OPTIONS APPRAISAL: NATIONAL, REGIONAL AND LOCAL DESIGN

Purpose

1. The Oversight Board asked the programme team to consider how best to achieve a “whole system” approach for the new public health arrangements in Scotland.

2. This discussion paper aims to:
   
   2.1 Briefly summarise the background situation and in particular, how the goals of the Public Health Review relate to reorganisation.
   
   2.2 Outline the basic case for the establishment of a national body for public health in Scotland.
   
   2.3 Describe potential options for an organisational structure at regional and local level that complement the vision for the new national body.
   
   2.4 Propose that Community Planning Partnerships be recognised as the best existing entity to implement local action on public health priorities.

3. The views and comments of the Oversight Board are welcomed. Specifically, the Board are asked to:

   3.1 Note the case for a national body which will take a whole system approach to its role, and decide if further consultation work should proceed (Question 1).
   
   3.2 Provide general views and guidance on a proposed approach to sub-national models outlined (Question 2).
   
   3.3 Provide specific views and guidance on an approach to partnership working and governance that supports the new arrangements and achieves the aims of reform (Questions 3, 4, 5 and 6).
   
   3.4 Confirm that the work to date aligns with the reform principles set out at Annex A.
   
   3.5 Advise on any additional next steps.
Background

1. Public Health is defined by the Faculty of Public Health as the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society.

2. Within this definition, there are three widely accepted domains, with a fourth (intelligence) spanning the others. Each of these domains must be adequately attended to at local, regional, national and international level for a public health system to be said to be functioning completely:

   2.1 **Health Improvement** is concerned with primary and primordial prevention including lifestyles, social determinants of health, the built environment and other influences on our health;

   2.2 Improving health services (**Healthcare Public Health**) is the work related to clinical effectiveness, health service efficiency and quality, audit and clinical governance;

   2.3 **Health Protection** includes the surveillance and response to infectious disease and environmental hazards (such as air pollution); and

   2.4 **Health Intelligence** (and academic public health) underpins all of the above, providing data and insight to assess, develop and improve public health work across the domains.

3. The Public Health Review (PHR) recommended:

   3.1 Further work to review and rationalise organisational arrangements for public health in Scotland;

   3.2 Exploration of greater use of national arrangements, including for health protection;

   3.3 The development of a national public health strategy and clear priorities;

   3.4 Clarification and strengthening of the role of Directors of Public Health (DPH), individually and collectively;

   3.5 Supporting more coherent action and a stronger public health voice in Scotland;

   3.6 Achieving greater coordination of academic public health, prioritising the application of evidence to policy and practice and responding to technological developments;

   3.7 An enhanced role for public health specialists within Community Planning Partnerships (CPPs) and Integration Authorities (IAs); and

   3.8 Planned development of the public health workforce and a structured approach to utilising the wider workforce.

4. Specifically, in relation to the potential formation of a new national body - and a possible change in regional or local structures - the PHR concludes that any resulting organisational structure would need to:

   4.1 Have a clear vision;

   4.2 Provide leadership at every level; and

   4.3 Extend its reach far beyond NHS and health boundaries.
5. The Evidence Review that supported the PHR did not arrive at a definitive conclusion on the optimal structure for public health functions. On the issue of structure, it found that there are many shifting dynamic structures between the local and national and that there is no simple right solution. The responses to the engagement that was undertaken as part of the PHR provided no clear preference in relation to structure.

6. Alongside the PHR findings, the on-going NHS led Shared Services Public Health Programme also identifies the potential for regional or national working on several core public health functions, including health protection and cancer screening.

The Current System

7. The Public Health etc. (Scotland) Act 2008 sets out the current statutory requirement for Health Boards and Local Authorities to be able to respond to public health incidents. NHS Boards also have numerous other strategic and legal commitments to improve the health of the public out with their service boundaries, while Local Authorities have a statutory responsibility for facilitating a local community planning process to deliver national outcomes, including those relating to public health.

