the health of the whole population can increase inequalities

48. The NHS provides a range of universally available services, including cancer screening and eye tests, which aim to detect health problems at an early stage or prevent them altogether. However, there is evidence that these services may widen health inequalities if uptake is lowest among those who would derive the greatest benefits (Case studies 1 and 2).

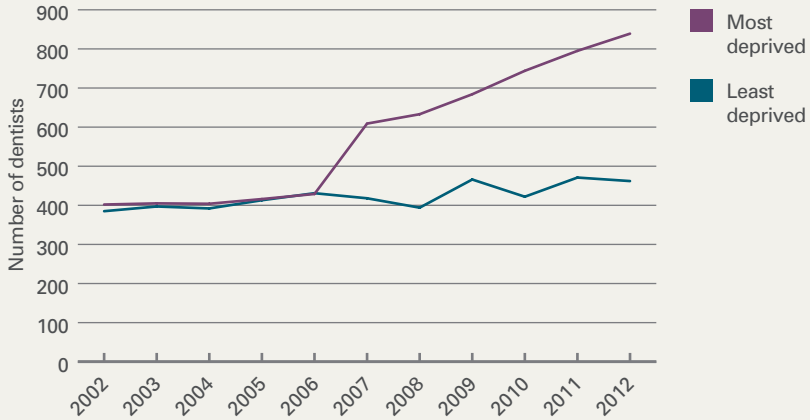
Better access to hospital services may help to improve outcomes for disadvantaged groups

49. Although primary care is the main focus of efforts to tackle health inequalities, better access to hospital services may also help to improve outcomes for disadvantaged groups. Audit Scotland's 2012 report on cardiology services highlighted research showing that patients from deprived areas receive over 20 per cent fewer cardiology treatments than expected while those from the least deprived areas received over 60 per cent more treatments than expected.[46] People from more deprived areas may have lower rates of treatment because they are less likely to reach hospital alive following a heart attack. This is due to people in more deprived areas having poorer awareness of the symptoms of a heart attack, and higher rates of sudden death from a heart attack for people who smoke. The report recommended that the Scottish Government and NHS boards should monitor access to procedures by different groups within

Exhibit 16

Distribution of dentists in the most and least deprived areas, 2002–12

The number of dentists in the most deprived areas increased following the introduction of the Deprived Areas Allowance in 2007.



Source: Information Services Division dental workforce statistics, 2012

Case study 1

The introduction of free eye tests in Scotland in 2006 led to an increase in the number of people having their eyes examined. In 2005, before the free tests were introduced, around 32 per cent of people in Scotland had an eye examination, the lowest figure among the UK countries. By 2008, this figure had increased to around 35 per cent and the relative difference between Scotland and the other UK countries had reduced. However, the increase in the uptake of optometry services was lower among people with low education and those from more deprived households, resulting in increased inequality.

Source: 'Utilisation of eye-care services: An examination of the effect of Scotland's free eye examination policy', H Dickey et al, University of Aberdeen, 2012

Case study 2

Child health reviews are available to all children but those living in the most deprived areas are less likely to have a review. Unavailability or lack of parental engagement were the most common reasons for missed reviews, but aligning the distribution of health visitors to the needs of the population is also essential to ensure children from all areas receive health reviews.

Source: 'Trends in the coverage of "universal" child health reviews: observational study using routinely available data', R Wood et al, *BMJ Open*, 2012

44 *An Analysis of the Dental Workforce in Scotland: A Strategic Review 2010*, Scottish Government, December 2010.
45 These data refer to General Dental Service dentists.
46 *Cardiology services*, Audit Scotland, 2012.

Exhibit 17

Patterns of access to hospital services

People in the most deprived areas require greater access to hospital services.

Issue	Pattern
Diabetes	People with diabetes who live in deprived areas tend to have higher levels of hospital admissions for complications relating to their condition. For example, those living in the most deprived areas are 52 per cent more likely to have a hospital admission relating to stroke, and 57 per cent more likely to have an admission relating to ischaemic heart disease compared to those living in the least deprived areas. There is some evidence that they are also less likely to have results of clinical tests recorded.[1 2]
Alcohol	Patients who are admitted to intensive care units (ICUs) with alcohol-related conditions are more likely to be from deprived areas, and around twice as many admissions to ICUs are from the most deprived areas compared with the least deprived areas. Patients from deprived areas also tend to have worse outcomes after admission to an ICU, where data was adjusted for severity of illness on admission.[3 4]

Notes:
1. 'Socioeconomic status and diabetes-related hospital admissions: a cross-sectional study of people with diagnosed diabetes', S Wild et al, 2010.
2. *Diabetes and the disadvantaged*, Diabetes UK, 2006.
3. 'A national service evaluation of the impact of alcohol on admissions to Scottish intensive care units', T Geary et al, 2012.
4. 'The effect of socioeconomic status on mortality in the critically ill: A national linkage study', N Lone et al, 2011.

Source: Audit Scotland analysis of published information, 2012

the population to help ensure that all patients have appropriate and timely treatment. In its subsequent inquiry into cardiology services, the Scottish Parliament's Public Audit Committee called on the Scottish Government to review whether GP numbers are adequate to meet the needs of patients in deprived areas.[47]

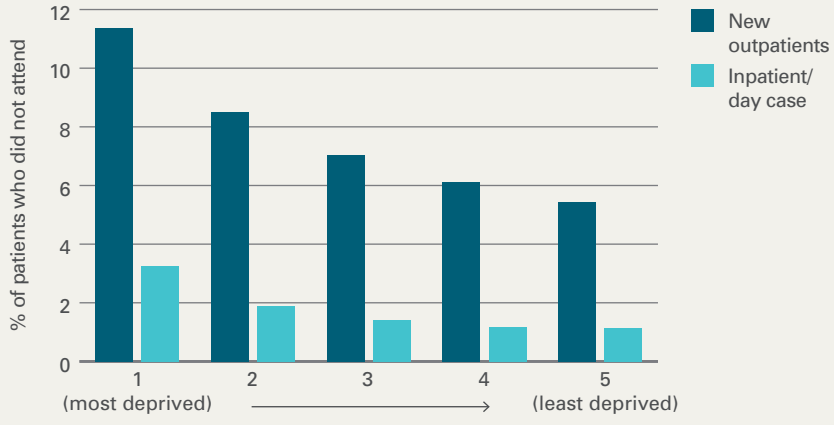
50. Other evidence also shows that people in the most deprived areas require greater access to hospital services (Exhibit 17).

51. People from deprived areas are more likely to miss hospital appointments. Analysis of waiting times data shows that in 2011/12 the percentage of patients living in deprived areas and failing to attend appointments was three times higher for new outpatients and more than twice as high for inpatients and day cases (Exhibit 18). These differences in missed appointments may be due to a range of factors affecting people in more deprived areas, such as a lack of access to transport.[48]

Exhibit 18

Percentage of patients missing hospital appointments by deprivation, 2011/12

Patients from the most deprived areas are more likely to miss hospital appointments.



Source: Audit Scotland analysis of Information Services Division data, 2012

47 *Cardiology Services*, Scottish Parliament Public Audit Committee, 2012.
48 *Transport for health and social care*, Audit Scotland, 2011.

Recommendations

The Scottish Government should:

- consider introducing incentives for GPs in the most deprived areas to help increase access to GPs in these areas.

The Scottish Government and NHS boards should:

- review the distribution of primary care services to ensure that needs associated with higher levels of deprivation are adequately resourced

- regularly collect and publish information on the number of whole time equivalent GPs and practice nurses across the various levels of deprivation.

NHS boards should:

- monitor the use of primary care, preventative and early detection services by different groups, particularly those from more deprived areas. If this identifies systemic under-representation of particular groups, take a targeted approach to improve uptake

- monitor the use of hospital services by different groups and use this information to identify whether specific action is needed to help particular groups access services

- review patterns of non-attendance for hospital appointments and target action to improve attendance rates of patients living in deprived areas.

CHPs should:

- involve GPs fully in local approaches to reduce health inequalities.

Part 4. Effectiveness

Better partnership working is needed to reduce health inequalities. To date, there is limited evidence that strategies and interventions aimed at reducing health inequalities have made a significant impact.

Key messages

- Reducing health inequalities is challenging and requires effective partnership working across a range of organisations. CPPs need to clarify the roles and responsibilities of local organisations in tackling health inequalities, and ensure they take sufficient ownership of initiatives.
- There is evidence to show that the ban on smoking in public places has improved health, including a reduction in passive smoking and a potential link to decreased rates of premature and low birthweight babies. This may have helped to reduce health inequalities given the link between smoking and deprivation. Other national policies and strategies which aim to improve health and reduce health inequalities have so far shown limited evidence of impact. Changes will only be apparent in the long term but measures of short-term impact are important to demonstrate progress towards policy goals.
- The Scottish Government and CPPs need a more systematic approach to assessing the cost effectiveness of actions to reduce health inequalities. Changes may not take effect for a generation or more making the measurement of success in the short term difficult. However, many initiatives lack a clear focus from the outset on cost effectiveness and outcome measures. This means that assessing value for money is difficult.
- Current performance measures are a mix of process measures, such as the number of smoking cessation services delivered, and outputs such as the prevalence of smoking among adults. CPPs' reports on delivering their Single Outcome Agreements (SOAs) are weak in the quality and range of evidence used to track progress in reducing health inequalities, and differences among SOAs means that a Scotland-wide picture is hard to identify.

A range of factors can help to reduce health inequalities

52. A significant amount of research has identified a range of factors, including clear priorities and local focus, which can help to reduce health inequalities (Exhibit 19).

Many organisations are involved in trying to reduce health inequalities

53. The Scottish Government and CPPs have the lead responsibilities for tackling health inequalities but a wide range of people and organisations are involved (Exhibit 20, page 30).

Better partnership working is needed

54. Reducing health inequalities requires effective partnership working across a range of sectors and organisations. However, a number of Audit Scotland reports highlight challenges in joint working across organisational boundaries owing to differences in cultures, priorities, planning and performance management, decision-making, accountability and financial frameworks.[49]

55. Our focus groups involving CPP managers, CHP managers and frontline staff identified a range of issues around local partnership working aimed at tackling health inequalities.[50] Managers generally felt that CPPs had helped to engage a wider range of local organisations to help tackle health inequalities than had previously been the case. CPPs had also provided a focus to link individual organisations' strategies and work towards agreed outcomes.

56. In some CPP areas, health inequalities were seen as a high priority, shown by the number of initiatives set up to tackle inequalities and the support received from senior managers. In other areas, however, addressing health inequalities was considered less of a priority owing to health budgets being mainly directed towards hospital care and pressure on funding for health improvement initiatives. There was also a lack of shared understanding among the various local organisations about what is meant by 'health inequalities' which could potentially hinder communication and progress at a local level.

57. Our focus groups highlighted the importance of involving individuals and communities in local initiatives aimed at reducing health inequalities, and of helping to engage with people and communities that were least likely to use health services.[51] For example, staff from the voluntary sector have trained former heroin users to engage with current users to encourage them to join a methadone programme. CPPs should work with local organisations to provide opportunities for individuals and communities to contribute to activities which may help to reduce health inequalities.

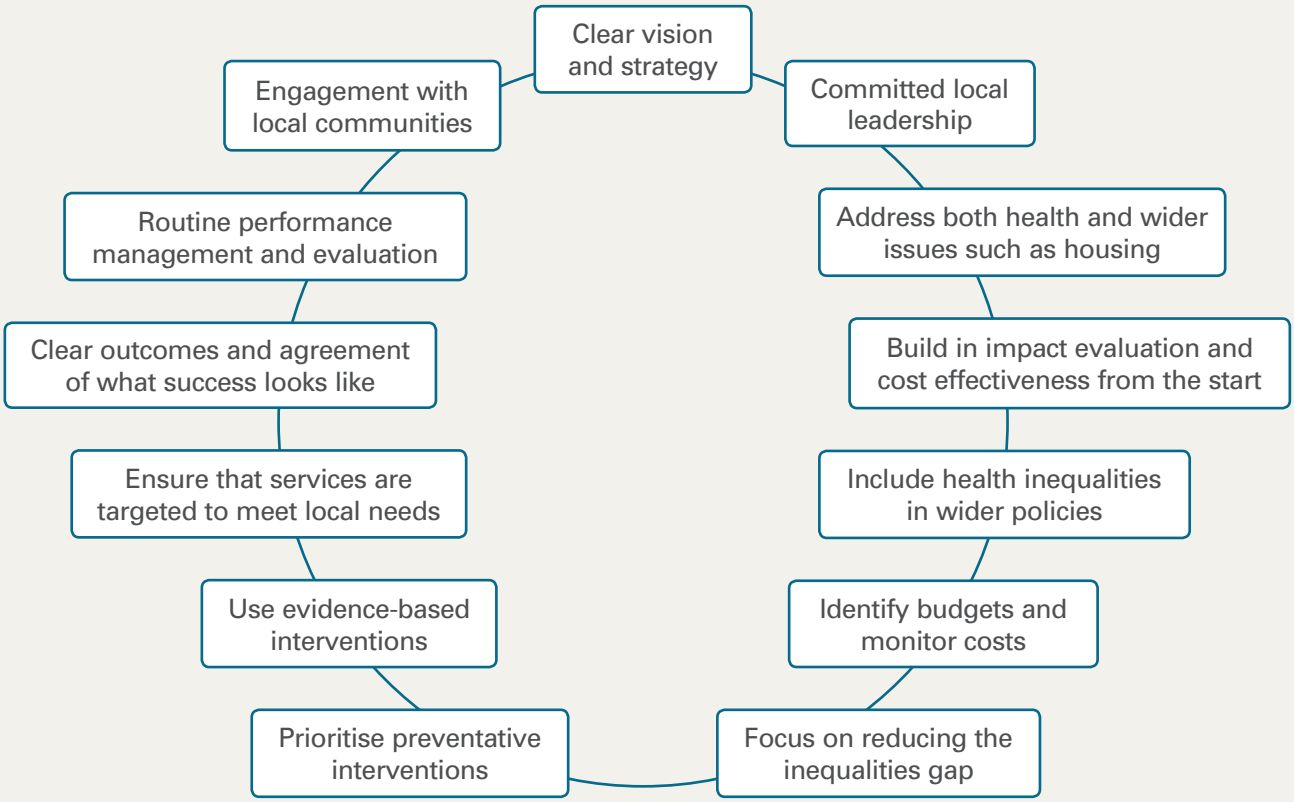
58. CPPs should ensure that they provide strong and supportive leadership to promote effective partnership working at a local level. Local leaders also need to clearly communicate their strategies and priorities to staff responsible for delivering services aimed at tackling health inequalities.

