Argyll and Bute Council
Comhairle Earra Ghaidheal agus Bhoid

Customer Services
Executive Director: Douglas Hendry

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27 October 2010

NOTICE OF MEETING

A meeting of the **SOCIAL AFFAIRS THEMATIC CPP GROUP** will be held in the **COUNCIL CHAMBER, KILMORY, LOCHGILPHEAD** on **MONDAY, 8 NOVEMBER 2010** at **9:30 AM**, which you are requested to attend.

Douglas Hendry
Executive Director - Customer Services

BUSINESS

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATIONS OF INTEREST (IF ANY)**

3. **MINUTES**
   Social Affairs Thematic CPP Group 9 August 2010 (Pages 1 - 6)

4. **MATTERS ARISING FROM MINUTES**

5. **EDUCATION ATTAINMENT**
   Presentation by Chris Shirley, Quality Standards Manager, Argyll and Bute Council

6. **EDUCATION REVIEW UPDATE**
   Verbal Report by Cleland Sneddon, Thematic Lead/Executive Director – Community Services and Chris Shirley, Quality Standards Manager, Argyll and Bute Council

7. **INTEGRATED RESOURCE FRAMEWORK PROJECT UPDATE**
   Presentation and Report by Simon Steer, Head of Community Care Integration, NHS Highland (Pages 7 - 20)

8. **JOINT PERFORMANCE UPDATE REPORT**
   Report by Joint Performance Planning Officer, Argyll and Bute Council (Pages 21 - 32)

9. **HIPPAG HIGHLIGHT AND EXCEPTION REPORT**
Report by Community Planning Manager (to follow)

10. **SCORECARD DEVELOPMENT UPDATE**
Verbal Update

11. **INTEGRATION OF STRATEGIC PARTNERSHIP GROUPS**
Strategic Partnerships List last updated December 2009 (Pages 33 - 42)

12. **REAP - ISSUES TO RAISE AT CONSULTATION EVENT**
Joint report by Senior Planning/Development Officer, Argyll and Bute Council and Community Planning Manager (Pages 43 - 46)

13. **ACCESS TO PYRAMID FOR PARTNERS - UPDATE ON PILOT PROJECT**
Verbal update.

14. **3RD SECTOR REPRESENTATION ON THE ARGYLL AND BUTE ADULT PROTECTION COMMITTEE**
Report by Area Manager, Adult Protection, Argyll and Bute Council (Pages 47 - 48)

15. **THEMATIC GROUP CHAIR REPORT TO CPP MANAGEMENT COMMITTEE**
Verbal report.

16. **FUTURE WORK PROGRAMME AND MEETING DATES**

SOCIAL AFFAIRS THEMATIC CPP GROUP

Councillor Vivien Dance (Chair)
Councillor Mary Jean Devon
Councillor Anne Horn
Councillor David Kinniburgh
Councillor John McAlpine
Councillor Roderick McCuish
Councillor James McQueen
Councillor Elaine Robertson
Marlene Baillie, Strathclyde Police
Geoff Calvert, Strathclyde Fire & Rescue
Glenn Heritage, Third Sector
Derek Leslie, NHS Highland
Eleanor MacKinnon, Third Sector
David Price, Association of Community Councils
Cleland Sneddon, Argyll and Bute Council (Thematic Lead)

Ronnie Mcilquham, Argyll and Bute Council
Chris Shirley, Argyll and Bute Council
Simon Steer, NHS Highland
Eileen Wilson, Community Planning Manager

Contact: Fiona McCallum Tel: 01546 604406

Agenda Item 3

MINUTES of MEETING of SOCIAL AFFAIRS THEMATIC CPP GROUP held in the MEMBERS ROOM, KILMORY, LOCHGILPHEAD on MONDAY, 9 AUGUST 2010

Present: Councillor Vivien Dance (Chair)

Councillor Anne Horn, Argyll and Bute Council
Cleland Sneddon, Thematic Lead Officer, Argyll and Bute Council
Geoff Calvert, Strathclyde Fire and Rescue
Derek Leslie, Argyll and Bute Community Health Partnership (CHP)
Glenn Heritage, Third Sector
Eleanor MacKinnon, Third Sector
Marlene Baillie, Strathclyde Police

Attending: Iain Jackson, Governance and Risk Manager
Eileen Wilson, Community Planning Manager
Lynda Thomson, Organisational Development Manager
Lorraine Todd, Performance Management Team

Apologies: Councillor Mary Jean Devon
Councillor David Kinniburgh
Councillor Roderick McCuish
Lynn Smillie, Area Customer Services Manager, Argyll and Bute Council
Elaine Garman, NHS Highland
Greig MacMillan, Strathclyde Fire and Rescue

1. DECLARATIONS OF INTEREST

None declared.

2. MINUTES

The Minutes of the Social Affairs Thematic CPP Group were approved as a correct record subject to the following amendments:-

- Under the list of those present - “William Rae” should read “John Rae”.
- With reference to item 6 Community Planning Conference – the dates referred to at decision 1 should read “March 2010” not “March 2009”.

3. SOCIAL AFFAIRS THEMATIC CPP GROUP SCORECARD - PERFORMANCE MANAGEMENT

A report providing an update on progress of the performance management arrangements for the Social Affairs Thematic CPP Group was considered along with reports from Heads of Service providing explanations as to why some of the indicators were showing as “red” or “amber” on the Scorecard. The Thematic Lead Officer also reported on background work currently being undertaken by the Council in respect of changes to the Pyramid system which will be rolled out over the next 2 to 3 weeks.

Decision

1. Noted that the “amber” tolerance would be removed from Pyramid;

2. Noted that there would be a clearer distinction between indicators reported on a quarterly basis and indicators reported on an annual basis;

3. Noted that 3 representatives from Argyll and Bute CHP now had access to Pyramid and that training for them has been arranged;

4. Noted that training was being arranged for Rachel Towsey and Rosie Lawrence, SWIA Inspectors, to enable them to gain access to the system in advance of the next SWIA inspection which was anticipated to take place in September/October 2010;

5. Noted that Officers were looking to improve the transition process for children affected by disability moving into Adult Care;

6. Agreed to request information on why Indicator EC6C3 (% ceasing to be looked after – at home – attending SCQF Level 3 in English/Maths) had gone down from Green to Red;

7. Agreed that wording of NP07 “School leavers positively employed” should be amended to read “School Leavers in positive and sustained destinations (FE, HE, employment or training) and noted that this was an annual figure;

8. Agreed that “% of Older People receiving Care in an Institution” should be amended to read “% of Older People receiving Residential Care”;

9. Agreed that an additional measure should be included in respect of Care in the Community to give a reassurance that there is no unmet need;

10. Agreed that more information was required in respect of Anti Social Behaviour statistics and that there was a need to have factual information relating to areas where there was high anti social behaviour activity rather than just information relating to the number of fixed penalties issued which was a measure of how proactive the Police were in dealing with Anti Social Behaviour;

11. Noted that the Thematic Lead Officer would report back to the next meeting on a proposed measure to replace “Increase extra curricular opps by 5% in schools”;

12. Noted that the Community Planning Manager would provide a list of suggested measures to be incorporated into the Scorecard following feedback received at recent Community Planning Events which took place across Argyll and Bute; and

13. Noted that once changes to the Scorecard were made this would be circulated electronically to the Group.

(Reference: Report by Social Affairs Thematic CPP Group Scorecard; Report by Head of Improvement and HR ; Report by Head of Adult Care and Report by Head of Children and Families, submitted)

4. IT ACCESS TO PYRAMID FOR PARTNERS

The Group received an update on progress with the Pilot currently being undertaken to enable Partners to access the Council's Performance Management System, Pyramid.

Decision

1. Noted that 3 representatives from Argyll and Bute CHP now had access to Pyramid and that training has been arranged for them; and

2. Noted that the outcome of this Pilot would be reported to the next meeting of the Group.

(Reference: Report by Head of Customer and Support Services, submitted)

5. INTEGRATION OF STRATEGIC PARTNERSHIPS

Consideration was given to a report outlining details of the integration of Strategic Partnerships process undertaken to establish the linkages within the Social Affairs Thematic provisions relating to health, housing and local area regeneration, poverty, voluntary sector issues, school and pre school education, young people and lifelong learning, social work services and matters relating to culture and sport as contained within the Argyll and Bute Community Plan.

Decision

1. Noted the contents of the report;

2. Noted that the Community Planning Manager would arrange for a proforma to be circulated to Lead Partners for completion in order to ascertain the work being undertaken by each of the Strategic Partnerships, to identify any overlaps and/or gaps and establish formal linkages between the Partnerships;

3. Agreed to sign off the proposed Partnership Agreement subject to the following amendments:-

   (a) Paragraph 5.7 should also include reference to disability, and marriage and civil partnerships;

   (b) Paragraph 7.4 should be removed as consensus at meetings would be reached through debate and if there was no consensus on a particular issue this would be referred to the

Management Committee;

(c) Paragraph 8.4 – last bullet point should read "at least 7 working days" not "within 7 working days"; and

4. Noted that the Community Planning Manager would make the necessary changes and circulate electronically the amended Partnership Agreement to the Group and would also recommend to the other Thematic CPP Groups that they consider taking on board these changes.

(Reference: Report by Area Customer Services Manager dated July 2010, submitted)

6. PRINCIPLES OF REPRESENTATION ON COMMUNITY PLANNING PARTNERSHIP

The Group considered a report in respect of arrangements for representation by Partners at Community Planning meetings.

Decision

Noted and agreed the contents of the report.

