



**West Dunbartonshire Community Planning Partnership
Health Improvement Strategy Group**

Tobacco Control and Physical Activity Outcome Models

Final Report

Brodies LLP and Avril Blamey & Associates

September 2008

Executive Summary

Introduction

In March 2008, the Health Improvement Strategy Group (HISG) within the West Dunbartonshire Community Planning Partnership (CPP), commissioned Brodies LLP and Avril Blamey & Associates to provide assistance in the development of outcome models for health improvement for the CPP. These models will subsequently inform the development of a health improvement outcome agreement, aligned with the Single Outcome Agreement (SOA) for West Dunbartonshire (which itself aims to relate explicitly to the local community plan).

The West Dunbartonshire CPP has identified four priority areas where they aim to improve health and reduce health inequalities – Tobacco, Physical Activity, Diet, and Alcohol. There is a phased approach to the development of the outcome models with initial concentration on the areas of Tobacco and Physical Activity. The tools and techniques used, and the knowledge gained in the initial phase will inform a similar process for the subsequent phases and topics.

The conclusions and recommendations in this report provide a robust starting point to inform the discussions about relative CPP emphasis (in terms of importance and resource allocation) across the four health improvement topics – Tobacco, Physical Activity, Diet and Alcohol. The health improvement outcome agreement – and the programmes of work that will be used to deliver on this agreement - are dependent on the outcomes of these informed CPP discussions.

These discussions will take place in the context of a re-invigoration of community planning in West Dunbartonshire. The aim is that the role of all thematic groups – of which the HISG is one – will be strengthened, and that a lead partner will be held to account for the delivery of the specified outcomes. This is intended to facilitate the design and implementation of appropriate programmes of work across all of the community plan themes. While the detail of the report focuses on Health Improvement, the principles, proposed activities and tools applied have common relevance across the breadth of CPP themes.

Approach

The outcome models were developed through a combination of desktop analysis and discussions with key staff across the HISG partner organisations. The desktop analysis included an examination of good practice in outcome modelling, consideration of emerging Scottish Government and Improvement Service thinking on outcome agreements, Scottish Government objectives associated with Health Improvement, and an examination of existing policies and strategies associated with Tobacco and Physical Activity within West Dunbartonshire and beyond. The consultation included HISG members, Council policy staff involved in the development of the SOA, West Dunbartonshire CVS, and operational and project staff in partner services that contribute to Tobacco and Physical Activity.

Content and conclusions

The report proposes strategic outcome models for Tobacco and Physical Activity that align local activities and outcomes with the SOA and national outcomes. They include prioritised local outcomes within those detailed in the models. It also sets out four detailed operational models for physical activity and three for tobacco control that show how existing and intended activities link to the local prioritised outcomes.

The report includes observations from the consultants regarding the logic and evidence base of current plans, the existence of monitoring systems, and the availability of local data to identify the potential reach, adoption and efficacy of current programmes. Where appropriate information was available the report highlights the likely contributions that the programmes will make to the outcomes. Information has been fed back to HISG that will be useful in planning how any current gaps may be closed as the health improvement agenda moves forward.

The report makes a number of recommendations as to where and how collaborative gain (added value through partnership working) can be enhanced and provides models, criteria and processes that can be used with partners to progress these tasks more fully over time.

Looking across the issues arising in the development of the emerging outcome models the consultants have reached a number of conclusions.

1. The identified health improvement outcomes link to the outcomes presented in the West Dunbartonshire SOA. These in turn link into the relevant national outcomes associated with health improvement.
2. Most of the activities and services that are recommended in the main evidence based guidelines supporting action in tackling tobacco and promoting physical activity are present within West Dunbartonshire partnership activities.
3. There are, however, areas where activities or services are not fully developed or, as yet, have limited coverage. There are activities and services where there is scope for improvement in relation to reach, effectiveness, adoption (across professionals or organisations), the way the programme is implemented or the extent to which it will be sustained or lead to maintained behaviour change. Some of the limitations that we have identified as part of this process were already known to the HISG and/or partners and in several instances plans or early actions are already being developed to address these.
4. If the identified gaps and weaknesses are addressed, the consultants believe that the energies and efforts of CPP partners are configured to deliver the desired health improvement outcomes. Any observations regarding opportunities for further improvement/investment should be seen in that light.
5. At a strategic level, the consultants have set out how collaborative gain may be 'designed in' as part of the new community planning arrangements in West Dunbartonshire, with a particular emphasis on the role of the HISG and the Health Improvement 'Themed Group'. It is important that the work of the HISG is not progressed in isolation from that of the other five community planning themed groups. The overarching arrangements/structures for community planning in West Dunbartonshire have been designed with this interdependency in mind.
6. Operationally, there have been a number of areas where there is potential to establish or increase collaborative gain in relation to these two outcome areas. In some instances, such possible refinements/ developments relate to physical activity, in others to tobacco. Typically though, the

opportunities identified are relevant to both of these outcome areas and the other outcome areas – Diet and Alcohol - that the HISG has prioritised.

7. Collaborative gain should be sought and delivered at a programme level – rather than through every activity stream. We consider that specific collaborative gain targets and performance measures can be developed that relate to compliance with/participation in identified collaborative activities and the delivery of collaborative outcomes.
8. There are a number of specific opportunities to enhance collaborative gain within these topics (these may also be relevant to other topics and themes). They include scope for partners to work jointly to:
 - identify and agree the most accurate and useful data source within each topic area, then use this consistently for planning purposes across agencies
 - identify and agree locally relevant performance targets in each topic area, clearly stating the rationale for their selection (relevant to the commitments made in the SOA).
 - encourage further deliberation within the Partnership regarding the available evidence base/logic used to inform the plausibility of current activities and interventions
 - increase the use of existing monitoring data from current services and programmes to inform the prioritisation and improvement of collaborative interventions
 - identify opportunities for tailoring and targeting existing services – often provided across West Dunbartonshire as a single population group - to maximise the impact of finite resources on priority outcomes
 - agree the key population groups being targeted by the Partnership, and identify the best means of engaging with these groups (across the breadth of partner communications).

Recommendations

Based on the findings and conclusions set out in the report, the consultants make the following recommendations:

- 1 The CPP/HISG note the content of the report and take assurance from the emerging conclusions
- 2 The HISG use the proposed strategic models as a basis for the development of the health improvement outcome agreement; refining/supplementing these as needs be in light of subsequent work on Diet and Alcohol outcomes
- 3 The HISG share the more detailed operational models with relevant partner managers to help refine the detail and provide an outcome focus for their subsequent service planning and resource allocation decisions
- 4 The HISG encourage partner agencies to continue to develop the monitoring information and evidence base associated with their activities and their contributions to health improvement

- 5 The HISG adopt the collaborative gain framework and the planning tools set out in this report as a basis for planning and delivering their forward work programme
- 6 The HISG considers the need to develop further outcome models for Diet and Alcohol, using these models in their own right, and as an emerging information base to inform the relative emphasis within the comprehensive health improvement outcome agreement
- 7 Within the context of the re-invigorated community planning arrangements, the HISG draft the health improvement outcome, linking into (and informing updates to) the West Dunbartonshire SOA
- 8 The HISG oversees the development of a work programme in each topic area that builds on the outcomes, contributions and roles and responsibilities highlighted in this report (for tobacco and physical activity), but acknowledges the relative emphasis across the four topic areas associated with health improvement.

Contents

1	Introduction	6
2	Context	8
3	Our approach	19
4	Findings: Tobacco Control	21
	Model one: Strategic outcome model for tobacco control	22
	Model two: Smoking cessation services	25
	Model three: Tobacco education and prevention	28
	Model Four: The enforcement of the smoking in public places legislation	30
	<i>Table one: Collaborative gain in tobacco control</i>	33
5	Findings: Physical Activity	36
	Model five: Strategic outcome model for physical activity	37
	Model six: Leisure Services	40
	Model seven: Exercise referral (Live Active).....	43
	Model eight: Active commuting/green travel/workplace interventions.....	46
	Model nine: Planning (SP11) and the built and natural environment	49
	<i>Table two: Collaborative gain in physical activity</i>	52
6	Conclusions and recommendations	55
7.	References	60
8.	Appendices	62
	Appendix one: Tools and techniques used in the development of the outcome models	62
	Appendix two: More detailed version of Model seven- Active Commuting (Active for Life)	65

Acknowledgements

This report was commissioned by and for the West Dunbartonshire Community Planning Partnership's Health Improvement Strategy Group (HISG). It was prepared by Brodies LLP and Avril Blamey and Associates. The work underpinning it was overseen by a sub-group of HISG members:

Soumen Sengupta -	Head of Planning and Health Improvement, West Dunbartonshire Community Health Partnership/Chair of HISG
Liz Tuach -	Co-ordinator, West Dunbartonshire Community Planning Partnership
Bobby Jones -	Lead Officer Public Health Development - West Dunbartonshire Council
Claire McGinley -	Health Improvement and Inequalities Manager, West Dunbartonshire Community Health Partnership

The work was also supported by, and benefited from, input from a range of colleagues from various local stakeholder organisations. It has also received valuable insights from colleagues from national agencies, most notably Alan Neilson (Improvement Service). The authors and the HISG would like to express their thanks to all of the above for sharing their knowledge and perspectives. However, this report, its recommendations and all of the views expressed within are solely the responsibility of Brodies LLP and Avril Blamey and Associates.

1 Introduction

In March 2008, the Health Improvement Strategy Group (HISG) within the West Dunbartonshire Community Planning Partnership (CPP), commissioned Brodies LLP and Associates to provide assistance in the development of outcome models for health improvement for the CPP. This is to be achieved through an integrated outcome approach that is evidence based and incorporates the concept of “collaborative gain”. The HISG are keen to encourage a multi-agency approach to identifying, planning and delivering the intended outcomes.

These models will subsequently inform the development of a health improvement outcome agreement, aligned with the Single Outcome Agreement (SOA) for West Dunbartonshire (which itself aims to relate explicitly to the local community plan). This outcome agreement is intended to allow effective integration of performance monitoring, management and reporting of progress, performance and partner contributions in delivering health improvement in West Dunbartonshire.

The West Dunbartonshire CPP, through a process of community needs assessment has identified four priority areas where they aim to improve health and reduce health inequalities. These are:

- Tobacco
- Physical Activity
- Diet
- Alcohol.

There is a phased approach to the development of the outcome models with initial concentration on the areas of Tobacco and Physical Activity. The expectation is that the tools, techniques used and knowledge gained in the initial phase will inform a similar process for the subsequent phases and topics.

This report introduces high level outcome-focused models for Tobacco and Physical Activity in West Dunbartonshire. It also sets out more detailed outcome models for each key area of activity under each topic. It makes a number of observations regarding the nature and extent of the current approaches to delivering these outcomes in West Dunbartonshire. Finally, it makes a number of recommendations regarding how the approaches may be further developed within the wider context of West Dunbartonshire’s emerging arrangements for community planning, and how these will feed into the development of an outcome agreement for health improvement.

Our initial brief included the need to provide support to develop draft outcome agreements on tobacco control and physical activity and to:

- 1 Identify and prioritise outcomes (for tobacco and physical activity) and align these with the emerging SOA
- 2 Map current partner activities that relate to the emerging outcomes
- 3 Use the available evidence base and service monitoring information to identify those activities and services that will best contribute to the outcomes and that require to be delivered collaboratively

- 4 Develop outline programmes that will deliver on the outcomes and that show partners potential contributions and where collaborative gain can be enhanced
- 5 Identify possible measures and targets that will enable the programmes to be performance managed.

The intention was that these would be used to further develop programmes of work for the CPP that focused on key outcomes, clarified tangible contributions and set out the basis for subsequent performance management.

In relation to one we have developed strategic outcome models for the two areas and aligned local activities and outcomes with the SOA and national outcomes. We have also suggested prioritised local outcomes within the models.

In relation to two we have developed four operational models for physical activity and three for tobacco control that show how existing and intended activities link to the local prioritised outcomes.

With regard to three we have attempted to use a mix of the existing evidence base and local data, to identify the potential reach, adoption and efficacy of current programmes and to identify the likely contribution they will make to the outcomes and how such contribution can be maximised. This former information is not presented in the current report but has been made available to the HISG for internal use and to aid further specification of the future programmes that will underpin the agreed models. The latter abstracted information is reported within this report.

We have been unable to fully deliver on tasks four and five as a result of the current structural changes within the CPP and due to limitations in existing monitoring data. We have, however, identified where and how collaborative gain can be enhanced and have provided models, criteria and processes that can be used with partners to progress these tasks more fully over time.

2 Context

This chapter is broken down into five sections. The first examines the health improvement context, with particular emphasis on outcome focused planning. The second provides background on the requirement to produce a single outcome agreement (SOA) covering each of Scotland's thirty two local authority areas. The third sets out details regarding the HEAT targets that encompass the NHS' particular contribution to the national health improvement framework. The fourth outlines specific contextual developments within community planning in West Dunbartonshire. The fifth introduces the notion of collaborative gain through partnership working, setting out its potential role in impacting positively on health improvement outcomes within West Dunbartonshire.

2.1 Health improvement

The development of an outcome-focussed approach to planning and service delivery in Scotland is being driven from a variety of agencies and perspectives. In 2005 two pieces of Health Improvement focussed research (Health Improvement Planning in Scotland: An analysis of JHIPs and ROAs and Health Improvement and Health Inequalities: A Local Government Perspective) indicated the need to:

- improve existing plans and planning structures;
- move further towards outcome focussed and evidence-informed planning; and,
- emphasise the role of local authorities and mainstream services in delivering on cross cutting agendas (such as health improvement and community safety).

In 2006 "Transforming Public Services: The next Phase of Reform" was published by the Scottish Executive and highlighted five core areas where public service delivery could be strengthened (by becoming user focussed, improving accountability, delivering more joined-up services, improving efficiency and increasing quality and innovation). At the same time "Community Planning: An Initial Review" was published by Audit Scotland and confirmed many of the above findings and identified the need for a strengthened role for Community Planning Partnerships in delivering joined up, community focussed services. Later in 2006, the report of the Community Led Supporting and Developing Healthy Communities Task Group emphasised the need for greater acknowledgement and improved articulation of the role and contribution of the community and voluntary sector in health improvement. The above developments indicated changes that were necessary in planning and delivering at both local and national level and led to a variety of aligned activity.

Given the importance and cross-cutting nature of the health improvement agenda at the national and local level, and the progress made to date in establishing the Community Health Partnerships [CHPs] (and integration of health and social work services), a range of activities have taken place to support the necessary improvements in planning and delivery highlighted above. NHS Health Scotland, Communities Scotland, the Improvement Service and the Scottish Government commissioned consultancy input to three Community Planning Partnerships to support 'Integrated Health Improvement Planning and Delivery'. The Scottish Government (Public Health and Well-being Directorate) established a cross cutting Steering Group to oversee the review of the NHS performance and accountability Framework (HEAT targets) and consult on the development of agreed national outcomes for Health Improvement. In addition, support is being given to develop local topic-based outcome focussed plans for reducing alcohol related harm (Angus and Aberdeenshire) and green space (Dundee and Glasgow). In relation to the former, the developing plans should align with outcome-focussed work at the national level on Alcohol.

2.2 The Single Outcome Agreement

In November 2007 the Scottish Government produced a National Performance Framework (Scottish Government Spending Review) highlighting fifteen outcomes and more than fifty indicators that are expected to guide delivery towards the five cross government Strategic Objectives (Healthier, Wealthier & Fairer, Safer & Stronger, Smarter and Greener). These outcomes will form the basis of the concordat between Central and Local Government and will inform the development of SOAs. The intention is for the SOAs to cover all council services and look to engage with Community Planning Partnerships in the process. All councils are required to submit their SOA by the end of March, with a SOA incorporating Community Planning Partners not required until 2009 – 2010. However, a significant number of councils are hoping to develop their SOA with their community planning partners in this year's submission. Along with the reduction in ring-fenced funding, SOAs are intended give councils greater flexibility to determine where budgets should be spent to achieve agreed outcomes.

West Dunbartonshire Council's draft SOA recognised the need to set the SOA in the context of the Community Plan 2007 – 2017, with its vision for West Dunbartonshire in 2017, i.e.:

“Working in partnership we want to reduce poverty and exclusion, deliver better services and continue to improve the quality of life for everyone living in West Dunbartonshire whilst protecting our natural environment”

This vision will be achieved through:

- Boosting business growth, regenerating communities and linking people to jobs
- Improving safety and a sense of security in our communities
- Promoting health and well-being and challenging health inequalities
- Maintaining and improving access to excellent education and lifelong learning
- Creating sustainable and attractive living environments
- Developing good quality, sustainable and affordable housing to meet changing demographic needs
- Enabling young people to achieve their full potential
- Valuing, protecting and enhancing the area's natural and historical resources whilst reducing our impact on the natural environment.