8. At local level, core specialist public health resource currently resides predominantly within the 14 Territorial Health Boards (public health/dental public health consultants and specialist, health improvement/heath promotion staff and health intelligence staff); 32 Local Authorities (environmental health professionals, licensing and other regulatory staff); and academia. In collaboration, or as a function of their large scale, NHS Boards also operate at a regional level and some Local Authorities deliver certain functions through shared services models.

9. Consultants and specialists have a mix of generic roles covering all domains of public health, while others are focused specifically on health protection or health and social care services, with fewer focused on the improving health services domain of public health. Health intelligence staff support all domains of public health at a local level with support from national staff.

10. At a national level, Health Protection Scotland broadly address the issue of health protection; ISD provide health intelligence; and Health Scotland support the delivery of national health promotion efforts. Healthcare Improvement Scotland and local Board staff provide input into healthcare public health and service improvement, and the Improvement Service provide support to Local Authorities in relation to health improvement. These delineations are not always true in practice, as public health is by its nature multi-disciplinary.

11. Efforts have been made to create more of a whole system approach to improving public health in Scotland. The COSLA guidance “Local Authorities as Public Health Organisations” (2002) was supported through the creation of new support roles based in councils and funded by Scottish Government (SG),
local Health Boards and the Local Authority. The aim of these roles was to develop the public health partnership approach to Community Planning as well as councils’ approach to health improvement. These posts were commonly referred to as Health Improvement Officers. Funding relationships have since changed and the function is now less distinct.

12. The ScotPHO collaboration, anchored within NSS and Health Scotland, but with close ties across public sector agencies and universities, already spans the health and local authority interface and is a productive provider of health related intelligence, health profiles at local level, analytical and interpretative work.

13. National Services Scotland currently provides a Local Intelligence Services Team (LIST) to IAs. This role provides sponsorship for the local role by providing some funding and professional support from the national agency to partnerships to use as appropriate locally and is seen as key to empowering local systems plans in relation to local need by making better use of the data and evidence.

14. Another example is the iHub based in Healthcare Improvement Scotland. This is based on the Joint improvement Team (JIT) approach which provides an “open” offer to IAs.

15. NHS Health Scotland also offers bespoke “consultancy support” to CPPs and IAs and works in partnership with the Improvement Service and others to provide this.

Other UK Systems

16. England and Wales have both moved to build a stronger national voice for public health in a single national body supported by some form of local and regional delivery units.

17. Public Health England is structured around a national body supported by ‘regions’ and ‘centres’. Four regions (North, Midlands, East and South) are focused on the effective functioning and professional development of the public health system and assure delivery in its local centres. Fifteen local centres provide the organisation’s local presence and leadership as well as the Health Protection function. In London, they operate a single office that serves as both centre and region.

18. Public Health Wales is the NHS Trust that provides a unified Public Health function in Wales. The organisation became fully operational in 2009 and it delivers the following statutory functions:

18.1 Provide and manage public health, health protection, healthcare improvement, health advisory, child protection and microbiological laboratory services and services relating to the surveillance, prevention and control of communicable diseases;
18.2 Develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters;

18.3 Undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales including cancer incidence, mortality and survival; and prevalence of congenital anomalies; and

18.4 Provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health-related matter.

The Case for a National Public Health Body and Whole Systems Approach

19. As set out above, the public health domains are not exclusive and they interact with each other and within a complex system. The range of related review and audit work undertaken in Scotland (e.g. Christie, PHR, Community Planning Partnership Audits) clearly demonstrate that it is not the structures of a system that matter, but the ability of ideas and influence to be passed across organisations and individuals through relationships and ways of working that lead to successful outcomes.

20. The work of public health is sometimes referred to as ‘everybody’s business’. Gains in public health have historically been achieved by multi-disciplinary teams working together to develop complex interventions that operate on many levels – i.e. a whole systems approach. A modern example is the public health gains against tobacco smoking, a victory that cannot be laid at the door of any one agency.

21. Current human resource capacity is limited at local level. The core/specialist/Local Government public health workforce is small compared to ‘downstream’ health service functions. The public health human resource spend is estimated to be 1.3% of the human resource spend for the NHS. Total spend on public health programmes is estimated to be 2.6% of the total NHS expenditure (PHR).

