

**Collaborative
Research Report**

March 2018

**Inquiring into Multi-layered,
Preventative Partnership Working**

Aberdeenshire Community Planning Partnership
and What Works Scotland



What Works Scotland (WWS) aims to improve the way local areas in Scotland use evidence to make decisions about public service development and reform.

We are working with Community Planning Partnerships involved in the design and delivery of public services (Aberdeenshire, Fife, Glasgow and West Dunbartonshire) to:

- learn what is and what isn't working in their local area
- encourage collaborative learning with a range of local authority, business, public sector and community partners
- better understand what effective policy interventions and effective services look like
- promote the use of evidence in planning and service delivery
- help organisations get the skills and knowledge they need to use and interpret evidence
- create case studies for wider sharing and sustainability

A further nine areas are working with us to enhance learning, comparison and sharing. We will also link with international partners to effectively compare how public services are delivered here in Scotland and elsewhere. During the programme, we will scale up and share more widely with all local authority areas across Scotland.

What Works Scotland brings together the universities of Glasgow and Edinburgh, other academics across Scotland, with partners from a range of local authorities and:

- Glasgow Centre for Population Health
- Improvement Service
- Inspiring Scotland
- IRISS (Institution for Research and Innovation in Social Services)
- NHS Education for Scotland
- NHS Health Scotland
- NHS Health Improvement for Scotland
- Scottish Community Development Centre
- SCVO (Scottish Council for Voluntary Organisations)

This is one of a series of papers published by What Works Scotland to share evidence, learning and ideas about public service reform. This paper relates to the What Works Scotland **Collaborative Action Research** workstream.

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Acknowledgements

Acknowledgements are extensive, as is to be expected with co-produced work. Please see the names and roles of the contributors on page 34.

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Overview

An Executive Summary of this report is available on the What Works Scotland website. Here an overview is offered to help readers understand the report's trajectory.

The report offers no simple formula for the challenges of how community planning partnerships (CPPs) can undertake multi-layered, preventative partnership working; nor for exactly 'what works' in seeking to prevent inequalities and shift to preventative spend and therefore make an impact (in real terms) on social, economic and health inequalities. Rather it provides descriptions and discussions of areas of emerging 'policy and practice' in Aberdeenshire as the CPP seeks to 'put Christie into action' and meet the challenges of the Community Empowerment (Scotland) Act 2015. So, it reflects an ongoing wrestling with the social problems ('wicked issues') that block (prevent) a fairer, healthier society.

Section 1 introduces the report as a bringing together of a range of inter-relating collaborative inquiry work undertaken by Aberdeenshire CPP and What Works Scotland in 2015 and 2016 and suggests its potential to support multi-layered partnership-working.

Section 2 sets the broader context to support understanding of the developing focus on 'preventative approaches' across this CPP, in particular the broad rationale set out by the Christie Commission 2011 of partnership and participation aimed at improving performance and creating a more equitable society by preventing inequalities, so reducing public service demand. Early thinking at both strategic and operational levels across Aberdeenshire CPP (autumn 2015) in relation to prevention and the Christie agenda is likewise established.

Section 3 highlights key learning points from a Collaborative Learning Day on preventative spend – the shift from spending on services concerned with meeting demand to those 'preventing' it. Evidence and experience from NHS Health Scotland, What Works Scotland and local policymakers and practitioners supported dialogue across the CPP, generating three areas of further inquiry: supporting collaborative partnership working; evidence-informed dialogue on preventative spend; and seeking creative, committed approaches to prevention.

Sections 4 and 5 explore two case studies from the CPP – generating concrete examples of 'putting Christie into action' – as they seek to develop preventative approaches:

- *Case study 1:* scoping discussions of a Local Outcomes Improvement Plan (LOIP) Priority on reducing alcohol-related harm led by Aberdeenshire Alcohol and Drug Partnership.
- *Case study 2:* ongoing inquiry led by Aberdeenshire Health and Social Care Partnership with its CPP partners on developing a shared strategic approach to community capacity-building for health and wellbeing.

Section 6 concludes by bringing together the range of policy and practice issues that are emerging from the CPPs' actual practices and reviewing the potential to develop relevant preventative practice through collaborative learning, engagement with evidence, and exploration of creative approaches to prevention. It illustrates the challenging policy context of public spending constraint, stubborn inequality, demographic change and high expectations on CPPs to make a difference.

1. Introduction: inquiring into ‘prevention’

1.1 Setting the scene to our inquiry activities

This co-produced report and case studies seek to support developing understanding of how multi-layered, preventative partnership working within public service provision can be pursued – as broadly understood through the 2011 Christie Commission report and now informed by the Community Empowerment (Scotland) Act 2015. It has been produced via various inquiring activities facilitated by What Works Scotland and involving diverse partners from across Aberdeenshire Community Planning Partnership (CPP); including Aberdeenshire Health and Social Care Partnership (HSCP) and Aberdeenshire Alcohol and Drug Partnership (ADP) – see the full Acknowledgements at the end of the report.

The report explores the potential for developing preventative approaches:

- Section 2: Outlines the starting context for such inquiring work drawing from the Christie Commission and existing learning from the CPP and What Works Scotland.
- Section 3: Outlines early, deepening investigations into preventing inequality and preventative spend undertaken at a Collaborative Learning Day held in May 2016.
- Section 4: Provides summaries of two accompanying case studies produced alongside this report:
 - *Case Study 1: A Changing Relationship with Alcohol* Illustrates the early work CPPs Alcohol LOIP Priority Scoping Group, led by the ADP, and its focus on developing a preventative, upstream approach.
 - *Case Study 2: Community Capacity-Building for Health and Wellbeing* Illustrates the ongoing work on a strategic approach to community capacity-building led by the HSCP as it pursues a preventative agenda.
- Section 5: Provides concluding commentary and reflections from What Works Scotland, NHS Health Scotland and others.

The learning presented in the report and the case studies veers towards evolving and, at times, subtle discussions of developing policy and practice. As in ‘this is complex and still forming set of approaches, so let’s try them and see what happens next’ rather than providing precise, definitive solutions to preventative partnership working.

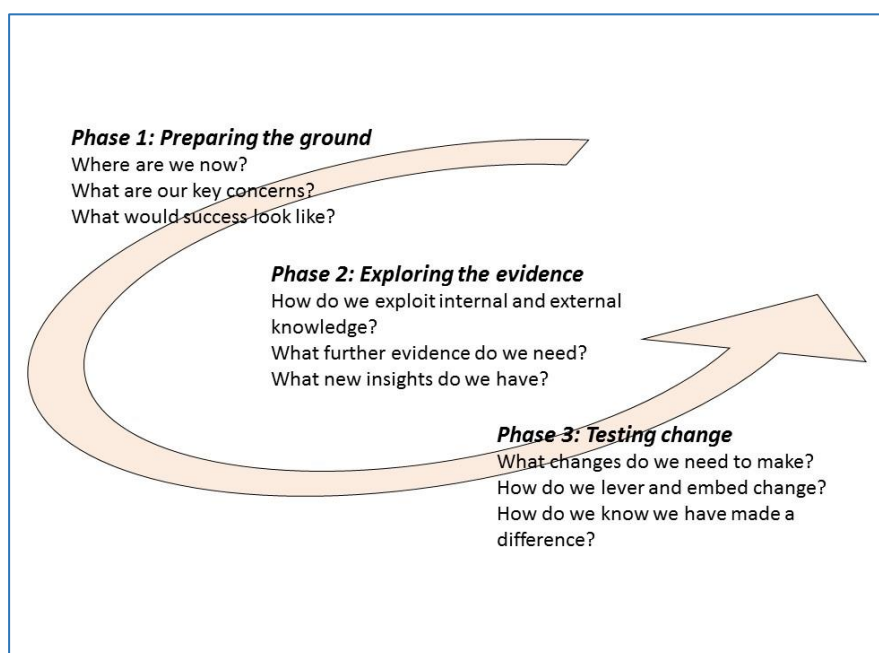
The report does not seek to evaluate Aberdeenshire CPP’s policy and practice. Instead, it works to help readers understand more about ‘what is happening and why’ (theory, policy and practice). It explores developing ‘policy and practice’ as a dynamic process in the face of complex public service challenges and aspirations to tackle actual social problems – as ‘wicked issues’. In the process, it aims to share learning and extend dialogue within this CPP and across CPPs in Scotland.

1.2 Exploring the potential of collaborative learning and action

The underlying approach or methodology being used by What Works Scotland is ‘collaborative learning and action’, in particular as collaborative action inquiry. This can be understood as part of a broad family of action research methods that are participatory, consider evidence and seek to develop practice and explore alternatives. In Aberdeenshire, we adopted a three phase, cyclical model for collaborative action inquiry – see diagram below – of: scoping, exploring the evidence, and testing change (action)¹.

This model can be used in a variety of circumstances from one meeting’s worth of work through to a year-long inquiry. It has been used flexibly in What Works Scotland’s work with Aberdeenshire CPP and has included: a full Inquiry (see Case Study 2, section 2); developing inquiring work (see Case Study 2, Sections 1, 3 and 4); Collaborative Learning Days (see 2.4; 3); Development Days with the CPP Board and Executive; and participatory workshops (see Case Study 1, section 3, and Case Study 2, section 1). Other examples of approaches to inquiry within Aberdeenshire CPP that are distinct from work with What Works Scotland are also identified e.g. Case Study 1, section 4; Case Study 2, section 3; and Appendix 2.

There is, however, no overall formal inquiry within the report about the development of preventative approaches. Instead, this is a series of inter-relating inquiry-based activities suggestive of the potential for a wider ‘culture of inquiring’. It is described as ‘co-produced’ given the extent of inquiring work and participatory discussion that inform it. Although mostly written by the What Works Scotland researchers, the report and individual sections have been consulted on widely and illustrate developing thinking within the CPP. It also illustrates the potential for deepening inquiry work within all CPPs with researchers and across multi-layered partnership-working.



¹ See Chapman & Hadfield (2015): <http://whatworksscotland.ac.uk/publications/how-to-design-collaborative-action-research/>

2 Working within current policy and practice

This section, firstly, sets out the policy and practice theme identified by the Christie Commission 2011, and developed through the Community Empowerment (Scotland) Act 2015, of preventative partnership-working (2.2).

Secondly, it establishes some of the initial understandings of partnership, participation and prevention that were active within Aberdeenshire CPP in autumn 2015 at both strategic and operational levels – and from which the report’s inter-relating inquiries build.

And thirdly, a What Works Scotland commentary, that points to the broader context of a ‘Scottish Approach’ that seeks a fairer, more equitable society and recognises that this cannot then be solely the work of CPPs but the state, economy and society more generally.

2.1 Christie Commission: prevention and empowerment

The Christie Commission (2011) puts great emphasis on reducing the growing demand for public services by tackling social problems and reducing inequalities:

In all aspects of our system of public services, therefore, from setting national policy to reforming the governance and organisation of public services, through the design and delivery of integrated services, all parties must prioritise and build action which has the effect of reducing demand for services in the longer run.” (p.56)

The Commission recognises: “significant spatial dimension to inequalities ... (and) the generational and geographical experience of poor outcomes”. It concludes that “tackling these multiple problems in isolation addresses neither the experience of negative outcomes through people’s lives, nor root causes” (p.56). An integrated approach to changing service provision, preventing inequalities and reducing public spending is advocated, including:

1. **Preventative approaches** that include: pooling budgets and extending a local partnership approach; empowering frontline staff, people and communities to design and provide services; helping communities to achieve their own ambitions
2. **Employability:** employability – and its devolution from Westminster² – and related training to improve life chances for individuals and their families.
3. **Regeneration or place-based approaches:** local partnership-working delivery and focus on community assets.
4. **Promoting equality:** recognising that among those that experience negative outcomes in Scotland, a disproportionate number of people are vulnerable to discrimination. The focus is on working with the Equality Act 2010; the SNP Government is legislating for a socio-economic duty for public sector bodies.³

² Employment services devolved (Scotland Act 2016): <http://www.gov.scot/Topics/Education/Employability>

³ Consultation document (July 2017): <http://www.gov.scot/Publications/2017/07/8131/downloads#res522478>

The Christie report gives recommendations as to the direction of public service reform and on working towards preventative goals but doesn't offer a roadmap on implementation, rather calling for *"a statutory framework ... to introduce common powers and duties"* (p.57).

The resulting Community Empowerment (Scotland) Act 2015 focuses on:

- CPPs as a statutory partnership with statutory duties for key and wider partners.
- Local Outcome Improvement Plans (LOIPs) focused on specific outcomes and action.
- Local Partnerships and Locality Plans for areas of socio-economic disadvantage.
- The roles of 'community bodies': across CPP activity and local leadership activity.⁴
- Preventing inequalities: reducing inequalities of outcome a sustained theme.

2.2 Developing thinking within Aberdeenshire CPP on prevention

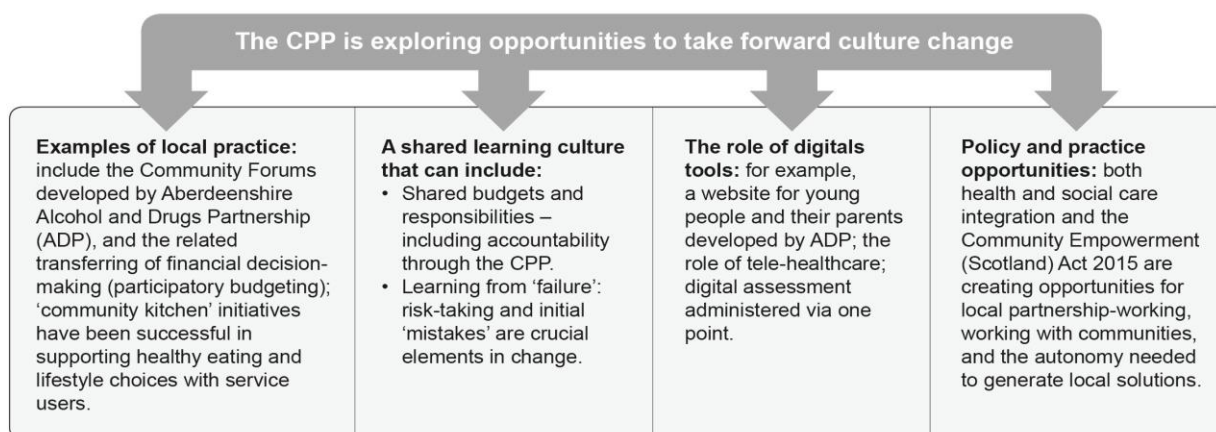
Thinking on the Christie Commission agenda and early preparations for the Community Empowerment (Scotland) Act 2015 were already under way within the CPP at both strategic and operational levels.