2.3 The HEAT targets

The key outcomes and indicators from the concordat most relevant to Health Improvement have been matched onto a specific Health Improvement framework within the recently published “Managing for Shared Outcomes: Towards achieving a Healthier Scotland” (NHS Health Scotland 2008). This paper also highlighted the first group of the recently revised HEAT targets and showed further work to be developed in this programme. The current revised HEAT targets include targets for smoking cessation, brief interventions in relation to alcohol, childhood obesity, breast feeding rates and suicide prevention. Those currently under development include CHD, mental well-being, and dental registrations. The revised HEAT targets will form the NHS' particular contribution to the national framework (although the NHS is likely to make further contributions through partnership working and other existing service activity). A set of intermediate level outcomes specifically for Health Improvement have been drafted after consultation with community planning partners across Scotland and using a set of criteria to aid prioritisation. The current programme for identifying further HEAT targets has been aligned with a process that is

developing possible outcomes and targets for consideration by Community Planning Partnerships in their refinement of future SOAs and performance reporting.

The importance of the current intermediate health improvement outcomes and the HEAT targets were emphasised in the Scottish Government's new Action Plan for a healthier Scotland "Better Health Better Care" published in December 2007. This plan again highlights the need for integrated, outcome focussed planning and delivery at both the national and local level and highlights the role of CPPs and CHPs in achieving such integration. It reinforced the intended move towards more health impact assessment of services and the increased focus on locally based preventative services and anticipatory care. "Better Health Better Care" stated that a new "Smoking Prevention Action Plan" will guide activity to reduce the availability, affordability and attractiveness of tobacco and increased investment will be provided to enhance smoking cessation support (with NHS Boards expected to support eight percent of their smoking population to quit by the end of 2010//11).

A similar national draft Alcohol Action plan has been launched for consultation in June 2008 (with the draft budget allocating £85.3 Million to reduce alcohol related harm). "Better Health Better Care" also identified an additional £11.5 million to fight obesity (with a particular emphasis on children). It heralded the publication of a Food and Health delivery plan during 2008 and emphasised the role of the existing Physical Activity Strategy and an increased focus on developing environmental and sustainable transport solution that will enhance opportunities for active commuting and use of green space.

2.4 Community Planning in West Dunbartonshire

In parallel with the health improvement outcome model development, Brodies have also been assisting the Council with a review of the governance and staffing arrangements in place to support community planning in West Dunbartonshire. These joint planning arrangements are clearly significant to the delivery of the breadth of community plan outcomes (of which health improvement is one). They influence priorities, impact on strategy and affect decisions about the allocation of resources between topics and geographies. They also impact on the extent to which collaborative gain is being/can be achieved within the Partnership.

In pointing to recommendations for a re-launching of the community planning arrangements in West Dunbartonshire, the review captured a number of issues which will have impacted directly and indirectly on the HISG (as the 'thematic group' with responsibility for health improvement). These relate primarily to the need:

- 1) For greater partner buy-in to the community planning process as a whole
- 2) To (re)harness the energy and enthusiasm across all partner agencies to create impetus for ongoing improvement across the Partnership
- 3) To improve the clarity of individual roles and responsibilities across the three levels of CPP – Board, PDG, Thematic Groups – helping to prevent uncertainty, confusion, duplication and any lack of accountability
- 4) To ensure that all projects / programmes of work are monitored and evaluated from a performance and financial perspective to monitor their contribution to agreed outcomes
- 5) For a more formal mechanism for allowing discussion, planning and coordination across thematic groups.

The conclusions and recommendations within this report should be seen in the context of these wider community planning proposals. Taken together, the recommendations aim to further strengthen the arrangements in place across West Dunbartonshire in delivering identified community plan/SOA outcomes. Our proposals aim to take account of the proposed arrangements, including the notion of the collaborative gain associated with effective partnership working.

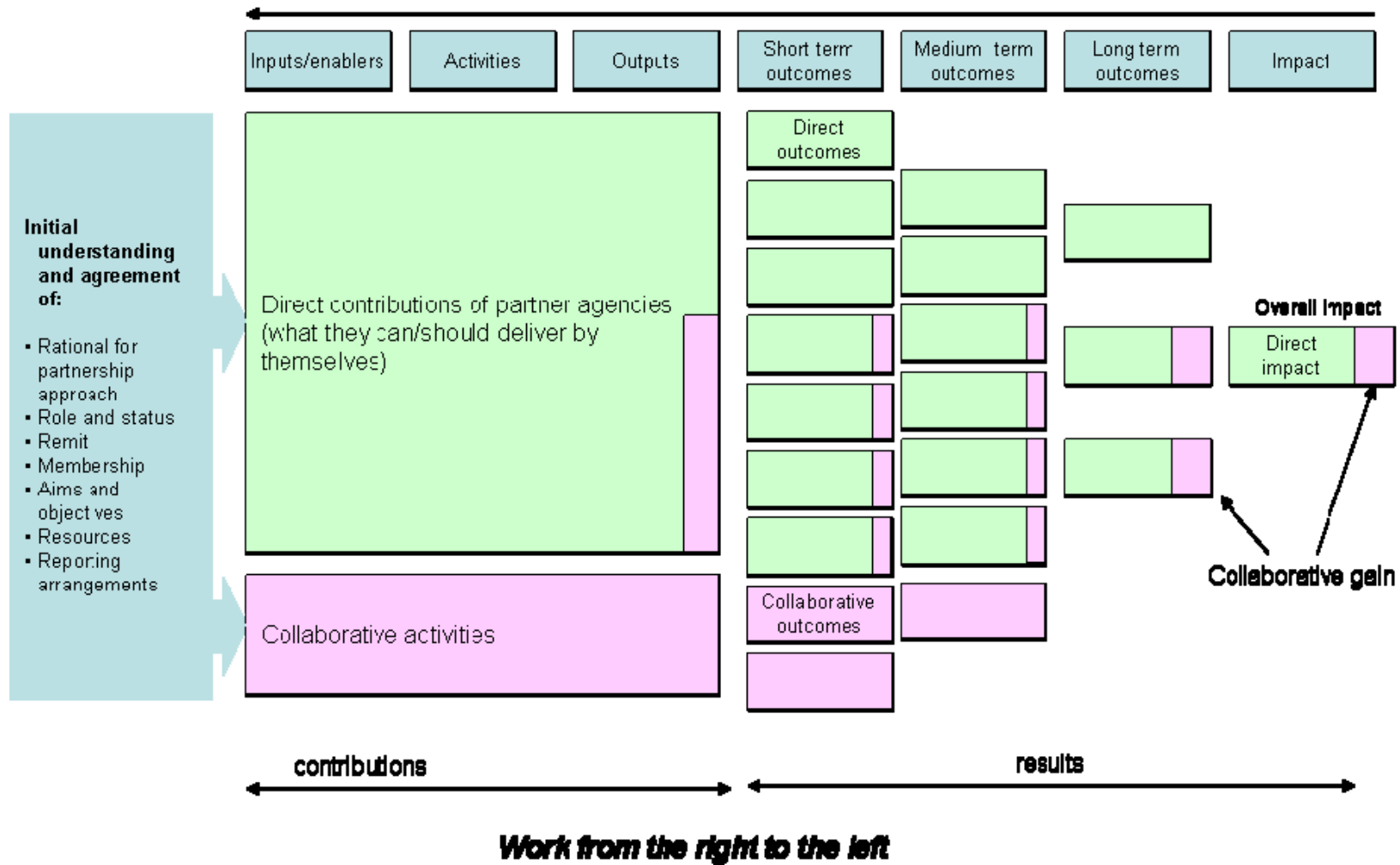
2.4 Collaborative gain

In a briefing note from the Improvement Service (Improvement Service, 2008) collaboration is defined 'as a *managed process whereby organisations, parts of organisations, or definable groups work together to achieve a pre-defined objective*' (p.1). Such collaboration may be a one-off event, time limited, task-limited, or continuing. It may include sharing information and knowledge, preparing plans and strategies, co-ordinating operational activity, solving problems, or developing opportunities. The notion of collaborative gain lies at the heart of the community planning process. "*Collaborative gain*' is achieved when those working within the (Partnership) deliver an output (leading to an outcome) that is consistent with their remit, has value for an identified stakeholder group, and is more than would have happened if they had not carried out their work. In other words, if all that is achieved is to aggregate what would have happened anyway, then there is no collaborative gain, and there is, therefore, negative value (because of the costs of the collaboration)' (p.2). There is more to collaborative gain than simply 'added value'. Collaborative gain assumes that the partnership is delivering added value for a specified stakeholder(s) in accordance with an *agreed partnership objective*. Put simply, it can make greater progress in achieving its specified objectives by working together.

Figure one (below) models how collaborative gain contributes to outcomes as part of an outcome-focused planning approach. The illustration adopts the logic modelling framework used for the health improvement outcome models later in the document. At the highest level, the notion is that the delivery of outcomes will be dependent on contributions (inputs, activities and/or outputs) from a range of partner agencies. The model illustrates these contributions on the left hand-side; showing the short term (interim), medium term (intermediate) and longer term (ultimate) outcomes on the right hand side. Note that the far left hand-side box simply illustrates the initial understanding and agreement of the focus and status of the partnership as a whole.

Looking at the left hand side first, each partner will make a contribution in their own right (shown in green box). This reflects what partners would contribute if working in isolation from each other. The pink box on the left hand side represents the collaborative activities undertaken in the partnership context. We say more about these later. Note that these collaborative activities also impact to an extent on the direct contributions of each partner (through wider perspectives, additional intelligence, additional resources and complementary/ supplementary activities). The right hand side of the diagram illustrates the direct partner contribution (in green), and the collaborative gain that results from working together (in pink). There will be some outcomes where collaborative working will have little or no direct impact (those where there is solely a green box). Similarly, there will be some collaborative activities that have collaborative outcomes (such as more effective partner liaison, enhanced mutual awareness/understanding, and increased trust (those where there is solely a pink box), although the tangible impact on wider outcomes may be difficult to measure.

Figure one: Illustrating collaborative gain in an outcome model

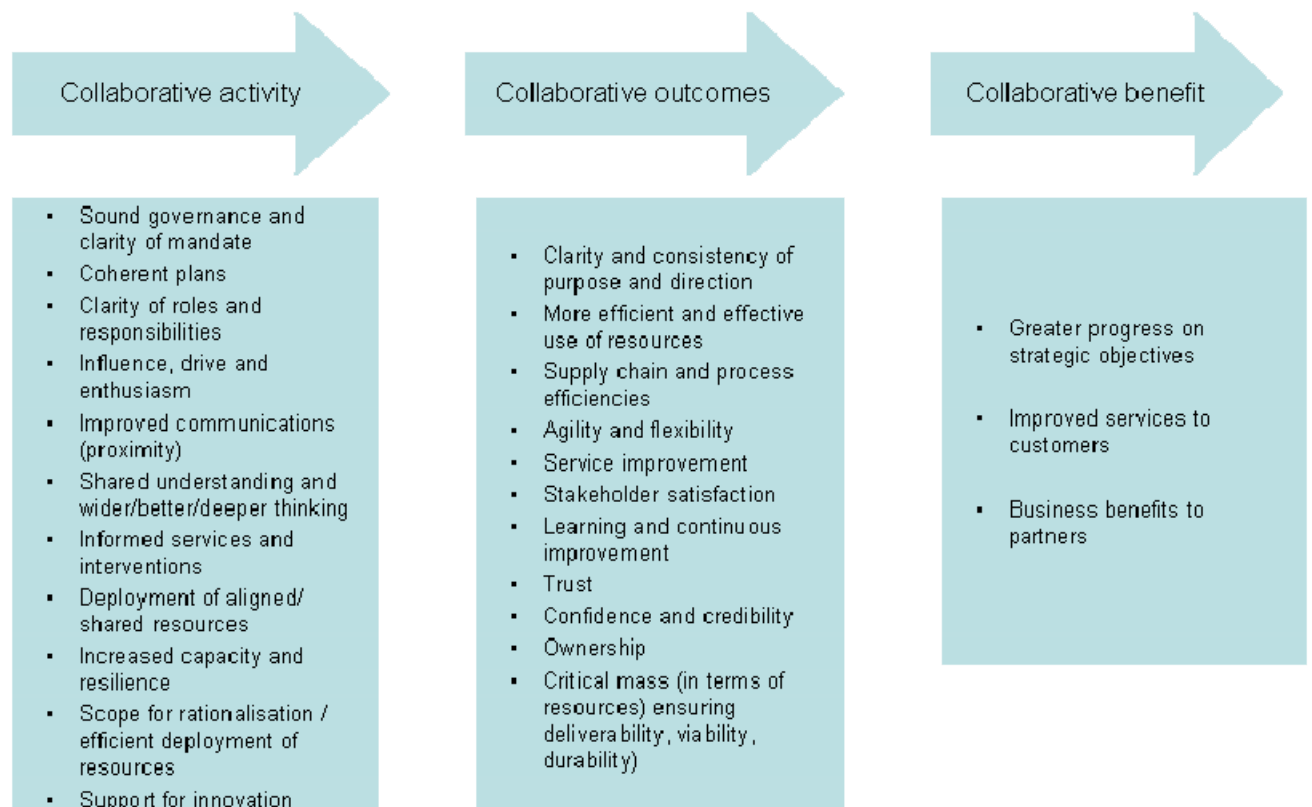


In essence, the dual pink/green boxes illustrate that collaborative working will allow more to be achieved than would have been the case if each partner was working in isolation. This can be measured as the collaborative gain. In the immediate term, this may include better targeting of key groups, higher levels of service uptake, increased frequency of services, or increased depth of provision. The intermediate and ultimate outcomes reflect the accruing benefit of these immediate outcomes.

A key issue for the West Dunbartonshire partnership is whether it can make greater progress in achieving the desired outcomes by investing in collaborative working, rather than through additional investment in individual partner agency services. Put simply, allocating expenditure to joint diagnosis, joint marketing and promotion, or integrated planning of interventions may achieve more than employing additional front-line staff to perpetuate single agency delivery.

Figure two (below) sets out our interpretation of how tangible collaborative activities will help to generate collaborative outcomes; and how these in turn result in measurable collaborative benefits. The proposed application of collaborative activities for health improvement within the West Dunbartonshire Community Planning Partnership is set out in the text that follows Figure two. The activities and outcomes are relatively self-explanatory. Many are mutually reinforcing/self-perpetuating. Note that each one encompasses the notion of joint working (e.g. the reference to sound governance under activities implies sound governance *across* a shared agenda and a breadth of partner contributions, rather than solely sound governance by each individual partner of their own particular responsibilities).

Figure two: Designing and delivering collaborative gain



The collaborative benefits are three fold. First, collaboration should allow the partnership to make greater progress in achieving its strategic objectives (in this instance delivery of health improvement outcomes). Second, it should further improve the services being delivered to customers/citizens (leisure services or smoking cessation). Finally, it should help to maximise the resources that can be freed-up for re-investment in activities/services or for re-allocation elsewhere within the Partnership.

We envisage that the collaborative *activities* in support of health improvement within the West Dunbartonshire Community Planning Partnership would be as follows:

Sound governance and clarity of mandate – governance of the health improvement partnership working within West Dunbartonshire is the responsibility of the Health Improvement Themed Group (the HISG), led by West Dunbartonshire Community Health Partnership (CHP). This is one of six themed groups that act as the ‘engine room’ for the work of the Community Planning Partnership, feeding their proposals through the Strategic Board (for refinement and links to other Themes) to the Executive Group (for agreement). Its mandate is to focus community planning partner health improvement activities on delivering health improvement outcomes. As lead partner, the CHP would be responsible for overall co-ordination of the development of a comprehensive and deliverable health improvement approach within West Dunbartonshire, drawing on specific and wider input from the other community planning partners. The arrangements – in terms of governance and mandate - aim to ensure comprehensiveness and cohesiveness of perspectives, inputs and performance management across the health improvement agenda. They also aim to ensure coherent and informed deployment of finite resources in delivering the agreed health improvement outcomes.