22. Bringing staff and budgets together to build focussed capacity and leadership speaks to some form of aggregation of some staff and functions into larger units. We propose that achieving the aims of the PHR will require (at a minimum) a new national organisation with specific responsibility for public health; which is better aligned with and more accountable to local community planning arrangements and which effectively interfaces with any emerging regional-level arrangements.

23. We believe that a national body would be likely to further the aims of the PHR, in particular to provide stronger leadership, vision and voice to the emerging public health priorities. At the national level, our reform work is focused on the opportunity to rationalise and re-organise the current dispersed national public health functions into a single, independent and authoritative voice - offering better vision, cohesion and critical mass. In doing so, we aim to improve
visibility and clarity and provide a single national point of expertise and leadership. Delivering a new national body with responsibility for all the domains of public health in this way will provide a critical mass of expertise, knowledge and leadership, along with an opportunity to evolve and widen that expertise to better-represent and serve the whole system.

24. The relationship of the new body with local-level partnerships, priorities and delivery processes will be crucial. There should be no sense that public health can be successfully delivered as a purely nationally-driven agenda. Future success will therefore be dependent upon developing a shared agenda, with shared national leadership and wide-ranging engagement across all sectors of society. The new national body will therefore need to be accountable in a meaningful way to Local Authorities and to the NHS.

25. We are also a relatively small country, one in which we are endeavouring to streamline layers of reporting and bureaucracy to free up resources for direct service to individuals, families and communities. Over time, different policy agendas have established their own approaches to regional and local partnerships and governance, with the effect that organisations are often operating in a mixed economy of arrangements. Our approach should not add further complication. Rather, we should consider how public health and the new organisation can bring new strengths and work within existing arrangements to improve performance and deliver improved outcomes.

26. With this in mind, we need to undertake work to better understand what aspects of public health are most valued and used and by whom; and identify what we want to maintain and strengthen and what we want to change. This work will be an important contributing factor to the way the new organisation works across the whole public service system. Taking a ‘Once for Scotland’ approach to efficiency, for example, would allow the new organisation to receive its finance, procurement, IT and HR functions on a shared service basis from elsewhere in the wider public service system.

27. The new body should also be able to provide some public health functions ‘Once for Scotland’. Those areas that are currently being considered under the shared services reviews include the collection, analysis and reporting of health intelligence data; screening and vaccination program planning; and out of hours health protection. This paper does not seek to set out what functions should be ‘in or out’, it simply notes that the potential exists to reduce duplication in some areas of public health work.

28. A single national body would also provide a clear and consistent partner to other UK public health efforts. The interdependency of health in Scotland and the rest of the UK is clear. Movement of goods, people and services (for example, carriers of exotic diseases) and the regulation of drugs including antibiotics (both human and veterinary practice) are also part of this UK dimension. Terms and conditions and professional frameworks for health professional, including public health, are also UK determined.
29. Additionally, we believe that a national body would strengthen Scotland’s position internationally and that our approach to public health has much to contribute to the international health agenda. Scotland is already recognised internationally for some of its work in public health, for example bold action on tobacco and alcohol; being a world leader in viral hepatitis; and our patient safety programme.

30. Public health has no borders when it comes to environmental issues or pandemics and proposed solutions must take account of this. New challenges and prospects are presented by the UK exiting the European Union (EU) and the impact of this decision on public health and sustainability.

31. A national agency would play a key role in achieving the aims of the PHR: to provide vision to public health; to corral efforts around a single agreed set of public health priorities; to support locally driven action; to develop the workforce; and to build better links with academia.

**Question 1:** With these functions in mind, do you agree that we now need to undertake the necessary engagement work to prepare the detailed blueprint for the new organisation, setting out our understanding of what the national body should encompass and identifying what we want to maintain and strengthen about our public health system and what we want to change?