Strategically: the CPP made a [submission](#) to the Scottish Parliament Finance Committee's Prevention Consultation (Oct 2015)⁵ which pointed to the range of issues and opportunities.

See the graphic below for initial thinking from Aberdeenshire CPP on preventative approaches:

⁴ Other key areas in relation to communities and community sector include: provision of allotments, use of Common Good funds, and Community/public involvement in Forestry and Football Clubs.

⁵ View at: <http://www.parliament.scot/parliamentarybusiness/CurrentCommittees/91915.aspx>



Strategically and operationally: Collaborative Learning Day 1: partnership and participation

Aberdeenshire CPP and What Works Scotland organised this Collaborative Learning Day to explore further the Christie themes of partnership working and participation. This considered many of the issues in 2.3 more widely across the different layers of the CPP and its partners – central, local area and local community; likewise, across various strategic, operational and community-facing roles. Approximately 40 staff took part including those across the layers and roles described above and those working in and across the CPP, HSCP and third/community sector including Aberdeenshire Voluntary Action and the Aberdeenshire Rural Partnerships. Presentations on What Works Scotland [Partnership Evidence Review](http://whatworksscotland.ac.uk/publications/creating-effective-partnerships-to-deliver-public-services/)⁶, the work of the Mearns and Coastal Healthy Living Network and the [community anchor model](http://www.scottishcommunityalliance.org.uk/anchor-orgs/)⁷ provided fuel to deepen discussions.

Rich discussion of developing local policy and practice in relation to Christie considered:

- **Working with communities:** empowering and sharing power and building capacity and reducing barriers to supporting community solutions.
- **Improving partnership working:** culture change within/between organisations to support: cooperation, (not competition), collaboration, learning communication.
- **Redesigning services:** moving away from silos and duplication; thinking about ‘whole systems’ and working with all partners including service-users.

Some examples from the four key discussions at the Day are given in the graphic below.

⁶ <http://whatworksscotland.ac.uk/publications/creating-effective-partnerships-to-deliver-public-services/>

⁷ <http://www.scottishcommunityalliance.org.uk/anchor-orgs/>

What does putting Christie into action mean to you?

- Fairer communities
- Get more community ownership
- Have to give up some of our control
- Making the shift to prevention from reactive/acute
- Changing mind set around personal responsibility
- Rural area developments
- Real sharing of budgets - Participatory budgeting
- Culture change - all staff working with same understanding
- Redesigning how services are delivered to 'Mrs Smith'
- Working together - blurring the boundaries - trust

Effective partnership working

- IT systems that 'talk to each other'
- Need local budget
- No-one just in one partnership - multiple perhaps - so stretchy
- Finding common focus - LOIP
- Shadowing / learning not assuming
- What is 'evidence'? How accurate is the data?
- Need to collect more effective evidence
- Co-location - effective if done properly
- Some partnerships driven by one partner
- Some partnerships are enforced from above - is this ok - sometimes?
- Public Sector internal silos and inconsistency across Shire
- Priority session to align and share vision with all stakeholders

Community-led approaches

- Distinction between co-production and community-led?
- Healthy living network
- Still can be just tick-box exercise
- 'Planning for real'
- Understand choices (Participatory budgeting)
- Should be a good example of community empowerment
- Good partnership - service - user
- The 'working poor' are too busy working
- Let communities try things with support - if things fail, learn from them and move on together
- But can it counter global economic power, corporate multinational interests?

What are we learning about putting Christie into action?

- Close gap not widen it! BUT participation won't feed the bairns!
- Start small - this cultural change won't happen overnight
- Recognise the good partnership working with communities that we already have
- We need to stop using jargon - common language - simple!
- A lot of views/ideas. How do these fit with practical service redesign?
- Need to engage those people within partner organisations who are not already engaging - people here already 'get it'.
- Sometimes you need to take a 'leap of faith'!
- Be aware that this is a huge cultural change for all involved and will be a lengthy project 'Slowly, slowly, catchy monkey'
- Asking the difficult questions
- Get the LOIP right

Discussion also increasingly focused on the ‘how’ of such partnership and participation:

- Working out how to do ‘prevention’ and balancing this with needs for acute services.
- Tackling inequalities: so, that it’s fairer for all and working for the common good.
- Working out what ‘local’ means: relationship between top-down and bottom-up.
- The ‘how’ of change management and redesigning services.
- Frustrations at the slow speed of change, lack of risk-taking and difficulties communicating with partners and communities.
- The risk of making inequalities worse: might emphasis on communities and local partnership benefit some communities better able to access resources than others?⁸

This scoping work generated further understanding of the challenges the CPP faced in ‘putting Christie into action’ and suggested the need to further focus on preventing inequalities and the process of managing change as next crucial steps. A summary scoping report on Collaborative Learning Day 1 is available [on the What Works Scotland website](#).⁹

2.3 WWS commentary: prevention and the wider policy picture

“So, the Commission does not regard public services as a drag on economic progress. It takes a positive view of public services and stresses the importance of a virtuous cycle between improving the delivery and effectiveness of public services and fostering stronger and more balanced economic development. And it strongly believes in the importance of developing a fairer society in pursuit of that goal.”

Christie Commission, 2011 (p 9)

The previous sections illustrate the challenges for CPPs: the Christie Commission’s call for preventative partnerships to reduce inequalities as per the Community Empowerment Act; yet, how to develop practical, evidence-informed preventative partnership working?

The scale of aspiration and challenge outlined by the Commission is considerable. On one hand, identifying the increasing demands on services through stubborn inequalities and an ageing population, and a public spending crisis (‘austerity’). On the other, arguing for a worldview of empowerment and local democracy, and a public service ethos concerned for inequality and future generations. It shares aspirations with the [Marmot Review](#) (2010) that evidences the value to all of a fairer society: to be achieved through universalist (whole population) approaches, but proportionate to those facing the greatest health inequalities; see too Wilkinson & Pickett (2009) on the social benefits of equality.¹⁰

⁸ Note: one discussion raised the theme of the role of ‘neo-liberal economics’ – often understood as continuing to widen the role of ‘the market’ and private sector across society, save where ‘the market fails’ and state and ‘community’ must fill this gap – in generating economic, social and health inequalities. As highlighted, too in Case study 1: section 4, the ‘harm paradox’ in relation to alcohol-use points to lower uses of alcohol in deprived communities compared to more affluent communities but higher levels of harm; those in affluent communities seem more adept at accessing resources, e.g. services, lifestyles factors, to mitigate higher usage.

⁹ Collaborative Learning Day 1 report: whatworksscotland.ac.uk/publications/scoping-report-from-the-aberdeenshire-cpp-and-what-works-scotlands-collaborative-learning-day-8-december-2015/

¹⁰ The Marmot Review (2010) (in England) pointed to a range of strategies: early years interventions; prevention of ill-health; ‘good work’ for all; healthy communities; and healthy living standards for all – see Appendix 1. Wilkinson and

The tension in Christie between concerns to reduce public service demand and spending growth *and* yet to create a fairer, healthier society is then passed to CPPs to work with through preventative partnership working. Yet, this type of complex working on such wicked issues is deeply demanding. Tim Curtis (2010: 90)¹¹ articulates the challenge:

“Social issues and problems are intrinsically wicked or messy, it is very dangerous for them to be treated as if they were 'tame' and 'benign'. Real world problems have no definitive formulation; no point at which it is definitely-solved; solutions are not true or false; there is no test for a solution; every solution contributes to a further social problem; there are no well-defined set of solutions; wicked problems are unique; they are symptomatic of other problems; they do not have simple causes; and have numerous possible explanations which in turn frame different policy responses...”

Such ‘messiness’ is likely increasingly familiar to CPPs, many of these inter-relating problems are likely beyond the ability of CPPs *alone* to impact as ‘we’ seek a fairer society. Christie sees such wider complexity and seeks a virtuous cycle between state activity and economic development. For CPPs, then, a considered, patient realism seems necessary, alongside an outward-facing perspective that looks to the wider context and learning from ‘failure’.

Pickett (2009) evidence more equal (income-wise) developed societies as likewise having social benefits for all e.g. re. health inequalities, levels of crime and so on in their book ‘the Spirit Level’.

¹¹ Curtis writes in Gunn & Durkin’s book *Social entrepreneurship: a skills approach*.

3. Scoping the challenges for preventative approaches

3.1 Introduction: Collaborative Learning Day 2

Collaborative Learning Day Two (May 2016) was organised by Aberdeenshire CPP, NHS Scotland and What Works Scotland with the aim of building from the first Learning Day (2.4) to explore multi-layered preventative partnership working. It aimed to support consideration of the 'economics of prevention' and a shift to 'preventative spend' and, also, to sustain questions about the potential of preventative approaches to reduce inequalities.

Approximately 50 participants¹² from Aberdeenshire, North East Scotland and further afield joined the morning session that aimed to deepen understanding of the evidence-base for prevention and potential opportunities to develop preventative spend. Approximately 35 of these from across Aberdeenshire CPP joined an afternoon session to focus on local preventative work.

Sections 3.2, 3.3 and 3.4 outline some of the evidence and information, while 3.5 presented the range of responses generated through discussions across the Day. Section 3.6 draws from across this learning to establish three key themes (What Works Scotland commentary).

Presentations and contributors at the Collaborative Learning Day

Key presentations worked to build understanding of the evidence and policy context:

- Neil Craig, NHS Health Scotland – evidence re. preventing inequalities (3.2)
- Ken Gibb, What Works Scotland – developments in preventative spend (3.3)
- Kim Penman, Aberdeenshire HSCP – HSCP/ CPP preventative approaches (3.4)

Keynote listeners responded to the presentations:

- Chris Littlejohn, Consultant in Public Health, NHS Grampian
- Cheryl Smith, Team Manager, Community Safety, Aberdeenshire CPP
- Alison Grant, Community Health in Practice, Aberdeenshire Voluntary Action

Practitioner presentations outlined some of the developing practices in Aberdeenshire:

- Dawn Brown, Garioch Rural Partnership
- Ally Birkett, Scottish Fire & Rescue Service
- Susan Donald, Service Manager (Support & Advice), Aberdeenshire Council
- Alison Grant and Keith Anderson, Aberdeenshire Voluntary Action
- Sophie Humphries, Aberdeenshire CPP Strategic Development Team

There were also wide-ranging table and plenary discussions from which a range of emerging themes were generated (see 3.5)

¹² Including Aberdeenshire Community Safety, Aberdeenshire ADP, Aberdeenshire Council, Aberdeenshire HSCP, Aberdeenshire Rural Partnerships, Aberdeenshire Voluntary Action, NHS Grampian, Scottish Fire and Rescue Service, Scottish Police Service – and others from North East Scotland and beyond.

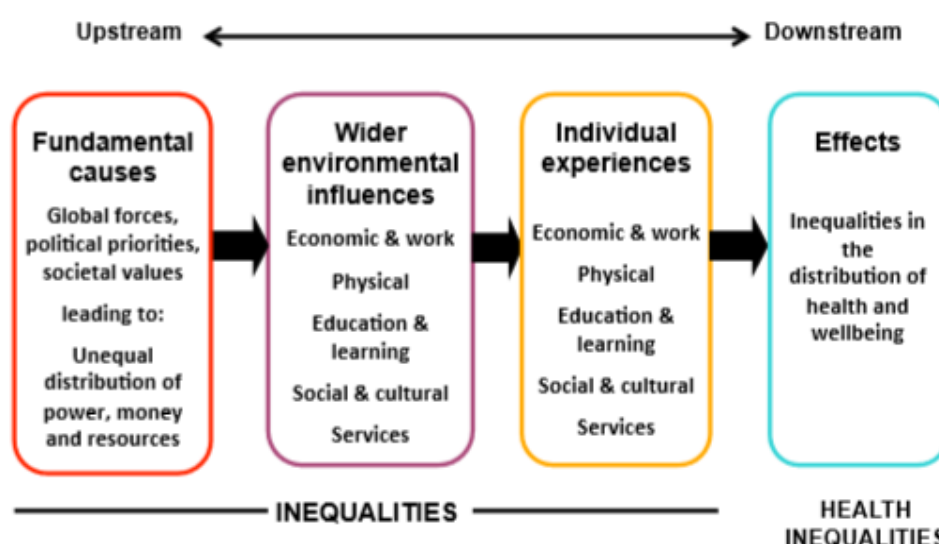
3.2 Evidence for preventing inequalities and preventative spend

Neil Craig, Principal Public Health Advisor with NHS Health Scotland, presented on the evidence base for preventing health inequalities, improving health and the economics of prevention in the context of the 'Christie agenda' and current financial pressures.

What is prevention? Any services or policy interventions – within healthcare and beyond – that prevent the onset or development of health and social problems¹³. Many preventative services have the potential to improve population health; some have the potential to reduce the use of health and public services, and related costs, *but* we're also seeking to prevent health inequalities. The ideal is to identify services that achieve all three outcomes.

Understanding health inequalities: these are linked to much wider social and political forces which affect how people experience work, education and learning, services, etc. and the distribution of health and wellbeing (see figure below). To be effective in reducing health inequalities, prevention needs to address these fundamental causes and wider environmental influences on people's health.