Coherent Plans – The SOA will provide the overarching framework for the work of all of the Community Planning Themed Groups. An integrated strategy and associated programme of work will be developed for each Themed Group, setting out how contributions to key SOA outcomes will be planned, managed and delivered. The specific health improvement outcomes are aligned to the health improvement aspects of national HEAT targets (set out earlier) and the commitments made in the Joint Health Improvement Plan. The HISG is developing integrated strategies in four related health improvement topic areas – Physical Activity, Tobacco, Alcohol and Diet. These strategies will inform the initiatives and work programmes of teams and individuals across the community planning partner agencies, being picked up in the operational/service plans of each partner agency.

Clarity of roles and responsibilities – are ensured through the community planning governance structures (including allocation of lead roles in each Themed Group), the statutory responsibilities of each partner, and the detail of the action plans in each strategy area. The coherent plans (described above) act as the vehicle for capturing these roles and responsibilities for health improvement (in general, and in each topic area). Performance (in terms of impact and contribution) is overseen by the Themed Group (in the first instance), being reported to the Strategic Board and Executive Group at a higher level thereafter. A further check on fulfilment of

roles and responsibilities is made through the performance management/scrutiny arrangements within each partner agency.

Influence, drive and enthusiasm – is ensured through the coherent and consistent involvement of all key partners (through the Themed Group and agreed plans). In addition to ensuring support and momentum (through more comprehensive involvement), the collaborative approach helps to ensure appropriate repetition of messages and exposure to linked interventions, embedding understanding and behaviours. In addition, influence can be exerted horizontally and vertically to a wider range of stakeholders than can be reached through a single agency approach. Drive and enthusiasm is ensured by leadership and clarity on roles and responsibilities for health improvement (by the CHP) *and* the comprehensive involvement of key partners from the outset. The drive is harnessed and channelled through the integrated strategies and plans, and perpetuated/enhanced by the ‘influence’ described above. Enthusiasm is more easily maintained by reduced fragmentation in planning and delivery, clarity of roles and contributions, by the streamlining of associated bureaucracy, and by perceptions/reality of progress and impact.

Communication – improves at three *levels* through formal opportunities for joint working (information sharing, joint diagnosis, and integrated planning, promotion, delivery and performance management). First, there is greater clarity of purpose, mutual understanding, and interdependency in contribution across the community planning partnership as a whole (at Executive Group and Strategic Board levels). Second, this is mirrored within the Themed Group, but with a much more specific focus on health improvement. Third, closer operational working on initiatives, projects and ongoing responsibilities – informed by information sharing, and more integrated planning, monitoring and evaluation – supports improved day-to-day communications, mutual awareness/ understanding, and shared learning. In a number of instances this is supported by proximity of key staff, with relationships developing through informal as well as formal contact.

Shared understanding and wider/better/deeper thinking – is achieved through information sharing, joint diagnosis, joint planning, joint delivery, and joint performance management and evaluation at all levels within the community planning partnership. In addition, collaborative working allows for a breadth of professional and theoretical perspectives on common challenges, wider sources and interpretation of evidence, and an increased capacity and resilience for policy planning and evaluation.

Informed services and interventions – can be tailored from the shared understanding and the wider/better/deeper thinking. These will be agreed and perpetuated through the joint governance arrangements and driven/supported by coherent plans.

Deployment of aligned/shared resources – including the pooling of staff, the sharing of (or enhanced/discounted access to) space, the sharing and/or alignment of information, and the integration of marketing and publicity activities/materials support effective joint working. In addition to supporting the tailoring of services and interventions, they can help to increase capacity and resilience, helping to maintain and/or enhance service delivery.

Increased capacity and resilience – through the pooling of staff resources, the more joined up commissioning of external advice and support and the more informed allocation of people to particular activities and tasks (detailed in the more coherent action plans)

Support for innovation – a more widely informed perspective on risk and innovation is provided through more integrated governance arrangements, confidence in mandate and remit, the testing of new interventions, richer perspectives and wider experiences of deliverability/implementation of more innovative approaches and new ways of working, and improved knowledge sharing/transfer from closer strategic and operational working.

We consider that these collaborative activities should allow for more stretching target-setting than would be the case for single agency intervention or less formal partnership liaison.

A key consideration relates to ‘who does what when’ when working collaboratively. It is not intended that all partners are involved at all stages of the collaborative process, or that collaboration assumes a move to generic working within or across teams. Rather, the notion of coherent collaborative planning assumes that the appropriate agency brings a tangible and unique contribution at the correct time in the planning and delivery process.

For example, in the case of smoking cessation services, we might assume:

- The gathering and presentation of the most accurate and appropriate evidence/data by the CHP regarding the scale and nature of tobacco abuse in West Dunbartonshire, analysed by population group and geography and socio economic status
- Agreement by all HISG partners of the relative importance of smoking cessation services within the wider approach to reducing the impact of tobacco, and to health improvement more generally (including links to other tobacco and health improvement activities, as well as wider community planning partner themes)
- The preparation of a coherent strategy/plan for smoking cessation, led by the CHP but informed by the perspectives of the breadth of HISG partners. This would include the identification of appropriate targets (informed by national, regional and/or local benchmarks)
- The allocation of direct (financial) or ‘in-kind’ support (e.g. access to Council space or voluntary sector promotion to target population groups) by relevant partners to facilitate the effective delivery of smoking cessation outcomes
- The provision and maintenance of dedicated staff resources and expertise provided by the CHP to ensure effective implementation

- HISG partner assessment of progress, impact and value for money against initial targets set out in the smoking cessation strategy/plan via agreed mechanisms and using consistent data sources
- Wider community planning partner assessment of impact and opportunities for refinement in the context of wider community planning objectives (by the Strategic Board).

The Improvement Service (2008) is keen to stress the importance of designing collaborative gain into the process, potentially through:

- a) 'Developing a comprehensive description of a complex situation (e.g. what are the problems facing a particular locality, what are the deficiencies in public transport for a particular locality, etc). The collaborative benefit arises from pooling knowledge and views.*
- b) Generating a holistic understanding of the causes of a situation (whether it is a 'problem', the needs of an area, the needs of a group or individual, etc). Again, the collaborative benefit arises because different organisations will have knowledge about different bits of the total picture, and these need to be brought together to provide the best basis for taking action.*
- c) Following on from the generation of a holistic understanding of a situation, stakeholders also agree to alter the sequencing or timing of what they are doing because there will be a cumulative positive impact that produces added value.*
- d) As for (b), but stakeholders are also willing to make changes to the nature of what they are doing because doing so will increase the cumulative impact.*
- e) As for (c), but stakeholders are also willing to do new things or stop doing existing things.*

In all of these scenarios, it is taken as axiomatic that any changes made by a stakeholder still have to be consistent with its remit and operational responsibilities' (p.5).

Existing evidence, where available (and in terms of both need and efficacy of selected interventions) should inform each of the design stages above to ensure maximum impact results from individual and collaborative activity.

Where possible, we have sought to identify current collaborative activities and collaborative outcomes relating to tobacco and physical activity (at an operational level) in the body of our report. We have also sought to consider whether we would expect collaborative gain in each individual activity in both topic areas, and whether this is more likely to manifest itself across the breadth of activities in any one topic or programme area. Finally, we have identified possible gaps in collaborative working and suggested how additional benefit may be accrued from closing these gaps as the Partnership moves forward.

3 Our approach

We adopted a five stage approach in completing this engagement.

stage one– inception meeting

We met with the Programme Management Group with a view to agreeing a common understanding of the parameters for the project; confirming the detailed methodology; defining a top level project plan that identifies roles, responsibilities and timescales; identifying the extent of information that could be made available to support the exercise; confirming individuals to be consulted as part of the process and dates for workshops; and confirming appropriate progress and reporting arrangements.

Stage two – orientation

First, we completed an overview desk-based analysis of the corporate, service and relevant operational plans of each of the partners to identify their individual priorities, objectives, and activities with regard to the two topic areas (or aligned outcomes) and health inequalities. We also considered wider Community Planning Partnership commitments that may impact directly or indirectly on health improvement and reducing health inequalities. We also considered the key needs assessment reports that informed the selection of the priorities (physical activity and tobacco).

Second, we had one-to-one discussions with key officers in each partner agency to confirm our understanding of the main messages arising from the desk-based analysis. We gathered further information on current activities and sought to identify and establish officer views on the robustness and evidence for current actions and the plausibility, do-ability and testability of plans. We also sought to gather their views as to the key contributions of their agency to delivering health improvement outcomes, the role and added value of the Partnership, and potential barriers to successful delivery of the desired outcomes.

Stage three - drafting an outcome-focused model

Based on the output from stage two we used a logic modelling approach to prepare initial outcome-focused models. These included high level strategic models for tobacco control and physical activity, and a number of related, but more detailed, outcome models relating to key activities in each topic area. These high level models were tested at group sessions with key officers from various service areas. The more detailed models drill down into the *main* service areas that contribute to the outcomes highlighted under each topic area. We have aimed to make links to other activities in the models and accompanying text.

As part of stages two and three the current programme activities were mapped using logic models (<http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf>) and a planning tool called the RE-AIM framework (<http://www.re-aim.org/>) to illustrate the extent to which their contributions to higher level outcomes could be identified. The extent to which service information was available to allow such analysis was variable depending on the stage of the service and the main reasons for which

the service was established (specifically health improvement or for other partnership outcomes). The information and learning from this mapping exercise has been given to the HISG for use in aiding programme development in the next stages of the outcome agreement rather than presented in this report. This information has, however, been used to inform the high level findings in this report. Details of the tools used for this mapping exercise are contained in Appendix one.

Stage four - refining the draft outcome model

We met with the Project Team as a group to discuss the emerging models and the range of related issues arising from the process of model development.

Stage five– final reporting

Finally, we refined the models based on the amendments from stage four and presented them to the Project Team (in this report). We drew a number of overarching conclusions relating to the objectives of the project and proposed recommendations for moving forward.

In the following chapters of the report we document our progress in relation to the first three tasks we were requested to deliver

- To identify and prioritise outcomes (for tobacco and physical activity) and align these with the emerging SOA
- Map current partner activities and contributions that relate to the emerging outcomes (only high level learning from this task is contained within this report)
- Using the available evidence base and service monitoring information identify those activities and services that will best contribute to the outcomes and that require to be delivered collaboratively

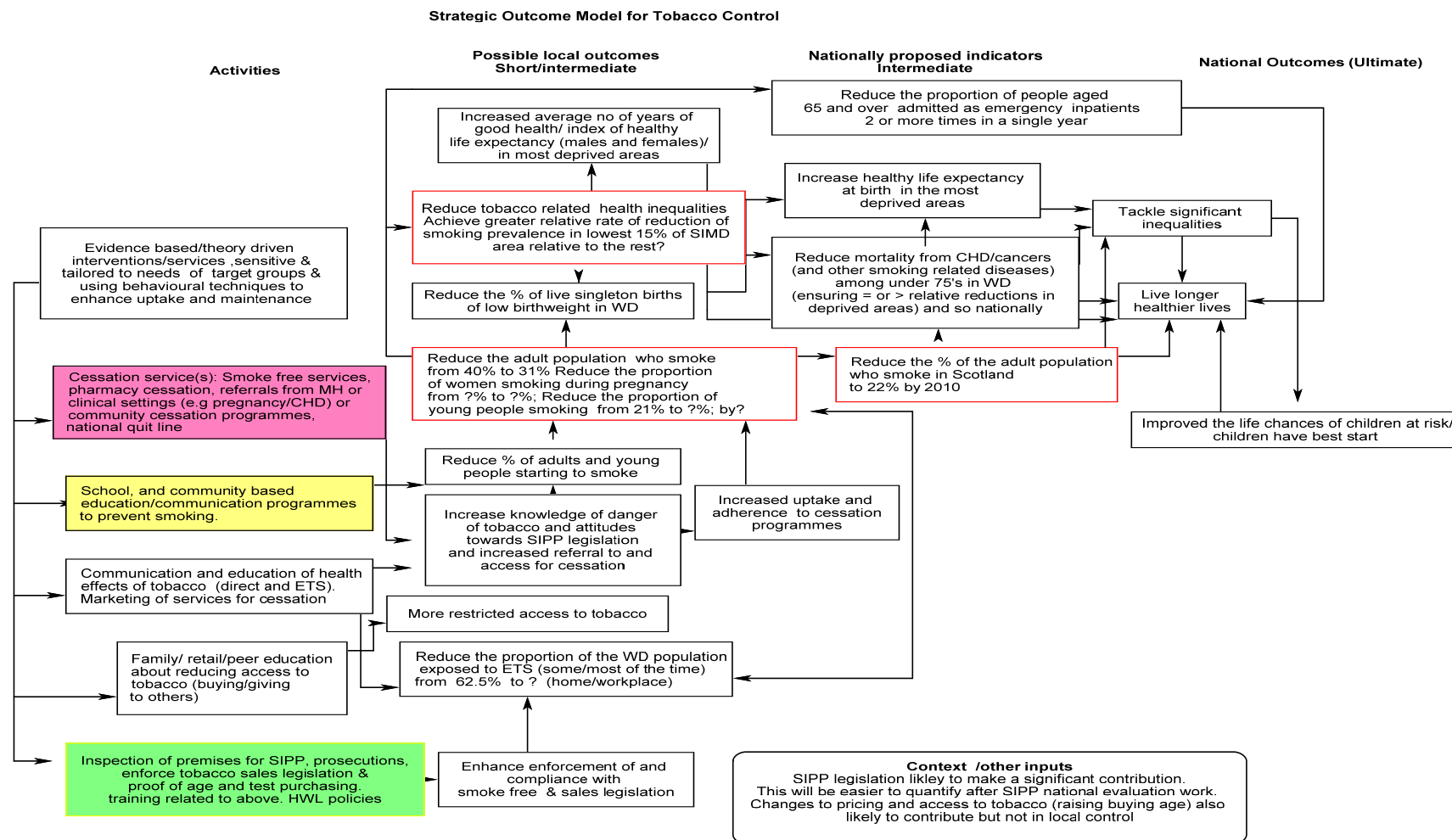
In addition we highlighted where the collaboration between these activities and services might be enhanced to improve their impact. We will firstly report our progress on these tasks in relation to tobacco and subsequently in relation to physical activity.

4 Findings: Tobacco Control

Prioritising outcomes for tobacco control and aligning these with the emerging SOA

We liaised with key staff from the partnership with responsibility for tobacco control to develop a set of nested logic models for the tobacco outcome agreement. As part of this process we developed a strategic model for tobacco control (Model one on the following page). This model highlights where anticipated local activity contributes to local outcomes (some, but not all, of which were detailed in existing local strategies). The model also shows where these local outcomes link with outcomes within the emerging SOA and the outcomes and indicators proposed by the Scottish Government and the Improvement Service as part of the SOA guidance.

Model one: Strategic outcome model for tobacco control



The ultimate outcomes in the model are selected from the fifteen possible outcomes in the National Government's Performance Assessment Framework. We have selected those that are most strongly associated with tobacco control activity. The intermediate outcomes are selected out of the fifty five possible local indicators/outcomes proposed by the Improvement Service as part of SOA guidance. The shorter term outcomes are those contained in local West Dunbartonshire strategic plans, however, where there were gaps we have inserted potential local versions of the proposed national indicators.

The local outcomes for the tobacco control model most likely to align with national outcomes are a reduction in the prevalence of smoking in the overall West Dunbartonshire population, a reduction in the smoking prevalence amongst pregnant women, a reduction in the smoking prevalence amongst young people and a reduction in the proportion of the population regularly exposed to Environmental Tobacco Smoke (ETS). Specific targets and thresholds for these outcomes will be set by the HISG after the new CPP structure is embedded and taking into consideration much of the learning from the mapping exercise and the process of this initial outcome focussed work.

We were also asked to consider possible health inequalities outcomes within the models. West Dunbartonshire (relative to other areas of Scotland) suffers from widespread levels of deprivation. Whilst impacting on smoking at a general population level within the area may contribute to reducing inequalities nationally, care should be taken not to further exacerbated local inequalities. ASH highlight that smoking is responsible for more than half of the difference in risk of premature death between social classes. They also indicate that death rates from tobacco are two to three times greater in disadvantaged groups than in the more affluent. There are more long-term smokers within more disadvantaged groups and those who smoke long-term have the greatest morbidity and mortality (http://www.ash.org.uk/ash_gvh5d7qz.htm). Effectively tackling smoking is undoubtedly important in addressing health inequalities. Evaluations of smoking cessation service data highlights that although services do engage smokers from deprived areas the quit rates within services are lower for more disadvantaged groups. Services should, therefore, ensure they are increasingly reaching more individuals from disadvantaged groups relative to affluent groups (to compensate for the lower quit rate) and should additionally find ways to further tailor and intensify the support to those who are disadvantaged and heavily addicted (Bauld, L., et al, 2006, Chesterman, J; Judge K; Lawson, L, June 2005, <http://www.gcph.co.uk/content/view/22/38/>). In order to tackle inequalities in smoking rates Chersterman et al, 2005 suggest the development of:

"... new approaches to identifying those smokers in greatest need and providing them with more appropriate and intensive services supplemented perhaps by specialist and targeted relapse prevention services are among the options worth considering".(page 15).