(Reference: Report by Community Planning Manager, submitted)

7. HEALTH IMPROVEMENT - HEALTH IMPROVEMENT PLANNING AND PERFORMANCE ACTION GROUP UPDATE

Consideration was given to a report prepared by Elaine Garman, Public Health Specialist within NHS Highland which highlighted the type of work being undertaken by the Health Improvement Planning and Performance Action Group (HIPPAG) and detailed the consolidated actions being taken across the 7 Local Public Health Networks which link into the HIPPAG.

Decision

1. Noted the contents of the report; and

2. Agreed to request the HIPPAG to identify a meaningful measure in terms of outcome and timescales which could be incorporated into the Social Affairs Thematic CPP Scorecard.

(Reference: Report by Public Health Specialist, NHS Highland dated April 2010, submitted)

8. DATE OF NEXT MEETING

Monday 8 November 2010.

It was agreed that in advance of the next meeting Partners would arrange to email Lynn Smillie, Area Customer Services Manager, with suggested strategic themes which they would like the Group to explore at future

meetings with a view to the Group looking at the strategic implications of any issues that arise. Email: lynn.smillie@argyll-bute.gov.uk

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Agenda Item 7

The Scottish Government

Integrated Resource Framework for health and social care

1. Introduction

The Integrated Resource Framework (IRF) for health and community care is under development as part of our focus on Shifting the Balance of Care. Its purpose is to enable partners in NHS Scotland and Local Authorities to be clearer about the cost and quality implications of local decision-making about health and social care; the programme is being developed jointly by the Scottish Government, NHS Scotland and COSLA. Work on the IRF began in 2008. A locally developed model - the Cost Cube - from NHS Highland, provided a starting point, with further development taking place to develop an understanding of the relationship with some of Highland Council social care activity and cost.

Key to the IRF is the principle that, in order to make best use of available resources, partnerships need to:

1. understand the costs associated with the activities they plan for, invest in and deliver across the entire resource spectrum; and
2. examine variation in practice and outcomes for patients and service users in different localities.

By providing Health Boards and their Local Authority partners with the information required to plan strategically and review services more effectively, and by developing financial relationships that integrate resources around populations instead of organisations, partners will be able to realign their resources to support shifts in clinical/care activity within and across health and social care systems. Examples of early emerging analysis from the IRF work are provided in Annex A. Further background on the philosophy underpinning the approach is provided in Annex B.

It is important to note that the IRF is *not* just a tool for Finance Departments - instead it focuses on clinicians and care professionals and the decisions they make that commit resources and determine outcomes for patients and service users. Structures and systems are required that ensure professionals are operating with a fuller understanding of their environment and the ramifications of their decisions, and are consequentially accountable for their decisions and actions. There is clear international evidence that more effective integration improves people’s experience of services, and enable better models of care to be provided without necessarily incurring additional cost.

2. Progress to date

The IRF development process has two main components:

- *Phase 1:* Explicit mapping of patient and locality level cost and activity information for health and adult social care, to provide a detailed understanding of existing resource profiles for partnership populations;
- *Phase 2:* Implementation of agreed and transparent mechanisms that allow resource to flow between partners, following the patient to the care setting that delivers the best outcomes.

Phase 1 - Mapping

Over the last year most Health Boards, some with their Local Authority partners, have started to apply the IRF approach by mapping their entire resource use and activity to patient and locality level.

Phase 2 - Mechanisms

Four test sites are taking forward the second phase of the IRF. These sites are focusing on selected populations of interest (either geographically or care group defined), and they will develop and implement mechanisms for shifting resources both within the NHS, and between the NHS and local authority partners, to achieve improved outcomes for their populations. The test sites (4 Health Boards and 12 Councils) are:

- Highland test site: NHS Highland with Argyll & Bute Council and Highland Council;
- Tayside test site: NHS Tayside with Angus Council, Dundee City Council and Perth and Kinross Council;
- Ayrshire test site: NHS Ayrshire and Arran with East Ayrshire Council, North Ayrshire Council and South Ayrshire Council;
- Lothian test site: NHS Lothian with City of Edinburgh Council, East Lothian Council, Midlothian Council and West Lothian Council.

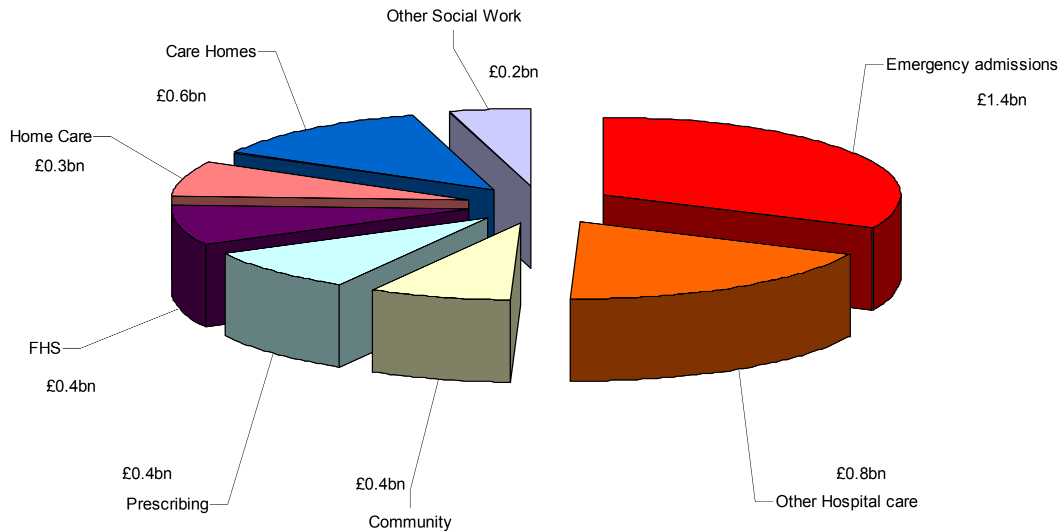
The test sites are now starting to implement the IRF - identifying their population(s) of interest; collecting the mapping data; identifying the integrator; and considering which financial mechanisms to use to move resources. The revised arrangements will go live in April 2011. We are in the process of discussing milestones and timescales with the test sites to assure the April 2011 date, and it will be important that the test sites' efforts are committed to the challenges already identified over that period to ensure progress. We are particularly aware of the cultural and organisational demands of the programme – establishing the analytical evidence is a vital first step, but real improvement will only be delivered if the test sites successfully use that data and new financial relationships to challenge and change current practice.

An action-learning based evaluation of the test sites has been commissioned and begun, concluding in November 2011. The purpose of the evaluation is to contribute to the process of change and determine the effectiveness of the approach. We have established a learning network for the test sites, which includes the evaluators, and which will help to share good practice between and beyond the test sites as the work is underway.

Annex A - Sample analysis

The following examples of analysis generated by the IRF mapping work (Phase 1) so far are provided to illustrate the opportunities this type of data can provide for professional discussion around the ramifications of decision making in terms of resource allocation and outcomes for people.

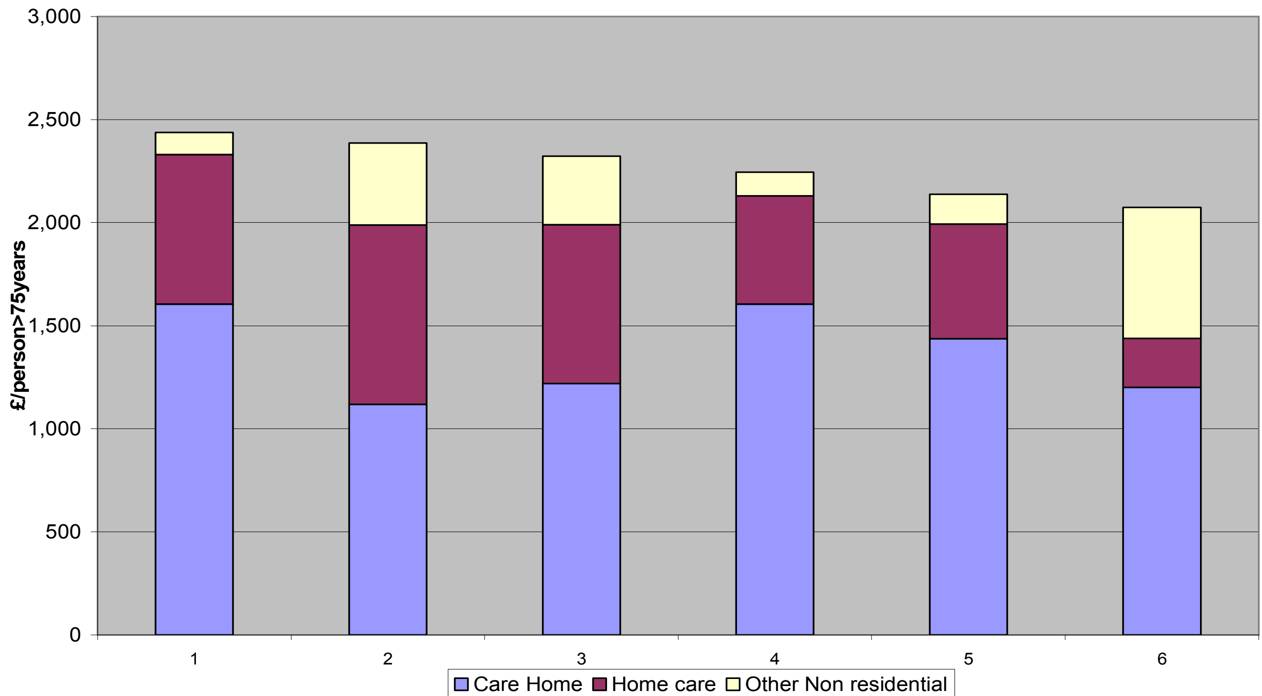
Figure 1: Health and Social Care Expenditure – Scottish Population aged 65+ (2007/08, total = £4.5bn)



Points to note:

- Nearly one third of the total spend - £1.4bn out of the total £4.5bn is accounted for by unplanned emergency admissions to hospital – a huge area of unplanned, reactive spend, which, it is widely recognised, often does not deliver the best outcomes for older people;
- More was spent on unplanned emergency admissions to hospital for this age group than the entire older person's social care budget - £1.1bn in 2007/08.