49 *Review of Community Health Partnerships*, Audit Scotland, 2011; *Transport for health and social care*, Audit Scotland, 2011; *The role of community planning partnerships in economic development*, Audit Scotland, 2011; *Commissioning social care*, Audit Scotland, 2012.
50 A full report on the focus group findings is available on Audit Scotland's website: www.audit-scotland.gov.uk/work
51 These 'assets-based' approaches focus on the capacity, skills, knowledge and connections in individuals and communities.

Exhibit 19

Factors which can help to improve the effectiveness of initiatives to reduce health inequalities

A range of factors should be considered when developing initiatives to reduce health inequalities.



Sources: *Inequalities in health in Scotland: what are they and what can we do about them?* S Macintyre, MRC Social and Public Health Sciences Unit, 2007; *Health Inequalities: Progress and Next Steps*, Department of Health, 2008; *Fair Society, Healthy Lives*, Marmot Review, 2010

'Some practitioners and even managers don't know what the CPP is – it's too distant. What's happening at the CPP needs to be filtered down more effectively, in whatever format.'

Frontline staff focus group

Greater clarity about roles and responsibilities is needed to tackle health inequalities

59. The focus groups of CPP and CHP managers commented on the lack of clarity about roles, responsibilities and ownership of services aimed at reducing health inequalities. In some cases, managers considered that a lack of joint working between CPPs and CHPs led to duplication of services. These views reflect the findings of Audit Scotland's 2011 review of CHPs which found that, in some areas, cluttered partnership arrangements contributed to a lack of clarity and duplication in roles and functions between CHPs and other health and social care partnership arrangements.

'When health inequalities are described as "everyone's business", there's a danger that it can become nobody's business.'

CPP manager

60. Participants in our focus groups considered that, although CPPs had helped to promote tackling health inequalities through their strategic frameworks, the NHS was generally expected by other organisations to deliver all health outcomes. CPPs should ensure that NHS boards, councils and other organisations are clear about their respective roles, responsibilities and resources in tackling health inequalities, and develop and publish performance information through the SOA to demonstrate progress in tackling health inequalities in their local areas. CPPs should also ensure that local organisations, both health and non-health, take ownership and shared responsibility for actions aimed at reducing health inequalities.

Exhibit 20

Organisations and professionals with key roles in tackling health inequalities

A number of organisations play an important role in addressing health inequalities.

Organisation	Key roles
Scottish Government	• Sets overall national policy, introduces legislation, publishes strategies and frameworks • Establishes national indicators and reports progress through the *Scotland Performs* web page • Agrees Single Outcome Agreements (SOAs) with CPPs • Allocates funding to councils and NHS boards • Reviews performance of NHS boards through annual reviews and performance against national targets
CPPs	• Have lead responsibility for addressing health inequalities at a local level • Bring together various local organisations including NHS boards, councils and voluntary organisations to plan and deliver services for local communities • Are responsible for monitoring and reporting performance through annual SOA reports
NHS boards	• Provide and commission a range of services to improve the health of local populations, including: – Health improvement initiatives, such as health protection and health promotion – Primary care services, including general practice, dentists, pharmacists, community nurses and optometrists – Hospital services
Councils	• Work with local organisations to plan services to help improve health and reduce health inequalities in the local area • Provide a range of services relating to health improvement, including: – Services for tackling substance misuse – Education to improve literacy and promote healthy living – Access to resources and services, including housing – Initiatives to improve local economic conditions and employment opportunities – Facilities for recreation and sport to promote physical activity
CHPs	• Work with local organisations to plan services to reduce health inequalities in local areas • Commission and fund voluntary and community-led activities that promote health and aim to tackle the underlying causes of health inequalities • Provide a range of local services, including: – Preventative care – Various actions to improve mental health and well-being – Drug and alcohol services (as part of local Alcohol and Drug Partnerships)
General Practices	• Provide services which contribute to improving health, including: – Immunisation and screening services – Health checks and services such as alcohol brief interventions[1] – Referrals to secondary care and to other services

Organisation	Key roles
Voluntary sector organisations	• Provide a means of engaging effectively with communities and individuals • Deliver a range of services which may help to reduce health inequalities, including: – Promoting healthy living to groups of people who may not use mainstream services – Supporting people to access relevant services
NHS Health Scotland	• Evaluates how well national programmes are tackling health inequalities • Develops outcome-based approaches to planning and monitoring the performance of health improvement activities • Promotes the use of health inequalities impact assessment to ensure that NHS boards' policies and services do not inadvertently exclude or discriminate against groups within the population
Research institutions (including universities and Glasgow Centre for Population Health)	• Produce and collate research on the causes of health inequalities • Evaluate and assess policies and interventions which impact on health inequalities • Review and summarise evidence on the effectiveness and cost effectiveness of interventions to reduce health inequalities • Enhance public and policy understanding of health inequalities by engaging with national and local decision-makers, the media, students and the wider public

Note: 1. An alcohol brief intervention is a short, evidence-based, structured conversation about alcohol consumption with a patient or client that seeks to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm.
Source: Audit Scotland, 2012

Plans for the integration of health and social care are at an early stage, and it is currently unclear how responsibility for tackling health inequalities in local areas will rest between CPPs and the planned Health and Social Care Partnerships.

61. Voluntary organisations provide a number of services which contribute to reducing health inequalities. Some participants in our focus groups from the voluntary sector suggested that the introduction of the Change Fund had improved partnership working between voluntary and statutory organisations.[52] Overall, however, frontline staff from the voluntary sector felt excluded from partnership working aimed at tackling health inequalities.

'From a voluntary sector perspective, much of the work into tackling health inequalities goes by without being heard about – we often feel removed from partnership working.'

Frontline staff focus group

More effective information sharing will help to improve partnership working

62. Sharing information among local organisations helps to facilitate joint working. However, a lack of compatibility between information systems, and a lack of clarity about what information can be shared may undermine local initiatives aimed at reducing health inequalities. The Scottish Parliament Local Government and Regeneration Committee has invited the Scottish Government to provide greater clarity to CPPs on what information can or should be shared, and has recommended that the Government work closely with the Scottish Information Commissioner and consider promoting formal sharing agreements between organisations.[53]

'A pharmacist who is undertaking health checks as part of community-based intervention is not able to email any information to the client's GP. The information has to be printed off and taken to the GP surgery because there is no secure email. This creates more work for the pharmacist and gives them little incentive to continue to carry out health checks in the community.'

Frontline staff focus group

52 The £70 million Change Fund was announced as part of the 2011/12 Scottish budget to help joint working between NHS boards and councils to provide older people's services.
53 *Inquiry into Public Services Reform and Local Government – Strand 1: Partnerships and Outcomes*, Scottish Parliament Local Government and Regeneration Committee, June 2012.

Equally Well test sites have improved local partnership working and helped to redesign services

63. In 2008, the Scottish Government established eight *Equally Well* test sites across Scotland to try new and innovative ideas for redesigning public services to help tackle health inequalities. Each test site had a separate theme, such as tackling alcohol misuse, improving mental health, providing early years interventions, and reducing smoking levels. The Scottish Government provided £4 million to fund the sites' activities, and appointed a National Programme Manager to support and coordinate the work of the test sites. It also established a social network site to encourage sharing of lessons learned. The test sites have made some progress in redesigning services to shift the emphasis away from dealing with the consequences of health inequalities towards preventing their occurring. However, there is no evidence that they have helped to reduce health inequalities, or that examples of service redesign have helped to inform spending decisions, either locally or nationally.

64. National and local evaluations have reported that all the sites had made some progress in improving local partnership working and sharing lessons learned (Case study 3). These improvements were due to: ongoing support from senior managers, boards and local politicians; shared understanding of organisations' roles and contributions; engagement with service users and communities; and having clear, shared outcomes.[54]

65. There has been considerable shared learning between the test sites, and some effective local approaches have been extended to other parts of Scotland. However, the national evaluation of the test sites reported difficulties in transferring an approach from one area to another.

Case study 3

Fife Test Site: Mobile Alcohol Intervention Team

This local project aims to reduce alcohol misuse among under-16s by increasing their awareness of the consequences of alcohol misuse and providing guidance on responsible drinking. The project started in 2009 and involves a partnership between Clued Up (a voluntary substance misuse organisation which led the project), NHS Fife and the police. The project offers alcohol brief interventions to under-16s drinking on the streets on Friday nights, followed by a further assessment two to three weeks later.

The project started in Kirkcaldy and has since been extended to other parts of Fife. The success of the project relied on effective partnership working, with all organisations having clear roles and responsibilities. Clued Up and NHS Fife produced a training pack for practitioners to deliver alcohol brief interventions to young people, including a DVD showing good and bad practice. NHS Health Scotland plans to extend the use of this training pack across Scotland.

Early results showed that between April 2011 and March 2012, 94 young people received alcohol brief interventions. Of the 64 who engaged with follow-up assessments, 69 per cent said they had followed some of the harm-reduction suggestions, and 41 per cent reported that they had reduced their alcohol use. A third of these participants were retained by Clued Up for further support. The programme is currently undergoing external evaluation.

Source: Fife Equally Well Test Site

There is limited evidence to date of the impact of national policies and strategies

66. Policies and legislation which introduce regulatory controls can contribute to reducing health inequalities.[55] For example, there is evidence that the 2006 ban on smoking in public places has led to improvements in health. In 1998, almost two-thirds of non-smokers were exposed to second-hand smoke but in 2010 this figure had fallen to a quarter of non-smokers.[56] The ban may have led to decreased rates of premature and low birthweight babies, and in the ten months following the ban hospital admissions for heart attacks were 17 per cent lower than in the ten months prior to the ban.[57] [58] These improvements may have helped to reduce health inequalities given the link between smoking and deprivation. The overall percentage of adults who smoke fell from 25.4 per cent in 2006 to 23.3 per cent in 2011.[59]

67. The issues underlying health inequalities are complex and many interventions are long-term, often taking a generation or longer before there are significant improvements. Successive governments in Scotland have introduced a range of strategies which aim to improve health and reduce health inequalities (Appendix 3). There is a risk that

54 *Equally Well Test Sites: Evaluation*, NHS Health Scotland, May 2011.
55 *Inequalities in health in Scotland: what are they and what can we do about them?* S Macintyre, MRC Social and Public Health Sciences Unit, 2007.
56 *Scottish Health Survey*, Scottish Government, 2011.
57 *Better Heart Disease and Stroke Care Action Plan*, Scottish Government, 2009.
58 'Impact of Scotland's Smoke-Free Legislation on Pregnancy Complications: Retrospective Cohort Study', D Mackay et al, 2012.
59 *Scotland's People Annual report; results from 2011 Scottish Household Survey*, Scottish Government, 2012.

policies which aim to improve the health of the whole population may widen inequalities, and although it is too soon to assess the long-term impact of these strategies on wider health and their contribution to reducing health inequalities, measures of short-term impact are important to demonstrate progress towards the policy goals. For example, the Scottish Government uses sales data to demonstrate the short-term impact of its alcohol framework.[60]

The NHS has new targets to reduce health inequalities

68. NHS boards report to the Scottish Government on performance through the national performance system for the NHS (HEAT), which includes targets aimed at improving health.[61] Two of the NHS targets due for delivery in 2013/14 – delivering agreed numbers of child healthy weight interventions and smoking cessation services – are specifically designed to help reduce inequalities, as a minimum number of services must be delivered in the 40 per cent most deprived areas. The NHS also has targets for at least 60 per cent of three- and four-year-old children at each deprivation level to receive at least two applications of dental fluoride varnish per year by March 2014, and for at least 80 per cent of pregnant women at each deprivation level to have booked for antenatal care by the twelfth week of pregnancy by March 2015.

Some specific interventions have reduced health inequalities but better evidence about cost effectiveness is needed

There is no evidence to date that targeted national programmes have helped to reduce health inequalities

69. *Keep Well* is the main national programme for tackling health inequalities in Scotland and invites all people aged between 40 and 64 living in areas of high deprivation to attend a health check.[62] These checks include screening for cardiovascular disease and its main risk factors such as high blood pressure, high cholesterol, smoking and poor diet. The programme costs over £11 million a year. NHS Health Scotland has evaluated *Keep Well* to assess the feasibility and challenges of delivering the programme, but there is little evidence yet of the impact of *Keep Well* on health outcomes or life expectancy as these will only be apparent in the longer term (at least ten years).[63] The evaluation did not cover cost effectiveness, and NHS Health Scotland has not yet determined how to evaluate the long-term impact and cost effectiveness of *Keep Well*.

70. Two other targeted national programmes have also yet to demonstrate effectiveness in terms of improved outcomes:

- *Childsmile*, introduced across Scotland in 2008, is a national programme designed to improve the dental health of children in Scotland, and reduce inequalities in dental health by targeting children in the 20 per cent most deprived areas. The Glasgow Dental School is overseeing a programme to evaluate the impact of *Childsmile*, including cost effectiveness.

- *Family Nurse Partnership*, introduced initially by NHS Lothian in 2010, offers intensive and structured home visits by specially trained nurses to vulnerable first-time teenage mothers from early pregnancy until the child is two years old. It aims to improve pregnancy outcomes, child health and development, and parents' economic self-sufficiency. The Scottish Government provided around £5 million to test the programme in two NHS board areas, Lothian and Tayside, and it plans to roll out the programme across the rest of Scotland. Initial evaluation of the programme indicates that there was high enrolment and low drop-out rates, and includes some brief data on changes in behaviours, such as alcohol consumption. The Scottish Government plans to assess changes in parenting behaviours but recognises that it may not be able to determine the direct impact of the programme.

Small-scale local interventions have demonstrated some impact but a greater focus on outcomes is needed

71. Some local initiatives aimed at reducing health inequalities have reported positive outcomes (Case study 4, overleaf), but these have only been implemented in small local areas. The Scottish Government and CPPs should ensure that, where appropriate, successful local initiatives for reducing health inequalities are rolled out more widely and receive sufficient funding. It is important to pilot new initiatives to determine whether they are effective but regular introduction of short-term local initiatives can be disruptive and will have limited lasting impact on reducing health inequalities.

72. Evaluations have tended to focus on process measures and outputs rather than outcomes, and have not considered cost effectiveness. CPPs need to ensure that robust evaluation, including a clear focus from the outset on cost effectiveness and outcome measures, is an integral part of local initiatives and that staff have the skills to carry out evaluations.