We would suggest, therefore, that local tobacco control outcomes should continue to be reported in manner that allows these issues to be measured and that services are tailored and targeted in response to such service information. To ensure a focus on inequalities a local intermediate outcome could be set for a greater relative rate of reduction in smoking prevalence in deprived areas compared to more affluent areas within West Dunbartonshire. There is also a need to further consider the balance of

different types of cessation services and the impact of the other tobacco control interventions in relation to their influence on inequalities and how this can be maximised.

The strategic tobacco control logic model identifies several services that should contribute to reducing smoking prevalence and reducing exposure to ETS. These include smoking cessation services (which are made up of specialist smoking cessation service(s), pharmacy support services, brief interventions, hospital discharge support/referral, and smoking cessation in pregnancy services), education and prevention activity, and enforcement of the SIPP legislation.

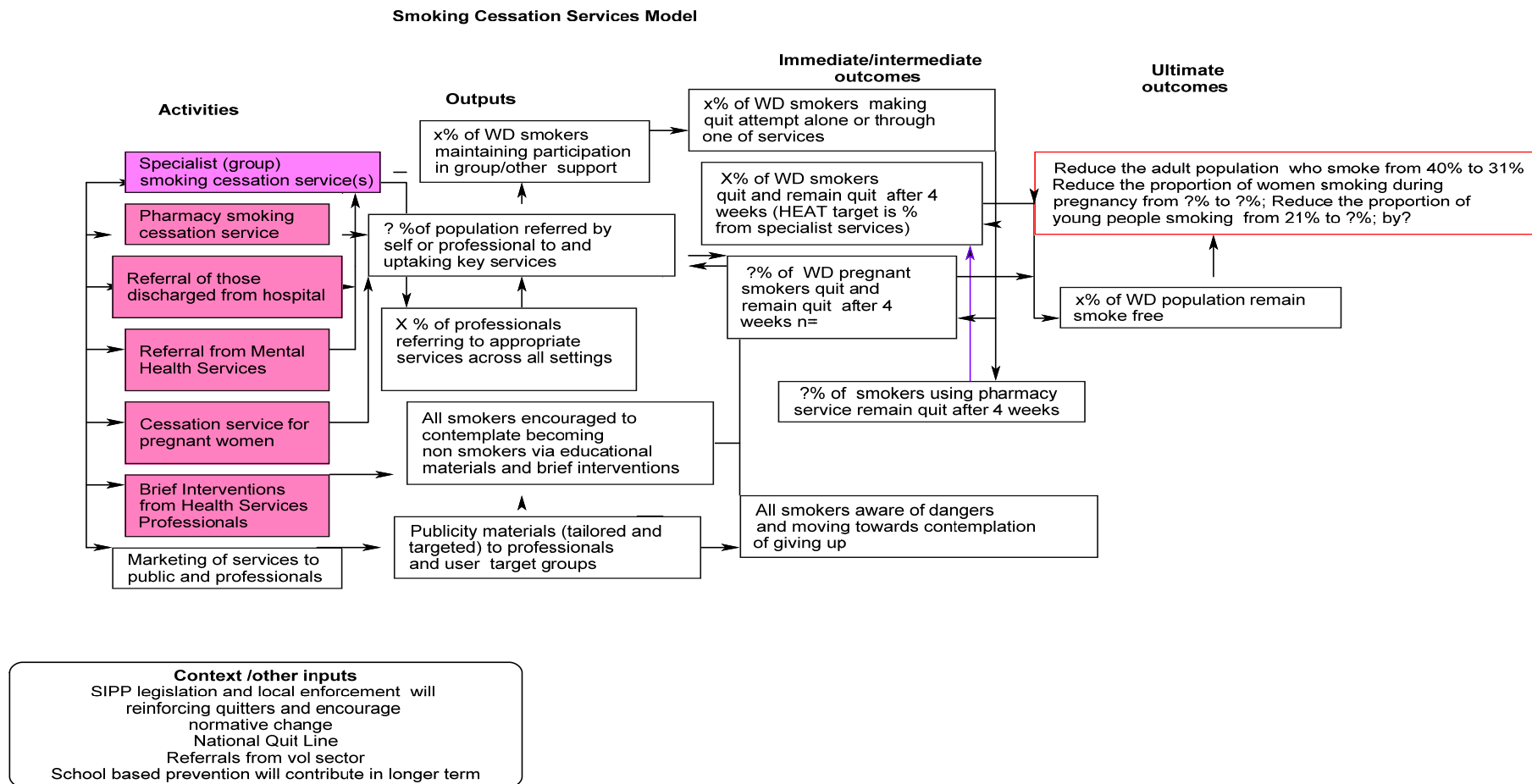
Our review indicated that the key services that the evidence base suggests should be in place are mostly present. Many of the services are comprehensive relative to other CPP areas and are of a high quality. However, there were several areas identified where improvements could be made in terms of implementation (reach, adoption, maintenance, as well as efficacy) and these have been fed back to the HISG. The model also highlights that all of the groups of activities should be informed by current guidance/learning in relation to how best to plan and implement behaviour change programmes (<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11868>) and to be informed by appropriate social marketing strategies.

Mapping current partner activities that relate to the emerging outcomes

Three operational level tobacco control models were developed as exemplars that sit beneath the strategic model. These models illustrate how the key groups of activities - representative of current or intended local programmes - detailed in the strategic model are expected to contribute (via a set of anticipated outputs) to the delivery of the prioritised local tobacco control outcomes. The key link back to the strategic model is via the prioritised local outcome of reducing smoking prevalence in the population overall and achieving a relatively greater decrease in smoking rates in the most deprived communities. This key outcome box is outlined in red.

These models cover the areas of smoking cessation, tobacco education and prevention, and the enforcement of SIPP (smoking in public places) legislation. The activities in the operational and strategic models are colour coded to show where they overlap. The models, therefore, illustrate the intended plausible pathways between some of the key activities and the prioritised local outcome(s).

Model two: Smoking cessation services



Model two: The smoking cessation services model

The smoking cessation services model has as its ultimate outcomes a reduction in the proportion of: the adult population who smoke; women smoking during pregnancy; young people smoking; and, a relatively greater reduction in smoking amongst those from the most deprived areas.

The model shows how a range of specialist smoking cessation services should interact to: raise awareness of the danger of smoking; get key professionals to refer smokers (or encourage smokers to self-refer) to the most appropriate services; maintain smokers involvement with services/cessation programmes; establish quit dates; stop smoking; and, sustain cessation amongst quitters.

The model also acknowledges that other activities, such as the enforcement of the SIPP legislation, in the strategic model will need to contribute to sustaining current and future ex-smokers if a reduction in population smoking rates and social norms are to be achieved in the longer term.

Issues from the application of the RE-AIM framework that should be considered to maximise cessation services contributions to the strategic outcomes

Successful implementation of these services will be needed to maximise their contribution to these long-term outcomes. Successful implementation should ensure that service uptake or reach (e.g. the number of potential smokers in the population who are currently accessing services) is maximised within available resources. Targets should be set with reference to rates achieved in other CPP/NHS Board areas but taking cognisance of the relative rates of disadvantage, consequent poorer anticipated outcomes, and therefore the need for additional support. In attempting to maximise service uptake geographical coverage of cessation opportunities/groups relative to smoking rates in local areas is likely to be important. Consideration should also be given to other population sub groups who may not currently have access to cessation support such as young people or looked after young people.

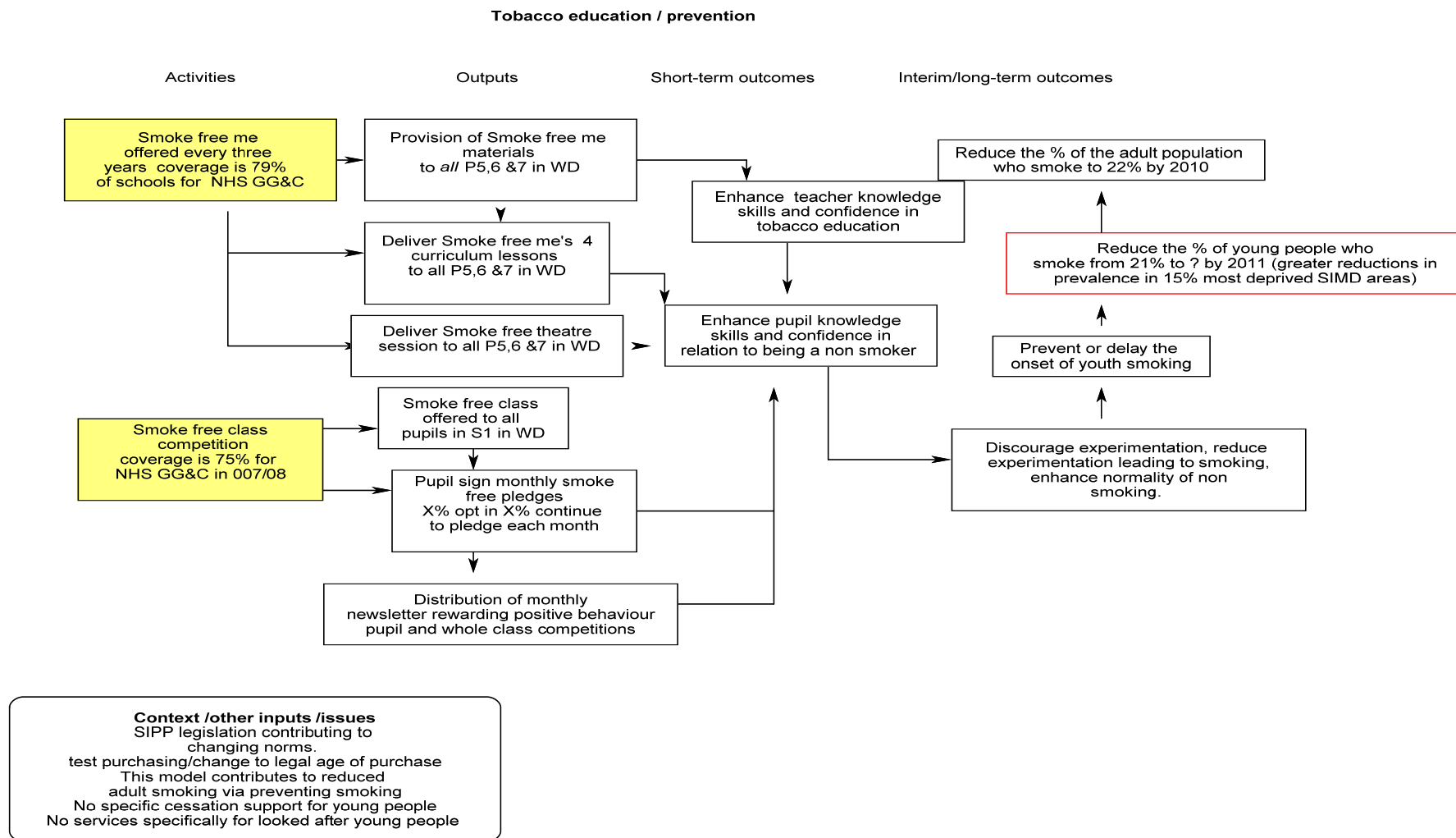
Similarly, issues relating to adoption such as the proportion of GPs (and other professionals) referring smokers in various settings (primary and secondary care and mental health units) should also be maximised where feasible. The recently established NHS 'HEAT target' for cessation suggests that eight percent of the local population should be supported to stop smoking (for at least four weeks). Further discussion may be needed in relation to capacity and throughput given this target. This should take into account the current number of groups run (and numbers attending) and anticipated throughput to achieve targets (HEAT and wider partnership targets once specified). If resources and, therefore, service capacities are limited then it is likely that criteria for prioritisation of key settings, geography, groups and contexts will be needed to maximise impact generally and more specifically in relation to health inequalities.

The two distinct sets of cessation services that historically existed in NHS A&C and NHS GG are being aligned to provide a consistent and equitable service across the CPP. It is likely that to ensure that health inequalities are not exacerbated that further consideration is given to ways in which additional support (perhaps from community or voluntary organisations) for cessation could be provided to, and tailored for, those with complex needs (e.g. heavily addicted, those with co-morbidity, looked after young people etc).

The impact of training programmes encouraging professionals to refer to, or deliver, cessation services should be considered in relation to their impact on referral numbers and how the planned implementation is influenced by staff turnover in key areas such as pharmacy.

A final issue relating to the potential contribution of cessation services is the extent to which all aspects of current evidence based recommendations are being implemented. For example, brief interventions have been shown to be effective and have substantial reach yet generally the main focus of cessation work tends to be on specialised services. It is likely that the balance between services that have a lower efficacy but greater reach, such as brief interventions within primary care compared to specialist cessation support, should form part of the discussion about relative contributions to achieving outcomes.

Model three: Tobacco education and prevention



Model three: Education & prevention in schools.

The education and prevention in schools programme contributes to the reduction in the smoking prevalence in West Dunbartonshire via the main outcome of reducing the proportion of young people who smoke and preventing the uptake of smoking. In the short term the programmes aim to enhance pupil knowledge, skills and confidence in being a non smoker and teacher knowledge and skills in preventing young people from experimenting and taking up smoking. The contextual box within the model also indicates that a range of other interventions such as enforcement of minimum purchase age for tobacco, test purchasing and the enforcement of SIPP legislation may all reinforce attempts to reduce experimentation and uptake of smoking amongst young people. Models for these activities may be developed in due course.

The local Youth Strategy states that twenty one percent of fifteen year olds in West Dunbartonshire smoke. The main prevention and education activity targeted at young people is the 'Smoke Free Me' and 'Smoke Free Class' initiatives. The former is aimed at Primary five, six and seven and the latter at Secondary one. The schemes use a mix of educational lessons and materials to prevent smoking and delay experimentation. The latter also involve a class pledge and competition elements. The materials and lessons for these programmes are developed by staff in and provided to teachers within local education directorates/schools for their use and further development.

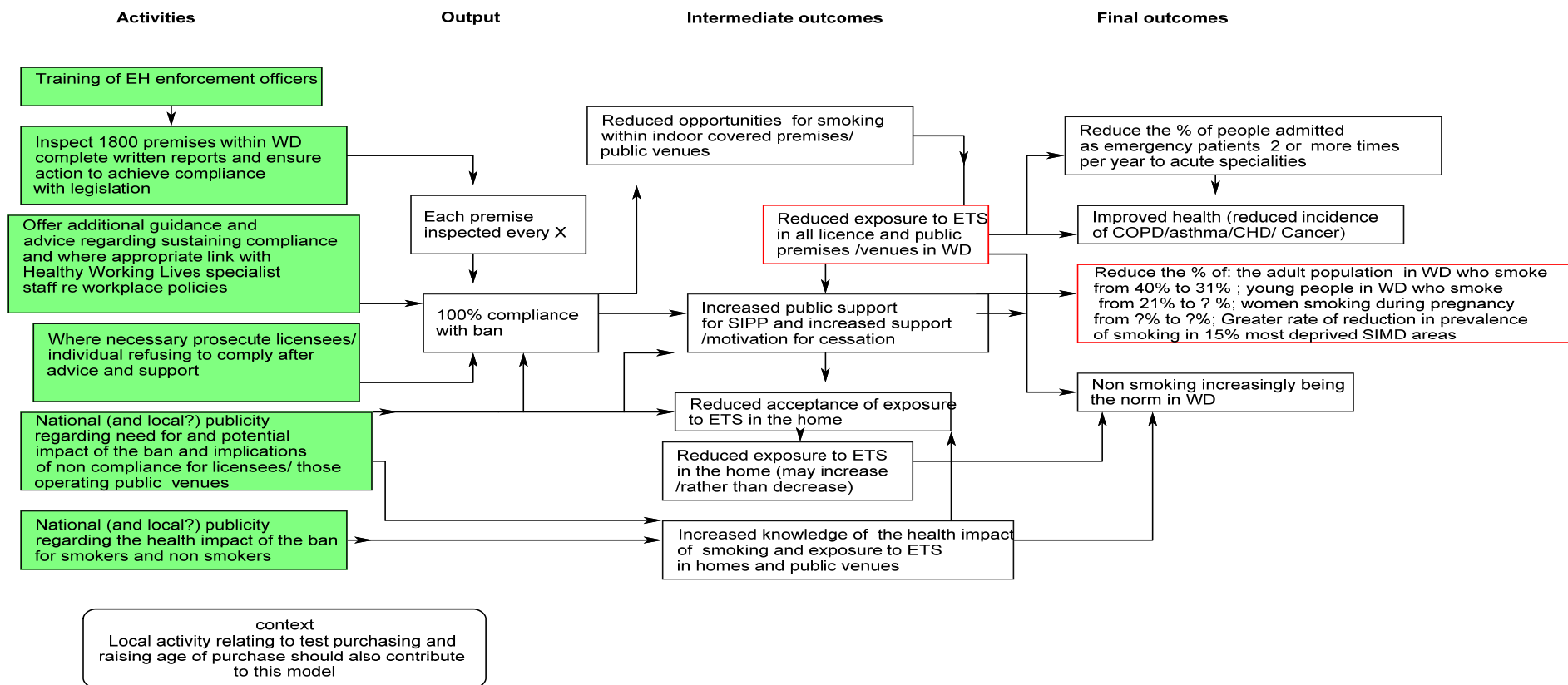
In terms of their evidence base Smoke Free Me evaluations have shown that children enjoy the intervention and teachers support and express approval for it. It has shown some increases in knowledge amongst school children but the impact of smoking rates/experimentation is in not known. Smoke Free Class is based on a European ENYPAT model (http://www.ktl.fi/attachments/suomi/julkaisut/julkaisusarja_b/2003b5.pdf).