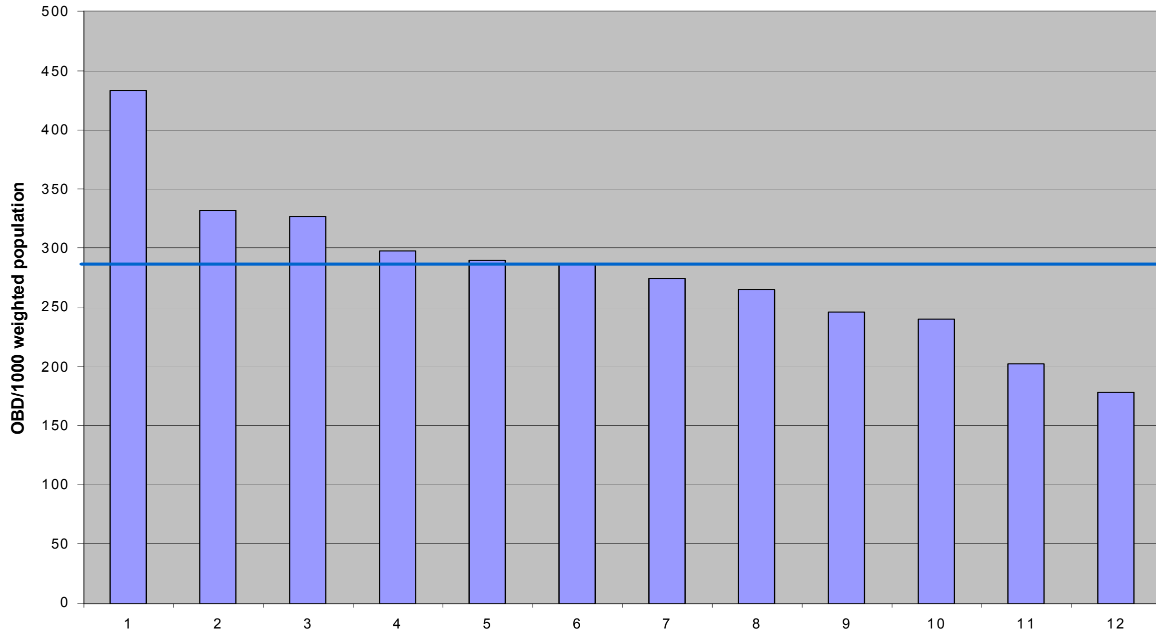
Figure 2: Local authority older persons social work expenditure for 75+ population - across 6 CHPs covering 2 Health Boards and 2 local authorities



Points to note:

- There is noticeable variation both in terms of spend per head and the profile of the spend itself, especially in light of our policy commitment to keep older people safe and well and as independent as possible, in their own homes, for as long as possible. This evidence is congruent with the results of SWIA's 2010 *Improving Social Work in Scotland* review, and also the outcomes of the 2008 Multi Agency Inspection of Older People's Services in Tayside and Forth Valley.

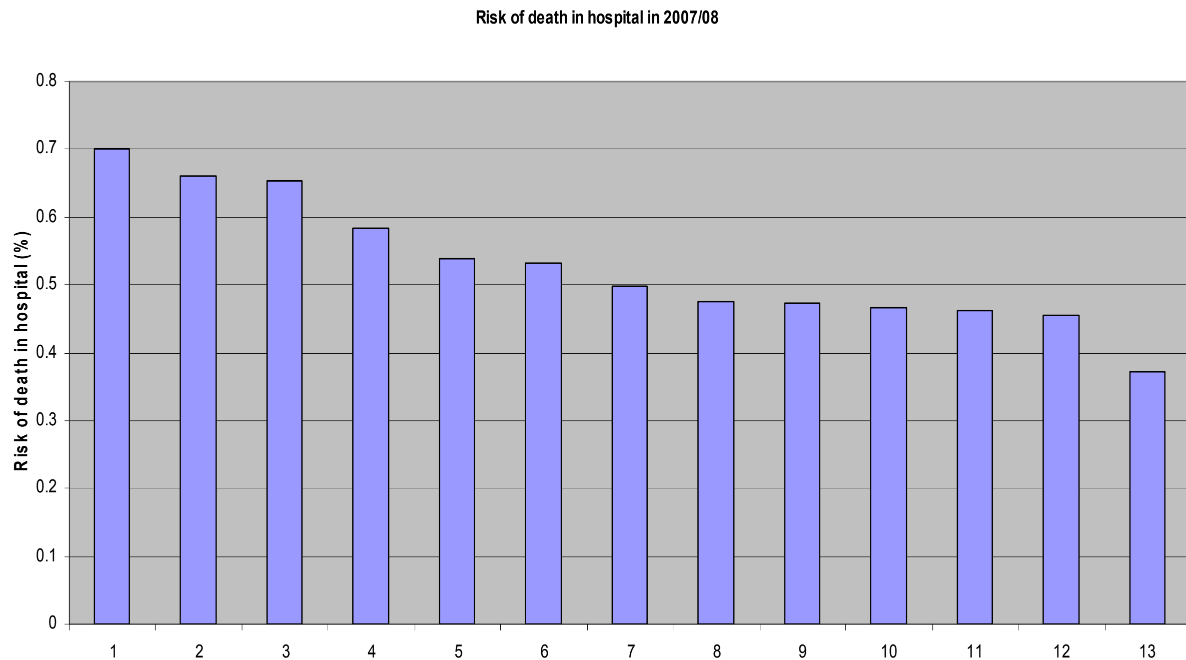
Figure 3: Acute General Hospital Occupied General Medical Bed Days, by GP practice (average 2006/07 – 2007/08)



Points to note:

- Material variation in terms of bed use by different GP practices can be seen across one city, after controls are applied to the data to account for factors of age, gender and deprivation
- Prompts the question – what General Medical bed capacity should the hospital plan for? If all practices were operating at the same level as Practice 1, 70 beds would be needed. If all were at the average, 44 beds would be required. If all were operating like Practice 12, the requirement would be 28 beds. What are the reasons underlying the variation in practice and outcomes?
- More generally, we estimate that approximately 45% of Health Board spend is determined by the decisions made by GPs, for which they are not directly financially accountable. This type of analysis will, we hope, provide data around which discussions can be focussed on current practice and its consequences.

Figure 4: Risk of death in hospital – across one Health Board, 2007-08



Points to note:

- This example provides a particularly direct illustration of the link between investment decisions and outcomes for people.
- We know that most people would rather die at home if possible than in an institution.
- In this Health Board, the risk of dying in hospital was measured across 13 localities (each locality is a geographical grouping of GP practices).
- Patients in locality 13 who died in this year had a 37% chance of dying in hospital. In locality 1 the risk was 70%.
- The question is – what accounts for the variation? And what should decision makers be considering with respect to current practice and investment decisions to ensure best use of resources and outcomes for people?

Annex B: The IRF and the Triple Aim of a rational care organisation

The principles underpinning the IRF are based on the 'Triple Aim' of a rational care organisation, which the Institute for Health Improvement (IHI) defines as:

- Improving population health;
- Improving individual experience;
- Reducing costs.

To achieve the Triple Aim requires:

- A clearly defined population (this may be geographical or care group);
- An understanding of the total resources spent on the care of the population;
- A care "integrator" that is empowered to direct resources to achieve the Triple Aim.

The first two of these preconditions are met by the mapping of health and social care resources in Phase 1 of the IRF; establishing the third is the focus of the work in the 4 test sites in Phase 2.

Empowering the integrator will require the test sites to develop financial arrangements to bridge the two disconnects within the local health and social care economy, i.e. within the NHS (between GP practices and CHPs; and between CHPs and acute hospitals), and between NHS boards and local authorities. These new financial arrangements will need to be incorporated into each partner's respective financial governance frameworks. The IRF team has commissioned research into financial mechanisms used in other health and social care systems and some of these have been suggested to test sites. However, the final decision on which mechanisms to use will be a local one.

Highland NHS Board
10 August 2010
Item 5.1

IMPLEMENTATION OF THE INTEGRATED RESOURCE FRAMEWORK (IRF)

Report by Simon Steer, Head of Community Care Integration on behalf of Roger Gibbins, Chief Executive

The Board is asked to:

- **Note** the update on progress of the Integrated Resource Framework (IRF) in Highland.
- **Endorse** the proposal to implement the IRF at strategic, district/locality and small exemplas of change levels in respect of older people; and to explore lead commission in respect of Mental Health and Occupational Therapy Services.

1. Background

1.1 The Integrated Resource Framework (IRF) has been the subject of a number of reports to the Board. This proposal has evolved alongside national policy from one focussed on collaborative contracting within the NHS to an integrated approach with local authority partners.

1.2 The Partnership of Highland Council, Argyll & Bute Council and NHS Highland has been identified by the Scottish Government as one of four of test sites. The purpose of these is to develop data, methodologies and protocols required for:-

- a resource framework built around the costs of health and social care activities which would empower commissioners of services to direct resources to appropriate services;
- a joint strategic commissioning and capacity plan that set down the large volume costs and balance of services required over the next 10 – 15 years, together with an implementation programme; and
- a partnership financial framework that would enable the partnership to identify the combined resources and support financial governance arrangements that would reinforce partnership working.