Figure 1: Health inequalities: theory of causation (summary version)



Source: Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities; included courtesy of NHS Health Scotland

Evidence available: He discussed the broad range of evidence available on prevention and early intervention – see evidence sources listed in Appendix 1 – recognising that there are gaps and variable quality. Less evidence is available on reducing health inequalities and on changing structures rather than behaviours. There is also a need to better understand how evidence can be used to make a difference within public service partnerships.

¹³ Prevention is often discussed as three forms: 'primary' – reducing the incidence of health problems; secondary – reducing the progress of health problems; tertiary – reducing the impacts of disease. View, Craig (2014):

<http://www.healthscotland.com/documents/24575.aspx>

Broadly, the evidence on ‘prevention’ says on effectiveness and cost-effectiveness ...

- approaches most likely to be *both* cost-effective and effective in reducing health inequalities use fiscal, regulatory and/or legislative measures; many of these are *potentially* cost-saving
- individual- and behaviour-based prevention is *often* cost-effective, but the evidence is more mixed... and it is less likely to reduce health inequalities.

He highlighted evidence suggesting a strong economic rationale for interventions in policy settings where health improvement and health inequalities have not been understood as a priority: for instance, reducing barriers to using leisure facilities to promote physical activity; transport policies supporting active travel; housing improvements; and support for those who are unemployed or on low incomes. He also highlighted some of the challenges in realizing potential savings from prevention (see below).

The challenge of ‘cashable’ savings: realising actual cashable savings through prevention in the short, medium and longer terms is difficult. Good evidence of where this has been achieved is scarce. Actual savings from prevention will depend on:

- the management and actual uses of resources released by successful prevention
- what counts as ‘savings’ from prevention e.g. many studies include the economic benefits of increased productivity where effective prevention reduces absenteeism from work, but these do not translate directly into financial or resource savings that health or other public services can put to alternative uses.
- how demand and supply for existing services changes in the future e.g. through a growing and/or an increasingly ageing population. The implications of an ageing population will depend on how healthily we age, which in turn will depend in part on how successful we are in achieving a shift to prevention.

What we can say:

- A lot of prevention is cost-effective
- A lot of prevention ‘upstream’ – tackling the ‘fundamental causes’ of health inequalities before problems arise – is cost-effective *and* likely to reduce health inequalities

What we can’t say:

- Prevention *necessarily* leads to savings
- Precisely what are the ‘best buys’, but we do have enough evidence to support a shift to prevention

Note: NHS Health Scotland’s submission to the Scottish Parliament’s Health and Sport Committee Inquiry into the Preventative Agenda (2017) is available on the Scottish Parliament website¹⁴.

¹⁴ [http://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/PA005_NHS_Scotland\(1\).pdf](http://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/PA005_NHS_Scotland(1).pdf)

3.3 Opportunities and barriers to pursuing preventative spend

Ken Gibb, Director, What Works Scotland and Policy Scotland, began by outlining key definitions of ‘prevention’ and related strategies in his presentation:

A prevention strategy is one: “which disrupts, mitigates or eliminates causes of harm through the identification, implementation and diffusion of effective interventions” ... and aims to build ... ‘a society that prevents problems from occurring rather than one that copes with the consequences.” (NESTA, 2011)¹⁵

Early intervention is about: “intervening before damage takes place in a way that avoids later costs in both human and financial terms of ... the consequences of the symptoms of that damage” (Graham Allen, MP, 2011)¹⁶

He outlined the likely characteristics of preventative spending in practice as looking to spend now to save later – or save elsewhere – and reduce longer-term demand. Whilst at the same time seeking ‘cashable’ savings so that reductions in spending can *actually* be transferred to budget lines for other services and activities to support further prevention work. In some circumstances, reducing the scope of a service might *not* generate spending reductions that can be transferred or savings might *not* be used for preventative activity.

This ‘disinvestment’ in one area is one way of establishing further investment in prevention, but there is also the potential to leverage in new external resources – see below.

Barriers to and complexities of pursuing preventative spend¹⁷

- Misaligned incentives for individuals/organisations, e.g. financial and other benefits accrue in other parts of the ‘system’ (partnership) to that investing in prevention.
- ‘Present bias’ and human tendency to prefer immediate benefits; so ‘discounting’ future financial benefits and assuming they carry less weight; leads to short-termism.
- Silos, conflicting timescales, public sector accounting rules – these make pooling budgets complex undertakings.
- Acute, symptomatic or reactive services nonetheless have crucial roles to play currently – until preventative approaches start to reduce demand.
- Partnership working and seeking integration over competition can be challenging.
- Whilst there is broad evidence for prevention, there can be a lack of compelling evidence as to ‘how to prevent’ in many particular cases.
- There is a need to develop ‘systems’ for supporting preventative strategies – e.g. commissioning prevention; appropriate funding; and the management of risk.
- Financing prevention in the short run can be problematic as savings may not be realisable until the longer-term.

¹⁵ NESTA Report (Puttick, 2011): http://www.nesta.org.uk/sites/default/files/innovations_in_prevention.pdf

¹⁶ View: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284086/early-intervention-next-steps2.pdf

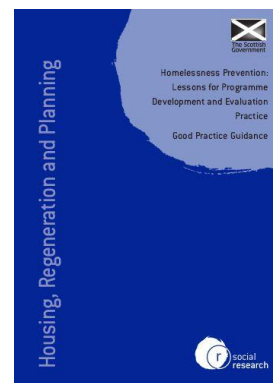
¹⁷ This overview of barriers to preventative spend draws from the NESTA Report (Puttick, 2011) – see above.

- Strategic and policy (local and national) level questions may need to be resolved first – before progress in service development and management can be achieved.
- ‘Disinvestment’ in services requires partnership-wide changes: political pressures may inhibit change, with little reward for individuals or organisations who seek it.

An example: Homelessness¹⁸

Reflecting on the complex, multi-dimensional nature of social challenges, typical of public policy areas, challenges for preventing homelessness include:

- Scottish legislation acclaimed but is reactive rather than preventative.
- Homelessness applications falling but in urban Scotland street homelessness and repeat presentations rising.
- Difficult to integrate e.g. critical partners may operate in a competitive funding environment inhibiting innovation.
- Requires integration between housing, NHS, community justice, health and social care, social security, and often service providers in the 3rd sector.



Ways forward – supporting disinvestment and external investment

- Multi-period, comprehensive, evidence-based accounting of costs and benefits of public sector funded project development to support preventative spend.¹⁹
- Rewarding prevention successes, especially where they are not immediately ‘cashable’ but are shown to be effective in preventing inequalities, through use of credits or other similar incentives to motivate public services.
- Encouraging traditional public sector borrowing by local authorities to invest in longer-term preventative approaches.
- Piloting innovations of special purpose vehicles e.g. Local Integrated Service Trusts to recycle surplus/profits; Social Impact Bonds (SIBs) and ‘Payment-by-results’ etc.²⁰
- Promoting a culture of ‘prevention’ within organisations and partnerships that support teams and staff in exploring options e.g. through human resources (HR), leadership roles, empowering frontline staff, and so on.
- Exploring the range of potential financing initiatives and governance models, and the full use of existing powers and flexibility; e.g. the opportunities through City Region Deals to develop longer-term strategic approaches to regional economic development that involve Scottish, UK and local government.²¹

¹⁸ Ken Gibb is now Director of the ESRC UK Collaborative Centre for Housing Evidence.

<https://blog.esrc.ac.uk/2017/10/25/work-begins-at-the-new-collaborative-centre-for-housing-evidence-project/>.

¹⁹ For instance, the development of a new ‘the Green Book’ to inform state accounting procedures:

<https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-government>.

²⁰ For instance, see Ian Marr at WWS event: <http://whatworksscotland.ac.uk/events/prevention-and-prediction-can-we-predict-the-impacts-of-prevention-to-inform-policy-and-practice/>. SIBs, however, present challenges:

<https://www.scrt.scot/wp-content/uploads/2017/10/SIBs-LOUD-report-Oct17.pdf>.

²¹ For more on City Region Deals, view: <https://beta.gov.scot/policies/cities-regions/city-region-deals/>.

Note: for further thinking on prevention from Ken Gibb see his submission with James Mitchell to the Scottish Parliament's Finance Committee for What Works Scotland (2015) on the What Works Scotland website.²²

3.4 Prevention, public health and community planning

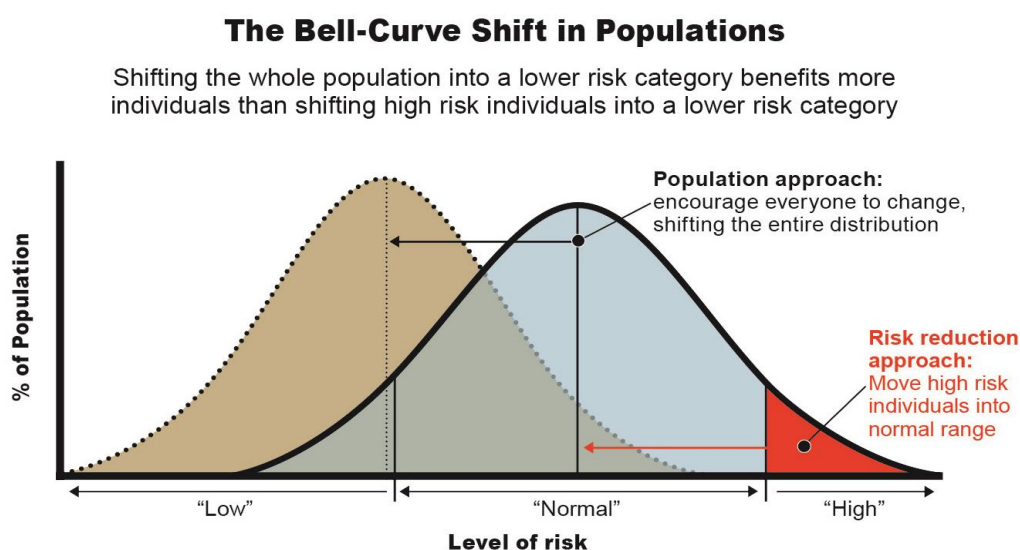
Kim Penman, Health and Wellbeing Lead for Aberdeenshire Health and Social Care Partnership (HSCP), presented on the HSCP's developing understanding of whole population (public health) approaches, how the HSCP seeks to focus on preventing health inequalities, and its links to the CPP's plans to develop preventative partnership working through its Local Outcomes Improvement Plan.

(1) Health inequalities – high risk lifestyle behaviours and social disadvantage

The four 'high risk' lifestyle behaviours of smoking, diet, alcohol and inactivity lead to many chronic diseases – respiratory disease, heart disease, cancer and strokes. They cause 50% of the 'burden of disease' (on services) – 'years lived with disability/illness' + 'years of life lost'.

Because of social, economic and environmental factors, a higher ratio of people from lower socio-economic groups adopt such high risk lifestyle behaviours. This then results in health inequalities between these socio-economic groups.

(2) Whole population health approaches seek to impact not only on 'high risk' groups but, by working across the whole population are understood to be more likely to make significant changes given they involve a much larger number of people in change – as per the chart below.²³ Looking across the whole population rather than solely at particular groups can then provide a more effective approach to preventing inequalities, improving health and well-being for all and in the process reducing the pressure on public services.



²² View at: <http://whatworksscotland.ac.uk/wp-content/uploads/2015/04/Note-for-Prevention-Evidence.pdf>.

²³ Source: Rose, G. Sick individuals and sick populations. Int. J. Epidemiol 1986 12. 32-38

(3) Aberdeenshire's emerging Local Outcomes Improvement Plan

The Community Empowerment (Scotland) Act 2015 requires CPPs to produce Local Outcomes Improvement Plans (LOIPs) that concentrate partnership working on particular goals or priorities. Aberdeenshire CPP's developing priorities for their LOIP are:

- Reducing Child Poverty in Aberdeenshire
- Changing Aberdeenshire's relationship with alcohol
- Connected and Cohesive Communities

These priorities then could provide opportunities for partnership working across the CPP that seeks to shift to whole population approaches that (for instance) reduce levels of these illness (prevention) – or other targets for whole population approaches (see 3.6). This shift in the focus of service provision or role would then be towards preventative spend and away from existing services responding to existing demands.

Note: Case Study 1 (section 4) focuses on the early development of Aberdeenshire CPP's LOIP priority on 'Changing Aberdeenshire's relationship with alcohol' and aspirations to pursue such whole population approaches.

3.5 Engaging with evidence: emerging discussions across the CPP

Following the key presentations, keynote listener feedback and practitioner presentations, small group discussions (table talk) and a wider plenary discussion were recorded. A wide range of issues, concerns and ideas were generated for supporting the development of multi-layered, preventative partnership working. The What Works Scotland researchers summarised these as ten broad, inter-relating policy and practice themes understood within the CPP as relevant to such emerging partnership-working. These are highlighted below under *three emerging areas of challenge*.

These three areas of challenge for preventative partnership work – see the three related questions in 3.6 – are then used to support discussion of developing policy and practice in the two case studies (sections 4 and 5) and the final concluding section (6).

Graphic showing three emerging areas of challenge:

Developing effective multi-layered partnership-working focused on prevention



- **Finding ways to improve collaboration and communication across complex partnerships:** investing in longer-term discussions so that organisations, services and communities can understand and monitor progress; and spot new opportunities, synergies and 'co-incidental' outcomes.
- **Culture change across partnerships needed to implement prevention:** unpacking what prevention means in detail across a partnership to develop shared outcomes and monitoring; learning with and from communities and the third /community sectors; and recognising the role of Human Resources.
- **Building a learning approach:** related to changing culture and learning from the evidence; allowing space for learning; recognising that in seeking new approaches some will 'fail' – at least initially – but will support development of preventative approaches.