**Sub-National Structures**

32. Whilst strengthening vision and leadership and de-cluttering the national landscape is a desirable aim that a national body will do much to deliver, its establishment will never remove the need for local planning and delivery of public health work. There will always remain a need for a local presence for public health in both NHS Boards and Local Authorities who, along with their CPPs, have on-going responsibilities for agreeing local public health priorities and driving local action to achieve them. Taking the example of Health Protection, with the improvement of electronic data records for laboratory and other investigations, epidemiological surveillance of disease can increasingly take place at a higher (national) level, but equally, local response to outbreaks and individual cases of notifiable disease are still required.

33. Satisfactory implementation of the requirement of the Public Health (Scotland) Act 2008 for Health Boards to be able to respond to public health incidents would be unlikely to be possible without some form of local presence, including Consultants in Public Health Medicine and Health Protection Nurses at a territorial board level and Environmental Health Officers at a Local Authority level.

34. Any sub-national structure must fulfil these legal requirements and must embody the essential qualities of an effective public health system:

34.1 Effectiveness and efficiency;
34.2 Critical mass and resilience, surge capacity;
34.3 Responsiveness and flexibility;
34.4 Quality and competence; and
34.5 Connectedness, strategic awareness, for key stakeholders, for professional development.

35. As highlighted in the PHR evidence review, the perfect organisational structure to deliver a whole system approach to public health does not exist. The PHR therefore called for clearer national leadership and strengthened local partnerships, without specifying what those structures should look like, but did specify that public health should have an enhanced role in both CPPs and IAs.

36. Before considering the structural or organisational questions that relate to where different groups of staff should be employed, it is important to consider the relationships that need to exist between a new national body and local partnerships and whether/what activity needs to be organised at the regional level.

37. The following diagram seeks to articulate one possible proposal for rationalised national activity, supporting a small number of regional public health hubs, with both linking to local partners sitting within CPPs and IAs.

38. It is important that the new national body is not seen as centralising public health. How regional and local approaches look is therefore just as important, if not more so, than the national body - and will be the key mechanism for ensuring local buy-in and influence to public health. The links between the new national body and regional hubs (and, beyond that, to communities) must be two-way. Local intelligence and activity will influence and inform national strategy, reflecting the PHR recommendation about the need for better connections between national and local activity. With this in mind, it is clear
that the new structures have to offer something better than what currently exists and so the relationship between the national and the local and the role of the regional hubs will need to be clear.

39. If we proceed with the above set of relationships as the broad approach to national/regional/local public health dimensions, a number of questions will need to be considered over the coming months, including which parts of the agenda should sit where and how budgets and staffing capacity should be organised in support of them. These topics are discussed in brief below and it is proposed that the new Executive Delivery Group is tasked with addressing them in specific detail, through the development of a blueprint Target Operating Model. It is envisioned that this work would entail seeking proposals from Local Government in relation to local authority functions, such as environmental health. In the interim, the Oversight Board is invited to offer high-level views on the broad approach set out in the diagram above.

**Question 2:** We seek specific guidance on the use of regions under the national body. To effectively deliver the aims of the PHR, is a national body enough, or is a regional structure also required? Do you agree that some functions might benefit from focused capacity at the regional level? What criteria should be used to decide this? What would the optimal regional structure look like?

**Question 3:** Bringing staff and budgets together to build focussed capacity and leadership speaks to bringing some staff and functions into regional units. How might these be achieved? One option is to devolve some of the current national capacity, another is to aggregate upwards, or a combination of both may be appropriate. Do you have a view?

**Question 4:** Another key aim of regional structures would be to provide leadership at the regional level. How would this best be achieved? One possibility would be a small number of new Regional Directors of Public Health, whose role would be to support and deliver regional improvements through strategic guidance only. Another would be to create new employment relationships regionally under the direction of such Directors. Do you have a preference?

**Question 5:** Successful relationships will be important, as will accountability to Local Authorities. We propose that if appointing Regional Directors of Public Health, they should be joint appointments with Local Authorities and with the new national body. Do you agree?