1.3 In short, the aim of the Integrated Resource Framework is to describe how we currently use our collective resources, ask if there is a better way and then find a method to reassign resources to support the redesign services to achieve better outcomes and improve patient care.

2. Decision Making Arrangements

2.1 The understanding of resource use and the ability to move resource around, and across the system, is seen as an important enhancement to emerging new decision making arrangements.

2.2 In the case of both Argyll and Bute, and North Highland Partnerships, there is a recognition that there requires to be an incremental devolution of decision making towards the lead professional, and if possible to the service users, through supported self assessment and direct access to some services. In addition, many of these processes need to become more integrated across the Council and NHS Highland, be that at practitioner or manager level.

2.3 A necessary first step in this process is to devolve significantly greater decision making to local managers, bringing together Health and Social Care Teams in local geographies. In North Highland, where there are some issues of non coterminosity, the phrase "District" has been adopted to describe this local level. In Argyll and Bute, this level is already well established as a "Locality" structure.

2.4 It is expected that this approach will enable both enhancements and efficiencies in the management of services and will create local collaborative relationships within a shared boundary, to achieve:
- Single point of entry for health and social care service
- Self-sufficient for non-specialist provision
- Collaborative partnerships
- Some co-location
- Local, joined up and devolved decision-making

2.5 In the Highland Council area there will be nine of these Districts:
- Caithness
- Sutherland
- Easter Ross
- Skye & Lochalsh
- Lochaber
- Mid & West Ross
- Nairn, Badenoch & Strathspey
- Inverness East
- Inverness West

2.6 In Argyll and Bute there are four established Localities:
- Helensburgh & Lomond
- Cowal & Bute
- Mid Argyll; Kintyre; Islay & Jura
- Oban; Lorne & the Isles

3. Mapping of Current Resource Allocation

3.1 "Mapping" (the exercise to define where resources are spent, how and on whom) has been progressed by NHS Highland with Highland Council and Argyll & Bute Council. This exercise indicates that there is variation in the use of resources across the Highlands which cannot be explained as a function of population characteristics such as age structure, deprivation or rurality.

This work forms the underpinning understanding to answer the question "How do you use our resources?" before moving to consider the next questions of "Is that the best way?", and "Is there a better way?"

3.2 This leads to two further key questions:

The first is the question of *equity*. Having allowed for different population characteristics, are some areas receiving more per capita resource than others even though we have allowed for issues such as rurality?

The second issue relates to *efficiency* of resource allocation, and asks whether the use of more resource per head leads to better outcomes?

3.3 More work is required to refine the mapping exercise, however, mapping of activity and cost, whilst compelling and interesting, could also be endless. We are therefore adopting a pragmatic approach whereby we focus on the information that we wish to do something with, i.e. those areas of variation in practice or population where we believe that a change for the better could, and should, take place.

4. Identifying populations of interest and implementing the Integrated Resource Framework

4.1 The mapping work has confirmed that there are major challenges regarding resource allocation across all client groups across both Highland and Argyll & Bute Partnerships. Clearly though, the greatest challenge involves older people, specifically because of:

- The very high proportion of resource dedicated to unscheduled care and institutional settings
- Expected demographic changes, involving growing numbers of older people
- The pressing need to shift the balance of care

4.2 **Older People**

The Integrated Resource Framework Project Board therefore recommends that we now take forward the framework in three particular ways with regard to older people.

- The Strategic NHS/Council population level, where the use of the total resource applying to a population, (in this case the per capita resource available to the over 75year old population of the NHS/Council area) will be the focus.

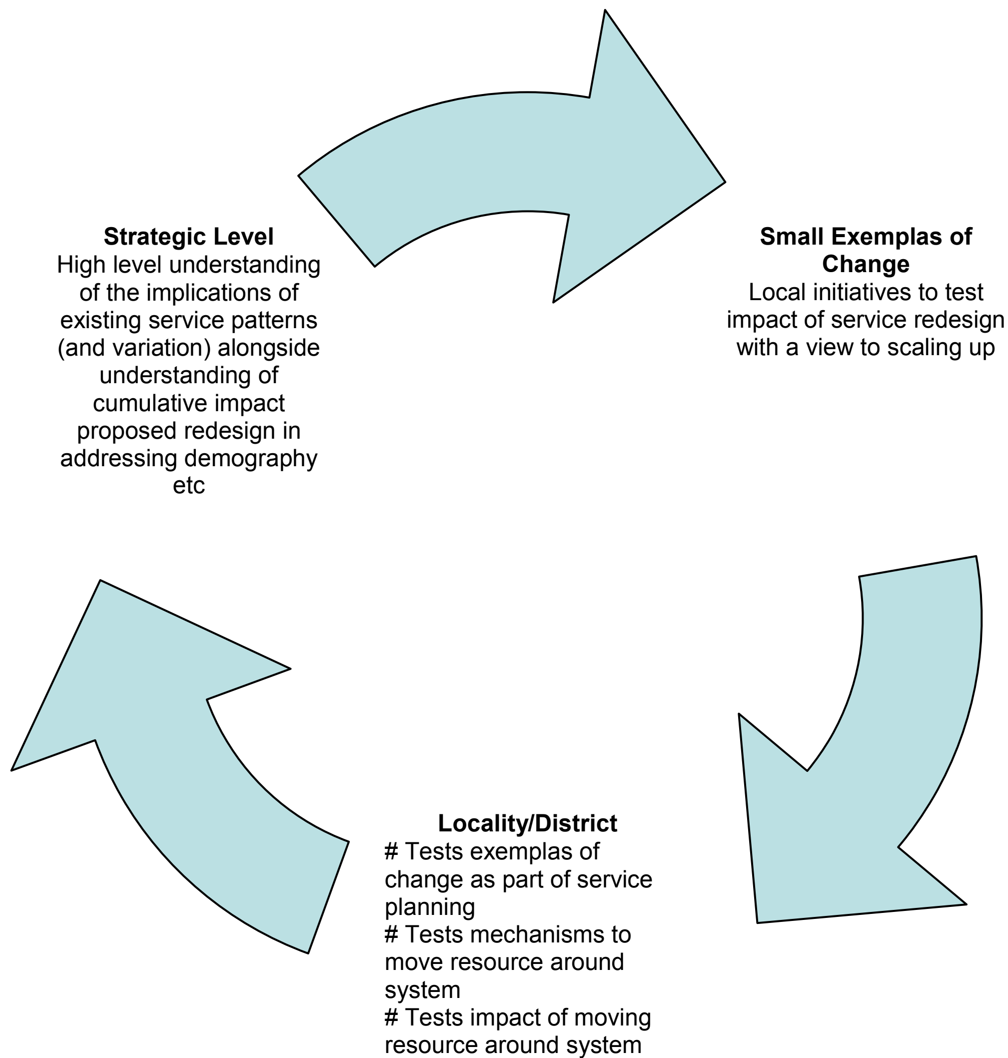
  One key area of interest lies in the activity and costs around unplanned emergency admissions to hospital, leading in turn to a high use of residential care. Achieving this will require further refinement of the available information (mapping) and interrogation of the variation in activity (that cannot be simply explained by demography) that we already know exists.

- Small, local exemplas of change, such as the innovative “virtual wards” in Nairn and Invergordon, will be supported across the Highlands and, where evidenced as positive, grown on.

- At a Locality or District level, to allow a joint per capita financial envelope to be used for the >75yr population to be used with flexibility across the normal NHS/Council budget divides.

  This represents a major initiative and challenge to free the chosen area from existing structural constraints to operate a “whole system” approach to planning and investment, where resource is allowed to move unfettered between and within organisations.

  The diagram below shows the interrelationship between each of these levels in developing innovation; practice and learning across the IRF programme.



In respect of level 3, work has been undertaken to identify the Locality or Districts that can best demonstrate where this approach can be implemented.

In Argyll and Bute the decision has been taken to focus on Cowal and Bute as the geographical area of interest.

In North Highland, proposals are currently being developed through the Joint Community Care Management Team, for consideration through the IRF project structure. As a Framework, the Project Board has agreed there should be two pilot district initiatives, one within the 70% Group area and one outwith.

This activity will require the development of governance and financial protocols at both the Locality/District and strategic levels to ensure that whilst the resource is able to be used flexibly, we are still able to account as required at present. This work will give an indication of the types of protocols that may be required in the future.

4.3 **Lead Commissioning**

Further, the Project Board also recommends that the IRF is taken forward on a pan-Highland basis across identified areas of service delivery. Using the provisions of the 2002 Community Care and Health (Scotland) Act, this means that the partners would:

- Agree the outcomes that they are looking to achieve
- Benchmark and define the partners contributions to the resource pool available to achieve these outcomes

- o Decide which partner will deliver these objectives
- o Frame the legal agreement and move resource
- o Redesign services as required
- o Review progress against agreed outcomes

Rather than achieve the better use of resources as part of total system change within one local geography, this uses a "lead commissioner" model, to achieve better deployment within one agency on behalf of the partnership, across a whole service area.

The Project Board has initiated work to examine the opportunities presented to take this approach forward in the spheres of:

Occupational Therapy Services

1. In Argyll and Bute, a single Occupational Therapy Service has already been developed, and the focus of work here will be to:
   - Consider any enhancements possible through the IRF programme.
   - Examine any possible pan Highland opportunities
   - Share Learning

2. In the case of North Highland, the initial scope of action is to explore the possibilities for a single NHS/Council service.

Mental Health Services

1. In North Highland there is an ambition to explore the possible opportunities for a single Mental Health Service. This will require consideration of not only the points in 4.5 above, but also a detailed examination of the statutory implications (already initiated with the support of the Scottish Government)

2. In Argyll and Bute, there is an enthusiasm to be engaged in the development of this model with a view to considering applicability to that area.