Deepening shared understandings of 'prevention' and preventing inequalities



- **Recognising evidence has a crucial role to play:** the prevention evidence-base can help with crucial decisions about where to invest and disinvest, but that this is a challenging area without easy answers; recognising too that community intelligence is invaluable re. priorities and monitoring.
- **The challenge of getting preventative spend to 'work':** recognising the range of tensions faced here: overcoming budget silos and the lack of pooling of resources; shifting away from unhelpful competition for resources; recognising that savings may not be in the short-term.
- **Being realistic about the constraints and speed of change:** preventing inequalities suggests a longer-term, complex process of change – with potential for some shorter-term gains; realism is required and there are constraints on what local actions can achieve given wider policy and economic contexts.
- **Common understanding of and commitment to 'prevention' across all partners:** working together toward strategies that provide shared understandings: what are the priorities; who does what and is responsible for 'taking it forward'; how to unlock the necessary resources; and how can Local Outcomes Improvement Plans (LOIP) help?

Seeking committed and creative approaches to preventing inequalities



- **The politics of sustaining a focus on preventing inequalities:** alongside national policy and politics, there's the politics of organisations and partnerships; elected members, their local accountability and political party commitments; and communities and their networks – political bravery and political capital is required.
- **Community capacity building and community sector development:** developing local community assets and drawing on community intelligence; supporting the development of local community organisations and groups; participatory budgeting can help, and the Rural Partnerships and Aberdeenshire Voluntary Action.
- **The need for flexibility, imagination and 'entrepreneurial' approaches:** related to learning, but emphasising the need to support more flexible, risk-taking organisations – particularly those from the third and community sectors including social enterprise.

3.6 WWS commentary: deepening preventative policy and practice

The three presenters generated challenges for the growing focus of (some) of the work between Aberdeenshire CPP and What Works Scotland on multi-layered preventative partnership working:

Neil Craig emphasised prevention as needing to bring together: preventing health inequalities; improving population health; and shifting to preventative spend that reduces costs/creates savings. He argued that the evidence broadly points to system-wide approaches, rather than individual approaches, as more likely to meet these three elements.

Ken Gibb pointed to the need to ‘get serious’ not only about disinvestment from existing services to new preventative approaches, but also in finding and freeing-up new forms of external investment that can develop preventative services whilst running existing services.

Kim Penman pointed to whole population approaches and how they can be integrated within the opportunities arising from the Community Empowerment (Scotland) Act 2015.

The local practitioners and policymakers responded to these inputs by generating discussion summarised as three *emerging areas of challenge* for the CPP (3.5). These challenges are considered (problematised) in this report as three broad questions:

1. How to support effective, multi-layered partnership working?
2. How to deepen understanding of the realities of ‘prevention’ and preventing inequalities across multi-layered partnership working?
3. How to generate the necessary commitment – including political capital – and creativity to making and sustaining change for preventing inequality?

There is potential here to draw more heavily on NHS Health Scotland’s (NHS) review of the evidence on best approaches to preventing inequality and shifting to preventative spend to give direction to developing strategies (and related inquiries) – see the text box below. Firstly, NHS puts emphasis on upstream and (often) whole population, system-wide approaches that seek to prevent both social and health problems arising across society – to tackle the social and economic determinants rather than the problems that emerge from them. So not solely a health service or even public health focus but a recognition of the need to work more widely across the state, market and communities to tackle, for instance, poverty and income inequality.

Secondly, the need to draw on more focused evidence too when developing preventative strategies to work on particular problems and responses. This needs to be carefully considered work.

This suggests then that CPPs, local partnerships and local communities will need to work together to building shared understandings of what they can *currently* achieve or support in relation to tackling the social and economic determinants – but in well-informed, focused ways – if they are to develop preventative approaches. Local actions may have limited *immediate* effects on wider social problems, e.g. low incomes. But collectively such local actions could build support across both services and communities for necessary longer-term changes across society.

[NHS Health Scotland](#)²⁴ (Craig, 2014) concludes in relation to prevention and evidence:

We [NHSHS] suggest the following priorities:

1. programmes that ensure adequate incomes and reduce income inequalities
2. programmes that reduce unemployment in vulnerable groups or areas
3. programmes that improve physical environments, such as traffic calming schemes
4. programmes that target vulnerable groups by investing in more intensive services and other forms of support for such groups, *in the context of universal provision*
5. early years programmes
6. use of regulation and price (e.g. minimum pricing, taxes) to reduce risky behavior

[NHSHS' submission](#)²⁵ (2017) to the Scottish Parliament's Health & Sport Committee argues for the economic case for prevention, but the need for informed application:

For example, a review of the economic evaluations carried out to inform the Public Health Guidance published by the National Institute of Health and Care Excellence (NICE) looked at 200 public health interventions such as workplace interventions to stop smoking, school based mental health and wellbeing interventions etc. Only 30 were estimated to be cost-saving, including NHS and workplace-based smoking cessation services. The vast majority (but not all) were cost-effective, in particular those aimed at the population as a whole, such as legislation to reduce young people's access to cigarettes. Similar results were found in perhaps the most extensive assessment of the cost-effectiveness of prevention carried out in Australia. Both studies, and a large body of other evidence, provide a very strong economic case for prevention, but the case needs to be based on careful interpretation of the evidence and specific recommendations about the best forms of prevention in which to invest.

²⁴ <https://www.scotphn.net/wp-content/uploads/2015/10/24575-Best-Preventative-Investments-For-Scotland-What-The-Evidence-And-Experts-Say-Dec-20141.pdf>

²⁵ [http://www.parliament.scot/S5-HealthandSportCommittee/Inquiries/PA005-NHS-Scotland\(1\).pdf](http://www.parliament.scot/S5-HealthandSportCommittee/Inquiries/PA005-NHS-Scotland(1).pdf)

4. Case Study 1: A Changing Relationship with Alcohol

This case study explores the early development or scoping of a Local Outcome Improvement Plan (LOIP) priority relating to alcohol and the reduction of harm relating to alcohol-use within Aberdeenshire Community Planning Partnership (CPP).

This priority continues to be led by Aberdeenshire Alcohol and Drug Partnership (ADP). The study describes an early scoping discussion, facilitated by What Works Scotland, drawing on an evidence-base produced by the ADP. This has supported discussions across the CPP partners on whole population approaches and in considering potential areas of action for inclusion in the LOIP Priority action plan.

Key elements are:

1. Local Outcome Improvement Plan: alcohol use as a priority
2. Scoping the Priority: identifying the evidence base
3. Engaging with CPP partners: early dialogue and deliberations
4. Using the LOIP to generate discussion of 'wicked issues'
5. What Works Scotland commentary: creating spaces for longer-term discussions

4.1 Local Outcome Improvement Plan: alcohol use as a priority

"The costs to Scotland and its public services of negative outcomes such as excessive alcohol consumption, drug addiction, violence and criminality are substantial. Addressing the 'failure demand' that results from focusing on consequences rather than causes, and approaches which alienate or disempower service users, has a high cost for society and high costs for public services."

(Christie Commission, 2011: 54)

Aberdeenshire Alcohol and Drug Partnership (ADP) has been working on complex approaches to strategy, service delivery and partnership working over the last eight years; responding to top-down Scottish Government National Outcomes and building bottom-up through ongoing local discussion, e.g. community forums. The ADP puts emphasis on prevention and early intervention; public protection and harm reduction; treatment and recovery; and community engagement. It promotes an asset-based approach – starting with strengths not problems – so people can re-build their lives and recover from problems.²⁶

When discussions began in earnest within Aberdeenshire CPP's Board and Executive Group²⁷ in autumn 2015 on LOIP priorities (Local Outcomes Improvement Plan), the ADP was able to contribute through its growing evidence base (see 4.2). Discussions across Executive and Board

²⁶ More re. services and initiatives Aberdeenshire ADP supports see: <http://aberdeenshireadp.org.uk/>

²⁷ See structures of Aberdeenshire CPP at: <http://www.ouraberdeenshire.org.uk/about-us/our-structure/>

enabled informed dialogue on potential priorities.²⁸ Reducing levels of alcohol consumption was seen to be clearly relevant (Aberdeenshire CPP, June 2016), given:

- **Extent of current problem in Aberdeenshire:** 43% drink above sensible limits – not falling; 10,400 dependent drinkers – only 14% engaged with specialist services; 37 alcohol directly-related deaths (2015).
- **Wider social consequences:** for example, the link between ageing and increasing drinking because of social isolation, life transitions, and dementia and frailty.
- **Impacts on people and services:** the cost of alcohol related hospital admissions for NHS Grampian is estimated to be over £7million per annum, which rises to £17million if partially-attributed alcohol deaths are included (see 4.2).
- **Health inequalities:** people on lower incomes are more likely to experience alcohol-related harm, e.g. hospitalised and death, than higher earners despite average levels of drinking being lower in deprived communities – known as ‘the harm paradox’.

Discussions within the Board and Executive saw the potential for the CPP to work to change the culture around alcohol consumption, for instance, through: the role of licensing boards; lobbying central government; education (adults) and increasing professional understanding. Scoping work (autumn 2016) was initiated and led by the ADP’s Lead Officer, Wayne Gault.

4.2 Scoping the Priority – identifying the evidence base

Wayne Gault (ADP Lead) developed a *LOIP Alcohol Priority Discussion Paper*²⁹ establishing in-depth understanding of the evidence and of possible strategies for further deliberation:

“International evidence emphasises the importance of a systems approach and clearly shows that increasing price, reducing availability and restricting marketing are amongst the most effective and cost effective policy measures to reduce alcohol consumption and harm in a population ... the ‘three best buys’ of alcohol policy.³⁰ Conversely, framing alcohol problems as the sole responsibility of individuals arising from the prolific marketing of an addictive carcinogenic product appears unjust.”

²⁸ Evidence bases for potential LOIP priorities were developed via Local Strategic Assessments; partner plans and Community Plans, horizon scanning. Criteria used to prioritise included: extent of evidence-base; links to prevention and inequalities; relevance to partners; and ‘adding value’ e.g. pooled resources, clear outcomes.

²⁹ View initial LOIP Priority Alcohol Discussion Paper at: <http://aberdeenshireadp.org.uk/wp-content/uploads/2015/08/5d-LOIP-Alcohol-Priority.pdf>

³⁰ Research points to ‘system-wide’ interventions such as pricing, regulating availability and limiting marketing as particularly effective in reducing harm from alcohol-use: (1) World Health Organization and World Economic Forum (2011) *From Burden to “Best Buys”*; (2) Babor T et al. (2010) *Alcohol: no ordinary commodity*.

The Paper sets out key learning and principles for discussion across the whole CPP including:

- Commitment to whole population approaches (see 3.3 in the research report) and the need for developing public support and mandate for such approaches.³¹
- ‘Willingness to implement’ in a society that values freedoms: important discussions to take forward – and potential for blocks via business interests and fears of politicians.
- ‘Universalism’ – is a public mandate possible for a whole population approach?
- Communicating levels of risk: for professionals and the public as there is no entirely safe level of regular consumption – UK Chief Medical Officer Guidance, 2016.³²
- Cultural change: some ‘Mediterranean countries’ have seen shifts to lower levels of consumption and so lower impacts on health and wellbeing – change is possible.³³
- Geographical inequalities: areas with highest density of off-sales premises have 150% more hospitalisations per head of population – tend to be deprived communities³⁴
- Health inequalities: Scotland-wide in 2014, levels of alcohol-related mortality in the 10% most deprived areas were eight times higher than in the 10% least deprived.³⁵
- Targets: a target of reducing alcohol consumption in Aberdeenshire by 10% over ten years could potentially deliver a 20% reduction in deaths and hospital admissions after 20 years – but data on levels of alcohol consumption is difficult to obtain.
- Campaigns and education: tend to focus on individual change and have not been found to be effective in generating population wide change (see 4.2).

³¹The Scottish Government is currently working on a ‘refresh’ of the 2009 national alcohol framework for action, *Changing Scotland’s Relationship with Alcohol*; the latter adopts a whole population approach view:

<http://www.gov.scot/Resource/Doc/262905/0078610.pdf>

³²https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs_report.pdf

³³ For instance, while UK average recorded consumption (15+years) per person has risen slightly since 1970 from to 2010 (10l); Italy in the same period has fallen dramatically from approx. 20l to 6.5l. In the UK (2010) 11.1% of this same population recorded ‘alcohol dependence and harmful use’; in Italy, this was 1.0%. (Source, WHO 2014, view: http://www.who.int/substance_abuse/publications/global_alcohol_report/en/

³⁴ <https://cresh.org.uk/webmap/about-creshs-map-of-neighbourhood-alcohol-and-tobacco-environments-in-scotland/>

³⁵ See: Beeston C et al. (2016) Monitoring and Evaluating Scotland’s Alcohol Strategy. Final Report (p24) at: http://www.healthscotland.scot/media/1100/mesas-final-annual-report_5780_mar-2016.pdf

Examples of plausible interventions outlined in the Discussion Paper:

- Reducing availability of alcohol through work with the three Licensing Boards
- Increasing the price of alcohol via indirect interventions e.g. health and safety levy
- Working for an alcohol-free childhood e.g. limiting local marketing; supporting parents – whole life interventions
- Bans of alcohol on CPP partner premises: to support public alcohol-free spaces
- Increased engagement with services: assertive outreach work with adults, children and young people; one initial addictions contact point; increased service capacity
- Increase screening/early intervention e.g. health assessments, brief interventions
- Bring alcohol into all policy discussions e.g. economic and social development
- Effective enforcement: reliably reduces levels of alcohol-related harms; clear expectations of enforcement re. drink driving; health and safety at work; sales to intoxicated people; drunkenness in public e.g. fixed penalties or treatment.
- Community engagement: to build deliberation on the need for culture change.
- Public education: hard-to-reach groups; older people; deprived communities; professionals.
- Partnership with private sector: e.g. seeking voluntary agreements with alcohol retailers to provide sales data – to support measurement against targets.

The Paper concludes by pointing out that the evidence base argues for system-wide and preventative up-stream approaches, which seek to change the political, social and economic factors (determinants) that create health inequalities. Yet, ‘we’ often end up taking forward a raft of downstream and individual activities that can’t create culture change and engage with health inequalities:

“If we are to successfully address the LOIP priority, we need to figure out how to make progress on the upstream systematic determinants so that low alcohol consumption becomes the norm and drunkenness becomes socially unacceptable. ... It seems inevitable that that would include tackling the political dimension head on by gaining a clear public mandate for change. Given the integral part alcohol plays in many of our lives, this LOIP priority requires all CPP partners to act with foresight and courage.”