60 *Changing Scotland's Relationship with Alcohol: A Framework for Action*, Scottish Government, 2009.
61 The HEAT performance management system covers indicators relating to Health improvement, Efficiency and governance improvement, Access to services and Treatment appropriate to individuals.
62 In 2012, *Keep Well* was extended to include carers, prisoners, homeless people and people with substance misuse problems.
63 *Evaluation of Keep Well*, NHS Health Scotland, 2011.

Case study 4

Quit4u smoking cessation programme

In 2009, NHS Tayside launched the quit4u programme to increase the take-up of smoking cessation support and quit rates among smokers in deprived areas of Dundee. The programme combined structured behavioural support and drug treatment with financial incentives for each week (up to a maximum of 12 weeks) that participants did not smoke. In May 2012, NHS Health Scotland published an evaluation of quit4u which concluded that, compared with other smoking cessation services and self-quit attempts, the programme was an effective and cost-effective model for engaging and supporting smokers in deprived areas to quit. NHS Tayside extended quit4u to smokers in deprived areas in Perth and Kinross from November 2010, and in Angus from August 2011. It is also currently being tested in Glasgow.

Source: *Evaluation of quit4u: Main report,* NHS Health Scotland, 2012

Performance measures should provide a clearer picture of progress

73. A range of performance information provides an indication of progress in reducing health inequalities. This includes both national and local measures, covering a range of process measures (for example, the number of smoking cessation services delivered) and outputs (for example, the prevalence of smoking among adults). The various national measures provide an indication of overall progress, but there is little detailed analysis to assess the performance of local bodies in reducing health inequalities.

Single Outcome Agreements do not provide robust evidence of progress in reducing health inequalities

74. CPPs prepare Single Outcome Agreements (SOAs) and agree these with the Scottish Government. The SOA sets the strategic priorities and outcomes which councils, NHS boards and other organisations aim to achieve for their local communities.

In *Equally Well*, the Ministerial Task Force stated that accountability for delivering action and change to tackle health inequalities would be through the SOA process.

75. CPPs publish annual reports on their performance in delivering their SOAs, including progress against a range of outcome indicators. These indicators include measures relating to health inequalities, such as reducing the prevalence of smoking among the local population and providing services aimed at tackling alcohol misuse. We reviewed all published CPPs' 2010/11 annual reports on their performance in delivering their SOAs (Exhibit 21).[64] Overall, CPPs' annual reports on performance in delivering the SOA do not provide consistent or robust evidence about how well they are tackling health inequalities in their local areas and differences among SOAs mean that a Scotland-wide picture is hard to identify. CPPs need to ensure that SOAs include clear outcome measures for reducing health inequalities which demonstrate impact, and improve the transparency of their performance reporting to allow a better understanding of how well they are reducing health inequalities.

76. Audit Scotland is currently carrying out audits of three CPPs in Scotland. This work will help to highlight effective practice and look at the progress CPPs are making particularly in relation to SOAs, CPP governance and leadership and the delivery of local outcomes. The audits are being carried out in the context of the 2012 review of community planning and SOAs by the Scottish Government and COSLA which made clear that effective community planning arrangements will be central to public service reform and proposed placing of formal requirements on CPPs and strengthening the duties of individual partners.[65] [66]

The Scottish Government should revise national performance measures to present a clearer picture of progress

77. The Scottish Government's long-term indicators of health inequalities present national-level data across deprivation levels. However, to allow a more detailed analysis of progress in reducing health inequalities, the Scottish Government should also publish information at a more local level (for example, by CPP area) and for other factors such as ethnicity.

78. The Scottish Government's *Scotland Performs* website presents information on how Scotland is performing against a range of National Indicators. A number of the current indicators, such as reducing death rates among under-75s, improving children's dental health, improving mental wellbeing and reducing the percentage of adults who smoke, aim to promote health improvements for the general population. Other indicators, such as reducing the proportion of individuals living in poverty, and reducing children's deprivation, are linked to the wider

64 Stirling CPP did not publish a 2010/11 report on its SOA.
65 *Review of Community Planning and Single Outcome Agreements: Statement of Ambition*, Scottish Government and COSLA, March 2012.
66 *Review of Community Planning and Single Outcome Agreements: Update*, Scottish Government and COSLA, May 2012.

Exhibit 21

Review of CPPs' 2010/11 annual reports on their performance in delivering their SOAs

CPPs' reports do not provide consistent or robust evidence about how well health inequalities are being tackled.

- Many reports were difficult to interpret, and varied widely in their quality and accessibility (for example, some reports were over 200 pages long).
- Reports used different baseline measures, and in some reports the baselines were unclear, making it difficult to establish what progress had been made.
- Some reports included commentary on how local indicators compared with Scotland as a whole but did not include trend data to demonstrate whether local progress had been made.
- How success was defined varied widely across the reports, with some including specific targets while others simply specified a change in direction.
- Some reports did not clearly specify whether targets had been met, or gave no indication of progress.
- Reports were inconsistent in the extent to which they included HEAT targets and national indicators relating to health inequalities.
- Health indicators were often presented for the general population rather than for different population groups.

Source: Audit Scotland analysis of CPPs' 2010/11 annual reports

determinants of health and health inequalities. However, none of the current indicators specifically monitors changes in health-related measures among people in deprived areas. Since reducing health inequalities is a Scottish Government priority, it should introduce appropriate national indicators to monitor progress through *Scotland Performs*.

79. The range of performance measures and reporting arrangements relating to health inequalities makes it difficult to establish a clear picture of progress. CPPs need a consistent set of measures to help focus their work on improving health inequalities. The Scottish Government, CPPs and the constituent organisations should consider ways of aligning and rationalising the current range of performance measures to present a more coherent picture of progress.

Recommendations

The Scottish Government should:

- develop measures of short-term impact to demonstrate the effectiveness of its strategies which aim to improve health and reduce health inequalities in the longer term
- assess the impact on health inequalities of policies which aim to improve the health of the whole population
- continue to support shared learning among the *Equally Well* test sites and encourage the transfer of effective local approaches to other areas
- publish information at a more local level than Scotland-wide, and include factors such as ethnicity, to allow a more detailed analysis of progress in reducing health inequalities
- introduce national indicators to specifically monitor progress in reducing health inequalities and report on progress.

The Scottish Government and CPPs should:

- ensure that cost effectiveness is built into evaluations of initiatives for reducing health inequalities from the start
- ensure that, where appropriate, successful local initiatives for reducing health inequalities are rolled out more widely
- align and rationalise the various performance measures to provide a clear indication of progress
- establish a shared understanding of what is meant by 'health inequalities'.

CPPs should:

- provide strong and supportive leadership which helps to promote effective partnership working to reduce health inequalities at a local level
- involve local communities in activities which are aimed at reducing health inequalities
- ensure that all partners are clear about their respective roles,

responsibilities and resources in tackling health inequalities, and take shared ownership and responsibility for actions aimed at reducing health inequalities

- clarify with CHPs (and, over time, with the proposed integrated Health and Social Care Partnerships) the respective roles and responsibilities for reducing health inequalities
- include in SOAs clear outcome measures for reducing health inequalities which demonstrate impact
- ensure that all partners take steps to improve the sharing of information to help joint working aimed at reducing health inequalities
- improve the transparency of their performance reporting to allow a better understanding of how well they are tackling health inequalities
- ensure that robust evaluation, using all available data and including outcome measures and associated costs, are an integral part of local initiatives aimed at reducing health inequalities and that staff have the skills to carry out evaluations.

NHS boards and councils should:

- carry out health inequalities impact assessments when designing new services or redesigning existing services.

Appendix 1.

Audit methodology

We reviewed a range of published information to inform our audit, including:

- Scottish Government *Equally Well* documents, annual reports on long-term indicators of health inequalities, national strategies, and National Indicators and HEAT targets
- Community Planning Partnerships' 2010/11 SOA reports
- evaluations of interventions to reduce health inequalities, including *Keep Well*
- NHS Director of Public Health annual reports
- reports by Glasgow Centre for Population Health
- reports by NHS Health Scotland
- academic papers, including the University of Glasgow's GPs at the Deep End series
- other published reports, including the 2010 National Audit Office report, *Tackling inequalities in life expectancy in areas with the worst health and deprivation.*

We reviewed published and unpublished data including:

- NHS Information Services Division (ISD) data
- National Records of Scotland statistics
- Scottish Health Survey data
- ScotPHO data
- Office for National Statistics life expectancy data
- NHS Scotland Practitioner Services Division (PSD) data on community pharmacies.

We issued data requests to the Scottish Government regarding funding allocations in various topic areas. We used this information to compile an overall estimate of the total funding to NHS boards to directly address the problems related to health inequalities.

We commissioned ODS Consulting to carry out focus groups with CPP managers, CHP managers and frontline staff from 12 CPP areas to gather views on how effectively local health inequalities are being tackled. We have published a separate report on Audit Scotland's website.

We carried out our own analysis of ISD published data on QOF payments, matching it with Scottish Index of Multiple Deprivation (SIMD) information. We used this information to explore how recent changes to the GMS contract have affected QOF payments in deprived areas. Additionally, we analysed PSD and ISD data on the distribution of pharmacies and dentists, again matching the data with SIMD information.

We carried out interviews with:

- staff at five *Equally Well* test sites to discuss their progress in improving partnership working and redesigning services
- ISD staff to discuss data, and to request unpublished statistics
- Scottish Government policy staff including the Chief Nursing Officer
- directors of Public Health from six NHS boards
- staff from NHS Health Scotland, Glasgow Centre for Population Health and COSLA
- academics from Glasgow University and Edinburgh University
- representatives from the voluntary sector.

Appendix 2.

Membership of the advisory group

Audit Scotland would like to thank the members of the advisory group for their input and advice throughout the audit.

Member	Organisation
Dr Pauline Craig	NHS Health Scotland
Dr Ron Culley	Convention of Scottish Local Authorities
Donald Henderson	Scottish Government
Tim Kendrick	Fife Community Planning Partnership
Susan Manion	Dunfermline and West Fife Community Health Partnership
Dr Kat Smith	University of Edinburgh
Dr Diane Stockton	Information Services Division, NHS National Services Scotland
Dr Drew Walker	NHS Tayside
David Walsh	Glasgow Centre for Population Health

Note: Members of the project advisory group sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 3.

National strategies for improving health and addressing health inequalities

Strategy	Description and impact
Strategies focused on addressing health inequalities	
Equally Well (June 2008)	• Considers the evidence for health inequalities in Scotland and how health and other public services might respond to factors that affect people's health. • The Ministerial Task Force carried out a review of *Equally Well* in June 2010. The Task Force did not expect to see changes in health outcomes since the publication of *Equally Well* as it had not been in place for long. Instead, it reviewed progress against the recommendations in *Equally Well* and made further recommendations for the Scottish Government and CPPs.
Child Poverty Strategy for Scotland (March 2011)	• The main aims of this three-year strategy are to maximise household resources and improve children's well-being and life chances. Expenditure will move more to early intervention and prevention. The Scottish Government plans to introduce a Children's Services Bill and a Sustainable Procurement Bill, both of which may help to drive improvements in child well-being. • Progress towards targets is reported in the annual report for child poverty strategy in Scotland. The first annual report was published in March 2012 but contained no evidence of impact to date.
Strategies aimed at improving health	
The Road to Recovery: A new approach to tackling Scotland's drug problem (May 2008)	• Sets out priorities and an action plan for prevention, support and recovery. • In May 2009, the Scottish Government published *The Road to Recovery: One Year On* which reported on progress and described future work needed to deliver changes but did not include any information about impact. The Scottish Government provides updates through its *Drug and Alcohol Delivery Bulletin*. These bulletins have reported some progress, such as a fall in self-reported drug use, and higher levels of testing for blood-borne viruses among injecting drug users, but not specifically linked to the actions in *The Road to Recovery*.
Better Cancer Care: An Action Plan (October 2008)	• Sets out actions to reduce the number of people who develop cancer and to support people with cancer. The Scottish Cancer Taskforce was established to oversee the delivery of the plan. • The Scottish Government published a progress report in December 2010 which highlighted separate action plans to reduce smoking, alcohol misuse and obesity, as well as early detection through screening programmes. However, it contained no information about the impact of the Cancer Plan to date.
Achieving Our Potential (November 2008)	• Sets out a new approach to tackling poverty in Scotland • The Scottish Government published a report in 2011 which considered the evidence around financial capability, affordable housing, education and childcare. The report also included recommendations for future work, but contained no evidence about impact.
Early Years Framework (December 2008)	• Seeks to maximise positive opportunities for children and address the needs of those children whose lives are constrained by poverty, poor health, poor attainment and unemployment. • The Scottish Government published a progress report in 2011 which outlined progress against a range of short- and medium-term indicators. This described a range of processes and actions since the framework was published but there was little information about outcomes.

Strategy	Description and impact
Changing Scotland's Relationship With Alcohol: A Framework for Action (February 2009)	• Contains plans to use legislation to achieve shorter-term goals and to effect cultural change for longer-term goals. Actions will involve the health service, local councils, the alcohol industry, police and the voluntary sector. • A monitoring and evaluation group was set up to oversee evaluation of the outcomes. In March 2011, its first annual report described baseline trends for alcohol consumption, affordability and alcohol-related harms. In June 2012, a report on the impact of the quantity discount ban on off-trade alcohol sales found a small decline in off-trade sales in Scotland since the ban, but this reduction was also seen in England and Wales where there was no ban. Further data is required to determine if this is a clear trend. Future annual reports will give further information on impact and relevant trends over time.
Towards a mentally flourishing Scotland (May 2009)	• In August 2012, the Scottish Government published its mental health strategy for Scotland, which reported on progress towards meeting commitments in *Towards a mentally flourishing Scotland: Policy and Action Plan 2009-12*. There are 36 specific commitments to be delivered over the period to 2015 covering mental health improvement, prevention, care, services and recovery. The strategy highlights achievements so far including a fall in the number of psychiatric readmissions and in the suicide rate.
Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight (February 2010)	• Outlines the various actions which central government, local councils and the NHS will take to prevent and manage obesity in Scotland. • The Scottish Government published an action plan in March 2011 (updated in September 2011) and a set of 16 indicators which it will use to monitor progress in tackling obesity. The plan includes milestones for achieving specific aspects of the strategy, and the Government plans to update the indicators every year. • The Scottish Government established a Joint Obesity Ministerial Group to oversee the implementation of the strategy and report on progress towards milestones and indicators. There is no evidence of impact to date.
Diabetes Action Plan 2010: Quality care for diabetes in Scotland (August 2010)	• Contains a wide variety of actions, including preventing diabetes, treatment and supporting people to help them to self-manage their condition. There are separate actions aimed at improving the care of people from black and ethnic minorities. • The Scottish Government has yet to report on progress.