Just as the locality/District model will require the development of specific protocols, work will have to be scoped to ensure that the lead commissioning model in these services is achievable in terms of both service delivery and sound with regard to governance and financial management.

4.4 Timescale

It is envisaged that the necessary further developmental and scoping activity for all this work should take place between now and early 2011, to enable this to be reported to the Council and NHS Highland, and (if agreed) for the changes to commence in April 2011.

5 NHS Specific Actions

NHS Highland has previously indicated a plan to support a "collaborative contracting", or commissioning, approach towards planning and investment, within the NHS.

The essence of this approach is that:

- The CHPs develop "capacity plans" which state the balance of acute and specialist to community activity
- These plans are costed and a view established and agreed on the levels of resource that can be released to follow patients to where their care is planned.

- Reviews take place to examine actual activity (and associated cost) against planned activity to make adjustments as required.
- Budgets are restated to reflect activity.

All CHPs have had the opportunity to reflect upon a previous iteration of cost and activity information with a view to developing costed capacity plans. This information is currently being updated to reflect 2010/11 costs.

Following from this report, a series of visits to CHPs have been arranged to:

- Discuss development of capacity plans to date
- Agree any further support or information required to support these developments
- Agree timeframes for capacity plan development
- Support development of the Capacity Plans

It is recognised that the progressing of this work will require development of commissioning competencies, and further clinical engagement. To this end, the NHS Highland IRF Steering Group will be developed as a setting in which to develop a local commissioning competencies programme.

6. Contribution to Board Objectives

The development of the IRF contributes to achievement of a *"Better Health, Better Care, Better Value"* recommendation.

7. Governance Implications

The principle **governance** impact lies in the requirement to develop new protocols and arrangements to allow resource to move across the whole system.

Finance impacts lie the implications of moving resource around the system.

Highland Council and Argyll & Bute Council will be seeking similar endorsement for this work within their own governance arrangements as appropriate.

8. Risk Assessment

The principle risk lies in the national expectations of this initiative as part of a national program. This paper reports that Highland progress is on track.

9. Impact Assessment

Update report, no update at present to impact status.

Simon Steer
Head of Community Care Integration
NHS Highland

30 July 2010

Joint Performance Summary: August 2010

Delayed Discharge as the census 15th July 2010:

Delayed discharges are patients who are deemed to be medically fit for discharge from hospital, but who remain in a hospital bed for non-medical reasons.

Argyll & Bute hospitals:

Delayed under 6 weeks = 10

Delayed over 6 weeks = 0

Exemptions code 9 = 1

Exemptions code 9/51x = 5

Exemptions code 9/71x = 2

A & B patients in Out of Area hospitals:

Delayed under 6 weeks = 1

Delayed over 6 weeks = 0

Exemptions code 9 = 0

Exemptions code 9/51x = 2

Exemptions code 9/71x = 0

Delayed Discharges over 6 weeks continue to be on target, at zero, both in Argyll & Bute and out of area, with the total number of delayed discharges (under 6 weeks and with exemption codes) falling from 26 in July to 21 in August. Whilst this is an excellent achievement in the reduction of delayed discharges, with the attendant benefits for patients, it is reasonable to expect that we will ultimately hit a plateau whereby further reduction will be dependent upon reduction of admission and re-admission to hospital.

Balance of Care for Older People:

The Outcomes Framework for Community Care 2009/10 requires us to move services closer to users and carers by achieving a shift in the balance of care, from institutional to 'home based' care.

Balance of Care targets for Argyll & Bute are 65% of people cared for in the community and 35% of people cared for in an institutional setting, these will increase to 70% and 30% respectively from 1st October 2010. A recent, short benchmarking exercise using annual data from Audit Scotland revealed that most partnerships routinely achieve a 70%/30% BoC and a few of the best performers achieve 75%/25% targets.

Balance of Care by Area:

Area	Clients cared for in the community	Clients cared for in an institutional setting	Trend
Helensburgh & Lomond	66.39%	33.61%	▲
Bute & Cowal	59.85%	40.15%	▼
Mid Argyll, Kintyre and the Islands	63.66%	36.34%	▲
Oban, Lorn & Isles	70.51%	29.49%	▼
Overall Delivery	64.73%	35.27%	▲
Target	65%	35%	
Overall RAG Status	Red	Red	▼

Source Pyramid: Joint Planning and Performance, August 2010.

The Balance of Care performance has improved overall this month. Amber RAG status has now been removed from Pyramid, so that any failure to achieve target attracts a red status. Overall totals are not calculated cumulatively, so one failure to achieve within any scorecard will result in an overall red status.

Helensburgh and Lomond are above target, with an upward trend.

Bute and Cowal are below target, with a downward trend.

MAKI demonstrates an upward trend, but is still below target.

OLI shows a downward trend, but is still above target.

From 1st October the targets are raised by 5%, based on current and recent performance only OLI are likely to achieve the new target. The planned overnight teams and re-launch of Telehealthcare should enable all areas to make progress towards shifting the balance of care in favour of care in the community.

NHS Continuing Care Bed Occupancy:

Hospital Code	Hospital Name	Designated CC beds as advised by Locality Managers July 2010	Occupied April 10	Occupied May 10	Occupied June 2010	Occupied July 2010	Occuoied August 2010
C101H	Argyll & Bute Hospital	**20**	15	15	10/15 tbc	10/15 tbc	10/15 tbc
C106H	Cowal Community Hospital	**0**	0	0	0	0	0
C108H	Islay Hospital	**0**	0	0	0	0	0
C113H	Rothesay Victoria Hospital	**0**	0	0	0	0	0
C114H	Rothesay Victoria Annexe	**16***	0	0	0	0	0
C121H	LIDGH	**2**	2	2	2	2	2
C122H	Campbeltown Hospital	**20**	5	5	3	3	2
H224H	Mid Argyll Hospital	**30 (20 dementia 10 frail elderly)**	23	21	22	20	20**
Total		**88**	**38**	**37**	**37/42**	**35/40**	**34/39**

Source Argyll & Bute CHP Information Services

** Of which 2 are Cowal patients, 1 is a Lorn patient and 1 is a Mull & Iona patient – all on Cara Ward, Mid Argyll Hospital.

Percentage Occupancy Actual 39% / 44% Target 30%

Work is proceeding well on the Cowal and Bute re-design, with all the Continuing Care beds in Cowal empty and resource Release plans under way. Similarly the re-design work in Bute is going ahead and is being used as the pathfinder for a model of care for the future.

NHS Continuing Care beds in Campbeltown and Lochgilphead remain in place, with no proposals to date, for further closures. Two of the 20 beds in Campbeltown are currently occupied by Continuing Care patients, whilst Mid Argyll and Argyll & Bute hospitals have significant numbers of Continuing Care patients.

- ***This figure had previously been stated incorrectly as zero – this was a typing error.***

Care home vacancies are detailed below for each area.

Social Care bed vacancies by area, 27th August 2010.

Area	Permanent vacancies	Respite vacancies
Helensburgh & Lomond	8	0
Bute & Cowal	13	1
Mid Argyll, Kintyre and the Islands	13	0
Oban, Lorn & Isles	15	2

Integrated Occupational Therapy Services:

Total active caseload.

Area	June 2010	July 2010	Aug 2010
Bute and Cowal	Data requested via Locality Managers	144	127*
Helensburgh & Lomond	Anne Stewart will provide data from July onward. This needs to be extracted from the ICT database	230	275
MAKI	Data requested via Locality Managers	175	198
OLI	237	237	231

Includes in-patient, out-patient and community work.

Additional data provided by Bute and Cowal indicates that there are 74 people in Cowal and 22 in Bute waiting for an OT service. Additionally 87 in Cowal and 56 in Bute are waiting for major adaptations to be carried out.

Occupation therapy input is a crucial element in the raft of services required to enable to continue to live well and safely in their own homes, to prevent hospital admissions and to facilitate discharge.

The figures supplied include all aspects of OT work.

In order to effectively monitor OT input and track unmet need we would require monthly data showing community caseloads, together with length and type of input and outcomes for the service user. This could then be linked to our key agenda issues, prevention of admission and facilitation of discharge. For IRF purposes it would be useful to monitor in-patient and out-patient cases in a similar manner.

This would require the OT services in each area to collect and collate in respect of each patient and provide this monthly for inclusion on Pyramid. At the present time the OT services have just begun to collate and provide total caseload figures on a regular basis and do not seem to have a system, or a designated worker, to provide any in-depth data.

Number of unallocated OT cases.

Area	May 2010	June 2010	July 2010	Aug 2010
Bute and Cowal	0	0	0	0
Helensburgh & Lomond	0	0	0	0
MAKI	11	12	12	5
OLI	0	0	0	0

Source Pyramid: Operational Services/Performance Framework

Number of OT assessments outstanding over 28 days.

Area	May 2010	June 2010	July 2010	Aug 2010
Bute and Cowal	1	0	0	0
Helensburgh & Lomond	0	0	0	0
MAKI	13	15	15	13
OLI	0	0	0	1

Source Pyramid: Operational Services/Performance Framework

There has been long term sickness in MAKI which has led to the delays in provision of OT services.

Integrated Care Teams:

Patients maintained at home following an acute incident or illness (MAH) would otherwise have been likely to be admitted to hospital by their GP.

Patients supported on discharge (SD) receive either a) intermediate care with no need for further services b) intermediate care at home prior to the start up of a CCP or c) continuing Physiotherapy, mobility or specialist post-discharge intervention. These interventions ensure that timely discharge takes place and delayed discharges are avoided.