Issues from the RE-AIM framework that should be considered to maximise the contribution of education and prevention programmes to the strategic outcomes

In order to ensure maximum impact from these programmes the evidence base, in terms of the actual impact on experimentation and smoking should ideally be further investigated where feasible. This may be more appropriately done at a national rather than a local level. If the programmes are to achieve maximum levels of adoption and reach then they should be delivered comprehensively across the schools, age groups and classes that they are designed to target within West Dunbartonshire.

Model Four: The enforcement of the smoking in public places legislation

Logic model for SIPP enforcement activity



Model four: the enforcement of the Smoking in Public Places Legislation

The SIPP enforcement model illustrates the potential of this activity to contribute to reducing the proportion of the population who smoke in West Dunbartonshire by the legislation acting as a motivation or catalyst for people to give up or seek help to give up. It also contributes by making non-smoking environments increasingly common and so impacts on normative change. In terms of wider health benefits the legislation's main aim is to enhance health through reducing exposure to Environmental Tobacco Smoke (ETS). The model attempts to show the indirect and direct linkages between the enforcement of legalisation and improvements in the health of non-smokers previously exposed to ETS and in encouraging smoker to stop. Again the model should be seen in conjunction with activity related to tobacco sales (test purchasing, enforcing retail legislation and raising the minimum age for buying tobacco) as all of these interventions may also impact on change in smoking behaviour and social norms.

Environmental Health is responsible for the enforcement of the Smoking, Health and Social Care Scotland Act 2005 which prevents smoking in enclosed public places thus reducing exposure to Environmental Tobacco Smoke.

Issues from the RE-AIM framework that should be considered to maximise the contribution of SIPP enforcement activities to the strategic outcomes

In terms of reach, Officers of the Commercial Licensing Team enforce the legislation and ensure compliance across 1800 premises in within West Dunbartonshire. Since the enactment of the legislation a substantial number of the population will have been exposed much less frequently to ETS.

The 1800 premises are inspected in accordance with a planned programme and to date the service reported total compliance with the legislation. Whilst the adoption of this intervention is substantial the planned programmes of visits means that in many senses the policy is self policed and that the compliance is based on the absence of reports of or prosecutions for breaches of the legislation. The high level of adoption across all public premises also indicates that this intervention has high levels of reach covering all those present within premises.

In terms of efficacy the impact of the legislation is being evaluated at a national level through a suite of aligned evaluation studies commissioned by NHS HS.

The legislation is anticipated to make significant contributions toward tobacco control outcomes (<http://www.ashscotland.org.uk/ash/5510.html>). Evaluation conducted at the national level to date has shown:

- a seventeen percent reduction in heart attack admissions to nine Scottish hospitals. This compares with an annual reduction in Scottish admissions for heart attack of three percent per year in the decade before the ban

- a thirty nine percent reduction in second hand smoke exposure in eleven year-olds and in adult non-smokers
- an eighty six percent reduction in secondhand smoke in bars
- an increase in the proportion of homes with smoking restrictions
- no evidence of smoking shifting from public places into the home
- high public support for the legislation even among smokers, whose support increased once the legislation was in place.

In time some of these outcomes should become manifest and measurable within local areas (e.g. using existing hospital admission data for example).

Table one: Collaborative gain in tobacco control

Activity area	Partner inputs	Collaborative activities	Collaborative outcomes	Opportunities
Smoking cessation	<p>Partner commitment NHS funding NHS expertise NHS/ CPP staff Council space NHS space Voluntary sector support</p>	<p>Shared drive and support Shared awareness and understanding Coherent joint plan/strategy Clarity of partner roles and responsibilities Joint promotion/ communication Better informed and targeted intervention</p>	<p>Increased focus/reduced fragmentation Better targeting of finite resources More effective and efficient resource use Enriched interventions Mutual learning Developing understanding and trust</p>	<p>Uptake and Reach can be enhanced by: greater use of partners venues (housing associations, shopping/ retail locations or other community venues such as schools or community centres/halls); using partner contact with client groups to raise awareness of the services (staff involved in SIPP enforcement, home safety, home care, housing, and social work); joint planning to ensure a balance between service reach and intensity; Integrated marketing of cessation opportunities across CPP services (environmental, home care, social work as well as NHS).</p>
Tobacco education and prevention	<p>NHS funding NHS/council expertise NHS/council staff Council facilitated access to target groups Council allocation of time in school curriculum Council space</p>	<p>Shared drive and support Shared awareness and understanding Coherent joint plan/strategy Clarity of partner roles and responsibilities Joint promotion/ communication Better informed and targeted intervention More consistent delivery across WD</p>	<p>Increased focus/reduced fragmentation Better targeting of finite resources More effective and efficient resource use Enriched interventions Mutual learning Developing understanding and trust Less pressure on cessation and SIPP enforcement activities (longer term)</p>	<p>Use education contact with children as catalyst to deliver interventions in families to enhance support for SIPP legislation, reduced ETS in home, increased uptake of cessation support by smoking parents. Also scope to jointly plan and deliver test purchasing/proof of age schemes linked to educational activity to enhance implementation/reporting of underage sales etc.</p>

Table one: Collaborative gain in tobacco control (continued)

Activity area	Partner inputs	Collaborative activities	Collaborative outcomes	Opportunities
SIPP enforcement	Scottish Government funding (for national promotion) Council funding Council expertise Council staff Voluntary sector support	Little local collaboration	Currently limited	Important not consider this activity in isolation from other tobacco control activities Use as exemplar of how legislative change reinforces local behavioural programmes and transfer learning into Diet, Alcohol and Physical Activity action plans between national and local government SIPP enforcement as ongoing catalyst/mechanism to promote cessation and maintenance.

The text in Table one points to evidence of, and future scope for, collaborative gain through partner inputs, tangible collaborative activities and collaborative outcomes. It suggests that collaborative gain is best sought at a programme level across a topic, rather than within each individual activity. In some instances, such as SIPP compliance, the work will be undertaken predominantly by one partner, but the level and nature of activity required will benefit from collaborative gain elsewhere in the programme (i.e. demand for cessation services rose in the lead up to/early stages of SIPP enforcement but demands for enforcement activity should reduce as smoking cessation and smoking education activities begin to deliver the desired long-term results). Consideration and planning of such interactions can enhance services capacity to respond flexibly and to maximise time limited opportunities.

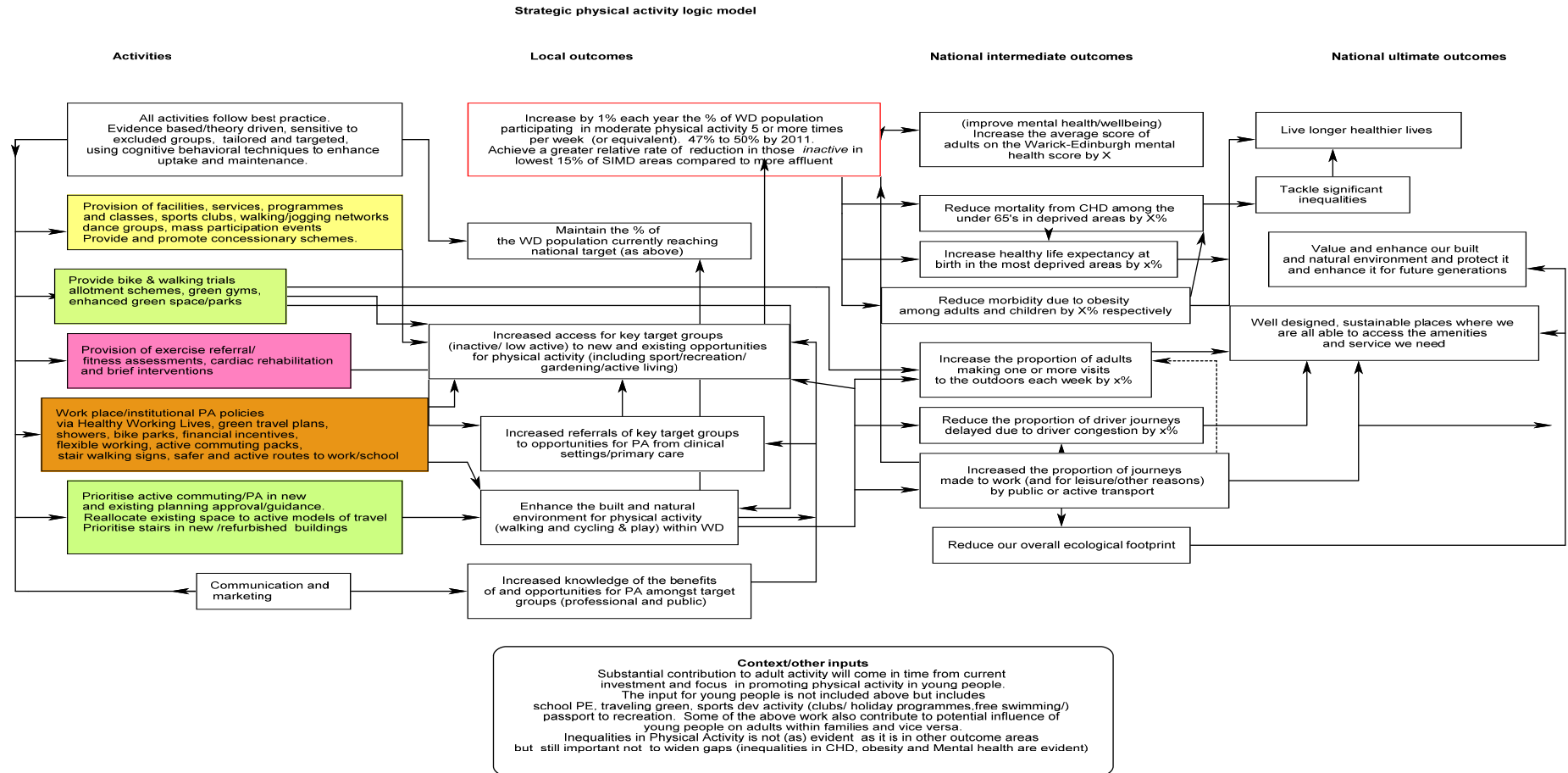
At this stage, the extent of collaborative gain is difficult to measure (in terms of collaborative outcomes and benefits). We consider that there is scope to develop qualitative targets for these outcomes and benefits as the CPP moves forward. These should, in part, relate to the outcome targets set for each topic area (i.e. how much more progress can we make in delivering these outcomes by working together?). More generally, they should also draw on recently commissioned Improvement Service research into measuring collaborative gain in community planning when the findings become available in autumn 2008.

5 Findings: Physical Activity

It should be noted that the following outcome models have been developed specifically to focus on activity in relation to enhancing adult (sixteen plus) participation in physical activity. This was the target group that the consultants were asked to focus on by the HISG.

We liaised with key staff from the partnership that have responsibility for promoting physical activity in order to develop a set of nested logic models for the physical activity outcome agreement. This resulted in the development of a strategic model for physical activity (Model five on the following page). This model highlights where anticipated local activity contributes to local outcomes (some of which, but not all, were detailed in existing plans and strategies), and where these link with outcomes within the emerging SOA and the outcomes and indicators proposed by the Scottish Government and the Improvement Service as part of the SOA guidance.

Model five: Strategic outcome model for physical activity



The long-term outcomes in the model are those considered to be most relevant to physical activity from the Scottish Government's fifteen national outcomes within the National Performance Framework. The intermediate outcomes are taken from the list of fifty plus proposed by the Improvement Service as possible local indicators/outcomes. The shorter term outcomes listed here are a mix of outcomes proposed in West Dunbartonshire strategic plans, those proposed by the Improvement Service. Some were also added to enhance the inherent logic of the model.

The prioritised local outcomes for physical activity most likely to align with national outcomes are an increase in the proportion of the overall West Dunbartonshire population participating in moderate physical activity on five or more days per week. The national target for this is to increase the proportion reaching this target incrementally by one percent each year (<http://www.scotland.gov.uk/Publications/2003/02/16324/17897>). Specific local targets and thresholds for these outcomes will be set by the HISG after the new CPP structure is embedded and taking into consideration much of the learning from the mapping exercise and learning from this initial outcomes work.

The model emphasises the need for all of the activities to be informed by the available evidence base regarding the promotion of behaviour change and to be informed by appropriate social marketing strategies (<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11868>)

There is a need for further consideration of what is an appropriate outcome in terms of addressing inequality in current physical activity levels given that generally the degree of inequalities in physical activity are varied across different modes of activity (walking, sports participation, attendance at leisure facilities). Inequalities in physical activity are usually most pronounced in relation to those participating in no moderate activity (inactive). A higher relative rate of reduction in this measure amongst the most disadvantaged compared to the more advantaged groups might be a possible outcome to address inequalities for this topic.

Mapping current partner activities in relation to the emerging outcomes.

Four operational level physical activity models were developed as exemplars. These sit beneath the strategic model. These models illustrate how the key groups of activities - representative of current or intended local programmes - detailed in the strategic model are expected to contribute (via a set of anticipated outputs) to the delivery of the prioritised local outcome. These models are set out below and cover the areas of

- Leisure services and sports development
- Exercise referral (Live Active)
- Active travel/transport
- Planning and guidance.

The models illustrate the intended plausible pathways between the activities and the prioritised local outcome(s).

