HEALTH IMPROVEMENT – HEALTH IMPROVEMENT PLANNING AND PERFORMANCE ACTION GROUP UPDATE

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The CPP Social Affairs Thematic Group is asked to:

- Note the paper

In the early part of 2008/09 the CPP multi-agency health improvement group (Health and Wellbeing Theme Group) started considering the planning mechanism required after the end of the existing Joint Health Improvement Plan. We recognised that despite having an SOA (and within that a health inequalities plan – Fairer Argyll and Bute Plan) we still required a plan and a group that would deliver on the multi-agency health improvement activity. We have reformed the group into Health Improvement Planning and Performance Action Group (HIPPAG) and have agreed that activity should be around the national health improvement performance priorities: health inequalities, mental wellbeing, tobacco, alcohol, obesity and early years.

In June 2009 the Scottish Government provided an Advice Note on the role of Community Health Partnerships (CHPs) in improving the health and reducing health inequalities in the context of the Single Outcome Agreement (SOA) process. This Advice Note explains the requirement for more detailed health improvement planning with community planning partners below the SOA previously provided by Joint Health Improvement Plans. The HIPPAG had anticipated the necessity the requirement for more detailed planning and undertook to produce a detailed plan. This paper outlines the work carried out that resulted in plans being produced during 2009/10.

The topics of mental wellbeing, tobacco, alcohol, obesity and early years have agreed national outcomes which have corresponding intermediate outcomes. We selected the intermediate outcomes in each of these areas and invited the Local Public Health Networks (LPHNs) (that link to HIPPAG) to consider their priorities. The aim was to merge the top down agenda with local grass roots priorities and enthusiasm. Working on these outcome-focussed plans represents a huge amount of work, in many cases being undertaken by community members and voluntary organisations working alongside their statutory agency partners. With these plans each of the Networks then allocated their portion of the Health Improvement Fund (HIF) according to their identified outcomes. However it should be noted that some of the work requiring HIF monies was slipped from last year to 2010/11 due to budgetary constraints. Appendix 1 shows the consolidated actions being taken across all the LPHNs. Now that this is complete we can consider whether there is further strategic work that needs to happen within the Argyll and Bute CPP to complement the local actions.

So far NHS Health Scotland has developed strategic logic models for alcohol and tobacco and is currently working on mental health and wellbeing. This draft logic model is contained in Appendix 2. It is populated with the different levels of outcomes and NHS Health Scotland is currently adding the evidence to support actions/interventions and a menu of suggested performance indicators. This will cut down substantial duplication of work across Community Planning Partnerships in Scotland.

In conclusion the way that we have developed health improvement planning within Argyll and Bute meets the requirements of the Advice Note sent out in June 2009. The consolidated plan now allows us to take forward further strategic work to complement these local actions.

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Public Health Specialist, 22 April 2010