Maintained at home.

Area	May 10	June 2010	July 2010	Aug 2010
Cowal (there is no ICT on Bute)	10	12	11	11
Helensburgh & Lomond	3	8	8	6
MAKI	6	10	8	6
OLI	14	15	16	18

Source Pyramid: Joint Planning and Performance

Supported Discharge.

Area	May 10	June 2010	July 2010	Aug 2010
Cowal (there is no ICT on Bute)	14	13	20	20
Helensburgh & Lomond	26	10	16	25
MAKI	9	14	10	10
OLI	9	3	8	9

Source Pyramid: Joint Planning and Performance

Providing support prior to emergency admission to hospital or care home:

Area	June 2010	July 2010	Aug 2010
Cowal (there is no ICT on Bute)	0	0	1 (prior to emergency placement in social care)
Helensburgh & Lomond	0	0	0
MAKI	0	0	2 (1 mid Argyll and 1 Kintyre)
OLI	0	0	0

Source Monthly Delayed Discharge Report.

The numbers maintained at home or supported on discharge appear to be those that impact on the agenda of prevention of admission or timely discharge. It is recognised that the ICTs do provide other service input, such as targeted rehabilitation, but it is not clear how this impacts on the agenda. A small number – usually a maximum of 1 or 2 per month, per area – of people will be diverted from A&E by the ICT input, this also prevents hospital admission.

In August 1 person had ICT in Cowal prior to emergency placement in a care home. 1 person in Mid Argyll and 1 in Kintyre had ICT input prior to hospital admission.

Integrated Learning Disability Service:

Total number of LD cases receiving a service.

Area	May 10	June 2010	July 2010	Aug 2010
Bute and Cowal	108	108	108	108
Helensburgh & Lomond	110	110	110	110
MAKI	78	78	78	78
OLI	98	99	98	98

Source Pyramid: Adult Services, Learning Disability

Number of LD cases with a PCP.

Area	May 10	June 2010	July 2010	Aug 2010
Bute and Cowal	33	33	33	33
Helensburgh & Lomond	88	88	88	88
MAKI	45	45	45	45
OLI	39	39	39	39

Source Pyramid: Adult Services, Learning Disability

Number of unallocated LD cases.

Area	May 10	June 2010	July 2010	Aug 2010
Bute and Cowal	1	0	1	1
Helensburgh & Lomond	0	1	0	0
MAKI	0	1	0	0
OLI	0	0	3	0

Source Pyramid: Adult Services, Learning Disability

Number of LD cases awaiting assessment for more than 28 days.

Area	May 10	June 2010	July 2010	Aug 2010
Bute and Cowal	1	0	0	2
Helensburgh & Lomond	1	0	1	1
MAKI	0	0	1	1
OLI	0	0	1	0

Source Pyramid: Adult Services, Learning Disability

Balance of care for LD service users.

Total LD service users	**Number in residential care**	**%**	**Number receiving community care**	**%**
324	37	9%	357	91%

Source Pyramid: Adult Services, Learning Disability

The number of LD service users is static, as would be expected with this service user group. The majority of service users are cared for in the community. Those in residential care are largely in specialist out-of-area establishments.

The numbers with PCPs varies across the areas. Although the PCP is the measure returned via eSAY, it is a specific tool used in life-changing events, such as a move to independent living, or the death of a carer and would not be a tool of choice for every service user.

The aim of this service, as with all others, is to move towards personalisation. This will be achieved through the use of a Personal Outcome Plan, regularly reviewed, which will ensure that every service user is being supported towards achieving his or her own desired outcome. Local monitoring of the use of Personal Outcomes Plans and some benchmarking with comparable authorities is planned for the near future.

Integrated Substance Misuse Services:

Data in respect of the integrated substance misuse services is currently only available on a quarterly basis. The data below relates to Financial Quarter 3 2009/10

Total number of substance misuse clients.

Area	FQ3 2009/10	FQ4 2009/10	FQ1 2010/11
Bute and Cowal	225	187	
Helensburgh & Lomond	57	63	
MAKI	78	63	
OLI	134	146	

Source Pyramid: Adult Care/Substance Misuse

Total Alcohol Misuse clients **240**

Total drug Misuse clients **219**

New referrals in the quarter.

Area	FQ3 2009/10	FQ4 2009/10	FQ1 2010/11
Bute and Cowal	32	37	
Helensburgh & Lomond	56	35	
MAKI	25	23	
OLI	43	40	

Source Pyramid: Adult Care/Substance Misuse

Number of substance misuse assessments outstanding over 21 days.

Area	FQ3 2009/10	FQ4 2009/10	FQ1 2010/11
Bute and Cowal	0	1	
Helensburgh & Lomond	0	3	
MAKI	1	5	
OLI	1	5	

Source Pyramid: Adult Care/Substance Misuse

Percentage of alcohol misuse clients offered treatment within 4 weeks of assessment.

FQ3 2009/10	FQ4 2009/10	FQ1 2010/11
90%	97%	

Source Pyramid: Adult Care/Substance Misuse

Percentage of drug misuse clients offered treatment within 4 weeks of assessment.

FQ3 2009/10	FQ4 2009/10	FQ1 2010/11
90%	96%	

Source Pyramid: Adult Care/Substance Misuse

Data for substance misuse is only collected on a quarterly basis. Accurate monthly data, spanning all services, would enable us to provide a more targeted and pro-active service.

There seems to be no data detailing the types of treatment being used, for example:

- Number of detox. Programmes commenced/completed
- Number of rehab. Programmes commenced/completed
- Numbers in substitute prescribing – commenced/retained
- Numbers receiving psycho-social interventions – commenced/retained

This data would support planning and commissioning of services in the future.

Harm reduction and reduction of the spread of blood-borne viruses is also a major issue in drug misuse, so monthly data in relation to this would allow us to estimate our success in maintaining safety levels amongst the drug using population. For example:

- Number of needles exchanged (pins in and out)
- Take up of BBV screening and vaccination
- Number of drug related deaths

Investigation into drug related deaths should also be undertaken and recorded.

The Treatment Outcome Profile (TOP) is now being used by the services we provide, to gain service user self-assessment of improvement and progress. This data is being collated by Joint Planning & Performance and will be built into Pyramid in the near future. Service Level Agreements currently being produced for third sector providers will include a requirement to apply TOP and to provide the forms to us for data collection purposes.

Data for FQ1 2010/2011 has not yet been entered onto Pyramid.

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Appendix 4

Argyll and Bute Strategic Partnerships (Last updated December 2009)

Argyll and Bute Advice Network	a partnership of advice agencies aiming to improve the quality of and access to advice for people in Argyll and Bute	Kate Connelly, Chair of Argyll and Bute Advice Network 01546 604116 kate.connelly@argyll-bute.gov.uk	✓
Argyll and Bute Against Domestic Abuse and Violence Against Women Partnership (ADA)	- The aim of ADA is to improve on the protection provision and prevention of Women and Children in Argyll and Bute who experience Domestic abuse and violence of any sort. The ultimate aim is to eradicate violence towards women and children.	Anne Horn, Chair of ADA PATNERSHIP Anne.horn@argyll-bute.gov.uk	✓
Argyll and Bute Agricultural Forum	Argyll and Bute Agriculture Forum purpose is to: raise awareness of agricultural issues across the area, to act as a Forum for discussion about agricultural issues, too promote the sustainable development of agriculture and to create a unique opportunity for all agencies with an interest in land use sectors to work together	Fergus Younger, fergus.younger@sac.co.uk	?
Argyll and Bute Child Protection Committee	The Argyll and Bute Child Protection Committee is the primary strategic planning mechanism for inter-agency child protection within Argyll & Bute. The Committee membership includes senior representatives from across the range of statutory and voluntary organisations in the area concerned with child welfare. The Committee meets on a regular basis to discuss issues of national interest concerning the protection of children. There is also a clear focus on the promotion of inter agency working and training in the field of child protection and the Committee ensures local policies and procedures are in place for responding to child protection concern.	Robert Grant, chair of committee Robert.grant@argyll-bute.gov.uk or Liz Strang, Elizabeth.strang@argyll-bute.gov.uk	✓
Argyll and Bute Childcare Partnership	Argyll and Bute Childcare Partnership aims to bring together a wide range of providers and service users in the public, private and voluntary sectors in a spirit of co-operation and genuine partnership. Using the shared knowledge, commitment and resources of all partners the partnership	Alison Mackenzie, Principal Officer Childcare and Education, alison.mackenzie@argyll-bute.gov.uk	✓

	promotes the expansion of high quality early education and childcare in Argyll and Bute. The partnership also addresses strategically the identified needs of children and families in Argyll and Bute seeking access to and information about early education and childcare services. The Childcare partnership plans and develops early education and childcare services as part of the integrated planning framework for children and young people's services in Argyll and Bute, ensuring that the plans for early education and childcare enhance the care, play and learning experiences of all children in Argyll and Bute recognising the special needs of particular individuals and groups. Note: The Partnership is now in the process of evolving into a group that will work towards implementing the Early Years Framework that was published by the Scottish Government in December 2008		
Argyll and Bute Community Health Partnership	Argyll and Bute CHP provides primary care and community services in Argyll and Bute and some acute services, including a wide range of out-patient and in-patient services across four localities: Oban, Lorn and the Isles; Mid Argyll, Kintyre and Islay; Cowal and Bute; and Helensburgh and Lomond.	Derek Leslie, General Manager, derek.leslie@nhs.net, 01546 605646 and David Ritchie, Communications Manager, davidritchie@nhs.net, 01436 655040.	✓
Argyll and Bute Community Safety Partnership	The Argyll and Bute Community Safety Partnership aims to improve the quality of life of residents and visitors to Argyll and Bute by, as far as possible, reducing risks and protecting them from hazards, threats and the criminal or anti social behaviour of others. The Argyll and Bute Community Safety Strategy 2009 – 2012 has identified five priorities based upon a strategic assessment of community safety issues which involved analysis of data, consultation with partner services and evaluation of resident perception and concerns. The strategic assessment underpins an intelligence led problem solving and planning approach to Community Safety. The following priorities have been identified: **Ensuring Neighbourhoods and Towns are Safe from Violence, Antisocial Behaviour and Disorder; Tackling Vandalism and Criminal Damage**	Robert Cowper, Tel 01436 658831, Robert.Cowper@argyll-bute.gov.uk	✓