**Question 6:** In order to achieve strengthened leadership at the local level, an additional proposition could be the creation of an ‘Associate Director’, to be appointed to each of the 32 CPP areas. Again, the recruitment and accountability of these posts would be a joint arrangement. What is your view of increasing connectivity and accountability in this way?
40. It is important to note that the arrangements and relationships discussed above could all be supported by different configurations of capacity at a local level. In this respect, five main configurations present themselves:

40.1 **Option 1 - Status Quo:** Maintaining current employment of public health staff within existing NHS Board, Local Authority and partnership arrangements. National body to provide them with guidance and support.

40.2 **Option 2 - Integration Authority Model:** Move public health resourcing, where appropriate, under the control of Integration Authorities. As above, national body to support.

40.3 **Option 3 - Local Authority Model:** Move all or some of the ‘local’ NHS provided public health functions into Local Authority control and some into the National Body where appropriate. This could be considered to be similar to the approach taken by the Health and Social Care Act 2012 in England.

40.4 **Option 4 – Single National Body Model:** Move all or some of the locally provided public health functions in Local Authorities and the NHS into a single national public health body. This body to employ and manage all public health specialist assets delivering local functions through embedded staff, central guidance or other methods to be decided.

40.5 **Option 5 – National and Regional Model:** In addition to the model above, establish a smaller number of regional hubs and Regional Directors to provide geographically focused public health services and leadership to local organisations and partnerships.

41. All these options are likely to require a complex transfer of employment and establishment of public entities, although to varying extents and such significant change would have to be carefully calibrated with wider NHS and public sector reform. As noted earlier, any of the options outlined above could be configured to support the relationships described in the earlier diagram. However, when considered within the context of the principles previously agreed by the Oversight Board (see Annex A), alongside previous Oversight Board discussions, it is possible to rule some in or out:

41.1 **Option 4 – a single national body encompassing all NHS and Local Authority public health functions, would appear to be in tension with the Oversight Board’s stated aim to avoid an overly-centralised approach and the desire for a strengthening of the role of local partnerships. That is not to say, however, that there is no role for a national body; simply that it should not be one of fully-centralised delivery of public health functions.

41.2 **Option 5 – a national and regional model supports the principle that de-cluttering of the landscape and supporting efficient delivery may**
require regionalisation of some activity. Indeed, the Oversight Board has previously indicated that national, regional and local approaches should be considered ‘in the round’ as part of a whole-system approach and to ensure that structures are considered in support of national priorities, rather than in a linear fashion inadvertently flowing from the final scope of the national body.

Conclusion

42. We now seek the views of the Oversight Board against the 6 questions set out earlier in this paper. The PHR evidence review found no clear data to favour one structure over another. The consultation responses supported this and cautioned against seeking the ‘perfect’ organisational structure. Instead, the solution was deemed to be determined by the culture and preferences of the systems in place in each setting at that point in time. Expert opinion is therefore vital to inform our choices.

43. We propose that, regardless of the option chosen, that CPPs be the primary forum for guiding public health at a local level. Agreement to this would not exclude any model, as it is about partnership decision making, not where any function is governed from. Annex B offers additional background to Community Planning in Scotland, following its statutory basis in the Local Government in Scotland Act 2003.

44. We seek guidance on how a national body can best respond to strategic needs at the local level. This may involve strengthening CPP’s influence, the use of joint appointments and clarifying lines of accountability. This strengthening is considered to be necessary regardless of the option chosen. Annex B provides additional background information on ensuring accountability at a local level.

45. We need clarity on which way we wish to proceed, as staff and partners need to be involved in owning the vision for public health and working together to bring about their respective roles, responsibilities and accountabilities. Responding to your guidance, the Executive Delivery Group now need to give careful consideration to which parts of the workforce and which activity should be aggregated together under regional or national structure and which activity should remain part of the NHS; or Local Authorities in the case of Environmental Health.
Public Health Body