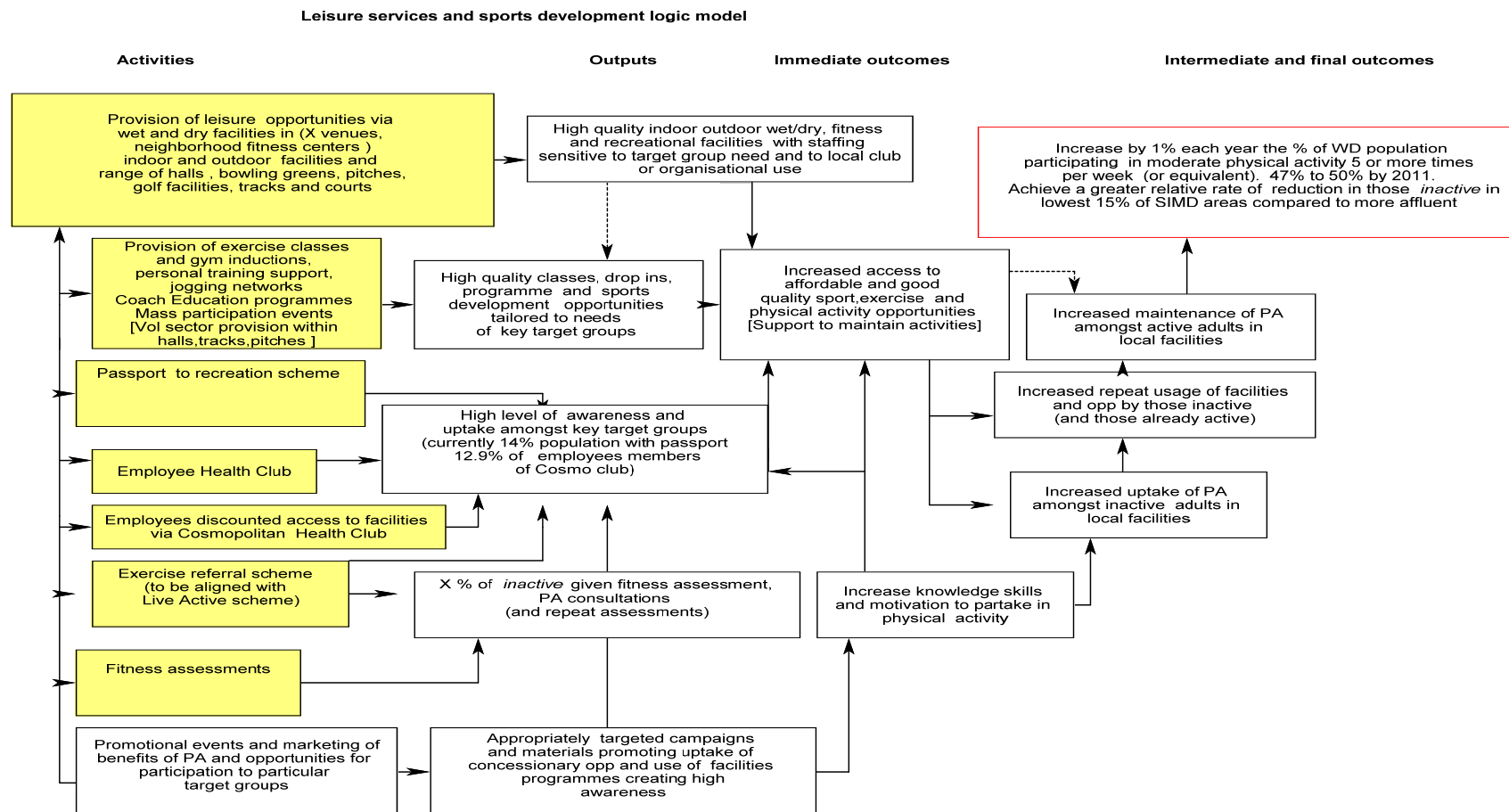
Due to the focus on adult physical activity in the models within this report, the models do not capture the substantial number of programmes and services (particularly by the educational directorate and leisure services/sports development) that promote physical activity to children and young people (under sixteen). The models acknowledge, however, that much of the work that will be targeted towards enhancing young people's physical activity will contribute directly to enhancing adult activity levels. Over the timeframe that the models cover a proportion of young people targeted by these programme will become adults. It is plausible that young people who are regularly physically activity are more able to sustain or re-engage in physical activity as adults (Aaron D, Jekal Y, LaPorte R: 2005).

Much of the activity that is recommended within the evidence guidelines for enhancing health related physical activity is present within West Dunbartonshire strategies and plans. However, there are a number of opportunities to align and improve the quality of the programmes to ensure that they maximise their contribution to the priority outcomes (increasing and maintaining activity). Again the detailed learning from the mapping process has been given to the HISG for their use in future discussion with the CPP rather than presented here. The learning below, therefore, is at a more abstracted and higher level.

The strategic logic model presents several clusters of services/activities that should contribute to increasing health related physical activity levels within West Dunbartonshire. Leisure services are expected to contribute substantially to this outcome through the provision of facilities (wet and dry), halls, and outdoor facilities (pitches). They also contribute through their related sports development programmes, employee activity schemes, and concessionary access opportunities. Finally, they provide opportunities for free fitness testing and exercise counselling. Other services that would be expected to contribute to increasing adult physical activity include exercise referral schemes (and related interventions for at risk/inactive groups), green travel and active commuting programmes and interventions, workplace physical activity policies, and planning. Much of this latter activity is encapsulated in the recent Scottish Government Planning Guidance (SPP11) open Space and Physical Activity (<http://openscotland.gov.uk/Resource/Doc/203046/0054103.pdf>) and in recent guidance NICE (National Institute for Clinical Excellence) programmes guidance (<http://www.nice.org.uk/guidance/index.jsp?action=byID&o= 11917>) and relates to green and open spaces and transport and infrastructure for cycling and walking.

The available general evidence base on what works in relation to promoting physical activity is patchy and underdeveloped in comparison to many areas in tobacco control.

Model six: Leisure Services



Model six: Leisure Services

The leisure service model has as its ultimate outcome an increased proportion of the population participating in thirty minutes of moderate activity at least five days a week (national target 1% annual increase). It also suggests a greater relative reduction in the proportion that is inactive in more deprived areas compared to more affluent. This key outcome links it back to the key local outcomes in the strategy model. It highlights how, via a set of local outputs, short and interim outcomes such as increasing access to affordable facilities and opportunities and delivering activities that increase knowledge and motivation might enhance uptake, participation and maintenance of physical activity (long-term outcomes). The model should be viewed as aligned to the other physical activity models (Live Active /clinical exercise referral and active commuting/workplace physical activity promotion) as there are overlaps in some of these related areas with the programmes currently offered by leisure Services.

Issues from the RE-AIM framework that should be considered to maximise Leisure Services contributions to the strategic outcomes

As with the tobacco control programme the implementation of the activities within the above model is key to ensuring maximum impact and contribution towards the prioritised goal of increasing activity levels. Given the size of the investment in leisure facilities and programmes the potential reach of the general services are substantial.

For this potential reach to be translated into increases in the proportion of the population who are active, programmes are needed that are specifically aimed at getting people who are inactive to become active (adoption) rather than simply maintaining or enhancing activity levels in those who are currently active.

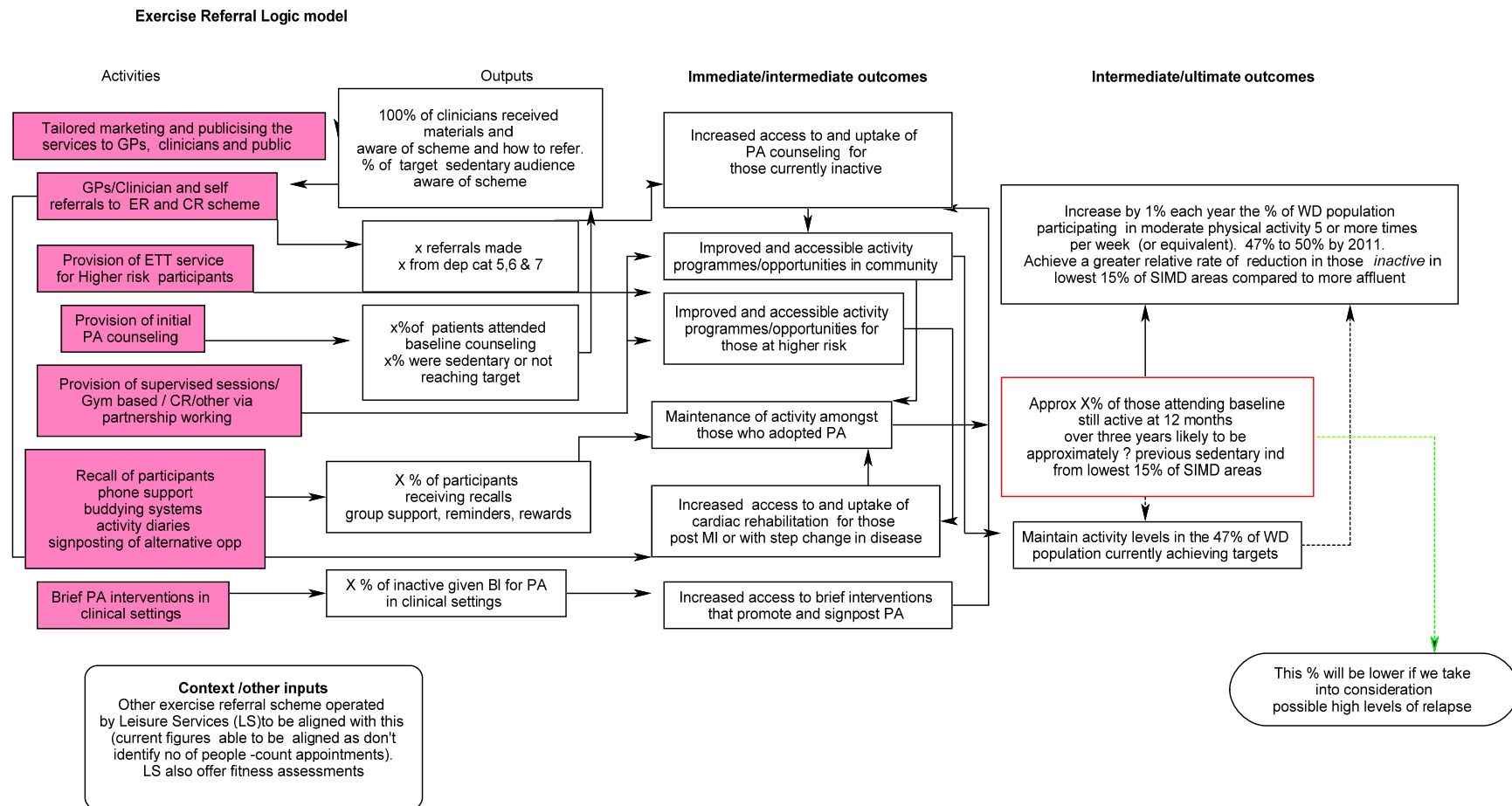
To ensure engagement of inactive groups the programmes will need the right marketing mix and to be tailored and delivered in contexts that make them appealing to inactive/low-active individuals. Programmes should be marketed beyond existing programmes and facilities and one-off events to maximise the uptake from inactive and high risk groups. Concessionary schemes are often viewed as mechanisms to engage inactive individuals or those at highest risk of ill health. Concessionary access may be limited as a result of income generation targets and so these schemes in particular should be sensitively targeted. It is likely that geographical or economic targeting alone will not maximise the potential health gain from getting inactive people active. The identification of prioritised target groups for particular interventions and the application of social marketing techniques might enhance engagement from those least active, those most at risk from being inactive and those most excluded.

The general evidence base for the impact of sport and leisure services on physical activity and health is relatively poorly developed and not well understood (<http://www.sportscotland.org.uk/ChannelNavigation/Resource+Library/Publications/Social+Benefits+of+Sport.htm>). This is partly due to lack of monitoring data that can track individual service users. As such whilst leisure services are likely to play a major role in enhancing physical activity the reality of that contribution

remains unknown. The few evaluations that have been done in relation to providing concessionary schemes including free swimming tend to show equivocal results. They often achieve short-term increases (often as a result of those already participating increasing their activity levels) but these are not fully sustained in the long-term <http://www.sportscotland.org.uk/Search.htm?searchTerm=passport%20to%20recreation>. The associated monitoring data from such schemes tends to be of a poor quality. These interventions may, therefore, increase adherence to activity rather than initiate activity (adoption) or engage new participants for only short periods. Without appropriate targeting and monitoring such programmes may, therefore, not maximise their contribution to the local health improvement outcomes.

Any available tracking data for individual participants within specific leisure schemes should be used to identify the extent to which those joining the schemes are the types of participants that are most likely to benefit from particular programmes and to inform whether they maintain their activity levels over time and so gain anticipated health benefits. In the absence of such data monitoring systems should be developed that highlight the baseline activity levels of those engaging in specific leisure service programmes and shed light on ongoing activity levels. Such information is vital to illustrating the contribution of these services to the enhancing physical activity (and sports and leisure) participation.

Model seven: Exercise referral (Live Active)



Model seven: Exercise referral (Active for Life)

The exercise referral model shows how the current Live Active scheme operates to enhance activity levels amongst those who are currently inactive/low active. Although this operational model also includes potential contributions from cardiac rehabilitation and brief interventions to promote physical activity, time did not allow detailed consideration of these areas. The model also included reference to the therapeutic exercise pilot; however, as yet this has not been extended to West Dunbartonshire. Appendix two provides this same model with greater specification based on actual data from the Live Active Scheme. This has been included as an appendix to illustrate how detailed monitoring information, if available, can be used to populate the logic model and this data can then be used to illustrate more specifically how programme contribution can be maximised.

The Active for Life exercise referral scheme is targeted at those who are inactive or have low activity levels and caters for high risk (e.g. post Myocardial infarction /post rehabilitation, diabetic) individuals. Those at high risk have an exercise tolerance test prior to referral. The scheme was developed initially within NHS GG and run in Glasgow then extended to other local authority areas. Again the logic model shows the ultimate outcome as increasing the proportion of the West Dunbartonshire population reaching the national activity recommendation.

The contextual issues in the model acknowledge that Leisure services currently operate a referral scheme that runs on a different model. It is intended that the schemes will be integrated. This model also acknowledges that those who become active through the scheme may relapse and so initial increases in activity may subsequently reduce and/or require additional activity, or linkage to other interventions, to ensure longer term maintenance.

Issues from the RE-AIM framework that should be considered to maximise exercise referral's contribution to the strategic outcomes

Exercise referral schemes in general achieve short term increases in activity that is not sustained in the longer term. Many schemes have been poorly monitored and evaluated. The recent NICE guidelines and the Scottish commentary on these highlights the limitations in this evidence (<http://www.healthscotland.com/documents/2375.aspx>). The scheme operating in West Dunbartonshire was initially based on national guidance for exercise referral although aspects of it may have subsequently been adapted. According to recent scheme monitoring figures thirty eight percent of those attending at baseline report being active at twelve months. This is higher than reported in most similar schemes (see above link) and from previous evaluation figures for the NHS GG wide scheme (http://www.glasgowcitycouncil.co.uk/healthycities/ghcp/pdf/eval_exe.pdf).

The provision of cardiac rehabilitation is recommended as in the Scottish Intercollegiate Guidelines Network (SIGN 57) (<http://www.sign.ac.uk/guidelines/fulltext/57/section3.html>) and this intervention is likely to make a substantial contribution in terms of enhancing physical activity in high risk sub groups. Although reach will be limited cardiac rehabilitation is likely to impact on hospitalisation

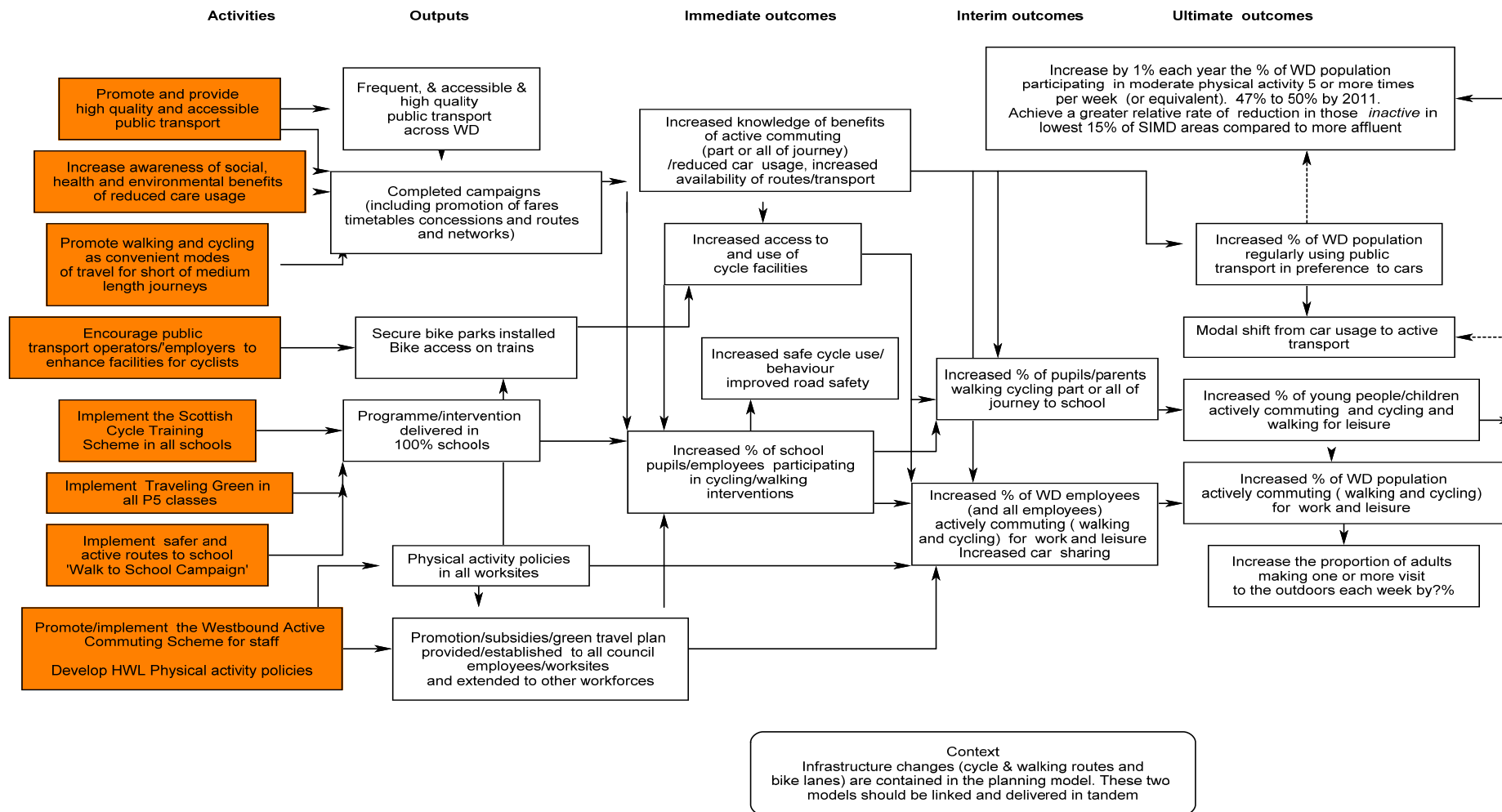
rates for acute angina and CHD morbidity and mortality provided patients adhere to activity programmes.