Source: Audit Scotland, 2012

Health inequalities in Scotland

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Audit Scotland Report – Health inequalities in Scotland

CPP Response for submission to Management Committee 06/02/2013

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
CPPs should provide strong and supportive leadership which helps to promote effective partnership working to reduce health inequalities at a local level	Yes	**TSP** Through appropriate lead partners and engaging other partners as is relevant to initiatives' lead partners working with health issues at local level are firmly rooted in co-production model of work (some nationally recognised) Appropriate partners are leading actions and working in partnership across a range of actions and initiatives. Eg Seminar planned – Reducing Social Isolation and Loneliness Older People, specifically including front line staff	Feb 2013	
		SP CPP's should ensure that although Health is the lead agency, that tackling health inequalities impact upon other partners such as the police. Action on improving public health can help to reduce crime, and vice versa. Reducing crime brings benefits to the health system and frees up resources that can be used for other NHS work.		
		SF&R Strategic Manager members must have an understanding of what each partner agency's role is, and must instil partnership responsibilities and ideals into those delivering their service at local level. There is often lack of understanding of partner contribution to addressing health inequalities.		
		ABC The CPP have a Management Committee who meet every 2 months, their main function is to ensure that the work of the partnership has the leadership and capacity to reduce health inequalities.		

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
		The structure of the management process is as follows: Argyll & Bute Community Planning Partnership Management Committee Thematic Leads for Economy, Environment, Social Affairs and 3rd Sector & Communities Strategic Partnerships and Local Community Planning groups. There is clear evidence linking the work of the CPP with that of the national and local health targets designed at tackling local inequalities. The Community Health Partnership make a significant investment in preventative health improvement initiatives and via the CPP process supports a number of structures: Argyll & Bute Health & Wellbeing Partnership Health & Wellbeing Grants Health & Wellbeing – Local Health Networks The Seven Key principles identified by the CPP process in relation to Health and Social Care in Argyll & Bute note: 1. Promoting good health, self-care and independence 2. Quality service that is fair , affordable and based on need and clinical evidence 3. More community based with hospital beds for those acutely ill and those needing specialist care 4. Joint working with LA, voluntary and private sector 5. Run by well trained and flexible staff working to the top of their skills 6. Using modern facilities and technology to best effect. Services and offices across fewer sites 7. On-going redesign to remove waste and inefficiency with minimal overhead costs		

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
CPPs should involve local communities in activities which are aimed at reducing health inequalities	Yes	**TSP** I think we miss some partners contributions and don't necessarily make best use of either community intelligence or initiatives partners are engaged with – possibly because they simply don't come up under an agenda item. We could be smarter on this. Self assessment and greater efforts by CPP partners have increased sharing of responsibility and ownership. Partners are able to report to CPP and can raise concerns or initiate actions with any other CPP partners – number of examples. Increased awareness of co-production and health issues planned with series local roadshows across the area rolled out over 2013 – 2014. CPP partners engage with local model of care / reshaping care partnerships and take active part in decision making bringing community intelligence, views to table and taking responsibility for actions. Room for additional work with wider partnership – making the maximum resource from partners' partners.	2012 – Over 2013-14 Established December 2012	
		SP CPP's should understand that crime affects health in a number of ways, directly, indirectly and by influences on the health care system. Crime affects health: • Directly, (eg) through violence, injury, rape and other offences against the person. • Indirectly, through the psychological and physical consequences of injury, victimisation and isolation because of fear. These effects persist across time. • As a determinant of illness, along with poverty and other inequalities, which		

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
		increase the burden of ill-health on those communities least able to cope. • By reducing the effectiveness of our health care systems through violence against staff, damage to patients and property, and revenue lost in replacement, liability/risk, repair and security, and • By preventable health burdens, such as alcohol-related crime, motor vehicle incidents and drug dependency.		
		SF&R In order to engage fully in the arrangement of activities, it is essential that those who are the target of the activity have an involvement. Deliver what the community needs the way they want it.		
		ABC Local examples of involving local communities are: • Telehealth Care- Pilot focussed on people with Chronic Obstructive Pulmonary Disease, resulting in a reduction in admission to hospital through the use of technology. As a result of this success there are now home pods in Bute, Cowal, Lochgilphead, Mull and Taynuilt. • Community Safety Partnership- This is a council lead partnership which brings together representatives from LA, Police and Fire & Rescue service, Health, Education, Public and Third Sector to promote a healthier and more inclusive communities through a wide range of day to day services • Argyll & Bute Alcohol and Drug Partnership- This partnership works together across Police, LA, Health and Third Sector to prevent and support recovery. • Argyll & Bute Strategic Housing and Communities Forum- The forum supports the development of local housing opportunities, jointly working across Scottish Government and Housing Developers- Mull Progressive Care is one of the key developments		

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
		• Argyll & Bute Local Services Initiative(ABLSI) - Developing and working to maintain sustainable communities, working jointly with voluntary and social enterprise organisations • Third Sector Partnership - This is a partnership between the infrastructure support organisations of ABSEN(Argyll & Bute Social Enterprise Network), Argyll Voluntary Action and Islay and Jura CVS. • Better Community Engagement Resource pack - This is an online resource across partners, that provides a pack to support Better Community Engagement. • HIE- Community Account Management- Currently nine Community Account Management areas in Argyll & Bute , with Local Development Officers supported by HIE and Leader to develop and deliver community plans		
CPPs should ensure that all partners are clear about their respective roles, in tackling health inequalities, and take shared ownership and responsibility for actions aimed at reducing health inequalities	Yes	**TSP** Self-assessment and greater efforts by CPP partners have increased sharing of responsibility and ownership. Partners are able to report to CPP and can raise concerns or initiate actions with any other CPP partners – number of examples. Increased awareness of co-production and health issues planned with series local roadshows across the area rolled out over 2013 – 2014. CPP partners engage with local model of care / reshaping care partnerships and take active part in decision making bringing community intelligence, views to table and taking responsibility for actions.	2012 – Over 2013-14 Established December 2012	
		SP CPP's should ensure that all partners work collectively in respect to spending on reducing health inequalities and to ensure that resources are targeted effectively, even if this takes funding away from NHS and Council and pass to		

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
		police in order to achieve joint outcomes and reduce overall cost and workload to partners.		
		SF&R As stated above, I believe that partners are clear about their own role but may be unclear about partners' roles and activities and where they fit in. This will come from members having an understanding of what information needs to be provided to partners.		
		ABC The CPP process identifies seven key CPP measures: • CPP08- Our children are protected and nurtured so that they can achieve their potential • CPP09- Our older people are supported to live more active, healthier and independent lives. • CPP10- We work with our partners to tackle discrimination • CPP11-Vulnerable adults, children and families are protected and are supported in sustainable ways within their communities • CPP12- Our young people have the skills , attitudes and achievements to succeed throughout their lives • CPP13-The impact of alcohol and drugs on our communities and on the mental health of individuals, is reduced. • CPP14- The places where we live, work and visit are well planned, safer and successful, meeting the needs of our communities. (Argyll & Bute Community Plan & Single Outcome Agreement 2012-13) Below each of these partnership indicators lies a series of smaller targets which are linked to HEAT targets for the CHP and identify directly the approach being taken in relation to child and adult health inequalities.		
CPPs should clarify with	Yes	**TSP**		

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
CHPs (and, over time, with the proposed integrated Health and Social Care Partnerships) the respective roles and responsibilities for reducing health inequalities		SAS is a gap – currently to be addressed at CPP and / or CHP level. SAS do engage with Transport initiative led by interface. Comments about partners' partners apply here.		
		SP CPP's should ensure that data collection techniques from all partners are reviewed to ensure single data zones to obtain adequate quantitative data at localised levels across the Council area that allow for localised differences, trends and patterns to be detected and addressed. Strathclyde Police break down analysis to levels such as Multi Member Ward areas but other organisations maintain wider spread data zones.		
		SF&R Undoubtedly required. The Health Inequalities report made no reference to the role of the Fire & Rescue Service in education and intervention activities and the massive reduction experienced in fire fatalities and casualties through targeting activities toward traditionally deprived and at-risk areas of the community.		
		ABC The partnership is currently in the early stages of identifying key areas of work which have to be taken forward in relation to the wider integration agenda. The respective roles and responsibilities will be reviewed following decisions on the model of integration to be pursued.		
CPPs should include in SOAs clear outcome measures for reducing health inequalities which demonstrate impact	Yes	**TSP** Recent work has been to emphasise that if a contribution is being made it should be captured – there are some fairly substantive areas where I don't see success being captured / measured (but I don't access pyramid so this could be my ignorance about how it is set up / recorded)		
		SP		

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
		CPP's should ensure a greater sharing of analytical data held by partners to ensure more efficient joined up working but also to review potential missing areas of work.		
		SF&R Agreed measurement required to demonstrate achievement of outcomes		
		ABC There is a clear identification throughout the CPP process and supporting documentation that the need to address health inequalities remains a priority. This is seen clearly in the CPP measures across social affairs; however it is recognised that this could be developed more to link with the Health Delivery Plan.		
CPPs should ensure that all partners take steps to improve the sharing of information to help joint working aimed at reducing health inequalities	Yes	**TSP** **1.** Co-production roadshows 2. Currently using the SOA / Community plan consultation as vehicle to address some of the gaps and improve understanding within third sector		
		SP CPP's should ensure that relevant partners, particularly Health, have long term plans in place for the expected rise in the elderly population of Argyll and Bute to ensure that all partners are fully aware of this demographic change and to ensure that any change in strategy by one partner in light of this does not have any overly adverse impact on any other partner (eg) Health increasing funding towards elderly care at expense of possibly young people, drugs, alcohol. CPP's should ensure that partnership working is undertaken effectively and efficiently and is continually reviewed to ensure fit for purpose. CPP's to ensure that recognition is given that mental health issues affect a wide range of partners including police who operate as first responders and is not solely a health related issue.		

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
		SF&R SF&R have found the issue of Information Sharing Protocols problematic. Current agreement in principle to include SF&R in the Highland Data Sharing Partnership pending formal participation. Sharing of information is vital to integrated partnership working. Formal use of Information Sharing Protocols should be encouraged between Partner agencies		
		ABC As previously noted the CPP process does identify the benefits of sharing information across the partnership and the development of the Better Community Engagement Resource Pack was key to tackling this issue directly. The production of an online resource which could benefit all CPP partners was developed by the Local Area Planning Groups. It exists to support Local Area Planning partners in relation to their own service provision aimed at reducing health inequalities. PYRAMID is identified as the main repository for joint data across the partners and this is supported by the jointly agreed Highland Data Sharing Partnership		
CPPs should improve the transparency of their performance reporting to allow a better understanding of how well they are tackling health inequalities	Yes	**TSP** Not sure the current system is designed for this – as an internal system it may work for public sector. TSP are looking at clear reporting matrix which can be public – it is likely to be tricky to map this across to internal system.		
		SP CPP's to ensure that effectiveness is measured in outcomes and that these are correctly joined up to ensure that the overall CPP outcomes are met and that the CPP calls organisations to account if not achieved.		
		SF&R SF&R provide incident statistics to CPP Governance for inclusion in Pyramid		

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
		and Area Senior Officers are required to provide information at CSF and CPG meetings relating to initiatives and actions being taken to address issues and promote engagement with at-risk members of the community. However, this may not, in the past, have been consistently the case. Media campaigns have also been utilised to ensure that the community is aware of our vision for safer communities. The performance reporting mechanism for scrutiny needs to be easily understood in order to demonstrate achievement of outcomes		
		ABC Performance against key targets is addressed at the 2 monthly Management Committee meetings and the targets and associated indicators linked through the CPP process are all available through the council website, along-with minutes from meetings and new development. Progress is also reflected in the Local Health Delivery Plan with its agreed partnership goals for responding to health inequalities. Key strategic document hyperlinks are available within the CPP text. In relation to communicating joint performance, PYRAMID is seen as the central depository, allowing complete transparency.		
CPPs should ensure that robust evaluation, using all available data and including outcome measures and associated costs, are an integral part of local initiatives aimed at reducing health inequalities and that	Yes	**TSP** There are capacity issues for some partners, notably third sector but the skills and tools exist and CPP interface works closely with CLD at local level to maximise. Matric referenced above will include financial out turn – considering expansion to include other 3rd sector organisations would enable much improved data though somewhat unwieldy to manage – the problem would be buy in from a wider sector – being discussed alongside SOA.		
		SP CPP's to ensure that Drug and Alcohol Misuse is a shared responsibility with all partners understanding their roles and local issues and that support is		

Key Point/Checklist/ Recommendation	Does the CPP have a position Yes/No	Action/Response:	Date for Implement ation	Lead Partner/ Officer
staff have the skills to carry out evaluations.		provided to the Alcohol and Drugs Partnership to ensure joined up working.		
		SF&R All of SF&R's seasonal strategies, educational activities and initiatives are subject to evaluation both for immediate impact on the target audience and for effect on operational activity in the longer term. In consideration of this issue, it would obviously be beneficial if these evaluations were made available to the CPP for transparency.		
		ABC Currently the SOA and underlying CPP process/indicators are detailed in the LA performance management system PYRAMID. Access to PYRAMID is available for partners as required.		

STRATHCLYDE
POLICE
Keeping people safe
POLICE

Argyll & Bute Local Policing Plan 2013-2014

Superintendent Barry McEwan
Divisional Commander
L Division

STRATHCLYDE POLICE | Keeping people safe

PRIORITIES

- VIOLENCE, DISORDER & ANTI-SOCIAL BEHAVIOUR
- PROTECTING PEOPLE
- SERIOUS CRIME & RESPONSE TO NATIONAL EVENTS
- ROAD POLICING
- INCREASE PUBLIC CONFIDENCE & LOCAL ENGAGEMENT

STRATHCLYDE POLICE | Keeping people safe

IDENTIFYING PRIORITIES & OBJECTIVES

RISK ANALYSIS & ASSESSMENT = PRIORITIES

- INFORMATION
- INTELLIGENCE
- LAW ENFORCEMENT AGENCIES
- PARTNER AGENCIES
- THE PUBLIC

STRATHCLYDE POLICE | Keeping people safe

Task Force - Intervention Strategy

DIVERT

- individuals (particularly young people) from engaging in or using the products of serious organised crime

DETER

- through measures to protect communities, businesses and the public sector from serious organised crime

DETECT

- by boosting capacity and improving co-ordination to give serious organised criminals no place to hide.