- The new body is being established to deliver recommendations from the Review of Public Health in Scotland, including ‘decluttering’ the national public health landscape.
- The new body will provide strong, visible public health leadership to support and deliver our agreed national priorities.
- For pragmatic reasons, the new body will be established as an NHS Special Health Board, but it will not be publicly branded as an ‘NHS’ body. Instead, the body will be publicly established as being focussed upstream and outside of the NHS (although for some specific activities there will continue to be important links to the NHS).
- The new body will provide critical mass to better deliver some ‘once for Scotland’ functions (such as health protection) but will primarily be focussed on supporting and challenging other parts of the public sector.
- The new body will deploy expertise and data to support local professionals (in local authorities, community planning partnerships, integration authorities and the NHS) around public health and inclusive growth – in areas such as service change, efficiencies and improved outcomes.
- The new body will work in ways that make it easier to develop a multi-agency approach to public health both nationally and locally.
- The organisational model for the new body will be co-designed by Scottish Government, Local Government and NHS – with an approach to governance that allows for rapid progress.
- We will seek to ensure that the delivery model for the new body includes meaningful accountability to Local Government.

Local / Regional Partnerships

- Our work will seek to build more effective / successful local public health partnerships between the different arms of the public sector in order to support delivery of public health priorities.
- Our approach will not be about creating additional or new structures on top of the existing complex landscape. In the short term, the primary focus of our work should not be about where staff are employed.
- Our work may require some regionalisation of activities – within existing public health resources and within Local Government public health functions.
- Our work will be informed by the agreed public health priorities (with form following function).
- We recognise that the successful establishment of a credible, effective new public health body is key to building momentum and support for stronger local / regional partnerships.
- We recognise that it may not be possible to define solutions immediately and that opportunities may arise naturally for us to try different models of strengthening local partnerships. We will seek to make effective use of such opportunities.
COMMUNITY PLANNING IN SCOTLAND

There are two main partnership infrastructures that are more or less based on the same ‘local’ geographies. There are 32 Community Planning Partnerships (CPPs) based on council geography and 31 Integration Authorities (IAs) based on the same council geography (with the exception of Clackmannanshire and Stirling which form one body). Below this, each partnership has a further iteration of smaller localities they plan for and serve. These sub-geographies are not always consistent between the CPP and the IA.

In setting out terms for the relationship between the new national body and regional and the local arrangements, we need to define what we mean by local. In other words, what local level would the new body be expected to serve and how meaningfully could that be resourced and managed in order to achieve the best possible outcomes for communities?

One view might be to simply accept that CPPs, as currently structured, are already public health organisations. This relates directly to the function of the CPP taking a whole community and whole service partnership approach. CPPs already undertake planning to make a difference across their whole community and when considering ‘public health’ and the social determinants of health, they take action across the entire National Performance Framework. Therefore, we propose that when considering the local dimension of the public health system, it is the 32 CPPs that we define as this local dimension.

CPPs are currently in consultation with communities to develop their Local Outcome Improvement Plan (LOIP) which cover the whole CPP area. Further to this, they identify smaller areas within the local authority area which experience the poorest outcomes and prepare and publish locality plans to improve outcomes on agreed priorities for these communities (the outcomes prioritised for improvement in a locality plan may differ from those in the LOIP).

Background to Community Planning

Community planning is about how public bodies work together and with local communities to design and deliver better services that make a real difference to local people’s lives. Community planning is a key driver of public service reform at local level. It provides a focus for partnership working driven by strong shared leadership, directed towards distinctive local circumstances. Partners work together to improve local services, ensuring that they meet the needs of local people, especially for those people who need those services most.

It was given a statutory basis in the Local Government in Scotland Act 2003. The Community Empowerment (Scotland) Act 2015 replaces the 2003 Act, and makes a number of significant changes to community planning legislation.
First of all, the 2015 Act gives community planning a statutory purpose for the first time. This focuses on improving outcomes and tackling inequalities of outcome, including in localities whose communities experience the poorest outcomes.

The 2015 Act requires CPPs to:

- prepare and publish a local outcomes improvement plan (LOIP) which sets out the local outcomes which the CPP will prioritise for improvement
- identify smaller areas within the local authority area which experience the poorest outcomes, and prepare and publish locality plans to improve outcomes on agreed priorities for these communities (the outcomes prioritised for improvement in a locality plan may differ from those in the LOIP)
- review and report publicly on progress towards their LOIP and locality plans, and keep the continued suitability of these plans under review.