4.3 Engaging with CPP partners – early dialogue and deliberations

The ADP worked with What Works Scotland on an initial participatory workshop on this LOIP priority involving key partners (see below) and with support from the Lloyd TSB Foundation.

Mapping current partnership working between alcohol-related services:

Dialogue illustrated the complexity of work across Aberdeenshire and, inevitably, neighbouring Aberdeen City. The Alcohol and Drug Partnership's role here is as a 'WD40' that facilitates partnerships across services, service users and carers, and communities. Other partners outlined their current roles in partnership working.

Scottish Ambulance Service (SAS)

Supports a range of 'acute' and crisis interventions for individuals with alcohol-related problems and/or in contexts where alcohol-use is particularly pertinent e.g. assaults. It works to integrate across health and other public services e.g. sharing and recording of information and referrals. SAS also undertakes on-going prevention-related work e.g. transport for older people, through an 'Every Contact' approach. Here wider concerns and opportunities re. supporting people at home, e.g. signs of social isolation, can be shared with other services.

Aberdeenshire Voluntary Action (AVA)

Within the context of increasing demand on third and community sector and communities to support people with alcohol-related, mental health and multiple longer-term conditions, AVA supports third sector organisations through 'backroom services' including training needs analysis; workforce development; building collaborative networks; generating procurement consortiums; and representing and involving third sector diversity.

Rural Partnerships in Aberdeenshire

Support 'the community voice' and actions in communities of place, working alongside AVA. Their work includes Community Action Plans (CAPs) developed with communities: CAPs raise local alcohol-related issues e.g. anti-social behaviour and seek local actions e.g. work with local shops; joint community sector working – Community Councils, CABs, community organisations; developing community enterprise e.g. for local transport and health and wellbeing.

Public Health, NHS Grampian

Examples of their extensive public health work regarding reducing alcohol consumption including:

- providing evidence to Licensing Boards on local alcohol-use and concerns
- dispelling the myths and related stigma re. alcohol-use, e.g. the diversity of those with chronic, long-term problems with alcohol ('functioning alcoholic')
- managing the impact of alcohol e.g. ABI programme
- supporting children and young people in relation to alcohol issues e.g. marketing, given issues of under-age drinking, safety and exploitation, parental and community health.

Police Scotland

Works with a range of partners – the ADP, schools and universities, Community Safety, (Community Justice) and the third sector – across a range of areas that include:

- supporting pupils and students in understanding the dangers and risks of alcohol misuse;
- supporting offender management programmes;
- on-street referrals, sharing information on vulnerable person database
- supporting the ABIs – Alcohol Brief Interventions – programme

Meaningful consultation and evidence generation with children and young people – *learning from national partner, the Lloyds TSB Foundation for Scotland (now the Corra Foundation).*

Specialist input from the Foundation's *Partnership Drugs Initiative* deepened the dialogue.

Key reports:

1. [Reversing the Trend](#): a report with young people by the Foundation and Evaluation Scotland on preventative work with young people³⁶
2. [Everyone has a story: overview](#): both illustrates effective consultation work with young people re. alcohol-use and evidences their experiences through stories³⁷
3. [Thinking Differently Partnership Fund and Projects](#): seeks to reduce alcohol-related harm and empower young people, families and communities through building skills and knowledge³⁸

Key discussions across the CPP partners generated via these reports:

Issues for children and young people:

- increased risks of under-age drinking in remote areas where there is little to do ...
- working with parents and families to understand how parent alcohol-use can impact.

What supports meaningful consultation and communication with children and young people:

- the right language, appropriate use of website and social media, right places to bring people together to talk are all important factors
- young people need to say 'what changes and why' are making sense to them ... it's important to both listen and then act on such consultation ... 'you said, we did'
- ... also, to be aware of the dangers of 'boomerang effect' – here interest in alcohol-use is unintentionally stimulated through such communications and education work.

Other areas to consider for further action:

- the potential for young people's evidence to be presented to Licensing Boards.*
- supporting young people in vulnerable situations – e.g. increased risk of sexual assault.
- engaging across partnerships to seek integrated, joint action and shared challenge.

*See, for instance, the [Imagining Project](#) where the Children's Parliament works with children to imagine Aberdeen as a city where all children are healthy, happy, safe and doing their best.³⁹

³⁶ <https://www.corra.scot/wp-content/uploads/2015/10/Reversing-the-trend-Key-Messagess-Summary.pdf>

³⁷ <https://www.corra.scot/wp-content/uploads/2015/10/Everyone-Has-a-Story-Overview-Report.pdf>

³⁸ <http://www.therobertsontrust.org.uk/innovation-and-learning/alcohol-misuse/young-people-and-families/thinking-differently-partnership-fund>

³⁹ <https://blogs.glowscotland.org.uk/glowblogs/imaginingaberdeen/2016/05/10/the-imagineer-issue-1/>

Talking with key partners: issues, opportunities and challenges raised:

OPPORTUNITIES

Developing effective partnership working challenges and opportunities:

- Targeting and supporting vulnerable people who are making most use of services
- Empowering staff to explore upstream opportunities in the midst of this downstream work
- Aberdeenshire Community Safety Hub developing CPP analytical capacity to bring together diverse sources of knowledge and data – can then be ‘sense-checked’ by local communities
- Pooling budgets and seeing preventative work as part of a shared remit to be resourced
- Untapped potential of the third and community sectors and community networks to promote health education, prevention and protection – but needs resourcing and training.

ISSUES

The issues around alcohol are complex:

- Involves stigma, prejudice and stereotypes, and blame; how to reduce this stigma?
- ‘Alcohol-use’ may be the presenting condition but should be seen in wider social context and the individual needs e.g. support for parents; multiple long-term conditions and ageing
- Safety and alcohol: link between alcohol and violence including domestic abuse, street assault, sexual assault and rape, drink driving and public safety.

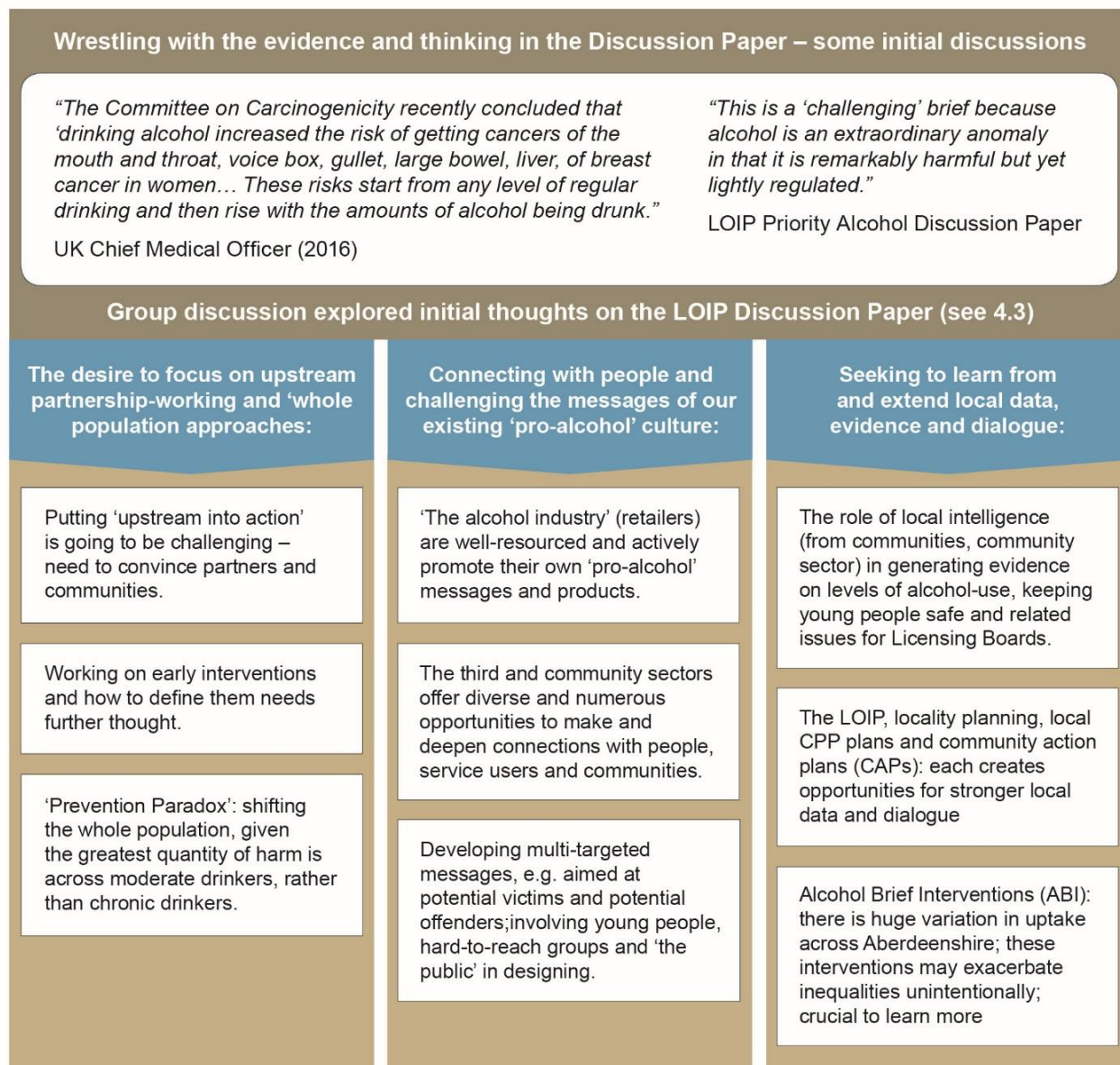
CHALLENGES

Shifting to a ‘low alcohol culture’ – avenues can include:

- Changing drinking habits: alcohol-free nights; drinking in pubs rather than at home privately.
- Rewarding responsible venues e.g. ‘Best Bar None’ Awards; talking with venues and retailers
- Working with universities, student bodies and pubs to reduce student drinking and increase safety
- Community enterprises to develop alternatives: alcohol-free pubs/venues; local transport
- Local democracy and social inclusion: Marmot Review and Christie Commission make the case for the need to challenge inequality and poverty – relates to alcohol harm too.

Wrestling with the thinking in the Discussion Paper: initial deliberations

This is a ‘challenging’ brief because alcohol is an extraordinary anomaly in that it is remarkably harmful but yet lightly regulated.⁴⁰



⁴⁰ See, for instance, the UK Chief Medical Officer’s Report 2016:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs_report.pdf

4.4 Using the LOIP to generate discussion of ‘wicked issues’

The ADP is seeking to use an *adaptive leadership approach* to develop this LOIP priority, and creating the space for partners to consider their existing approaches and what might be blocking progress towards a shared approach – drawing from Heifetz, Grashow and Linsky (2009).⁴¹ A learning culture, rather than a blaming culture, is crucial; supporting partners to suspend current views, consider fresh perspectives and see hidden issues and problems – in a supportive space.

Since the early scoping discussions in (4.3 above), the LOIP Alcohol Scoping Group has met monthly, engaging further partners e.g. Community Learning and Development; Community Safety; Local Community Planning Groups; Scottish Fire and Rescue Service; and sought input from the Chamber of Commerce and the Alcohol Standards Licensing Officers too.

Key areas of discussion and development on this LOIP priority and action plan include:

How to frame this priority: given the sensitivity of the issue it has been re-framed from ‘reducing alcohol consumption’ to ‘changing Aberdeenshire’s relationship with alcohol’ – with a longer-term aim of culture change over 10-20 years – and as two objectives:

- Normalising low-risk alcohol choices and challenging high-risk drinking cultural norms via education and promotion of gentle changes to achieve healthier relationships with alcohol.
- Reducing the number of high-risk drinkers by focusing on the needs of the individual and the nature of their environment.

Developing an action plan to include: the following key themes – and initially 50 possible actions – to provide a framework: safer and healthier choices; availability of alcohol/licensing; alcohol-free childhood; cultural norms; engagement with treatment services; improving data and sharing enforcing laws; lobbying; communications; and community involvement.

Emerging issues and questions that are generating further discussions across the CPP:

- How does alcohol impact on health inequalities and healthy life expectancy?
- How to avoid silo approaches to alcohol – it’s one of a range of risk factors.
- Is there agreement on taking a whole population approach across the CPP?
- The need for effective, ethical ways of working with and screening high-risk groups.
- How to support change that doesn’t extend inequality between places?
- Balance of actions across ‘primary, secondary and tertiary prevention’ (see 3.2).
- Locality Plans – what fits best ... natural communities, electoral wards, ‘hotspots’.

Community engagement and consultation (citizens’ panel) on the draft LOIP Action Plan will follow – in particular regarding the openness of the public to be challenged on this sensitive issue.

⁴¹ For a brief introduction to Adaptive Leadership see Giordano (2013; pages 8-9) published by the Kings Fund: https://www.kingsfund.org.uk/sites/files/kf/Leadership_challenge_for_general_practice.pdf

4.5 WWS commentary: creating spaces for longer-term discussions

It is too early to draw conclusions of substance in relation to this LOIP Priority scoping process but certain key questions relevant to all CPPs are being illustrated.

4.5.1 Developing effective multi-layered collaborative partnership working

In seeking an adaptive leadership approach (Heifitz et al., 2009), the ADP and CPP can be understood as working towards multi-layered *dialogue* across diverse CPP partners and in a supportive, facilitated space. Views and perspectives can be broadened and both rational and emotional capacities engaged (Escobar, 2011)⁴². The LOIP can then offer a safe space for tackling wicked issues (see 2.4). Whether this can be seen as fully *deliberative* yet – as in seeking to evaluate alternatives and work for consensus-based decision-making following *substantial exchange of reasons* (Escobar, 2011) – is beyond the evidence available here. Yet, there is clearly ambition for such deliberation and an opportunity for significant learning as to what happens when you try it.