DISRUPT

- the activities of serious organised crime groups

STRATHCLYDE POLICE | Keeping people safe

THE CONTEST STRATEGY

UK GOVERNMENTS STRATEGY TO COUNTER THE TERRORIST THREAT POSED TO THE UK.

- **PREVENT- People supporting or becoming a terrorist**
- **PROTECT- Our infrastructure by strengthening our protection against attack**
- **PREPARE- To mitigate the impact of an attack**
- **PURSUE- Terrorists and stop Terrorist attacks**

STRATHCLYDE POLICE | Keeping people safe

LOCAL POLICING ARRANGEMENTS

VISIBLE, ACCESIBLE & RESPONSIVE POLICING TO THE NEEDS OF THE COMMUNITY THROUGH PARTNERSHIP WORKING

- L DIVISION COMMANDER
- 3 PORTFOLIO SUPERINTENDENTS
- AREA COMMANDERS OBAN, DUNOON, CAMPBELTOWN
- LOCAL OFFICERS
- CPT, RESPONSE, CID & INVESTIGATION TEAMS

STRATHCLYDE POLICE | Keeping people safe

NATIONAL POLICING OUTCOMES

SCOTTISH GOVERNMENT HAS IDENTIFIED 15 OUTCOMES TO CREATE A MORE SUCCESFUL COUNTRY WITH OPPORTUNITIES FOR ALL OF SCOTLAND TO FLOURISH THROUGH INCREASING SUSTAINABLE ECONOMIC GROWTH

STRATHCLYDE POLICE | Keeping people safe

LOCAL PLAN FOR
ARGYLL & BUTE

Argyll Bute COUNCIL

Area Commander Jim Scott
Argyll & Bute

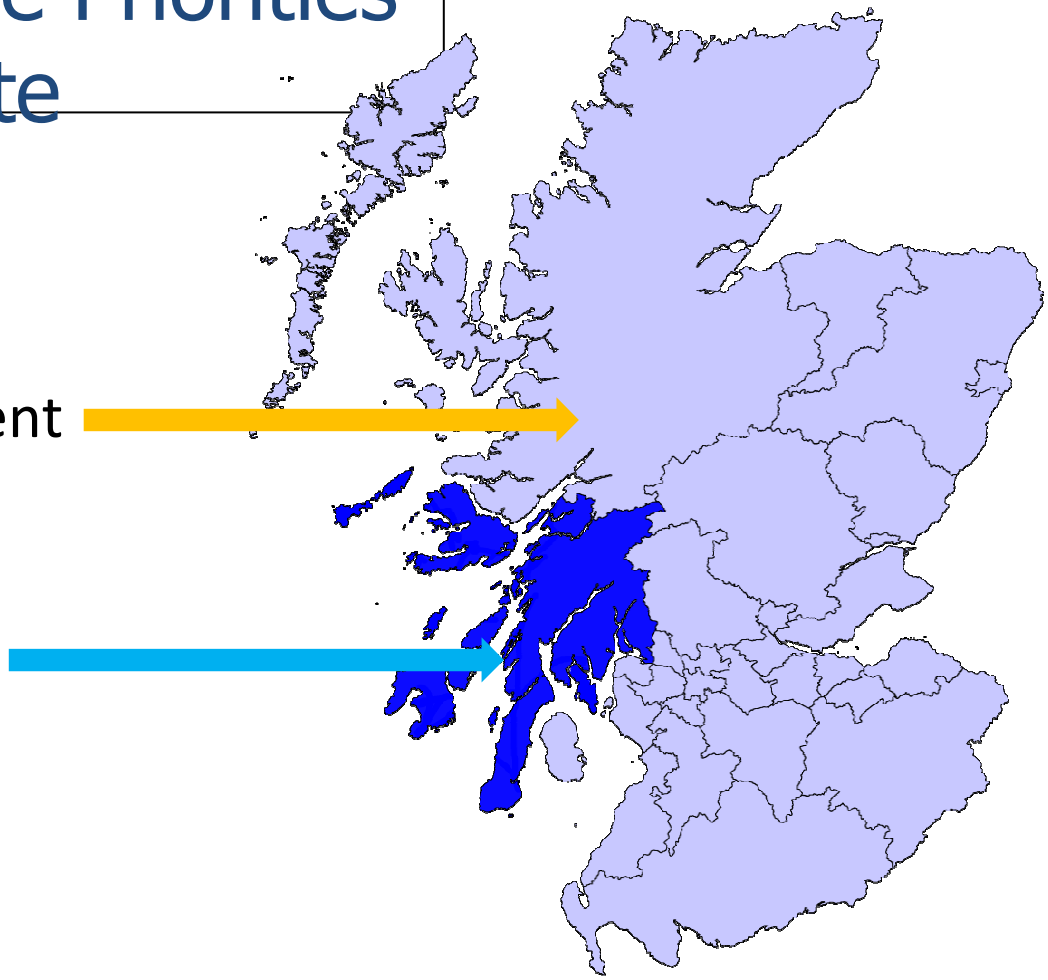
Fire & Rescue Service Priorities Argyll & Bute

SFRS Strategic Plan

National Strategic Assessment

Local Authority Assessment

Local Fire & Rescue Plan



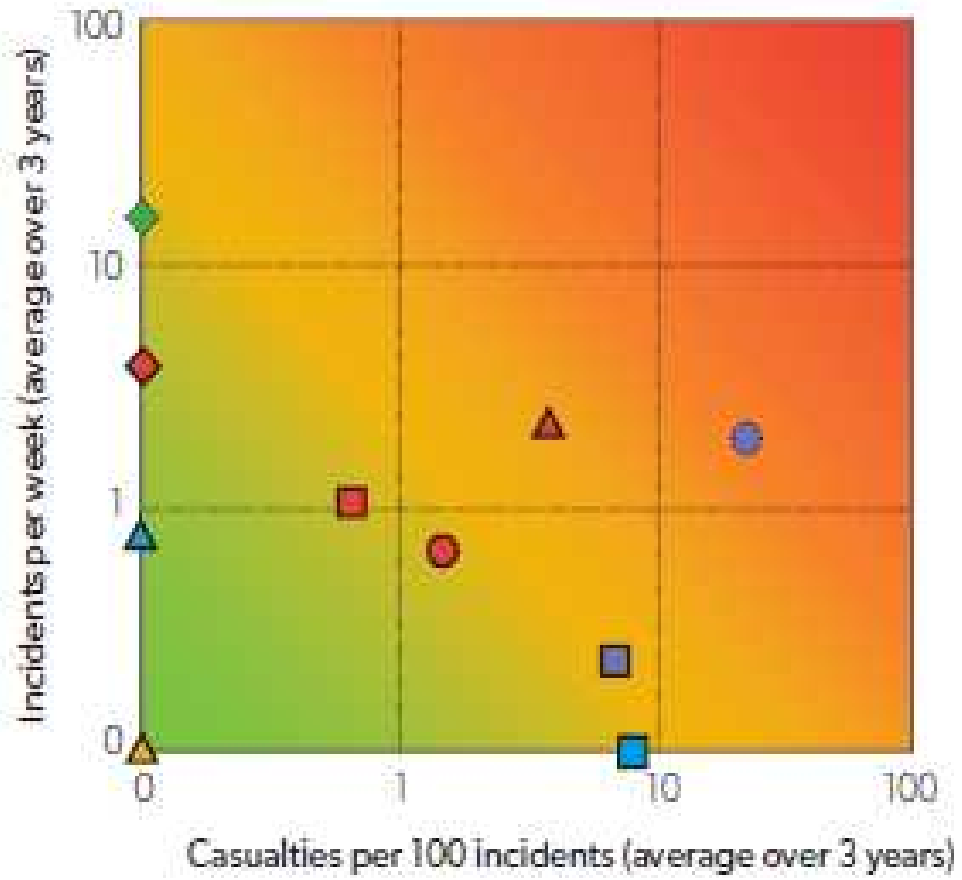
Local Fire & Rescue Plan

- Priorities and objectives for SFRS to carry out duties & functions
- Reasons for selecting those priorities and objectives
- How SFRS propose to deliver those priorities and objectives
- How they can be measured (as far as is reasonably practicable)
- How those priorities and objectives are expected to contribute to the delivery of any other relevant local outcomes which are identified by community planning

Service Activity in Argyll & Bute

	2009/10	2010/11	2011/12	Average
Total	1969	1875	1901	4.3%
Fatalities	12	5	10	10%
Casualties	83	90	87	6%

Fire & Rescue Service Priorities
Argyll & Bute



Fire & Rescue Service Priorities
Argyll & Bute

- Accidental Dwelling Fires
- Fire Casualties
- Deliberate Fire Setting
- Fires in Non Domestic Premises
- Unwanted Fire Alarm Signals
- Road Traffic Collisions

Fire & Rescue Services - Argyll & Bute

Thank You

Questions

Argyll and Bute Community Planning Partnership

Management Committee
6th February 2013

Title: New Community Plan/SOA Progress report

1. SUMMARY

1.1 The current Community Plan / SOA will end in March 2013. This report sets out progress so far in developing the next community plan/SOA.

2. RECOMMENDATIONS

2.1 That the Management Committee considers the proposed format for the new community plan/SOA as outlined in appendix A.
2.2 That the Management Committee considers the proposed outcomes.
2.2 That the draft plan be tabled for comment at the next round of Area Community Planning group meetings in March.
2.3 That the draft plan be tabled at the Council meeting scheduled for the 21st March 2013.

3. BACKGROUND

3.1 The proposed approach to developing the new community plan was agreed at the Management Committee on 22 August 2012. The proposals approved set out an integrated approach to developing the new community plan. The approach was based on a 3 stage approach covering planning and prioritisation, performance management and financial management.

3.4 As part of developing the new community plan it was proposed to undertake a needs analysis and establish a sound evidence base. This was essential in order that there was a clear rationale for the outcomes and priorities included in the new community plan. This was taken forward from September to November 2012 in 2 ways:

- A survey of partners.
- Analysis of current community plan/SOA and national outcomes.

3.5 The information gathered from both the partner survey and analysis of current community plan/SOA and national outcomes has been analysed and refined into an overall evidence base with draft options for consideration by the CPP.

3.6 The outcome from the partner survey and analysis of current community plan / SOA and national outcomes was presented to the Management Committee on 12 December. It was also

presented to special meeting of the Area Community Planning Group (ACPG) with a request for feedback.

3.7 Three discussion groups have since been established to look at the findings of the needs analysis and to start to formulate the proposed outcomes for the new community plan/SOA. The groups are considering outcome under the six Scottish government key priority areas. The members of the groups are noted below

Group 1 Douglas Cowan (HIE) Sue Gledhill (HIE) Robert Pollock (ABC) Ishabel Bremner (ABC) Andrew Campbell (SNH) Frances Webster (SDS) Roddy Bailey (SDS)	Key Policy Priority Areas -Economic recovery and growth -Employment
Group 2 Cleland Sneddon (ABC) Andrew Campbell (SNH) Alison McGrory (NHS) Glenn Heritage (TSP) Mark Wilson (SP)	Key Policy Priority Areas -Early years -Health inequalities and physical activity -Outcomes for older people
Group 3 Jim Scott (SF&R) Barry McEwan (SP) Robert Cowper (ABC) Eddy Renfrew (SF&R) Mark Wilson (SP) Alistair McLaren (TSP)	Key Policy Priority Areas -Safer and stronger communities, and reducing offending
Also attending all three groups Eileen Wilson (ABC – community planning) Chris Carr (ABC – research and information) Lyndis Davidson (ABC – performance management)	

3.8 A copy of the draft set of long term outcomes is attached as Appendix B. It would be helpful if the Management Committee consider these.

3.9 A further round of meetings will take place in late February. These meetings will focus on taking the long term outcomes (10 years) and developing a set of short term outcomes (1-3 years) and actions to deliver the outcomes. The actions will set out what the CPP will do to deliver the outcomes. In developing this element of the plan it will be critical to identify the contribution of each CPP partner and to identify actions that are SMART in order that clear performance measures can be developed and there is a clear line of sight for delivering outcomes.

3.10 It is also envisaged that individual partners will be able to confirm their commitment to the outcomes and actions proposed in the

community plan during the period to 20 March.

3.11 For the CPP Full Partnership on 27 March it is envisaged the final draft of the community plan will be circulated which in addition to setting out the outcomes also has details of short term outcomes and the actions all agreed by individual partners.

3.12 Following the 27 March meeting of the CPP Full Partnership the next stage in the process to be concluded by 30 April will be

- Submit community plan to Scottish Government for consideration (By 31 March).
- Fully develop performance measures for each action.
- Develop reporting timetable for performance measures.
- Develop reporting framework – scorecard and exception / narrative reports on success, challenges and action etc along with analysis.

4. CONCLUSION

4.1 The development of the new community plan/SOA is on track. Following discussion on the 6th of February at the Management Committee the discussion groups will continue to develop the plan. A further draft plan will be tabled at the Management Committee meeting on the 6th of March with the final draft being signed off at the Full Partnership meeting on the 27th of March 2013. Once signed off the document will be submitted to the Scottish Government.

For further information contact: Eileen Wilson
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Appendix A – Proposed structure

Argyll and Bute Community Plan – SOA 2013-2023

INTRODUCTION

What the SOA is and how it works, etc Logos of partners….

UNDERSTANDING PLACE

About Argyll and Bute

Overview of area, economy and growth, employment, demographic change, inequalities,

Our communities

Admin areas, population breakdown, regeneration and town centres, etc.

Key issues, challenges and opportunities

Demographics, local economy and growth, community wellbeing, community engagement and development,

PLANNING FOR OUTCOMES – Key Policy Priority Areas

The National Review of Community Planning and Single Outcome Agreements has identified six key policy priority areas to be reflected in agreed outcomes for community planning partnerships. The key areas are:-

.

PP1 - Economic recovery and growth;
PP2 - Employment;
PP3 - Early years;
PP4 - Safer and stronger communities, and reducing offending;
PP5 - Health inequalities and physical activity; and
PP6 - Outcomes for older people.