The 2015 Act places specific duties on community planning partners, all linked to improving outcomes. These include:

- co-operating with other partners in carrying out community planning
- taking account of LOIPs in carrying out its functions;
- contributing such funds, staff and other resources as the CPP considers appropriate to improve local outcomes in the LOIP and secure participation of community bodies throughout community planning.

The 2015 Act expands the number of public sector bodies that are subject to statutory community planning duties. The 2003 Act had placed duties on local authorities, NHS boards, Police Scotland, Scottish Fire and Rescue Service, Scottish Enterprise, Highlands and Islands Enterprise, and regional transport partnerships. The expanded list of bodies in the 2015 Act includes, for example, health and social care partnership integration joint boards, regional colleges, Skills Development Scotland and Scottish Natural Heritage.

Under the 2015 Act, running the CPP and making sure it works effectively is a shared enterprise. It applies duties to support shared leadership and collective governance on specified community planning partners, i.e. the local authority, NHS, Police Scotland, Scottish Fire and Rescue Service and Scottish Enterprise or Highlands and Islands Enterprise. These duties include:

- facilitating community planning
- taking all reasonable steps to ensure the CPP conducts its functions effectively and efficiently.

The participation of and with communities lies at the heart of community planning, and apply in the development, design and delivery of plans as well as in the review, revision and reporting. The 2015 Act and this guidance make it clear that consultation is no longer enough and that CPPs and community planning partners must act to secure the participation of communities throughout.

So CPPs must take all reasonable steps to secure the involvement in community planning of any community body which it considers is likely to be able to contribute to
it, to the extent that the community body wishes. They must in particular have regard to community bodies which represent those communities experiencing socio-economic disadvantage. And statutory community planning partners must contribute such funds, staff and other resources as the CPP considers appropriate to secure participation of community bodies in community planning.

Whilst the provisions in the 2015 Act sets out statutory duties on CPPs and community planning partners, effective community planning requires more than simply complying with these duties. CPPs and community planning partners need to apply the principles of effective community planning summarised in this guidance, as without them then community planning is unlikely to make the difference to people and communities that it can and should.
ENSURING ACCOUNTABILITY AND ACTION AT A LOCAL LEVEL

The form of the local partnership is secondary to how it is governed and how it ensures impact at local level. We need to consider whether the existing CPP structure is adequate for achieving the goals of public health and if not, how it can be strengthened.

CPPs are not formal organisations, their performance and scrutiny has developed over many years and has had differing approaches. Prior to the LOIP, the Single Outcome Agreement (SOA) and the SOA annual report were scrutinised by the Scottish Government (SG). A component of this was a visit from a SG Director to each CPP area.

When LOIPs were first introduced, a change to this approach was made and a group of people visited for a conversation about strengths and areas for improvement, using a peer support and challenge approach. This group comprised representatives from SG, Improvement Service, CoSLA, national NHS representatives and a CPP Manager from another area. This approach is no longer in place.

A National Community Planning Group was formed in 2012 to play a pivotal role in implementing and communicating the overarching vision for community planning and identifying and addressing issues that have a national dimension and building skills and capacity of partnerships. This group no longer meets.

Audit Scotland have a scrutiny role for CPPs and have conducted numerous Community Planning audits over the years. This role is not envisaged to continue.

The 2014 Audit suggested that there was no coherent framework for assessing performance and pace of improvement within Community Planning. Coupled with this, there remains a challenge for Community Planning to work in an upstream preventive way and use budgets and resources to effect wider system outcomes that may not directly impact on the individual organisations - for example, asking LAs to spend on smoking prevention when the cost of smoking may be primarily borne by the NHS.

The Improvement Service has a key role in supporting CPPs. For example, one governance and scrutiny function that has remained in place and has developed its function over the years is the ‘Outcomes, Evidence and Performance Board’ within the Improvement Service. This group considers how data and evidence is being used to inform decision making. The Improvement Service offer support in other ways, including the Community Planning Outcomes Profile, CPP Checklists and the CPP portal.