4.5.2 Deepening understanding of ‘prevention’ and preventing inequalities

The *LOIP Alcohol Priority Discussion Paper* (see 4.2) provides an impressive in-depth discussion of the evidence base; one that resonates with the NHS Health Scotland’s (Craig 2014) focus on whole population health approaches (3.2, 3.6). For instance, the availability of alcohol; targeting services to more vulnerable groups, e.g. deprived communities, in the context of universal provision; and early years working and concern for the impact on children and their health of current culture. It is too early to say to what extent the emerging action plan will prioritise whole population health approaches over individual behavior change. Yet, this LOIP is offering opportunities to building understanding and share learning on *how* to deliberate with sometimes skeptical partners on this and other issues – including recognising how shared work re. alcohol use can relate to other factors generating health inequalities, and so avoiding silo approaches. For instance, Fitzgerald et al. (2017)⁴³ in considering how public health practitioners can advocate for whole population approaches point to the longer-term relational work needed. One participant also suggested the value of specialist resource for ‘critical assessment’ to support preventative LOIP development across all CPPs – ‘prevention proofing’ perhaps.

4.5.3 Seeking committed and creative approaches to preventing inequalities

One key area of potential innovation highlighted above (see 4.2 and 4.3) is the concern to build a public mandate for work in relation to alcohol use. And further, the potential of the community sector (community organisations) to engage with communities in exploring culture change, for instance: in supporting local dialogue and deliberation e.g. as Community Action Plans; and, in providing local activity and services – including through trading activity – that support alternatives to a ‘pro-alcohol culture’ e.g. transport, community social activity and ‘recovery housing’. There is scope for such work with the community sector to be part of wider health inequalities strategies and work on the LOIP.

⁴² Escobar (2011) report at: <http://www.beltanenetwork.org/DialogueTheory2012.pdf>

⁴³ Fitzgerald et al. (2017) article at: <http://www.mdpi.com/1660-4601/14/3/221>

5. Case Study 2: Community Capacity-Building for Health and Wellbeing

The shift towards the integration of health and social care services, most recently through Public Bodies (Joint Working) (Scotland) Act 2014 and the arrival of Health and Social Care Partnerships and Integrated Joint Boards has brought an increasing focus on the role of communities, service users and carers in working with services to improve their health and wellbeing.

With an ageing population, stubborn health inequalities and (currently) constrained public service spending, the fear is that services will be overwhelmed by demand. A shift away from reactive or 'symptomatic' services, and towards preventative approaches that seek to reduce demand, is therefore a key element in the HSCP's strategic thinking – in particular as a focus on 'population health' (see 3.3). The 2011 Christie Commission, in advocating for such preventative approaches to inequality, also puts emphasis on the importance of the local accountability of services, community-led solutions, local partnerships and the development of a 'virtuous circle' between public services, balanced economic development and community empowerment (see 2.2, 2.5).

With such thinking in mind, Aberdeenshire HSCP and CPP have been working with What Works Scotland to explore various collaborative learning approaches across public and third/community sectors that can inform the HSCP's developing strategic approach to such community capacity-building (CCB) – and in the context of seeking to prevent health inequalities. This case study illustrates three such collaborative processes that seek to build (accumulate) understanding of good practice in CCB and integrate this learning with developing approaches and evidence on preventing inequality, namely:

- a participatory workshop to map current 'community approaches' and related CCB work across the CPP; and consider emerging issues and solutions
- the use of an in-depth collaborative inquiry – to deepen understanding of 'good practice' and the policies and contexts that support good practice
- ongoing discussions drawing on local and national evidence sources to support the HSCP to develop a strategic and preventative approach to CCB.

This case study concludes with What Works Scotland commentary on the learning from this developing collaborative approach to prevention through CCB.

1. Dialogue: a strategic approach to community capacity-building
 - a. Initial mapping: community approaches and community capacity-building
 - b. Shared learning: strengths, gaps, opportunities and issues
 - c. Shared learning: recognising the wider policy context and challenges
2. Community Links Worker: towards a preventative approach
3. Learning and reflection on a developing strategic approach
4. What Works Scotland commentary: the need for a deliberative approach
 - a. Developing effective multi-layered collaborative partnership working
 - b. Deepening understanding of 'prevention' and preventing inequalities
 - c. Seeking committed and creative approaches to preventing inequalities

5.1 Dialogue: a strategic approach to community capacity-building

In December 2016, Aberdeenshire HSCP and What Works Scotland facilitated a participatory workshop with partners from across the CPP including the third and community sector(s) and those working in strategic, operational, development and community-facing roles.⁴⁴ This had the broad aim of building shared understandings of partners and their community capacity-building (CCB) plans and capacities – in relation to health and wellbeing – so that longer-term shared agendas, strategies and activities can better emerge.

Providing the ‘challenge’ for the day: the HSCP’s Strategic Plan 2016-19⁴⁵ recognizes that:

... there is already a strong network of partners working with and in communities. So.. what should or can we collectively focus on? How can we optimise our shared capacity? Who is best placed and able to deliver what?

The HSCP was therefore keen to explore further across its CPP partners the variety and extent of existing approaches to working with communities (community approaches); and related work by public sector and third/community sector bodies to develop the capacity of communities to support their own health and wellbeing. Alongside the HSCP’s own consultative work, two other sources of evidence were highlighted before the workshop:

- Nationally: Joseph Rowntree Foundation’s (Crisp et al., 2016) *Community-led approaches to reducing poverty in neighbourhoods: a review of evidence*.⁴⁶
- Locally: *Community Links Worker Report* (see 5.2), with three of the workshop participants having direct experience of community and partnership working there.

A process for participation and dialogue: the workshop was designed as three phases:

- scene-setting: getting to know more about other participants and organisations; and understanding more about the HSCP’s strategy and some relevant evidence.
- initial mapping: to use the experience in the room to understand more about co-production, community enterprise and community sector activity across the CPP.
- shared learning: considering opportunities and barriers to developing a strategic approach and in the process building understanding of the wider policy context.

Both the scene-setting and initial mapping work aimed to support the participants and the What Works Scotland researchers to engage in deepening discussions.

Some examples are in the following illustrations.

⁴⁴ Including: Aberdeenshire ADP; Older People and Community Care Services; HSCP Locality Team; Local Community Planning; Community Health in Partnership Team (AVA); Friends of Inscr Hospital and Community; Rural Partnerships; Community Learning and Development; and Public Health (NHS Grampian). Participants included those working in strategic management, operational management, development and community-facing roles and volunteer/activist roles.... some attending as staff pointed to their volunteer/activist roles too.

⁴⁵ <https://www.aberdeenshire.gov.uk/media/16182/health-and-social-care-strategic-plan-march-2016-final.pdf>

⁴⁶ <https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/community-led-approaches-to-reducing-poverty-in-neighbourhoods.pdf>

5.1.1 Initial mapping: community approaches and community capacity-building







Examples of community enterprise

Networks of Wellbeing
in Huntly – mental
health charity that
refurbishes old
bicycles, has worked
with Syrian 'New Scot'
refugees

SensationAll
for young
people with
multiple
support needs

Bellwade
Farm
(Learning
disabilities
support)

Community Development
Trusts:

- Laurencekirk
- Huntly – has a farm, turbine
(grid access an issue)
- Boyndie Trust – Café,
Community Transport
- Stonehaven Towns
Partnership

Meldrum
Community
Café

Maggie Law
Maritime
Museum

Community
Halls at
Mintlaw, Inch,
New Macchar,
Blackburn

Fly-Cup in Inverurie
– catering social
enterprise that
employs adults with
learning disabilities

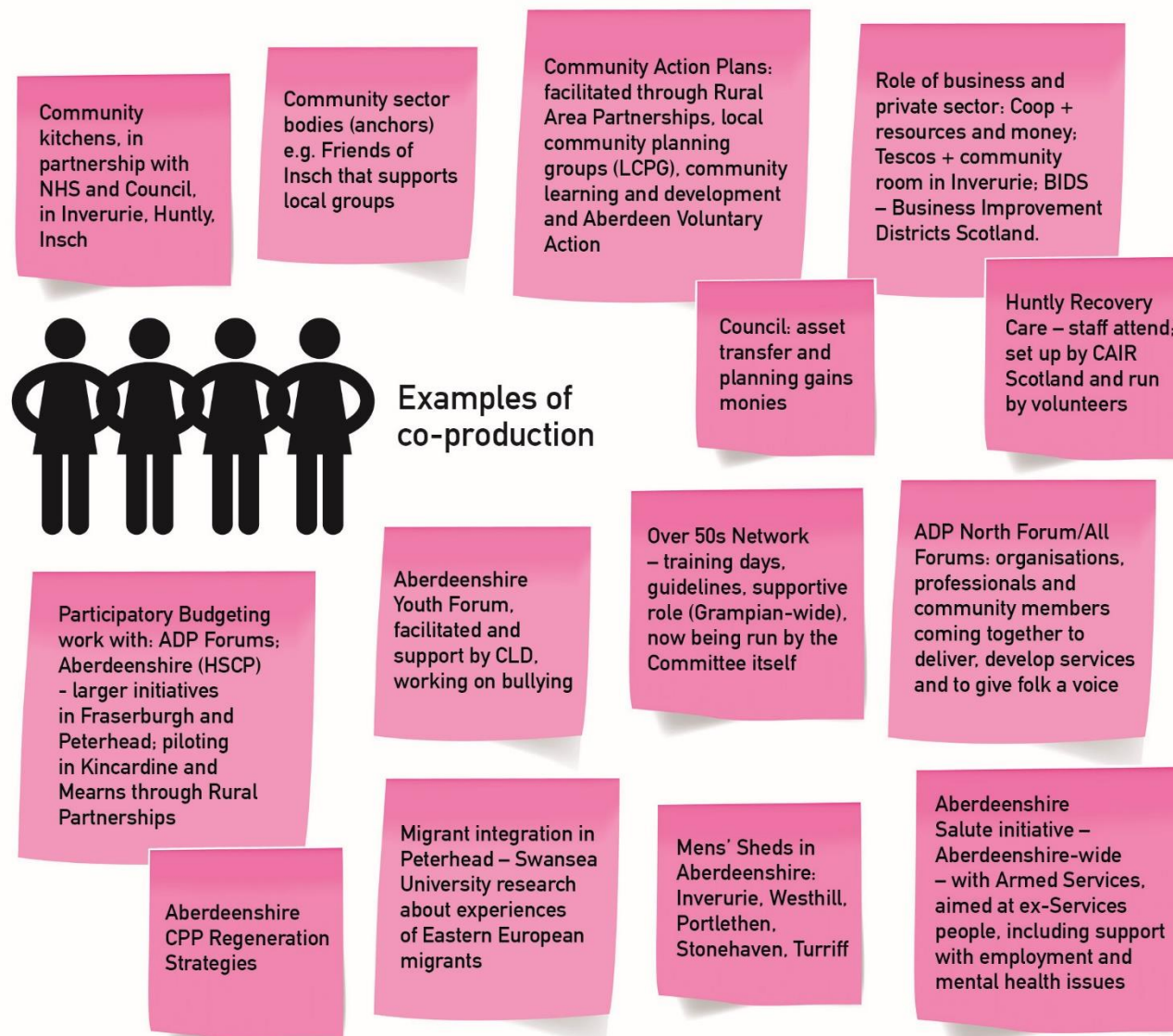
Port Soy Boat
Festival – self-
sustaining, and
bring its money
to community

Friends of Inch
Hospital and ICAN,
Inch Community
Association

Ellan Recycling
(Can Do)
and Wood
Recyclability

Pitscurry
Project
Buzzard Café

Axis
Sports
Centre



5.1.2 Shared learning: strengths, gaps, opportunities and issues

Discussions of the learning and issues arising from the mapping discussions highlighted:

Current strengths across the CPP:

- *Good links between organisations in some (local) places;* inclusive of people and partners bringing together the community sector and community planning.
- *Existing platforms for sharing knowledge* e.g. Aberdeenshire Voluntary Action, Rural Partnerships, ADP Forums and building links between sectors and partners.
- *Lots of increasingly complex local community sector activity developing,* e.g. development trusts, patient safety groups, local community provision (lunch clubs).

Gaps and concerns:

- *Complexity of good practice* – it takes time to learn how to work with communities:
 - Targeting (hard-to-reach) groups doesn't always work – need to 'go to them'.
 - Community conversations may not lead to actions – needs patience.
 - Don't have strong evidence on all local approaches – need to collect learning.
- *Needing to further build the 'community infrastructure':*
 - Communities are filling gaps as statutory services focus on complex cases.
 - Public service contracting is not necessarily aimed at smaller local bodies.
 - Sharing information: both a shortage and an overload – how to find balance?
 - Need for more volunteers – suitable funding and support for volunteer bodies
- *Dialogue, diversity and difficult conversations:*
 - Communicating with communities on health, social care and wider changes.
 - Complex change is asking challenging questions of services and communities.
 - Working with realities – not all communities are close-knit, some change fast.
- *Policy context:* the challenge as 'austerity' continues and funding gets tighter still.

Opportunities and resources:

- *Local organising and coordination:*
 - Local third sector hubs, e.g. ADP in SE Aberdeen sharing offices with other third sector organisations and partners – building local third sector capacity.
 - Community development trusts as 'community anchors' and bringing together community and public sector partners.
 - Local funding initiatives e.g. ADP Forums, local health improvement funds – how to coordinate local preventative work and simplify funding applications.
- *Opportunities to explore and further develop:*
 - The Community Empowerment Act 2015 and the roles of 'community bodies' – participation requests, asset transfer, common good funds and so on
 - Investing time in partnership-building across community/third and public sectors: e.g. learning/support plans for people being released from prison.
- *Role of crisis in creating the conditions for change* – e.g. hospital closure, flooding.

5.1.3 Shared learning: recognising the wider policy context and challenges

The participants also began to raise and consider the challenging policy context in which HSCPs, CPPs and all involved in public service delivery are working, and specifically in relation to prevention.