In order to maximise the potential contribution of the exercise referral scheme to local outcomes reach and adoption would both need to be enhanced. This would require increased proportions of GPs and other professionals refining the scheme and increased proportions of patients from each practice being referred. To avoid exacerbating inequalities there would be need to be an increased proportion of referrals from more deprived practices (or of more economically deprived or excluded individuals) relative to more affluent ones and/or additional support available to ensure equitable outcomes in terms of uptake and adherence.

West Dunbartonshire plan to align the two different exercise referral schemes that operate in the area as a result of the merge of the two NHS Boards and potentially adapt them to follow a more generalised health coaching model. This may impact (either positively or adversely on effectiveness). Monitoring data does currently indicate the SIMID area that participants live in/are referred from and indicates baseline activity levels and self reported activity at one year (for those returning for assessments). Future schemes should be closely monitored to ensure they achieve similar outcomes given the relative success of the programme compared to schemes reported in national guidance. The current or future scheme's impact will be enhanced if strategies to ensure ongoing adherence are developed/expanded.

Model eight: Active commuting/green travel/workplace interventions

Promotion of active commuting/ workplace PA policies



Model eight: Green travel/active commuting

The green travel /active commuting model shows the potential linkages between the cluster of activities relating to promoting active commuting, stair walking and encouraging physical activity in the workplace. The model shows how these activities would contribute to increasing the proportion of the West Dunbartonshire population reaching the national physical activity recommendations and so links back to the strategic model. This model, like the subsequent planning model, could also contribute to the national level outcomes relating to reducing car usage, increasing active/public transport and visits to the outdoors.

The model is based predominantly on theoretical information and the general evidence base rather than on local monitoring or service implementation from West Dunbartonshire. This is partly due to time limitations within the consultancy work, there being no single service lead for these issues which makes gathering local implementation information more difficult. We suggest that this model should be seen as a set of actions that should support and be aligned to the infrastructure changes that would occur as part of the subsequent planning model.

Activities that include more structural changes such as green travel plans, showering facilities, bike parking and financial incentives/ concessionary schemes for employees that also promote active transport choices are also included in the model. Many of these interventions may be delivered via Healthy Working Lives and their workplace award scheme that encourages the development of workplace physical activity policies.

Issues from the RE-AIM framework that should be considered to maximise green travel/active commuting programmes' contribution to the strategic outcomes

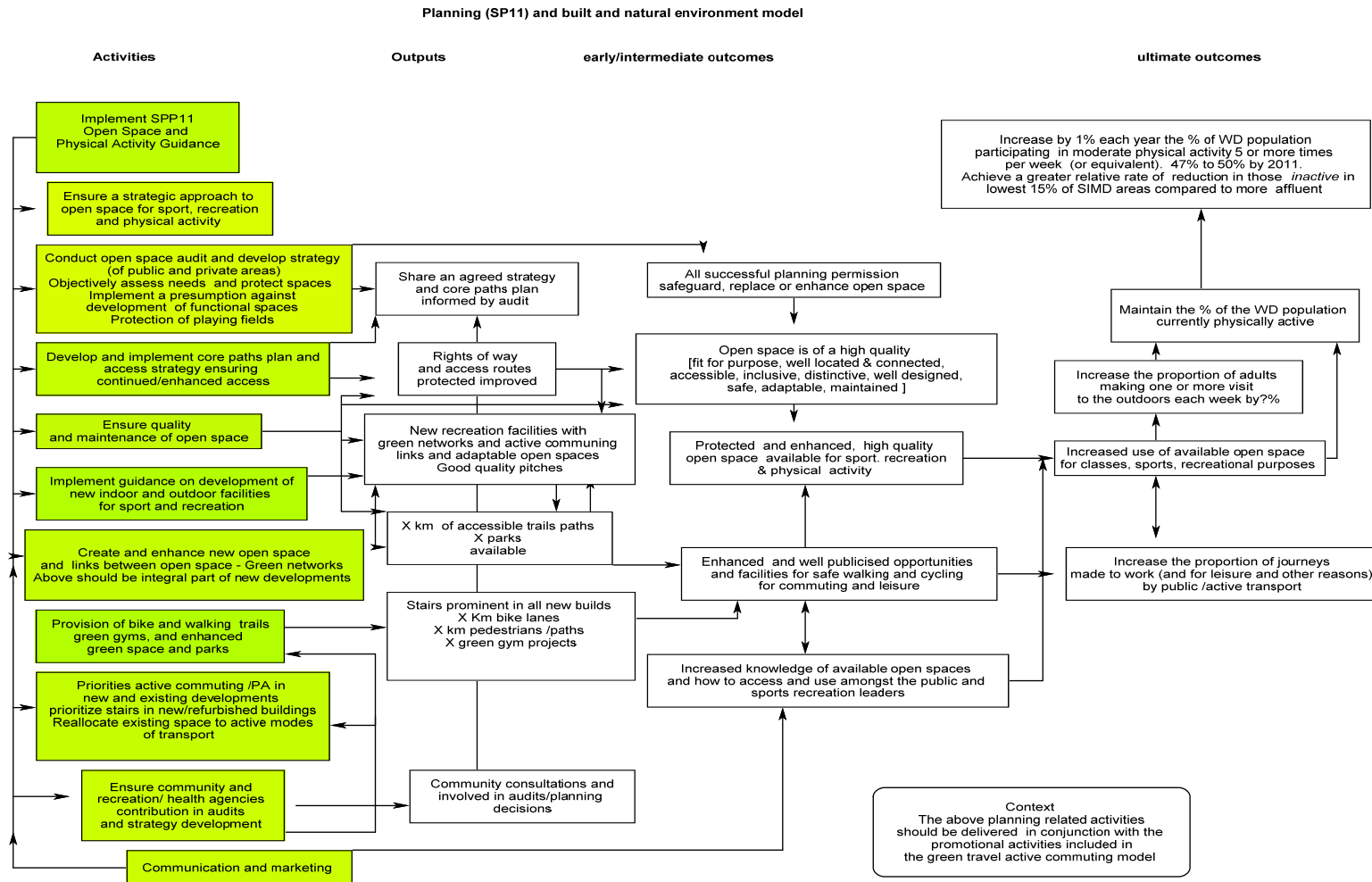
Some of the activities in this cluster have been developed initially as independent research programmes testing the effectiveness of cognitive behavioural interventions. They have then been published and rolled out in practice. Examples of this include use of the stair walking promotional signs, the Walk into Work Out – active commuting pack and travelling green (although this is targeted predominantly at school children) (Blamey, A and Mutrie, N 1995, Mutrie, N. et al 2002, McKee et al 2007). The other activities are supported by review level evidence or in national guidance. There is a National Institute of Clinical Excellence evidence synopsis that illustrates the effectiveness of various health behaviour change programmes targeted at the workplace (including stair climbing, walking and screening programmes) (<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11670>). Guidance is also provided in relation to pedometer schemes and community based walking and cycling schemes (<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11373>)

The reach of these activities will depend on the extent to which they are adopted across organisations and settings and the degree to which they are implemented as recommended in available guidance. If delivered as an integrated set of promotional programmes they will have the potential to encourage small but significant increases in daily physical activity amongst relatively large groups. They might have limited impact on long term physical activity increases unless

programmes are refreshed and reinforced regularly. Many of them are, however, relatively inexpensive interventions relative to their potential impact. These interventions will predominantly impact on the working population.

Extensive, consistent and sustained adoption of these programmes will be needed to provide a large scale contribution to local increases in physical activity. There could be potential additional benefit in terms of reinforcing awareness of non-work based opportunities for being active and in contributing to longer-term cultural change in promoting people making active choices in their daily lives.

Model nine: Planning (SP11) and the built and natural environment



Model nine: Planning and the built and natural environment

The draft model for the cluster of activities relating to planning (to enhance and protect green and open spaces) shows how the development of infrastructure for walking and cycling can contribute to increasing the proportion of the West Dunbartonshire population achieving the national physical activity recommendations. Like the previous model, however, this model also shows how it can contribute to the other national level outcomes relating to increasing visits to the outdoors and journeys made by active and/or public transport. This is again a theoretical model informed by the recent Scottish Government Planning Guidance (SP11) and the NICE guidelines on physical activity and the environment (<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11917>). It has not been informed to any great extent by a detailed understanding of current practice on the ground in West Dunbartonshire. Much of this work is at a relatively early stage in its development given the that the SP11 guidance was published in November 2007

The model should be aligned with the previous behavioural and workplace interventions supporting the use of the above infrastructure.

Issues from the RE-AIM framework that should be considered to maximise the contribution of activities relating to planning and green space to the strategic outcomes

The activities contained within this model have the potential for enormous reach given that they aim to change the infrastructure and our built and natural environment and through that impact on individual and population behaviour. This reach will potentially be enhanced through joint development of infrastructure with effective behavioural change programmes highlighted in the previous model.

The NICE guidance on physical activity and the environment (<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11917>) summarises the wide ranging evidence behind the recommendations that have been used to develop the above model. The available evidence has many limitations relating to the way in which physical activity is conceptualised and measured and problems in relation to attributing outcomes to specific interventions and generalising across settings and geography.

Whilst there is potential for such interventions (if appropriately implemented) to make substantial contributions to increasing physical activity levels any estimation of the thresholds of change that might be expected would need to be modelled based on the actual infrastructure changes that were planned (e.g. Kilometres of bike/walking trails or segregated cycle lanes, development of green space and parks etc). The evaluation of such infrastructure change in term of its impact on physical activity is underdeveloped.

Collaborative gain

The following section sets out our observations regarding collaborative gain *across* the physical activity headings. It summarises current partner inputs, collaborative activities and associated outcomes, and proposes opportunities to further increase collaborative gain in the future.

Table two: Collaborative gain in physical activity

Activity area	Partner inputs	Collaborative activities	Collaborative outcomes	Opportunities
Leisure services and sports development	<ul style="list-style-type: none"> Partner commitment Council funding Council staff Council space Voluntary sector support NHS input for specific initiatives 	Limited local collaboration to achieve health improvement outcomes (beyond co-ordination of Council and voluntary sector programmes and access to facilities for voluntary/community groups)	<ul style="list-style-type: none"> Increased focus/reduced fragmentation Better targeting of finite resources More effective and efficient resource use Enriched interventions Mutual learning Developing understanding and trust 	<p>There is scope for more integrated planning to improve the balance and delivery of programmes aimed at increasing or maintaining activity. This should be done via enhanced targeting (e.g. to clinical groups) and the use of social marketing.</p> <p>Scope for improved joint monitoring and evaluation of concessionary schemes or analysis of 'passport' tracking data to enhance knowledge of health impact.</p>
Exercise referral	<ul style="list-style-type: none"> NHS funding NHS expertise NHS staff (Primary Care) Council staff Council space 	<ul style="list-style-type: none"> Shared drive and support Shared awareness and understanding Coherent joint plan/strategy Clarity of partner roles and responsibilities Joint promotion/communication Better informed and targeted intervention 	<ul style="list-style-type: none"> Increased focus/reduced fragmentation Better targeting of finite resources More effective and efficient resource use Enriched interventions Mutual learning Developing understanding and trust 	<p>Potential for greater alignment of the scheme with wider Leisure Service opportunities to enhance adherence.</p> <p>Greater alignment of exercise referral programme with activities in local halls/ facilities (bowling etc).</p> <p>Joint marketing across services to increase awareness self/other referral</p>

Table two: Collaborative gain in physical activity(continued)

Activity area	Partner inputs	Collaborative activities	Collaborative outcomes	Opportunities
Active travel/transport	<p>Scottish Government funding Council expertise NHS expertise SPT expertise Council funding Council staff Council facilitated access to Council staff Council facilitated access to school pupils Council allocation of time in school curriculum Voluntary sector support</p>	<p>Shared drive and support Shared awareness and understanding Coherent joint plan/strategy Clarity of partner roles and responsibilities Joint promotion/communication More consistent/repeated messages Better co-ordination of individual partner activities Better informed and targeted intervention</p>	<p>Increased focus/reduced fragmentation Better targeting of finite resources More effective and efficient resource use Enriched interventions Mutual learning Developing understanding and trust</p>	<p>WD Active Commuting strategy yet to be implemented Joint diagnoses of key target groups and agreement of the balance and emphasis on key behavioural change programmes that will enhance infrastructure changes (see explanation in text below)</p>
Planning and guidance	<p>Scottish Government guidance Council expertise NHS expertise SNH expertise Council staff Council funding</p>	<p>Limited local collaboration to achieve health improvement outcomes (beyond co-ordination of Council and voluntary sector programmes and access to facilities for voluntary/community groups)</p>	<p>Currently unknown (though supportive of active travel/transport activity and wider <i>direct</i> outcomes relating to physical activity/health improvement)</p>	<p>WD Planning response yet to be scoped Scope for joint Health Impact Assessment of plans prioritisation of areas for protection and enhancement Planned alignment of behavioural support programmes and infrastructure (e.g. bike loan schemes in communities with redeveloped bike trails) Above leading to jointly seeking funding for evaluation of the impact of new linked interventions</p>

The text in Table two once more points to evidence of collaborative gain through partner inputs, tangible collaborative activities and collaborative outcomes. It reinforces the notion that collaborative gain is best sought at a programme level across a topic, rather than within each individual activity. In some instances, such as planning and guidance in support of physical activity (and even leisure service provision), the work will be undertaken predominantly by one partner (the Council). Taking the planning and guidance example, the level and nature of collaborative activity will have knock on benefits to other parts of the programme (e.g. the use of new infrastructure developments such as bike trails/paths may be enhanced by simultaneously implementing behavioural support programmes such as cycle training, bike loan schemes and the 'walk into work' or travelling green interventions. This would likely involve collaboration from the voluntary sector and NHS-who have evaluated or delivered such schemes. These routes may also be used more readily if perceived as safe if other partners are involved in 'policing' them to minimise dangers from parking, antisocial behaviour, poor lighting etc).

Once again, the extent of collaborative gain is difficult to measure (in terms of collaborative outcomes and benefits). We repeat our observations about the scope to develop qualitative targets for these outcomes and benefits as the CPP moves forward, in part relating to the outcome targets set for physical activity but also drawing on the Improvement Service collaborative gain research.

6 Conclusions and recommendations

The five tasks that were set out for this consultancy project were to:

- 1 Identify and prioritise outcomes (for tobacco and physical activity) and align these with the emerging SOA
- 2 Map current partner activities that relate to the emerging outcomes.
- 3 Use the available evidence base and service monitoring information to identify those activities and services that will best contribute to the outcomes and that require to be delivered collaboratively
- 4 Develop outline programmes that will deliver on the outcomes and that show partners potential contributions and where collaborative gain can be enhanced
- 5 Identify possible measures and targets that will enable the programmes to be performance managed.