	within Communities and Towns and Ensuring the Environment is Respected and Valued; Improving Road Safety and Promoting Safe Driving; Improving Water Safety; Engaging Residents in Developing Safe Neighbourhoods and Providing Public Reassurance about Personal Safety. These priorities are developed into clear outcome based and focused action plans that are risk based and demonstrate links with wider local and national outcomes. The priorities and action identified by the Argyll and Bute Strategic Community Safety Partnership contribute to the achievement of Argyll and Bute Community Plan objectives and the Argyll and Bute Single Outcome Agreement. Action by the Community Safety Partnership also links with the Scottish Government national objective of a Safer and Stronger Scotland. The five locally based Community Safety Partnerships play a key role delivering the strategy at area level and contribute to monitoring of outcomes and reporting to the Strategic Partnership. Delivery is based upon education and prevention, early intervention and, where appropriate, enforcement action. These multi agency partnerships operate in each of the Council's decentralised areas of Bute and Cowal, Helensburgh and Lomond, Mid Argyll, Kintyre and the Islands, Oban, Lorn and the Isles.		
Argyll and Bute Health and Care Strategic Partnership	The Argyll and Bute Health and Care Partnership is the strategic working forum between the council and NHS Highland / Argyll and Bute CHP. Led by senior members and officers of the Council including the Leader, Spokesperson for Community Services, Chief Executive and Director of Community Services. From the NHS, General Manager and Clinical Director of Argyll and Bute CHP and Director of Community Care NHS Highland. Partnership manages all issues relating to: Joint Service Planning and Service design / re-design; Integration of Services and Management structures; Joint financial planning including resource release proposals; All issues relating to the Joint Performance Indicators and Assessment Framework; (JPIAF) e.g. Delayed Discharge, Local Improvement Targets.	Council: Douglas Hendry, Director of Community Services Douglas.hendry@argyll-bute.gov.uk and James Robb, Head of Adult Care jim.robb@argyll-bute.gov.uk , 01369-708911 0r 01546-604323 NHS: Derek Leslie, Argyll and Bute CHP General Manager Derek.leslie@nhs.net and Josephine Bown, Argyll and Bute Head of Integrated Care	✓

		Josephine.bown@nhs.net	
Argyll and Bute Local Access Forum	The Argyll and Bute Local Access Forum are an independent statutory body established under the Land Reform (Scotland) Act 2003. Its members are drawn from land managers, public agencies, community groups and access users. The Forums aim is to provide expert and impartial advice on outdoor access and matters relating to Part 1 of the Land Reform (Scotland) Act. Because of the disparate and complex issues associated with outdoor access this aim can only be achieved through working in partnership with various interest groups	Douglas Grierson, Access Officer, 01546 604228 Douglas.grierson@argyll-bute.gov.uk	✓
Argyll and Bute Local Biodiversity Partnership	The Argyll and Bute Local Biodiversity Partnership was established in 1997 with 31 partners representing government and non-government agencies and organisations. The Argyll and Bute Local Biodiversity Action Plan (AandBCLBAP) was launched in September 2001 with 67 action plans representing land, freshwater and marine and coastal habitat and species. Partners are delivering the actions through projects and as part of their remits. In order to increase public awareness and engagement in the LBAP, Phase I and Phase II of the Community Action for Biodiversity project was developed to support community activities, training and demonstration projects. The Partnership supports the Community Planning Partnership, the Argyll Agricultural Forum, Access Forum, Scottish Working Group on Invasive Non Native species, Firth of Lorn and Loch Creran SAC, Local Action Group- LEADER, the Argyll and Bute Beach Forum and formed the Argyll and Bute Invasive Species Forum.	Marina Curran-Colthart, Local Biodiversity Officer, Kilbowie House, Gallanach Rd., Oban, Argyll PA34 4PF. Tel 01631-569160. email: marina.curran-colthart@argyll-bute.gov.uk Website: www.argyll-bute.gov.uk/biodiversity/	✓
Argyll and Bute Renewable Alliance	This will be an action coming out of the Renewable Strategy and Action Plan which is currently in very early draft form and which is an action in the new CPP Plan. Hopefully ABRA will be up and running in the early part of the new year.	Audrey Martin Audrey.martin@argyll-bute.gov.uk	✓
~~**Argyll and Bute Social Economy**~~	~~To provide strategic support to social enterprises in Argyll and Bute~~	~~Jim McCrossan jim.mccrossan@argyll-bute.gov.uk~~	~~✓~~

~~Partnership~~			
Argyll and Bute Social Enterprise Network	Argyll and Bute Social Enterprise Network is a network for all established and emerging social enterprise throughout Argyll and Bute and Arran and the Cumbraes. A trading social enterprise in its own right as well as a membership based organisation, ABSEN promotes meetings, training, events and newsletters on a regular basis in response to Members needs and to encourage sharing and dissemination of relevant information; it promotes social enterprise as an alternative business model in the area including working directly with community groups, emerging social enterprises, schools and other agencies; it represents Members' interest to statutory bodies and agencies; delivers services throughout the area under contract with HISEZ and the Local Social Economy Partnership; is a signed partner in the Third Sector Partnership, has Director representation on the Demonstration Board, is a Member of the Local Social Economy Partnership and the Economic Thematic Group of the CPP.	Mike Geraghty ABSEN Development Officer: email mike.geraghty@absen.org.uk Tel 07767 383 380	✓
Argyll and Bute Strategic Housing and Communities Forum	The Argyll and Bute Housing and Communities Forum was established in 2006, following the merger of the Strategic Housing Forum with the Community Planning Partnership Sustaining Our Communities, Culture and Environment theme group. The core membership currently comprises over 22 individual representatives from around 12 separate partner organisations with over a dozen further additional members who participate on an ad hoc basis. Membership reflects a range of interests from national and local perspectives and statutory, private or voluntary sectors. The partnership has an extended remit to monitor, and support the development and implementation of, a range of plans and strategies relevant to housing, land use, infrastructure capacity, and community development, sustainability and engagement. These include: the Local Housing Strategy; the Homeless Strategy; Supporting People Strategy; Fuel Poverty Strategy; Argyll and Bute Local Plan and the Loch Lomond and the Trossachs National Park Plan; Affordable Housing Policy; Communities Scotland Investment Programme; Scottish Water	Malcolm MacFadyen, Head of Community Regeneration, Argyll and Bute Council, 01546 604412 malcolm.macfadyen@argyll-bute.gov.uk	✓

	Development Programme; RSL Wider Role Strategy; Community Regeneration Fund and Outcome Agreements; and the Renewable Energy Policy		
Argyll and Bute Youth Forum	Argyll and Bute Youth Forum is a constituted voluntary organisation with charitable status bringing together young people from a number of local youth forums across Argyll and Bute. There are 32 young people on the ABYF with 8 members from each of the Council's 4 decentralised areas. In partnership with Dialogue Youth, ABYF promote and assist with the election of two MSYPs for Argyll and Bute. The ABYF rotates its AGM round the communities of Argyll and Bute and there are normally 4 meetings of the forum each year, including the AGM.	Martin Turnbull Martin.turnbull@argyll-bute.gov.uk	✓
Argyll and Bute's Children	This group has responsibility for :(i) The commissioning, publication, reviewing and monitoring of Argyll and Bute's integrated children's services plan.(ii)The development of integrated children's service systems including; the further development of FUSIONS, the response to GIRFEC, integrated assessment, and the operational implementation of integrated working.(iii) Ensuring consistency of service and policy development in respect of Child Protection; Early Years; and Children With Additional Social Needs	Douglas Dunlop, Head of Service – Children and Families, 01546 604256, dougie.dunlop@argyll-bute.gov.uk	✓
Argyll and the Islands LEADER Local Action Group	LEADER is part of the Scottish Rural Development Programme (SRDP). The aim of LEADER is to increase the capacity of local rural community and business networks to build knowledge and skills, and encourage innovation and co-operation in order to tackle local development objectives It is a bottom-up method of delivering support for rural development through implementing a local rural development strategy. Support is aimed primarily at small-scale, community driven projects that are pilot and innovative in nature. The Argyll and the Islands Local Action Group is a partnership made up of community sector, public sector and private sector organisations which delivers the programme in the Argyll and the Islands area (Argyll & Bute excluding Helensburgh and Arran and the Cumbraes). The Partnership has 24 members and is chaired by Argyll & Bute Volunteer Centre The secretariat is provided by Argyll & Bute Council	Argyll and the Islands LEADER Project Co-ordinators Lorna Elliott lorna.elliott@argyll-bute.gov.uk and Sheila McLean sheila.mclean@argyll-bute.gov.uk see also www.argyllandtheislandsleader.org.uk for further information.	✓