EMERGING OUTCOMES

PEOPLE

- **Argyll and Bute has a stable population with an increased proportion of economically active people (PP1, PP2)**
- **Children in Argyll and Bute have the best possible start (PP3) ***
- **People live active healthy lives (PP3, PP5, PP6) ***
- **People have the skills, attitudes and achievements to succeed throughout their lives (PP2, PP4)**
- **Health inequalities are reduced (PP3, PP5, PP6) ***
- **People in Argyll and Bute are safe (PP3, PP4) ***

PLACE

- **Communities are safe, strong, resilient and self-reliant (PP4, PP6) ***
- **Communities respect and care for their environment, making use of natural resources to support health and social aspirations.**
- **The natural and built environment is respected valued and free of environmental crime (PP4) ***
- **Argyll and Bute has thriving diverse businesses in rural and urban areas (PP1, PP2)**

PUBLIC SECTOR (PARTNERSHIP WORKING)

- **Argyll and Bute is empowered to deliver its public services (PP1)**
- **Responsibility for delivering outcomes is shared through effective partnership working (PP 1-6) ***

*** Prevention/protection**
i.e shifting focus towards prevention and early intervention; integration of public services; capacity building; accountability, transformational change, etc…

COMMUNITY PLAN VISION
• The strengths in Argyll and Bute's social, natural and built environment can be turned into opportunities for our communities to prosper.
• Argyll and Bute's greatest assets are its people and its stunning and diverse environment. If we are to release the potential of our people and environment, then the community, business and education providers must work together.

CPP STRUCTURE

New structure (diagram)

CPP GOVERNANCE

New governance arrangements

PLANNING AND PERFORMANCE FRAMEWORK

Pyramid, etc….

ENGAGEMENT AND EMPOWERMENT

How we involve our communities throughout the life of this plan

Other information to be included

Police and fire plans for Argyll and Bute
Third sector interface
Reference to Gaelic activity

Appendix B – feedback from discussion groups

GROUP 1 - ECONOMIC RECOVERY AND GROWTH; EMPLOYMENT

21/01/13

Long term outcomes (10 years)	Priority action areas (years 1-3)
Argyll and Bute has a stable population with an increased proportion of economically active people • Halt population decline • Increase working age population • Increase proportion of economically active • More school leavers go into employment, education or training. • The workforce is better qualified	• Attract more working age families into the area • Create more high value jobs • Reduce the impact of welfare reform on families and the local economy through support for employment and training *(possibly including provision of integrated advice, information and support services, which include debt and money management)*
Argyll and Bute has thriving diverse businesses in rural and urban areas • People are better skilled, trained and ready for employment • There are more businesses of scale • There is a higher level of entrepreneurship • The environment is protected and enhanced for all • Our businesses are diverse and thriving • Argyll and Bute is known for its opportunities for new and expanding businesses • Visitors and residents benefit from the areas environment and attractions (tourism) • We make the best use of our environment	• Encourage local apprenticeship and training schemes which align with the demands of the local job market. • Work with local employers, training and FE providers to review current and future skills requirements locally. (Strategic Skills Pipeline) • Work with local traders and property owners, to revitalise our high streets and town centres
Argyll and Bute is empowered to deliver its public services	• Review of current practices in public sector procurement policies and

• The economic impact of the public sector will be maximised in recognition of the socio-economic and geographic characteristics of the area • Local people have support to take up local jobs	processes that gives a more accurate reflection of best value (community benefit clauses, etc) • Promote community benefit clauses • Consider carbon footprint • Review current partnership interventions and programmes to assess impact and alignment with priorities. Public sector – • Plays a key role in developing and maintaining a buoyant local economy. • Provides sustainable community, business and cultural infrastructure. • Improves and protect the environment. • Ensures security and community safety. Promote health and wellbeing. Foster community and individual learning and attainment. • Protects and supports the vulnerable and those in need. • Empowers the community to work in partnership to help shape the places and community in which we live
Long term performance outcomes	**Performance indicators**
Using Menu of Local Outcome Indicators	

GROUP 2 – EARLY YEARS; OUTCOMES FOR OLDER PEOPLE; HEALTH INEQUALITIES AND PHYSICAL ACTIVITY
25/01/13

Long term outcomes (10 years)	Priority action areas (years 1-3)
Children in Argyll and Bute have the best possible start • We invest in future generations • Target investment towards effective prevention where it makes the most impact	• Invest in early years • Develop risk matrix • Send signal to existing partners that we need to something different • Promote intervention and prevention where children are involved in crimes or other areas of concern (eg) serious organised crime, Hate Crime, parental drug or alcohol misuse • Reduce number of looked-after children • Achieve child healthy weight targets
People live have active and healthy lives **Adults living healthier, sustainable, independent lives safeguarded from harm** • Older people live active, independent, healthy lives • People are active members of the community and contribute to the local economy • People choose to maintain independence and are an integral part of their local communities • (Older) People are empowered to make their own choices and supported by their communities to do so	• Develop greater tolerance for risk • Promote and develop Telecare • Promote and build social networks • Reshape care • Develop more cycle tracks • Tackle obesity • Reduce smoking • Tackle hazardous/harmful drinking including alcohol dependency • Promote mental health and wellbeing (23 ½ hours!)
People have the skills attitudes and achievements to succeed throughout their lives • Flexible skillsets enable positive destinations/career path • Capture the contribution of our communities to deliver education	• Self-directed support

• Our school-children are successful learners	
Health inequalities are reduced • Support prevention • Promote positive choices • Tackle/target disadvantage	• Improve track surfaces (walking groups) • Work in partnership to provide health promoting options
Communities respect and care for their environment, making use of natural resources to support health and social aspirations	
Long term performance outcomes	**Performance indicators**
Using Menu of Local Outcome Indicators	

GROUP 3 – SAFER AND STRONGER COMMUNITIES, AND REDUCING OFFENDING
28/01/13

Long term outcomes (10 years)	Priority action areas (years 1-3)
People in Argyll and Bute are safe • People are safe in the community • People are safe in their homes • People are safe while travelling • There is an interagency approach to prevention and intervention	• Develop CPP communication strategy - Promote positive perception and improvements • The CPP takes a lead role in driving the Community Safety Strategy forward
Communities are safe, strong, resilient and self-reliant • Partners work together to support communities to be safer, stronger and more resilient	• CPP to be structured in recommendations on how to work more effectively with Community Councils and other community groups
The natural and built environment is respected valued and free of environmental crime • Our residents and visitors enjoy travelling on our roads • Amenity areas are improved • Our town centres are improved • Communities take responsibility for their environment	
Responsibility for delivering outcomes is shared through effective partnership working • Lines of communication are clearly defined and effective	
Long term performance outcomes	**Performance indicators**
Using Menu of Local Outcome Indicators	

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Argyll and Bute Community Planning Partnership

New Community Plan / SOA 2013-2023

EMERGING OUTCOMES

February 2013

New Community Plan / SOA

- Scottish Government review of Community Planning (throughout 2012)
- Argyll and Bute CPP Needs Assessment (Oct/Nov 2012)
- SOA Guidance published (Dec 2012)
- 3 strategic discussion groups established (Jan 2013)

Discussion group 1

Key Policy Priority Areas

-Economic recovery and growth (PP1)

-Employment (PP2)

Douglas Cowan (HIE)
Sue Gledhill (HIE)
Robert Pollock (ABC)
Ishabel Bremner (ABC)
Andrew Campbell (SNH)
Frances Webster (SDS)
Roddy Bailey (SDS)

Discussion group 2

Key Policy Priority Areas

-Early years (PP3)

-Health inequalities and physical activity (PP5)

-Outcomes for older people (PP6)

Cleland Sneddon (ABC)
Andrew Campbell (SNH)
Alison McGrory (NHS)
Glenn Heritage (TSP)
Mark Wilson (SP)

Discussion group 3

Key Policy Priority Areas

-Safer and stronger communities, and reducing offending (PP4)

Jim Scott (SF&R)
Barry McEwan (SP)
Robert Cowper (ABC)
Eddy Renfrew (SF&R)
Mark Wilson (SP)
Alistair McLaren (TSP)

EMERGING OUTCOMES - PEOPLE

•Argyll and Bute has a stable population with an increased proportion of economically active people (PP1, PP2)

•Children in Argyll and Bute have the best possible start (PP3)*

•People live active healthy lives (PP3, PP5, PP6)*

•People have the skills, attitudes and achievements to succeed throughout their lives (PP2, PP4)

•Health inequalities are reduced (PP3, PP5, PP6)*

•People in Argyll and Bute are safe (PP3, PP4) *

EMERGING OUTCOMES - PLACE

•Communities are safe, strong, resilient and self-reliant (PP4, PP6) *

•Communities respect and care for their environment, making use of natural resources to support health and social aspirations.

•The natural and built environment is respected valued and free of environmental crime (PP4) *

•Argyll and Bute has thriving diverse businesses in rural and urban areas (PP1, PP2)

EMERGING OUTCOMES - PUBLIC SECTOR (PARTNERSHIP WORKING)

•Argyll and Bute is empowered to deliver its public services (PP1)

•Responsibility for delivering outcomes is shared through effective partnership working (PP 1-6) *

NEXT STEPS

- Discussion at Management Committee 6th February 2013
- Discussion groups meet again
  - Group 1 – 22nd February 2013 (10 am)
  - Group 2 – 22nd February 2013 (2 pm)
  - Group 3 – 18th February 2013 (2 pm)
- Long term outcomes/short term outcomes and priority action areas tabled for further discussion at Management Committee 6th March 2013
- Final draft of New Community Plan / SOA presented to Full Partnership 27th March 2013
- New Community Plan / SOA submitted to Scottish Government at end of March 2013

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Argyll and Bute Community Planning Partnership

Management Committee
Date:

Title: Inspection of Children's services In Argyll and Bute

1. SUMMARY

1.1 This report provides the CPP Management Committee with a brief update relating to the Inspection of Children's Service in Argyll and Bute.

A copy of the two important timeline reports is attached at Appendix 1 and 2.

1.2 Key agency leads are actively writing leadership statements which form an important part of the Inspection. These statements set out the progress the Partnership are making in relation to improving outcomes for children and young people across Argyll and Bute.

There are 9 statements in total covering a range of topics including Corporate Parenting, Involvement, GIRFEC, Getting The Best Start, Achieving, Nurtured, Healthy and Active, Children are Safe, and Our Children are Included.

2. RECOMMENDATIONS

2.1 The CPP note that the Inspection will be conducted over 13 days between Monday 4th March 2013 and Friday 19th April 2013.

The CPP note the Inspection Lead who will have overall responsibility for the pilot inspection and the reporting of findings is Judith Tait, Senior Inspector, Care Inspectorate.

The CPP note the Lead Officer for the partnership during the inspection is Liz Strang Argyll and Bute Council.

3. BACKGROUND

3.1 Inspections of care services for children will be used to obtain evidence of:-

- the quality of care services within the Community Planning Partner area
- the experiences of and outcomes for individual children and young people within a care service
- the views of carers – for example foster carers
- the views of staff

3.2 Phase 1

In advance of the Joint Inspection, careful scheduling of a series of short notice or unannounced inspections of regulated care services have been conducted and completed prior to the inspection commencing .A selection of the most relevant services have been selected. This scoping phase of the inspection is currently on-going.

3.3 Phase 2 and 3

Phase Two will be carried out by inspectors on-site and start on the inspection date. Together, the team will carry out a series of scrutiny events.

Phase Three will comprise a review of practice by reading the core records of a statistically valid sample of children. This activity is a core element for each inspection and is designed to provide evidence of the quality of practice.

Proportionate scrutiny will then be carried out in relation to areas of uncertainty about the quality of outcomes for children currently being achieved after the scoping and core phase of the inspection is completed.

3.4 Findings

At the conclusion of the inspection, the findings of Inspectors will be shared with Chief Officers and the CPP.

4. CONCLUSION

CPP Management Committee note the Inspection of Children's services are now underway across Argyll and Bute.

For further information, please contact:

Allen Stevenson
Service Development Manager – Social Work

CARE SERVICE INSPECTION - 2013

PREPARATION								PHASE 1		
WEEK 1 w/b 17.12.12	**WEEK 2** w/b 24.12.12	**WEEK 3** w/b 31.12.12	**WEEK 4** w/b 07.01.13	**WEEK 5** w/b 14.01.13	**WEEK 6** w/b 21.01.13	**WEEK 7** w/b 28.01.13	**WEEK 8** w/b 04.02.13	**WEEK 9** w/b 11.02.13	**WEEK 10** w/b 18.02.13	**WEEK 11** w/b 25.02.13
					On-site - 0.5 days 1. Brief Community Planning Partners 2. Receipt of PIR material for scoping phase including position statements on corporate parenting and involvement. 3. A&B Issue survey to staff. 4. CI - Selection of case sample					
Develop multi-agency inspection plan.√	Confirmation of template. √	Development of Corporate parenting statement - Alex Taylor/ Mark Wilson. √		Consultation on corporate parenting statement with support forum.			Update progress to CP Partners at CPP.	Multi-agency briefing.	Multi-agency briefing.	
Sharepoint site confirmed suitable.√	Allocate worker. √	Development of involvement statement - Bryan Evans/ Mark Lines. √		Consultation with 3rd Sector on involvement statement.			Activities identified for Inspectors for wk beginning 04.03.13.	Focus groups on statements arranged.	Confirm timetable and send to Inspectors.	
Lead for each agency identified.√		Structures on each agency submitted.√		2 x Statements signed off by partners.					New A&B Children	
Agree high level outcomes.√		Structure A&B. √		2 x Statements signed of by Community Planning.				Timetable for inspectors created.	Statements to CPC (safe statement confirmed) (21.02.13)	
Development of templates for statements.√				Briefing dates arranged for staff.						
Sample date to be confirmed.√				Paper on process ICSP.	Meeting for ICSP. X			Implementation Plan for ICSP	ICSP consultation event (19.02.13)	
Assign statement to lead professionals. Development of 6 statements.√					Submit PIR. √					
Template for activities for Inspectors. √					Community Planning partners sign CP Promise. ???	List of Sample cases to Carefirst trainers for data cleansing.	HOS takes 2 x statements to CPP.			
					Business meeting re New A&B Children	List of allocated workers to DH.				
						9 Statement catch up.				
						Corporate Parenting statement submitted.				
						Sharepoint evidence repository started.				