Challenging economic context: researchers on health inequalities – the Scottish Public Health Observatory and NHS Health Scotland (see 3.2, 3.5) – continue to point towards ‘whole population’ and economic approaches to preventing health inequalities e.g. the role of welfare, employment. Economic change is both difficult to predict and potentially powerful e.g. the impact of oil and gas downturn on employment in Aberdeenshire. How can communities and the community sector realistically seek to impact on inequalities in such a context?

The potential of community sector infrastructure – and its risks: community approaches often tend to be low cost even if there are not huge financial savings to existing services or other financial returns. The JRF research (see Crisp et al., 2016 above) illustrates small but potentially valuable differences that community approaches and community capacity-building (CCB) can make in seeking to reduce or mitigate poverty. More generally, investing in community infrastructure e.g. community organisations, community anchors and community assets can build local resilience ... but this won’t be uniform: additional investment and support will be needed in some communities, often the more deprived, if inequalities aren’t to increase.

Building understanding of the community sector within public services: the activities of ‘community’ and the community sector will be ‘new’ to many working in public services. The language of community capacity-building (CCB) is currently unfamiliar and there is a lot of discussion needed. There is a huge diversity of organisations, groups, activity and infrastructure – *as the mapping work above* – which the participants quickly recognised, and much for the public sector to learn in order to build towards preventative partnership working with the community sector.

This emerging body of shared learning, what’s already happening in communities and the community sector and where the opportunities and challenges lie for further joint-working across partnerships and communities, is now feeding into the HSCP’s developing strategic approach – see section 3 for further discussion.

5.2 Community Links Worker: towards a preventative approach

A cross-partnership inquiry met regularly over about 12 months to explore the learning from a Community Links Worker (CLW) pilot project in Inch, Aberdeenshire (2013-16). The CLW was supported by the Friends of Inch Hospital and Community, Aberdeenshire Voluntary Action and wider local community, third and public sector partners – see Box 2 (1) below.

The Inquiry team included the public sector – Council Improvement Officers; Policy officers from both the HSCP and CPP; Public Health; the third/community sector – a development worker and the Inch Community Links Worker; and two What Works Scotland researchers. It used this diversity to generate collaborative in-depth discussions of the evidence from desk research, a study visit and interviews, and improvement tools – see Box 2 (2) below.

Learning from this Inquiry that supports a developing approach to preventing inequalities

As discussions deepened, themes of preventing inequalities, the preventative role of a CLW and of community capacity-building (CCB) inevitably surfaced. The Inquiry highlighted:

The CLW role – with the right wider support – as a ‘promising area of practice’ that can:

- support local health and wellbeing for older people: potentially increase healthy lifespan and reducing pressures on services.
- undertake anti-poverty activities: with the community sector and local community planning e.g. accessible transport; fuel poverty; advocacy for older people’s issues.

However, it also raised a challenging question for further consideration in relation to preventing inequalities: might CCB increase inequalities between communities – with some communities gaining extra resources and other communities struggled to use or find them?

Consultation responses to the draft report also generated further key, related questions:

- what is the most effective targeting of resources for community capacity-building?
- how can CCB impact on HSCP spending and support a shift to preventative spend?
- what scope is there for integration of CCB and its benefits across public services?

Whilst the upstream, ‘population health’ approaches (see 3.1 and 3.5) that NHS Scotland emphasise as most supportive of preventing inequalities also generate important questions about how to generate a strategic approach to CCB that will effectively support prevention.

A Research Brief for a second phase of inquiry was therefore outlined as to the potential for a CLW, and CCB more generally, to support preventative partnership working: what activities might be involved and what impacts likely; how might information and resources be shared; and what are the links to the current developments and resourcing of ‘child poverty focused-action and strategies’ in Aberdeenshire? (See Appendix 2.3). Other relevant existing evidence also emerged through the research, as outlined in Box 3 below.

The Community Links Worker model considered here and the collaborative inquiry approach to research and development is influencing HSCP’s strategic thinking – see sections 1 and 3.

Box 1: Key learning points from the Community Links Worker inquiry and report

The post was funded by, the then Aberdeenshire Community Health Partnership, using the Scottish Government's Change Fund (2013-15) and then Integrated Care Fund (2015-16). The worker engaged with people age 65 and older – and then more widely – within the catchment area for Inch Community Hospital and developed activities, groups and support within the community and supported accessing to public services.

Outputs figures for the Community Links Worker project included:

- Up to 200 older people a month engaging in community activity initiated by CLW.
- 20 people volunteering through these activities – and wider informal volunteering.
- Participants in the local activities developed reported (self-reported) widely on the value of their involvement to their physical, mental and community health.

Good practice in 'community linking' – the work of a community links worker involves:

- *Building a rich, on-going picture of each community:* via relationship-building, developing the project profile via listening/learning – don't make assumptions.
- *Linking community members into community networks:* through on-going asset mapping work and supporting peer promotion of activities
- *Developing community activities that respond to community views:* continuing discussions with communities, being realistic and learning from 'failure'.
- *Partnership working with the local community sector:* using every opportunity for learning and being very flexible and creative about community involvement.
- *Partnership working with services and wider third sector:* drawing on their knowledge, specialism and resources, and advocating on local inequality/poverty.

Supporting development of good practice in community linking requires:

- *Building from and on existing public and third/community partnership working:* collaborative work with partners provides a platform for community activity.
- *Working with one (or more) local community organisation(s):* provides local credibility, knowledge and networks; locally controlled funding 'pots' important.
- *Flexibility and openness to learning:* a worker needs to pursue this 'way of working' to build their own knowledge; partners, too, need to be open to learning.
- *Developing suitable strategies:* discussion locally and area-wide to talk through 'risk taking' and longer-term funding to support third/community sectors.
- *Make links and learning from wider regional and national experiences* about both policy and practice and the issues, challenges and opportunities that arise.

View the full Inquiry Report [on the What Works Scotland website](http://whatworksscotland.ac.uk/publications/learning-about-community-capacity-building-from-community-links-worker-approach-aberdeenshire/)⁴⁷

⁴⁷ <http://whatworksscotland.ac.uk/publications/learning-about-community-capacity-building-from-community-links-worker-approach-aberdeenshire/>

Box 2: Collaborative inquiry as 'space' for deepening discussions of alternatives

The Inquiry Team and researchers reflected on their learning across their work together. Discussions pointed to the value of space to read, reflect and share learning.

"... it makes you more confident when you go into these meetings, that you've got a bit of knowledge behind you, where things have come from, and ideas behind it."

"... it was a truly collaborative process. In other pieces of work, we speak about working collaboratively, but now I've done this what we did before wasn't that."

"... a huge luxury of the time, is to be able to do the reading. Because we see reading as a luxury, but actually it's not, it's an essential part of our job. But we are programmed to be operational, doing the whole time ..."

The Team considered too their research process – getting a wide enough range of evidence and how best to analyse it? Is there value in external research input?

"... It's part of the whole system, when you go and speak to your customer that is a very, very important voice to hear. But there are other important voices in the system that you need to hear. So, it is part of the whole. What you do is you hear what they say; you analyse what they say; and then you look for validation of what they're saying elsewhere in your system. So, it gives you that triangulation."

"... I wonder if there is a benefit of having somebody external from a university working [with us] in that research is their thing, and what that brings to a piece of work. I can't compare it, because I don't know another way, so it's difficult to say. But, at this stage, could this have been done with somebody internal?"

The thinking also sought to imagine how the inquiry might contribute to wider preventative approaches, culture change and making 'hard decisions' about resource-use.

"Many of the activities had a focus on prevention, I think a lot of what we're doing today will have benefits in the future. So, they may start to see a reduction in treating conditions such as high blood pressure, and type two diabetes, and other conditions if people stay active and look after themselves. ... I used to use those [financial costings] for volunteering, because the activities volunteers were doing – taking folk out, socialising, keeping them connected to community, visiting family – at £7.50 an hour. You were able to put a monetary value on their contribution."

"... (we) have touched six, seven, eight people, and effected some change in those people: how they think; how they work. There are 14,000 people in the Council; how many in the third sector? how many in the NHS? ... Unless we think what it is we want to change in these systems, and then change the attitude of the people that work in these systems, we're on a hiding to nothing...."

"...[but] for me, it is what happens now, and the influence it [the research] can have. So, in a way, it almost doesn't feel finished, for me. I would like something, you know, either for

it to have influence over something still to happen, or to know that folk have given it consideration when they're looking at something new."

5.3 Learning and reflection on a developing strategic approach

Since 2015, Aberdeenshire HSCP has been on a journey of collaborative learning to build its understanding of community capacity-building (CCB) to support community health and wellbeing; and consider what makes for good practice locally and nationally. It has piloted new activities to develop its relationship with communities and supported research to deepen understanding – as illustrated in 5.1 and 5.2 and evidence box 3..

In the process, the HSCP has come to understand that a simple strategic framework supporting a linear, one-size fits all approach can't do justice to the complexity of different communities and their respective capacities and needs. There is potential for on-going dialogue across a range of community planning partners including third/community sector organisations and groups to build a shared approach to community capacity building, or at least common understanding and principles – but this will likely be 'slow burner' and needing to work through local relationships and build local ownership.

There is a considerable challenge, too, to invest in the culture change – rather than tokenistic change – needed across the HSCP services and staff – and likewise other public sector bodies – so that they can recognise the potential of community sector organisations and groups and build the most productive relationships. *One key element in this process for the HSCP will be establishing a Programme Board to lead on implementation of strategic priorities for community empowerment and engagement.* It will seek to:

- share good practice, evidence and toolkits re. prevention and participation
- foster local relationships between HSCP teams and the community sector.

There are also several emerging lines of inquiry that *could* be considered through partnership and community dialogue and the work of the Programme Board(s), for example:

- The diverse roles of local partnership hubs to coordinate activity.
- 'Promising area of practice' – community links worker, community anchors and hubs
- The potential of small pots of shared local funding to support local initiatives
- Building shared dialogue re. community capacity-building tools and practices.

Integrating health and social care, the Community Empowerment (Scotland) Act 2015 and other national initiatives are creating further opportunities and challenges; for example, participatory budgeting, community links workers (social prescribing)⁴⁸, community participation requests and community asset transfer. It is crucial then to draw the depth and diversity of local knowledge and practice. Staff, managers, volunteers and activists from across services, sectors and layers offer a wealth of experience for the HSCP and CPP to

⁴⁸ The Scottish Government National Programme puts emphasis on a GP-based, social prescribing model of Links Worker rather than that piloted in Inch (5.3) which pursued wider community development too.

draw from. There are likewise a range of flexible options, see 4.2 in the main report, to support collaborative inquiry work and which can be tested out to see what works in which context.

Box 3: Evidencing on community capacity-building and prevention

(1) The diversity of community approaches and community capacity-building

What Works Scotland (draft) *Evidence Review on Community Capacity-Building for Health and Wellbeing in Rural Areas* considers relevant research, highlighting:

- The importance of local context for any CCB activity. This needs to build from the assets that a community possesses or can access. The Review identifies methods of capturing information e.g. 'asset-mapping', 'community capitals framework'.
- The importance of local social cohesion and solidarity as foundations for CCB efforts. Early CCB activity may need to support the development of cohesion and solidarity first, where this is lacking or fragile.

Community-led approaches to reducing poverty in neighbourhoods (Crisp et al., 2016): sets out four types of community-led approach – community organising; social action; community enterprise; and voluntary action – and then considers the evidence-base for the potential of each to impact on both material (income-related) and non-material (social experience) poverty. This is mixed with smaller scale initiatives lacking rigorous investigation and many approaches fitting to local conditions and opportunities.

Local research supported by the HSCP in Aberdeenshire: this includes material relating to exploring the 'Nuka' model and tools for community capacity-building, for instance: a series of research reports on the role of 'conversation cafés' illustrates how this approach can positively influence health and wellbeing, and increase community support/inclusion for people experiencing mental health problems ... contact carolynlamb@nhs.net for details.

(2) Health and social care: community-based approaches and prevention

NHS Scotland's report on best preventative investment (Craig, 2014): as highlighted in 3.2 and 3.6 in the main report, argues that upstream, system-wide and whole population approaches to prevention have the strongest evidence of: reducing health inequalities; reducing costs to services; and reducing 'failure demand' – the shift to preventative approaches. The report also notes the current limits to the evidence based on community asset approaches – which creates uncertainty – and the risk of widening inequalities given the unequal distribution of assets between communities. It concludes with the need to create a more level playing across communities to support effective asset-use and help reduce inequalities.

Building Community Capacity: evidence, efficiency and cost effectiveness (Wilton, 2012) highlights evidence on the potential for community-based approaches to generate wider local economic and social benefits. Note, however, this cannot be assumed to mean that such approaches can be applicable in every context; nor, produce actual ‘cashable’ savings for public service budgets.

National Evaluation of Partnerships for Older People Projects (Windle et al, 2009) does provide some evidence of the potential for *cashable savings* for particular services through an extensive initiative and evaluation in England. It found that an integrated approach that brought together services and community-based activity could impact on service delivery and costs, e.g. emergency admissions, delayed discharge, duplication. There were, however, difficulties in passing savings across partners, e.g. local authorities and health services.

5.4 WWS commentary: the need for a deliberative approach

5.4.1 Developing effective multi-layered collaborative partnership working

The case study illustrates *the potential* that ongoing, multi-layered and cross-partnership inquiring and discussions can offer in seeking to build a common strategic approach across HSCPs and CPPs. Generating such a shared strategic approach to community capacity-building (CCB) is necessarily a slow-burning process and involves deepening understanding across all partners over time e.g. in understanding the complexity of issues and evidence around CCB and prevention. The suggestion here is of developing preventative partnership-working via collaborative learning, in facilitated and supportive spaces, that looks to the medium-term and shares language and knowledge to support local policy and practice. There may be quicker, shorter-term, strategic ‘wins’ to be had, but the potential here is to make longer-term gains through diverse knowledge and relationship-building.