Argyll Regional Project Assessment Committee (RPAC)	Responsible for making recommendations for funding under the Rural Priorities Scheme (part of the Scottish Rural Development Program). The committee meets between three and four times a year and consists of representatives from Scottish Government Rural Payments and Inspections Directorate (SGRPID), Scottish Natural Heritage (SNH), Forestry Commission (FC), Argyll and Bute Council, SEPA and Highlands and Islands Enterprise. The committee considers case summaries prepared by officers from SGRPID, FC and SNH and makes recommendations to the Cabinet Secretary for Rural Affairs and Environment who makes the final decision on funding of individual projects	Bill Dundas Bill.Dundas@scotland.gsi.gov.uk	✓
Fairer Argyll and Bute Partnership	The FAB partnership brings together all relevant partners to coordinate policy and action on tackling poverty, deprivation and health inequalities. A detailed analysis of data for all communities in Argyll and Bute has helped direct future action. Specific areas of work within the FAB Plan are coordinated by other groups that feed into the full FAB Partnership. For example: the Health Improvement Planning and Performance Action Group (HIPPAG) ensures that there is alignment between action on local needs and national priorities with a focus on: mental wellbeing; tobacco; alcohol; obesity; and early years, and the development of the Community Learning Strategy to ensure that community based learning opportunities are widely available to people of all ages	Jim McCrossan jim.mccrossan@argyll-bute.gov.uk	✓
Health Improvement Planning and Performance Action Group (HIPPAG)	This is a group that comprises a cross section of statutory and voluntary organisations and community representatives. The focus of its work is on public health issues that affect the whole population as well as playing particular attention to health inequalities. It comes together to tackle issues that are better dealt with within such a partnership because of the multi-faceted nature of the problem or where the issue is not addressed by separate organisations.	Elaine C Garman, NHS Highland, Victoria Hospital, Rothesay, 0700 501534 elaine.garman@nhs.net	✓
Argyll and Bute Health Improvement	The group is working on tackling the areas of the Council's Sport and Physical Activity Strategy which have potential of tackling health issues within the wider public services. This group consists of representatives of	Muriel Kupris, Community Resources Manager, 01631 572181.	

Group	direct services where physical activity and sport can or do play a part in tackling other priorities such as mental health, ageing, physical disability, general health as well as specific health issues such as obesity, exercise on referral, cancer, heart disease, musculoskeletal health etc. Members are drawn from Argyll and Bute Council's Services for young people, older people, community regeneration, children with disabilities, sport and leisure, NHS Highland, Active Schools and sportscotland.	Muriel.kupris@argyll-bute.gov.uk	
Young Scot – Dialogue Youth	The Scottish Government, Young Scot and Argyll and Bute Council are working in partnership to deliver a localised youth information package under the initiative of Dialogue Youth. The project aims to ensure young people aged 12 - 26 are fully represented in community planning, enabling them to make informed choices by providing information and opportunities, engaging young people through surveys and consultations and empowering them by providing platforms for them to express their views	Roanna Taylor, MAYP, Union Street, Lochgilphead, PA31 8JS Tel: 01546 600035 Roanna.taylor@argyll-bute.gov.uk	✓
ALL SCOTLAND 2014 LEGACY GROUP	Willie Young, Principal Leisure Officer represent the Council and CPP on the All Scotland 2014 Legacy Group. This consists of nominated officers from all 32 Local Authorities in Scotland along with their counterparts in all of Scotland's Health Boards. The aims of the group are to promote and drive forward the four pillars of the Scottish Government's 'Games Legacy for Scotland' (Active Nation, Connecting Scotland, Sustainable Scotland and a Flourishing Scotland) using the build up to the 2014 Commonwealth games in Glasgow as a platform to develop a lasting legacy.	Willie Young, Principal Leisure Officer, willie.young@argyll-bute.gov.uk	
REGIONAL SPORTS PARTNERSHIP	Since the restructuring of sportscotland over the past year, the Government have decided that the development of sport should be progressed on a regional basis in future. Argyll and Bute are designated within the West Region which consists of 13 local authorities stretching from Argyll and Bute through west central Scotlsnd 9including Glasgow) to	Willie Young, Principal Leisure Officer, willie.young@argyll-bute.gov.uk	

	Dimfries and Galloway. The Region is the largest of the six in Scotland and will bring additional resources to the area such as coach and club development teams from sportscotland as well as Regional staff from Governing Bodies of Sport.		

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Agenda Item 12

Argyll and Bute Community Planning Partnership

Management Committee
Date: 8 September 2010

Title: REAP – sub group update

1. SUMMARY

1.1 The Renewable Energy Action Plan (REAP), which was approved by the CPP on the 16 June, was developed from a key action in the Argyll and Bute Community Plan 2009-2013 in order to facilitate a co-ordinated partnership approach to renewable development in Argyll and Bute. In light of the implications on public sector resources from the onshore requirement from off shore wind and marine renewables the management committee recommended the establishment of a sub-group to look specifically at these implications.

1.2 The group met on the 20 July and discussions centred around the links with REAP, responsibilities of partners, infrastructure issues, communications and the potential impact on existing service provision and resources.

1.3 We have the opportunity to work in a proactive manner with the key developers to ensure that we are in a position to influence the outcome.

2. RECOMMENDATIONS

2.1 That the Management Committee agree to the planning and delivery of a CPP consultation event with the off shore wind developers and marine consenting authority, Marine Scotland, to take place on the 10 February 2011 following the CPP full partnership meeting.

2.2 In advance of the meeting on the 10 February 2011 the Management Committee consent to the sub group approaching the CPP thematic groups and Local Area Community Planning Groups requesting that they give consideration to the questions that should be asked and issues that should be raised at the consultation event.

3. BACKGROUND

3.1 As partners will be aware there are significant renewable development proposals coming forward in our area. Argyll and

Bute has three proposed off shore windfarm sites, the Argyll Array, off Tiree, being the largest consisting of anywhere between 300 and 500 turbines and having a capacity to generate enough power for 1,000,000 households (1.8GW). These developments can only be described as transformational projects given their scale and potential impact on our communities. In addition the recent Scottish Government Saltire Prize Scoping study proposed a number of wave and tidal sites within Argyll and Bute which may well form part of a future Scottish commercial wave and tidal leasing round by the Crown Estate. Scottish Power Renewables are also proposing a 10MW tidal device in the Sound of Islay with an application due to be submitted to Marine Scotland in the near future. If consent is given for this later this year and further testing in Orkney is successful in 2011 then the ten tidal turbines would be manufactured in 2012 and installed in 2013. This is likely to be a world-leading development and would help to put Islay and Argyll at the centre of the marine renewables industry.

3.2 There could well be implications on public sector resources from the on shore requirements associated with these off shore wind and marine renewable developments however we are still at an early stage in the development of these projects, with construction not anticipated to start until 2015 at the earliest. There is therefore still an opportunity to proactively engage with the developers and to discuss the implications and influence the outcome. It was for this reason that the sub group was established.

4. CONCLUSION

4.1 The Renewable Energy sector has the potential to fundamentally and positively transform the economy and communities of Argyll and Bute. The scale of the off shore developments as well as potential future wave and tidal developments that are being considered for Argyll and Bute are significant and could be described as transformational projects in their own right. However, it is critical that the CPP partners work with the developers and key stakeholders at a local and national level to ensure that these developments happen in a sustainable and co-ordinated manner, that we are all fully aware of the implications, including public sector resource implications, and requirements and the optimal benefits for our communities are secured. In order to achieve this outcome there is a need to proactively engage with the developers to ensure that we minimise the impact on our limited resources but maximise the benefit to our communities..

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Argyll and Bute Community Planning Partnership

Social Affairs Thematic Group
Date: 8th November 2010

Title: 3rd sector representation on the Argyll and Bute Adult Protection Committee

1. SUMMARY

1.1 This report identifies the need for 3rd sector representation on the Argyll and Bute Adult Protection Committee.

2. RECOMMENDATIONS

2.1 This report recommends that the Argyll and Bute Community Planning Partnership Social Affairs Thematic Group takes to its membership the request for 3rd sector representation on the Argyll and Bute Adult Protection Committee (Argyll and Bute APC).

3. BACKGROUND

3.1 The Scottish Government passed the Adult Support and Protection (Scotland) Act in March 2007. This Act brings into law a range of duties to statutory bodies to inquire into and take action to offer support and/or protection to 'adults at risk of harm'.

3.2 The Argyll and Bute Adult Protection Committee came into existence in June 2008 and in its initial phase undertook communications with the Scottish Government to access funding to develop the work to protect adults who are at risk of harm. This resulted in the appointment of one worker in each of the areas of Argyll and Bute to allow for the statutory follow up of reports of adults who may be at risk. The AP Committee also appointed a manager to oversee the development of adult protection work and an administrative officer to collate and maintain records relating to reports of adults at risk'.

3.3 Since then the committee has been developing mechanisms to address its statutory functions these being:- Reviewing procedures and practice / offering advice and information to public bodies / arranging training for staff in all sectors and working towards improving co-operation between public bodies.

3.4 The Committee had made direct contact with care organisations to seek representation on the committee from the third sector however the committee recognises the importance of doing so through a more structured framework such as is provided by the CPP. The APC has arranged for regular attendance of the LAAS advocacy service who have a defined role under the ASP Act.

3.5 The APC meets on a quarterly basis and is seeking representation

from the 3rd sector to contribute to the development of adult protection practice in Argyll and Bute. It would be expected that this representative would give appropriate feedback on the development of this work to the CPP and its constituent organisations. And also feed into the development of the adult protection framework from the perspective of 3rd sector organisations.

3.6 It may be of advantage for the representative to have experience in working in the care sector and/or knowledge of work carried out to support adults at risk.

4. CONCLUSION

4.1 The APC would welcome the contribution from the 3rd sector to its work and awaits the CPP response to this request with interest.

Ronnie McIlquham
Area Manager Adult Protection

Allen Stevenson
Lead Officer adult Protection

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