PHASE 2		PHASE 3						REPORTING OF FINDINGS
WEEK 12 w/b 04.03.13	**WEEK 13** w/b 11.03.13	**WEEK 14** w/b 18.03.13	**WEEK 15** w/b 25.03.13	**WEEK 16** w/b 01.04.13	**WEEK 17** w/b 08.04.13	**WEEK 18** w/b 15.04.13	**WEEK 19** w/b 22.04.13	**WEEK 20** w/b 29.04.13
On-site 3 days - Scoping phase 2 1. Receipt of remaining position statements. 2. Activity in relation to strategic leadership, planning and delivery of services for children including corporate parenting and involvement.		On-site 5 days - Scoping Phase 3 1. Review practice through reading children's records				On-site 5 days Core/ proportionate phase 1. Network supports		On-site 0.5 days - Reporting of findings
Note - need to book activity for Inspectors						Focus Groups		
Arrange network supports →						Network supports		
→								

Pilot Joint Inspection of Services for children (Argyll and Bute Local Authority)			
On-site **3 days**	**On-site** **5 days**	**On-site** **5 days**	**On-site** **0.5 day**
(Mon – depending on access to evidence) **Tues 5th** **Wed 6th** **Thurs 7th**	**w/b 18/03/13**	**w/b 15/04/13**	**w/b 29/04/13 – date tbc**
Scoping phase 2 Judith Tait Joan Lafferty Jacqui Rennie Trish Gillespie Isobel Dumigan John Brown (ES) Young Inspector/s	**Scoping phase 3** Judith Tait Joan Lafferty Jacqui Rennie/HMICS Secondee Trish Gillespie Isobel Dumigan Ruth Swanston (HIS) John Brown (ES) Linda Connelly Helen Happer Paul Silk Alisdair Dawson	**Core/Proportionate phase** Judith Tait Joan Lafferty HMICS Secondee Trish Gillespie Isobel Dumigan Ruth Swanston (HIS) John Brown (ES) Linda Connelly Helen Happer Paul Silk Alasdair Dawson Young Inspector/s	**Reporting findings** Judith Tait Joan Lafferty Other members of the team - tbc
Activities and requirements Reading documentary evidence and background material you provide that will provide us with evidence of the impact of collaborative leadership and partnership working on improving the wellbeing of children and young people. Meeting with strategic leaders/strategic groupings around:- ○ The ICSP and position statements ○ Self-evaluation and improvement ○ Corporate parenting	**Activities and requirements** Review of practice by reading children's records to give us evidence of the impact of services on the wellbeing of children and their families, and the effectiveness of key processes in assessing and planning for children. This as you know is likely to be the paper and electronic records for a sample of approximately 85 children. We will need an inspection base which can accommodate all of the team.	**Activities and requirements** This week will include a range of meetings with staff – both around the children in the sample and around key groupings/processes e.g. early screening groups etc. We would want as far as possible to see people in their work base rather than for them to come to us but a balance is probably needed. I will identify the "teams around the child" we will want to bring together once we have agreed the case sample. We will be mindful of the geography and may need	**Activities and requirements** We have yet to agree a date for reporting findings and I would suggest Wednesday 1st May if you can arrange for Community Planning partners to be available that day. We don't need an inspection base that week. We will come to you at an agreed date, meeting place and time.

○ Involving young people in service development (across services). In addition to attending discussions/meetings, we will need an inspection base that will house us for the 3 days – to read material and to have team discussions. I will work on a list of actual activities and suggested inspectors for these.	As we are looking at lead professional files/named persons in the main a venue where we can access health, education and social work electronic records in one place. Enough of our team have experience of accessing SEMIS, but it might be helpful to have a briefing on the social work system you use at the start of the week (we are familiar with the systems in use this but just need a briefing on your particular system).	to base inspectors in different areas. We will identify a sample of children and families / carers we may wish to follow up during scoping week 3. We will follow up on potential examples of good practice that we have identified in the scoping phases. I will work on a full list of activities around an inspector timetable as we go and get this in place soon but this will be need to remain flexible until we complete the case file reading and consider what else we might need to see/seek.	

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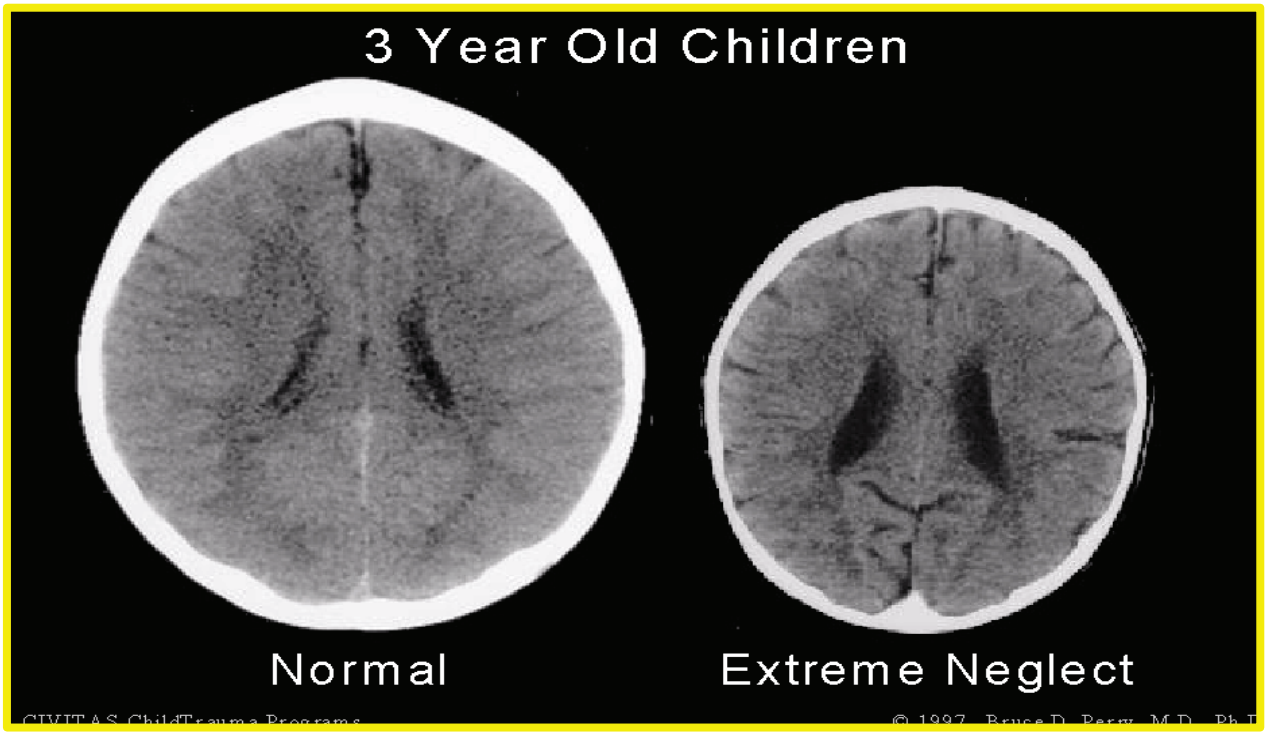
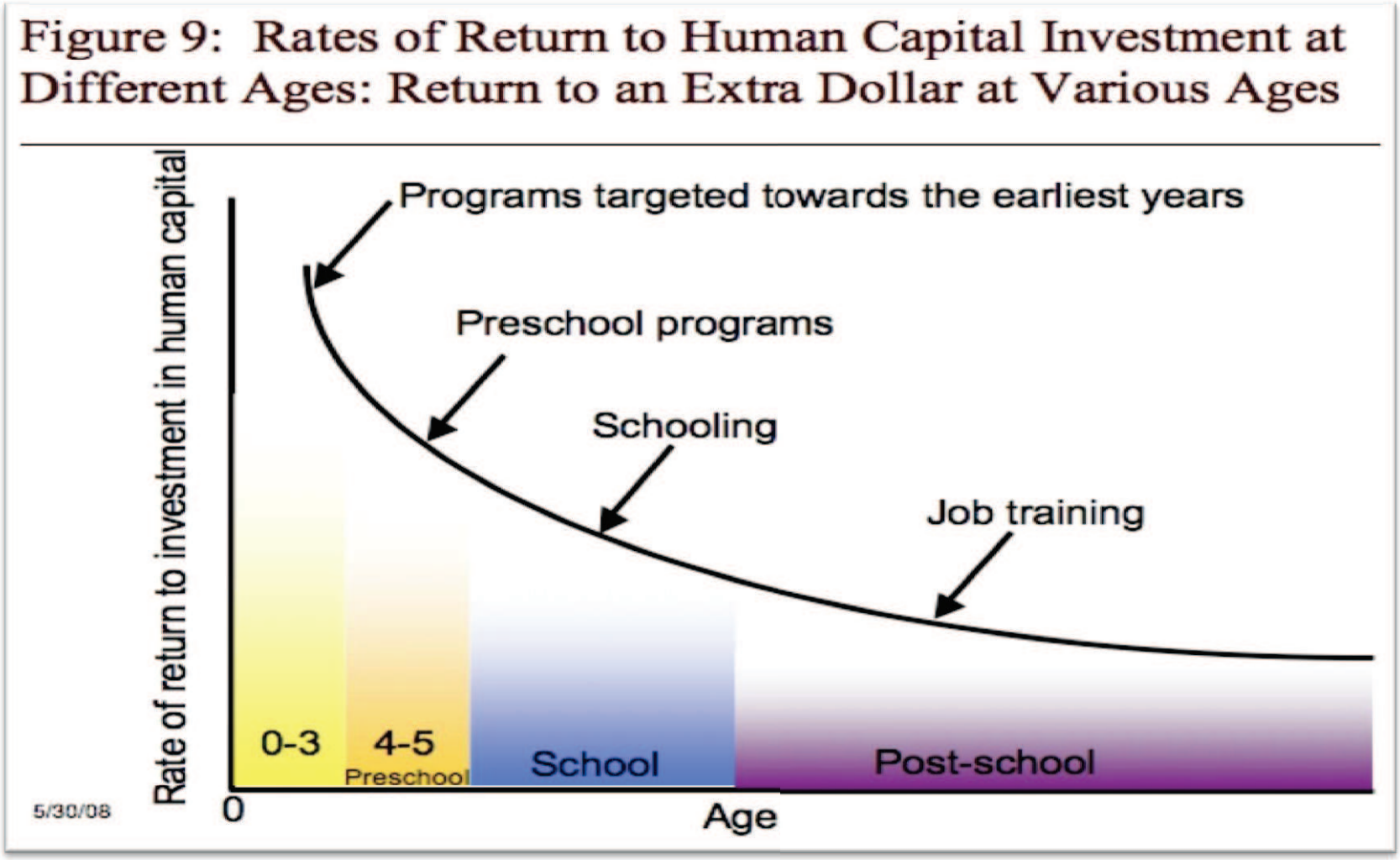
Why does Early Years matter?

Bruce Perry's work shows what happens if you don't have positive interaction.
The smaller of the two brains is of a child who received little interaction

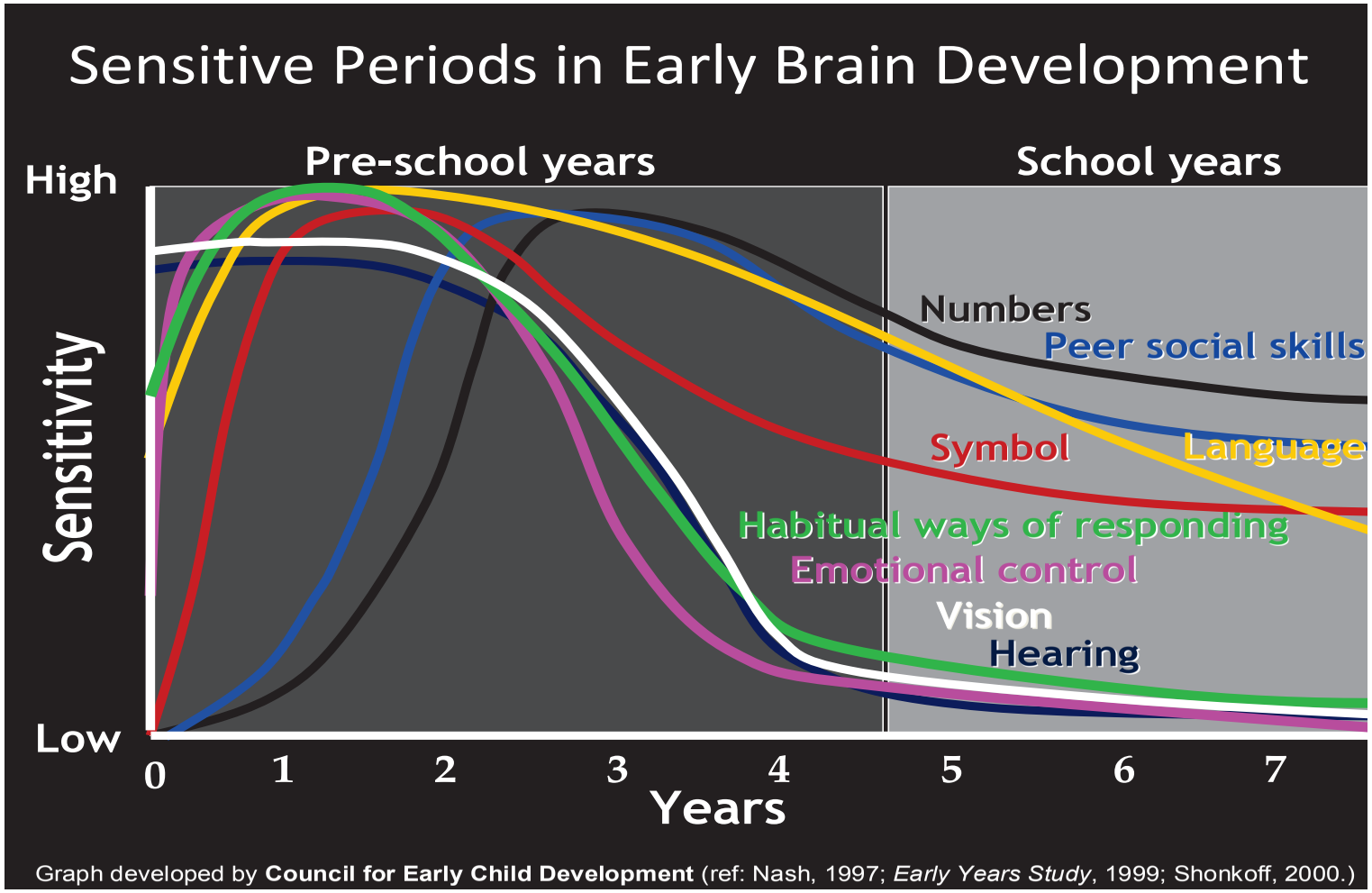


...Brains are affected by experience!