In relation to one we have developed strategic outcome models for the two areas and aligned local activities and outcomes with the SOA and national outcomes. We have also suggested prioritised local outcomes within those detailed in the models.

In relation to two we have developed four operational models for physical activity and three for tobacco control that show how existing and intended activities link to the local prioritised outcomes. The extent to which targets and thresholds could be set for the outcomes was hampered by the current restructuring of the CPP and variation in the availability of service information relating to health impact.

With regard to three we have fed back our observations regarding the existing evidence base and the availability of local data to identify the potential reach, adoption and efficacy of current programmes and our scoping of the likely contributions they will make to the outcomes. The lack of appropriate monitoring data, and limitations in the evidence base, has limited progress in relation to this task. We believe that the information fed back to HISG will be useful in planning how the health improvement agenda is moved forward.

Whilst we have not fully delivered on tasks four and five we have made recommendations as to where and how collaborative gain can be enhanced and have provided models, criteria and processes that that can be used with partners to progress these task more fully over time.

This learning will also be useful in the development of further outcome models to be developed for Alcohol and Diet.

We feel we have made substantial progress against the first two tasks, some progress in relation to three and four, and have established models from which five can be developed.

Looking across the issues arising in the development of the emerging outcome models we have reached a number of conclusions.

The identified health improvement outcomes link to the outcomes identified in the West Dunbartonshire SOA. These in turn link into the relevant national outcomes associated with health improvement.

It is our opinion, as a result of identifying and reviewing the key activities and services that are contributing to the models, that there are no major gaps in the range of these activities and services that would be expected within such models. Most of the activities and services that are recommended in the main evidence based guidelines supporting action in tackling tobacco and promoting physical activity are present within West Dunbartonshire partnership activities.

Although most of the key services that would be anticipated are present there are areas where activities or services are not fully developed or, as yet, have limited coverage. There are activities and services where there is scope for improvement in relation to reach, effectiveness, adoption (across professionals or organisations), the way it is implemented or the extent to which it will be sustained or lead to maintained behaviour change. Some of the limitations that we have identified as part of this process were already known to the HISG and/or partners and in several instances plans or early actions are already being developed to address these.

Taking into account the identified gaps and weaknesses, we believe that the energies and efforts of CPP partners are configured to deliver the desired health improvement outcomes. Any observations regarding opportunities for further improvement/investment should be seen in that light.

The strategic and operational level outcome models developed as part of this process should be seen as draft models. Given the limited timescales and resources available for this work the models should be viewed as developmental and should ideally be revisited and strengthened as a part of ongoing partnership dialogue and joint working. This needs to be taken forward by looking across the four topic areas, rather than solely the two covered in the first phase of this work.

Services and activities are at different stages in their history and development and as such there are many services and related outcomes which will require additional specificity. For example most still require agreed targets and more detail regarding the thresholds of change and the anticipated timelines for these. These changes should be made as decisions are agreed between partners in relation to which of the key data sets available will be the primary one used for both planning and target setting. They also need to be made in reference to the available funding and service capacity.

At a strategic level, we have set out how collaborative gain may be 'designed in' as part of the new community planning arrangements in West Dunbartonshire, with a particular emphasis on the role of the HISG and the Health Improvement 'Themed Group'. It is important that the work of the HISG is not progressed in isolation from that of the other five community planning themed groups. The

overarching arrangements/structures for community planning in West Dunbartonshire have been designed with this interdependency in mind.

More operationally, there have been a number of areas where there is potential to establish or increase collaborative gain in relation to these two outcome areas. In some instances, such possible refinements/ developments relate to physical activity, in others to tobacco. Typically though, the opportunities identified are relevant to both of these outcome areas and the other outcome areas – Diet and Alcohol - that the HISG has prioritised. The detail of collaborative activity set out in tables one and two (on collaborative gain) identify partner inputs to each topic area. These help to identify how/where collaborative gain could be increased. They also form a basis for identifying subsequent programme roles and responsibilities in each topic area.

Our findings suggest that collaborative gain should be sought and delivered at a programme level – rather than through every activity stream. We consider that specific collaborative gain targets and performance measures can be developed that relate to:

- compliance with/participation in identified collaborative activities
- delivery of collaborative outcomes.

These activities, targets and measures will be shaped by the prioritised outcomes for each of the four topic areas, as well as the more generic messages from the IS research project on collaborative gain.

There are a number of specific opportunities to enhance collaborative gain within these topics (these may also be relevant to other topics and themes). They include scope for partners to work jointly to:

- identify and agree the preferred data source within each topic area, then use this consistently for planning purposes across agencies (there appear to be a number of different data sources currently used for planning purposes within the Partnership, leading to inconsistency in baselines and target thresholds for change). Thereafter, identify and agree the preferred data source(s) for ongoing monitoring and utilise developing outcome models to agree a monitoring and evaluation framework for health improvement activity
- identify and agree locally relevant performance targets in each local area, clearly stating the rationale for their selection (relevant to the commitments made in the SOA). The RE-AIM framework provides a helpful and robust mechanism to identify possible contributions and targets as it highlights issues of reach, efficacy, adoption, implementation and maintenance as well as achievable timelines. It would also encourage consideration of the appropriate balance between programme reach and intensity/efficacy. This is key for achieving reductions in health inequalities
- encourage further deliberation within the Partnership regarding the available evidence base/logic used to inform the plausibility of current activities/interventions

- increase the use of existing monitoring data from current services and programmes to inform the prioritisation and improvement of collaborative interventions
- identify opportunities for tailoring and targeting existing services – often provided across West Dunbartonshire as a single population group - to maximise the impact of finite resources on priority outcomes
- agree the key population groups being targeted by the Partnership, and identify the best means of engaging with these groups (across the breadth of partner communications).

The HISG's intention is to use the emerging outcome models for all four areas to prepare an outcome agreement for health improvement in West Dunbartonshire. The outcome agreement will determine the programmes of work for the CPP. Each programme will articulate the agreed priority outcomes and encapsulate the tangible contributions of each partner in ensuring their successful delivery. The detail of the outcomes and contributions provide the basis for subsequent performance management within and across the programmes.

We believe that the conclusions and recommendations in this report provide a robust starting point to inform the discussions about relative CPP emphasis (in terms of importance and resource allocation) across the four health improvement topics – Tobacco, Physical Activity, Diet and Alcohol. The health improvement outcome agreement – and the programmes of work that will be used to deliver on this agreement - are dependent on the outcomes of these informed CPP discussions.

These discussions will take place in the context of a re-invigoration of community planning in West Dunbartonshire. The intention is that the role of all thematic groups – of which the HISG is one – will be strengthened, and that a lead partner will be held to account for the delivery of the specified outcomes. This is intended to facilitate the design and implementation of appropriate programmes of work across all of the community plan themes.

Recommendations

Based on the findings and conclusions set out in this report, we make the following recommendations:

- 1 The HISG note the content of the report and take assurance from the emerging conclusions
- 2 The HISG use the proposed strategic models as a basis for the development of the health improvement outcome agreement; refining/supplementing these as needs be in light of subsequent work on Diet and Alcohol outcomes
- 3 The HISG share the more detailed operational models with relevant partner managers to help refine the detail and provide an outcome focus for their subsequent service planning and resource allocation decisions
- 4 The HISG encourage partner agencies to continue to develop the information and evidence bases associated with their activities and their contributions to health improvement
- 5 The HISG adopt the collaborative gain framework and the planning tools set out in this report as a basis for planning and delivering their forward programme of work
- 6 The HISG considers the need to develop further outcome models for Diet and Alcohol, using these models in their own right, and as an emerging information base to inform the relative emphasis within the comprehensive health improvement outcome agreement
- 7 Within the context of the re-invigorated community planning arrangements, the HISG draft the health improvement outcome, linking into (and informing updates to) the West Dunbartonshire SOA
- 8 The HISG oversees the development of a programme in each topic area that builds on the outcomes, contributions and roles and responsibilities highlighted in this report (for tobacco and physical activity), but acknowledges the relative emphasis across the four topic areas associated with health improvement.

7. References

Audit Scotland (2006) "*Community Planning: An Initial Review*" Audit Scotland

Aaron D, Jekal Y, LaPorte R. *Epidemiology of Physical Activity from Adolescence to Young Adulthood*. In Simopoulos AP (ed): Nutrition and Fitness: Obesity, the Metabolic Syndrome, Cardiovascular Disease, and Cancer. World Rev Nutr Diet. Basel, Karger, 2005, vol 94, pp 36-41. (DOI: 10.1159/000088204)

Bauld, L., Judge, K. and Bishops Consulting (2005), *Health Improvement Planning in Scotland: An analysis of JHIPs and ROAs* NHS Health Scotland.

Bauld, L., Ferguson, J., Lawson, L., Chesterman, J., Judge, K., (2006). *Tackling Smoking in Glasgow Final report*. NHS Health Scotland/ Glasgow Centre for Population Health

Blamey A, Mutrie N, Aitchison T. Health promotion by encouraged use of stairs. *British Medical Journal* 1995;311:289-90.

Chesterman, J., Judge, J., Lawson, L. (2005), *Reducing Smoking Inequalities in Glasgow Estimating potential impact of smoking cessation services*. NHS Health Scotland/ Glasgow Centre for Population Health.

Coalter, C., (2002) *Entrance Charges and Sports Participation: A review of evidence*. Centre for Leisure Research, Edinburgh University. Published by the Physical Activity Task Force April 2002 <http://www.sportscotland.org.uk/Search.htm?searchTerm=passport%20to%20recreation>

Hexagon Consulting (2005), *Health Improvement and Health Inequalities: A Local Government Perspective*, NHS Health Scotland

Improvement Service (2008) *Briefing Note on Collaborative Gain*, March 2008.

McKee, R., Mutrie, N., Crawford, F., Green, B.,(2007) *Promoting walking to school: results of a quasi experimental trial*. Journal of Epidemiology and Community Health 2007;**61**:818-823; doi:10.1136/jech.2006.048181. Copyright © 2007 by the BMJ Publishing Group Ltd

Mutrie N, Carney C, Blamey A, Crawford F, Aitchison T, and Whitelaw A. *Walk in to Work Out: a randomised controlled trial of a self help intervention to promote active commuting*. Journal of Epidemiology and Community Health 2002;**56**:407-12.

NHS Health Scotland (2008) *Managing for Shared Outcomes: Towards achieving a Healthier Scotland*", NHS Health Scotland.

Scottish Executive (2006), The report of the Community Led Supporting and Developing Healthy Communities Task Group. Scottish Executive.

Scottish Executive (2006) "*Transforming Public Services: The next Phase of Reform*" Scottish Executive

Scottish Government's (2007) "Better Health Better Care" Scottish Government, December 2007.

Scottish Government (2007) National Performance Framework (Scottish Government Spending Review). Scottish Government

All other references within the report are hyperlinked

8. Appendices

Appendix one: Tools and techniques used in the development of the outcome models

The following tools can aid outcome focussed planning and improve service delivery:

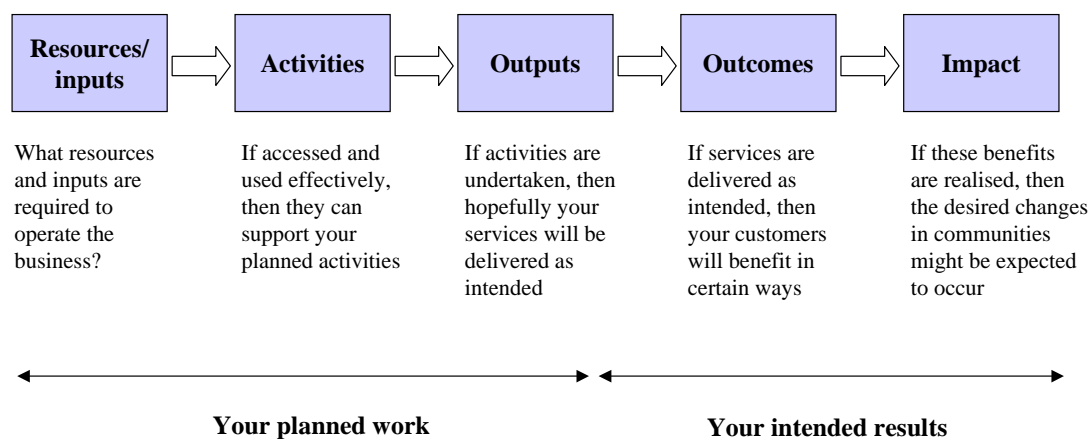
- logic modelling;
- the RE-AIM framework; and
- criteria to critique and enhance developing plans (such as considering the plausibility, testability and do-ability) as recommended in Theory of Change methodology.

We justify the selection of these tools below.

Logic modelling

While the partnership approach enriches policies and services, it is less straightforward than a more traditional and linear service delivery approach. In addition to demanding that each partner becomes more open and flexible about its roles and responsibilities, partnership working requires shared objectives to be developed and the activities and contributions of each partner to be planned in close liaison with other partners. This is crucial to maximising impact and minimising unnecessary duplication of effort.

In response, a logic modelling approach aims to provide a 'roadmap' or 'journey' that projects the sequence of related events that logically come together to deliver the desired outcomes. A generic logic modelling approach is illustrated below:



Source: W K Kellogg Foundation (2001), 'Logic Model Development Guide: using Logic Models to Bring Together Planning, Evaluation and Action' (www.wkkf.org)

Planning approaches in many public bodies traditionally work by moving from the left of the diagram to the right (i.e. what impact can we make by continuing to do what we do?). The logic modelling approach works from right to left, working back from the desired impact, through the outcomes (long, intermediate and short-term), to identify the outputs, activities and inputs needed

from each partner. It reflects proven practice in many high performing organisations. It encourages adjustments in policies or service delivery based on a real understanding of what results in success. It often involves difficult decisions about changing the focus of current activity to make sure that the greatest impact is made.

Logic modelling requires commitment from partners to utilise existing evidence (including evidence of need, evidence from literature and practice reviews and evaluations, and professional and professional tacit experience and organisational knowledge) to:

- 1) identify and agree the desired long-term outcome(s)
- 2) identify, agree and link the intermediate and shorter-term outcomes (changes in structures, environments or behaviours) influencing health improvement and reducing health inequalities to the longer term outcomes
- 3) identify and prioritise appropriate key activities/interventions which will most plausibly lead to the agreed outcomes
- 4) identify the necessary inputs (such as the funding, resources, workforce & skills) awareness, understanding, attitudes and behaviours/processes of partners ; influence and power);
- 5) highlight the enablers and contexts (partnerships, community involvement), the assumptions (mechanisms likely to lead to change) and values (ways in which the services should be delivered) that underpin the anticipated changes.

For further details please see:

<http://www.wkkf.org/default.aspx?tabid=101&CID=281&CatID=281&ItemID=2813669&NID=20&LanguageID=0>.

The Re-Aim Framework

The Re-aim Framework is a planning and evaluation tool that aids the assessment of whether proposed or delivered interventions are likely to be/are successful in achieving population level public health impact (i.e. are 'generalisable' to large groups/different contexts). It uses a range of criteria with related question the extent to which interventions:

- will **reach** enough participants (be offered and taken up by sufficient individuals in the targeted population);
- have **efficacy** (have they been shown to work/are evidence based);
- can be easily **adopted** by a range of agencies, partners or organisations ;
- are **implemented** as intended (according to evidence and best practice); and
- can be **maintained** over a long enough period of time by individuals and organisations (sustainability).

For more information please see: <http://www.re-aim.org/>.

Plausibility testability and do-ability criteria

The above criteria are used as part of the Theory of Change approach (a theory-based evaluation method) to test out the logic models (theories of change) developed by practitioners. **Plausibility** relates to the extent to which a logic model is informed by available evidence (like efficacy above) but in the absence of such evidence relates to the degree to which the plan is at least logical and based on some degree of theory or previous knowledge (again considering likely reach, quality and exposure to the interventions). **Do-ability** considers whether the time scales, resources, funds skills etc available are realistic and feasible for the levels of changes anticipated (are the targets too ambitious). **Testability** questions the extent to which the plan is laid out and expressed in a manner that make it capable of being measured or evaluated.

For further information please see: <http://www.theoryofchange.org/>.

The consultancy team believe that the combination of these tools will lead to logical, evidence informed plans that can be used to develop appropriate future monitoring and evaluation plans.

Appendix two: More detailed version of Model seven- Active Commuting (Active for Life)

Exercise Referral Logic model