The Heckman Curve



Why the Early Years are So Important



Early years change activity

- Early Years Framework (2008) Winning Hearts and Minds but very broad in scope
- Early years emphasis in 2011 manifesto commitments
- Development of Early Years Taskforce and Change Fund
- Now need to focus on priorities (like SOA discussion)
- Get joint clarity about what needs to be done to achieve these priorities (Taskforce vision and priorities)
- Use CPPs to move statement of vision and review within SOA to have maximum impact

What are the aims of the Early Years Collaborative?

Annex A - Early Years Collaborative- Scotland the Best Place in the World to grow up

Workstream 1- -9months to 1 month

What do we want to improve?

- Improve AGA Weight for all children from x% to x% by 2017
- Reduce avoidable stillbirth rate by x% by 2017
- Reduce avoidable neonatal death by x% by 2017
- Reduce avoidable injury/harm to children by x% by 2017
- Increase stability/attachment for all LAC by yyyy

How will improvement be achieved?

- Increase Smoking Cessation pre-/during pregnancy
- Reducing Substance misuse pre-/during pregnancy
- Improving Nutrition pre-/during pregnancy
- Better planning and decision making for LAC

Who will support the improvement?

- CPPs are the microsystem
- Primarily Maternity Services, GPs, Public Health Nurses, Social Work
- Police, 3rd Sector
- Parents, Families & Communities

How will we know if improvement has been achieved?

- Improved AGA Weight Statistics
- Reduction in avoidable stillbirths rates
- Reduction in avoidable neonatal deaths rates
- Reduction in avoidable injuries/harm
- Number of LAC Placements reduces and permanence achieved within x months

Workstream 2 - 1 month to 3 years

What do we want to improve?

- Reduce avoidable infant mortality rates by x% by 2025
- Reduce avoidable injury/harm to children by x% by yyyy
- Reduce % of children (at age 27 months) with difficulties in: Early Language and Communication, Social & Emotional and Fine/Gross Motor Skills by x% by yyyy
- Increase stability/attachment for all children by yyyy

How will improvement be achieved?

- Supporting strong attachment
- Improving child and maternal mental health
- Improving nutrition / breastfeeding
- Stimulating brain development
- Improving and promoting physical activity and Play
- Additional Support for the most vulnerable
- Better planning and decision making for LAC

Who will support improvement?

- CPPs are the microsystem
- Primarily Public Health Nurses, GPs, Social Work, Speech & Language and Educators
- Police, 3rd Sector
- Parents, Families & Communities

How will we know if improvement has been achieved?

- Needs recorded and addressed at the 24-30 month review: language, communication, social, emotional, obesity, etc.
- Reduction in avoidable infant mortality rates
- Increase in breastfeeding rates
- Number of LAC Placements reduces and permanence achieved within x months

Workstream 3 - 3 years to 5 years

What do we want to improve?

- Reduce % of children starting school with difficulties in: Early Language and Communication, Social & Emotional Behaviours, Mobility & Coordination Skills and Creativity/Enquiry skills by x% by yyyy
- Reduce % of children experiencing avoidable harm/injury by x % by yyyy
- Increase stability/attachment for all children by yyyy

How will improvement be achieved?

- Supporting development of positive relationships
- Improving child and maternal mental health
- Improving nutrition
- Improving and promoting physical activity and Play
- Stimulating brain development
- Better planning and decision making for LAC

Who will support improvement?

- CPPs are the microsystem
- Primarily Public Health Nurses, GPs, Social Work, Speech & Language and Educators
- Police, 3rd Sector
- Parents, Families & Communities

How will we know if improvement has been achieved?

- Children have the skills they need to continue their learning journey as successful learners, confident individuals, effective contributors & responsible citizens. Measured at Primary 1.
- Number of LAC Placements reduces

Led By: CPP Chairs, Local politicians, Local Authority CEx, NHS CEx , Directors of Finance, Chief Constables, Third Sector leaders

All underpinned by support from: Addictions Services, Adult Public Health, Criminal Justice Social Work, Police & Third Sector

EY Collaborative – progress and nest steps

- Launched on 1st October – Ministers, COSLA, Senior Civil Servants
- Expert groups – September and November to scope out each workstream
- Engagement with CPPs to encourage participation with the programme and learning sessions in November/December
- Final draft Aims to Early Years Taskforce to sign off in December
- 1st learning event 24/25th January with further events in May and October 2013.

Early Years Collaborative Ambition and Aims

Aileen Campbell

Minister for Children and Young People

Ambition

- ***To make Scotland the best place in the world to grow up in by improving outcomes, and reducing inequalities, for all babies, children, mothers, fathers and families across Scotland to ensure that all children have the best start in life and are ready to succeed.***

Stretch Aims

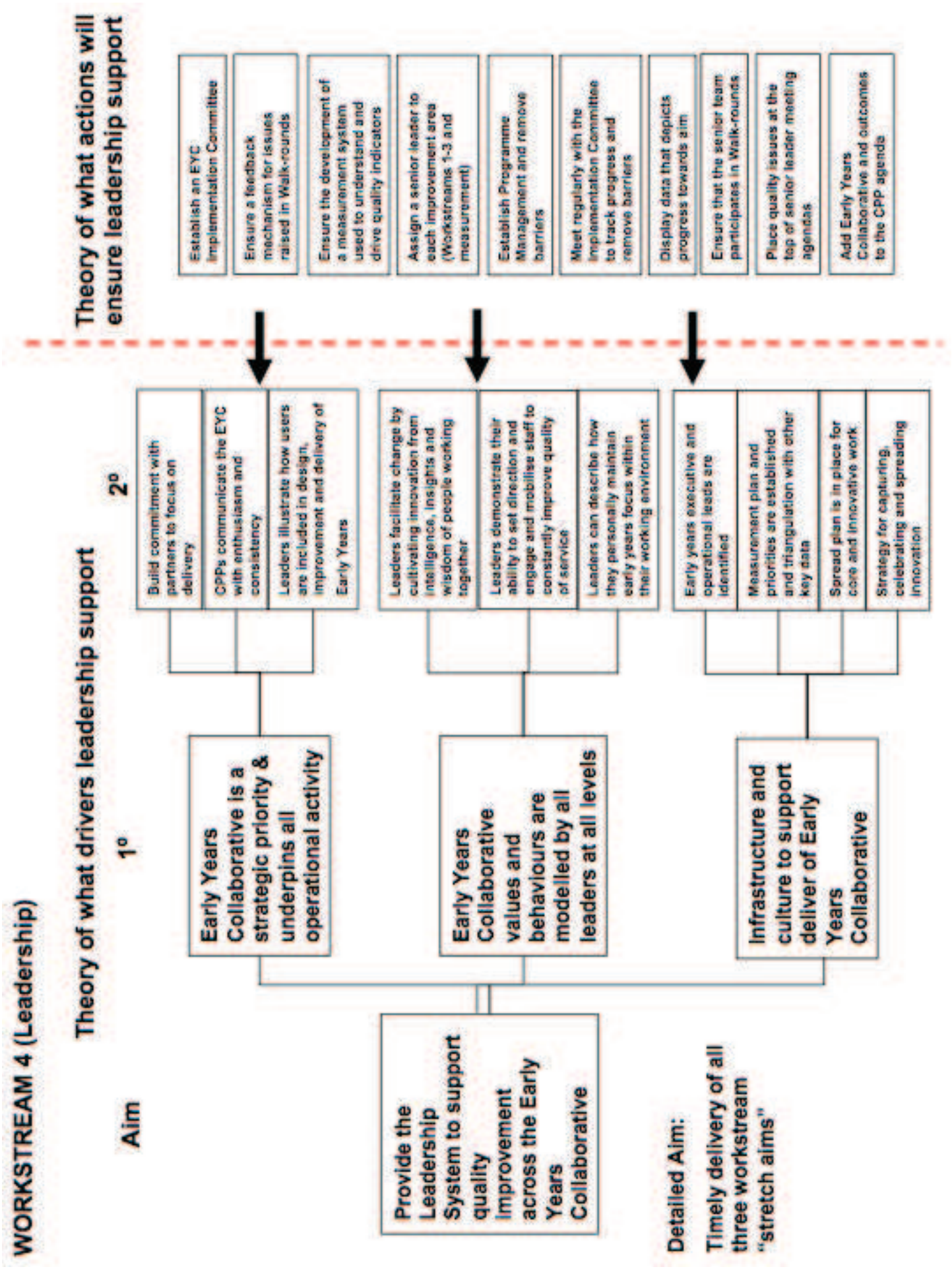
1.To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths (from 4.9 per 1,000 births in 2010 to 4.3 per 1,000 births in 2015) and infant mortality (from 3.7 per 1,000 live births in 2010 to 3.1 per 1,000 live births in 2015).

Stretch Aims

2. To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review, by end-2016.

Stretch Aims

3. To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017.


WORKSTREAM 4 (Leadership)
Aim
Provide the Leadership System to support quality improvement across the Early Years Collaborative
Theory of what drivers leadership support
1°
Early Years Collaborative is a strategic priority & underpins all operational activity
Early Years Collaborative values and behaviours are modelled by all leaders at all levels
Infrastructure and culture to support deliver of Early Years Collaborative
2°
Build commitment with partners to focus on delivery
CPPs communicate the EYC with enthusiasm and consistency
Leaders illustrate how users are included in design, improvement and delivery of Early Years
Leaders facilitate change by cultivating innovation from intelligence, insights and wisdom of people working together
Leaders demonstrate their ability to set direction and engage and mobilise staff to constantly improve quality of service
Leaders can describe how they personally maintain early years focus within their working environment
Early years executive and operational leads are identified
Measurement plan and priorities are established and triangulation with other key data
Spread plan is in place for core and innovative work
Strategy for capturing, celebrating and spreading innovation
Theory of what actions will ensure leadership support
Establish an EYC Implementation Committee
Ensure a feedback mechanism for issues raised in Walk-rounds
Ensure the development of a measurement system used to understand and drive quality indicators
Assign a senior leader to each improvement area (Workstreams 1-3 and measurement)
Establish Programme Management and remove barriers
Meet regularly with the Implementation Committee to track progress and remove barriers
Display data that depicts progress towards aim
Ensure that the senior team participates in Walk-rounds
Place quality issues at the top of senior leader meeting agendas
Add Early Years Collaborative and outcomes to the CPP agenda
Detailed Aim:
Timely delivery of all three workstream "stretch aims"

What next in Argyll and Bute

- Test the collaborative approach
- Report to Community Planning Partners
- Early Years Event 15th/16th March
- Clarification of funding across partnership
- Consideration of appointment of improvement manager
- Development of Integrated Children's Service Plan June 2013 detailing how improve outcomes
- Develop Argyll and Bute Early Years Collaborative Team
- Attend events 28th/29th May and 29th/30th October – Scottish Government

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Argyll and Bute Community Planning Partnership Management Committee

Argyll and Bute Local Services Initiative Launch Event.

1. SUMMARY

1.1 The purpose of this paper is to provide details of the Argyll and Bute Local Services (ABLSI) launch event which will follow the full Community Planning Partnership meeting on 27th March 2013, as agreed at the CPP Management Committee on 12th December 2012.

2. RECOMMENDATIONS

2.1 That the CPP Management Committee note the contents of the report.

2.2 That the CPP Management Committee encourage target audience to attend, and provide contact details of those within their organisations to invite.

3. BACKGROUND

3.1 ABLSI is a partnership of statutory and third sector organisations, and the Carnegie UK Trust project. It has provided reports to the CPP Management Committee on activities, the most recent in February 2012.

3.2 ABLSI aims to identify service areas where there is a real potential for the public sector in Argyll and Bute to work with the third sector to determine ways in which co-production might improve the quality of services while also achieving efficiencies. It also aims to share this learning with others.

4. DETAIL

4.1 The aim of the event is to launch the final report which contains findings and recommendations from the work of ABLSI. This work took place over a two year period and included working with managers and third sector organisations through the Council's Service Review Process and researching case studies of social enterprise in Argyll and Bute.

4.2 The outcomes we hope to achieve at the launch event are;
4.2.1 Learning from the ABLSI initiative influences future action by the Council and CPP partners, and in the longer term,
4.2.2 ABLSI products and recommendations are adopted by Council and CPP partners.

4.3 The target audiences for the event are directors and senior management from public and third sector agencies in the area, and elected members.

4.4 The launch event will be from 1-3pm in the Council Chambers and an agenda is attached.

4.5 Following the launch, the ABLSI Report will be promoted and distributed across the UK through Carnegie UK Trust and our own contacts. Target audiences include local and national government, government agencies, policy makers and others.

5. CONCLUSION

5.1 The launch of the ABLSI learning and recommendations following the full Community Planning Partnership will help ensure partners awareness of the initiative and provide a platform for following up on the recommendations.

6 IMPLICATIONS

6.1 Policy – The event will assist in raising awareness for delivering on aspects of the Scottish Government's Sustainable Procurement Bill.

6.2 Financial – This event will be funded by ABLSI.

6.3 Legal - None

6.4 HR - None

6.5 Equalities - None

6.6 Risk - None

For further information contact:

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Argyll and Bute Local Services Initiative

New Ways to Deliver Local Services

Launch of findings and recommendations

on

27th March 2013 from 1-3pm

at

Argyll and Bute Council Chambers, Kilmory Castle, Lochgilphead

AGENDA

10mins	Introduction – Council Spokesperson
20mins	Opening remarks (external speaker tbc)
15 mins	Findings - Critical Factors, Learning from examples
30mins	How we did it…
30mins	Recommendations and next steps
15mins	Q and A and closing remarks (external speaker tbc)

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Argyll and Bute Community Planning Partnership

Meeting Dates 2013

Full Partnership Meeting Dates:

DATE	VENUE
27th March 2013	Council Chambers, Kilmory
2nd October 2013 - * To be Confirmed	TBC

MANAGEMENT COMMITTEE DATES:

DATE	VENUE
6th February 2013	VC Facilities available at: • Lochgilphead • Oban • Dunoon/Rothesay • Helensburgh
6th March 2013	Committee Room 1, Kilmory – As Above
17th April 2013 - * To be Confirmed	Committee Room 1, Kilmory – As Above
21st August 2013 - * To be Confirmed	Council Chambers, Kilmory – As Above
16th October 2013 - * To be Confirmed	Council Chambers, Kilmory – As Above
11th December 2013 - * To be Confirmed	Council Chambers, Kilmory – As Above

- **These dates are subject to change on agreement of the new governance arrangements.**

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