5.4.2 Deepening understanding of ‘prevention’ and preventing inequalities

By drawing on a range of different evidence sources – local practices; national evidence reviews; and critical commentaries – in relation to CCB and ‘prevention’ – the scale of the task at hand for HSCPs and CPPs in making sense of policy and practice, and the range of options and alternatives, continues to emerge. There are growing bodies of evidence on: CCB practices – what makes them more effective and their limitations; on upstream, whole population approaches to preventing health inequalities and poverty; and on how/if prevention can reduce service demand and pressures on spending. Some of this evidence is challenging of any simple formula for *CCB as providing low cost prevention of inequalities and ill-health*; pointing to the need for good advice on evidence and understanding the wider policy context. Given complex aspirations and diverse local contexts, the resulting ‘solutions’ are unlikely to be precise models – rather illustrations of what can be achieved.

5.4.3 Seeking committed and creative approaches to preventing inequalities

Discussions in 5.1 and 5.2 are illustrating the creative potential of cross-sector working. In the inquiry (see 5.2), the potential of a community links worker, a strong local community organisation and a well-organised local community planning partnership comes to the fore. In the participatory workshop (see 5.1), two emerging areas of practice are highlighted:

- Local hubs of various forms: third sector hubs, partnership hubs, community anchors
- Shared or pooled 'community resources' from across different budgets.

These approaches show the potential to pull together and pilot options from the wider field of community approaches (Crisp et al., 2016) including: co-production between services and community sector; community enterprise; community organising and social action; and voluntary action. There is potential here to work creatively to develop 'community infrastructure' and to engage with local communities, local politicians and 'the public' as to where to invest time, credibility and resource. This should in turn build local commitment and understanding of the policy context and opportunities for preventing inequalities.

6. Concluding commentaries: what to learn next

6.1 Introduction

This final section brings together the learning from across the scoping work and collaborative learning days (sections 2 and 3) and accompanying two case studies (sections 4 and 5) to support discussion of developing understandings of multi-layered preventative partnership working across CPPs in Scotland.

A series of short, reflective commentaries are offered from What Works Scotland in 6.2 using the three emerging broad themes from the Collaborative Learning Day (3.5, 3.6).

Wider reflections from the report and Collaborative Learning Day are offered in 6.3 from Neil Craig at NHS Health Scotland and Aberdeenshire CPP Partners.

6.2 WWS commentary: towards creative preventative partnership

6.2.1 Developing effective multi-layered partnership working for prevention

Discussions at Collaborative Learning Day 2 (section 3.5) highlighted that the participants present from across the CPP were (then) broadly looking to develop suitable partnership working arrangements – across strategic, operational and community-facing work – that sought to:

- improve collaboration and communication
- support culture change across the partnership (so significant change aspired to)
- build a learning approach – and giving teams the time to do this work.

The What Works Scotland evidence review of (previous) partnership working presents a wide body of areas to consider in developing good practice in multi-agency public

partnership working – see a summary of these in Appendix 2.4 below. The three aspirations above are consistent with the review – although the review goes beyond them in terms of detail. Although a note of caution is adopted here, in that in this particular context of the Christie Commission narrative, and with a focus on multi-layered preventative partnership-working, there is a vision of ‘partnership and participation’ that is arguably distinctive from earlier aspirations and articulations of public service partnership. So use of the word *partnership* can ‘hide’ differences in actual policy and practice.

Across this report a variety of collaborative learning and action approaches have been explored and illustrated, as outlined in 1.2, as key tools for supporting *partnership development*. For instance, in Case Study 1 (4.3, 4.4 and 4.5) the use of:

- Participatory mapping, evidence-use and dialogue to explore emerging issues (p28).
- Adaptive leadership approach to create safe spaces for challenging discussions (p33)

In Case Study 2 (5.1 and 5.2) the use of:

- Participatory mapping and dialogue to explore emerging issues and local contexts. (p35)
- In-depth collaborative action inquiry – with a diverse, cross-partnership team. (p35)
- Ongoing dialogue on evidence and practice with strategic management. (pg 42)

In both cases, such collaborative learning and action has been exploratory in nature and has supported strategic management (ADP, HSCP, other partners) in mapping thinking and experience across different partners, working to build and sustain longer-term relationships, and in Case Study 2 in building a stronger evidence-base around both strategy – community capacity-building and prevention – and practice options e.g. community links worker.

What emerges in both cases is that such collaborative learning and action, and related aspirations for culture change, require the commitment of time, leadership and resources from strategic, operational and community-facing teams. In both cases, the collaborative learning aspires to build relationships and trust; generate *safe spaces* for exploring difficult questions and potentially alternative solutions; provide access to relevant expertise, evidence and advice; and seeks to traverse different political interests across services, sectors, layers, communities, service users, policymakers and elected representatives - complex collaborations then.

The ‘tone’ of such work is one of patience and longer-term investment and so requires significant ongoing and ‘underlying’ commitment from senior management across key partners – see also the *Beyond Action Learning* report via Appendix 2 (2) – as well as local politicians. Yet CPPs find themselves in a complex policy and funding environment, and often face pressures for change ‘right now’ to meet cost efficiencies and existing priorities from policymakers and individual partnership organisations – and in the context of budgetary constraints and related urgency highlighted by the Christie Commission.

It is important to ask then, how might collaborative partnership working be up to the task of aspirational change envisaged by the Christie Commission whilst in a time of reducing public spending budgets? The exploratory nature of the work here suggests that this is a

developing and ‘promising area of practice’ rather than a fully formed or working one. Further exploration of the tools to hand will be needed, and over a longer period of time, to understand how/if they can deliver a ‘culture of inquiry’ that can engage with the diversity of stakeholders needed to work on wicked (social) issues and problems *and* yet support inevitably tough (political) decision-making re. resources, strategy and policy.

The case studies certainly illustrate developing *dialogue* across partners and this could move on to a deepening *deliberation* between partners that supports decision-making and shared action planning and prioritisation through the ‘substantial exchange of reasons’ (Escobar, 2011). What Works Scotland’s research more generally has illustrated a growing range of collaborative learning into action practices, approaches and tools:

- In Aberdeenshire, the ‘*Beyond Action Learning*’ approach: action learning and improvement tools to empower frontline staff – see Appendix 2(2) or [view report](#).⁴⁹
- A *Citizen Jury* with community members from Buchanhaven, Peterhead, in Aberdeenshire, with the support of public services, to consider the safety of a local community bonfire – [view report here](#).⁵⁰
- The *Pioneer Collaborative Process* where in-depth facilitation and reflective dialogue are supporting a Total Place approach in Musselburgh – [view report here](#).⁵¹
- *Outcomes-based Approach*: developing a ‘theory of change’ (logic model) to support critical thinking and informed service development – [view report here](#).⁵²

Here are *some* of the core tools and processes that could take *exploration* of the potential of multi-layered preventative partnership working a number of steps further by deepening informed *deliberation* within partnerships.

6.2.2 Deepening understanding of preventative spend and inequalities

Discussions at Collaborative Learning Day 2 (3.5) highlighted that the participants present from across the CPP were seeking to engage and develop understanding of this growing pool of preventative evidence and knowledge. They pointed to:

- use of diverse evidence: evidence reviews, community intelligence, statistics
- exploring options for preventative spend – disinvestment and external investment
- realism as to the speed of change that is possible through partnerships
- the need for shared understanding and dialogue to develop across the CPP.

NHS Health Scotland’s evidence-based advocacy of preventative approaches to inequality (3.2; 3.6) as needing to prioritise upstream, whole population approaches, provides valuable fuel for the CPPs challenging discussions; as illustrated in the two case studies (p24 and

⁴⁹ <http://whatworksscotland.ac.uk/publications/collaborative-learning-research-and-action-in-public-service-reform/>

⁵⁰ <http://whatworksscotland.ac.uk/wp-content/uploads/2017/06/SIPRAnnualReport2016NickBlandLocalParticipation.pdf>

⁵¹ <http://whatworksscotland.ac.uk/publications/pioneering-collaborative-leadership-a-facilitated-approach-for-learning-in-action/>

⁵² <http://whatworksscotland.ac.uk/publications/outcomes-based-approaches-in-public-service-reform/>

p34). Likewise, in both cases the need for and examples of more particular evidence being engaged with e.g. in relation to alcohol-related harm; in relation to community-led solutions to poverty. Yet, also in both cases, there is the sense of more questions than answers at this point. What upstream, whole population approaches will make this sense to CPP partners to adopt – and what won't – is still emerging.

One intriguing suggestion (p33) of 'prevention proofing' strategies through, for instance, access to expertise on 'best current practice and evidence' could help CPP partners to engage further with these testing questions around upstream, whole population approaches.

The case studies also highlighted awareness amongst participants of the wider policy context and so constraints on local action. Other evidence encourages a certain realism. See for instance, John McKendrick⁵³ who, in considering local opportunities for anti-poverty action, argues for prioritising: (1) protecting those living with poverty from its worst excesses; and (2) enabling people to increase their chances of living a poverty-free life. There is much that can be done, and learnt from, but also limits to local actions alone.

In terms of seeking a shift to preventative spend – and seeking 'cashable' savings to support disinvestment in existing services and re-investment in preventative services *and/or* forms of external investment – then this too is very early days. Too early for Case Study 1, but in Case Study 2 participants pointed to two options where investment might be freed up or gained:

- Local hubs which can support a variety of inter-relating, complex activities from one co-located and local resource could provide 'economies of scope'.⁵⁴
- Pooling of local funding pots – that could then be used more strategically to support community capacity-building or even support community enterprise (trading).

These are smaller scale actions but suggest a direction-of-possible-travel. Larger initiatives were beyond these two case studies, and it is worth recognising that this is a developing area of policy and practice. Ken Gibb (3.3) points to a number of options including:

- *Local Integrated Services Trust model*: where a trust or similar, owned by public sector bodies, can coordinate preventative solutions and sources of investment.⁵⁵
- *Predictive analytics*: to locate priority areas of welfare and relevant (more vulnerable) target groups to understand the potential 'lifetime investment costs' rather than the current financial year alone – [view What Works Scotland event report](#)⁵⁶.

⁵³ Presentation at WWS Seminar on 'Community-led approaches to Poverty' in Dundee, September 2016, view: <http://whatworksscotland.ac.uk/wp-content/uploads/2016/10/JohnMcKendrick23092016.pdf>.

⁵⁴ Economies achieved through integration of complex activities, rather than as economies of scale through single purpose organisations working over much wider areas.

⁵⁵ View thinking on a proposed Local Integrated Service Trust model at: http://www.housinglin.org.uk/library/Resources/Housing/Support_materials/Viewpoints/Viewpoint27_LIST.pdf.

⁵⁶ See WWS event on predictive analytics at: <http://whatworksscotland.ac.uk/events/prevention-and-prediction-can-we-predict-the-impacts-of-prevention-to-inform-policy-and-practice/>

- ‘Traditional’ *local government borrowing* to support preventative investment.

With the policy context and expectations for policy and practice changing, there is now greater potential to consider options outside of the private sector, such as those concerned for public ownership and enterprise and community ownership and enterprise; for instance:

- *Community-wealth model*⁵⁷ provides coordination across local public and third sector bodies or ‘anchor institutions’, e.g. council, hospitals, colleges, housing, to resource local economic and social development strategies. Including public procurement that can support local community enterprises and cooperatives.
- *Community anchor model*⁵⁸ based on multi-purpose community organisations built on community ownership and community enterprise which generate local resources.

The ‘wicked issues’ approach (2.4) suggests a dynamic engagement across partners in search of solutions. In which there is unlikely to be one single or final ‘preventative approach’ – an off-the-shelf model – but rather diverse strategies and options to be understood, piloted and continually wrestled with. As with multi-layered partnership working above (5.2.1), the case studies illustrate this as a new, developing area of policy and practice in which shared practices and understandings are still very much forming.

6.2.3 Seeking committed and creative approaches to preventing inequality

Discussions at Collaborative Learning Day 2 (3.5) highlighted that the participants present from across the CPP were seeking to engage *creatively* to make progress in this complex area(s) of practice by:

- building political support (capital) across diverse stakeholders
- supporting community capacity-building and developing the local community sector (local organisations)
- working flexibly, imaginatively and in (socially) ‘entrepreneurial’ ways.

The Christie Commission puts great emphasis on ‘local’ partnership and participation as:

- local public service partnerships and co-production with service users and communities
- empowerment of frontline staff and a commitment to a shared public service ethos
- community empowerment, community resilience and community-led approaches
- local democratic accountability of services to communities and service users.

Further, local democratic reform is in the air: the [Commission on Local Democracy](#) (COSLA, 2014)⁵⁹; the Community Empowerment (Scotland) Act 2015; and now the development of

⁵⁷ Community-wealth approach: <http://democracycollaborative.org/> and see also: <http://community-wealth.org/strategies/cw-cities/index.html>. See too, the Centre for Local Economic Strategies report (2017): https://cles.org.uk/wp-content/uploads/2017/02/Community-Wealth-Building-through-Anchor-Institutions_01_02_17.pdf

⁵⁸ View WWS thinkpiece on community anchors: <http://whatworksscotland.ac.uk/publications/community-anchors/>

⁵⁹ View at: <http://www.localdemocracy.info/news/final-report/>

[Participatory Budgeting](#)⁶⁰ across Scotland, a [local governance review](#) and a proposed '[Local Democracy Bill](#)'. There is no one way to respond to this developing agenda of 'local democracy and empowerment'. Empowerment, for instance, can support a focus on developing: staff and the roles of public enterprise and ownership; service users' groups; carers' and families' groups; citizen action and local democratic participation; and many varieties of community action and ownership (Crisp et al., 2016 – see p35). The dialogue in both case studies (p28 and p35) has a particular focus on the creativity and innovation that community action can generate:

Case Study 1: through building community understanding of local alcohol provision and use; community enterprise to develop spaces for alternative low-alcohol culture; and more generally the building of public political support (capital) for social change.

Case Study 2: through recognising the potential for diverse forms of community action (Crisp et al., 2016) – co-production with services, community organising and social action, community enterprise and ownership, volunteering; and building 'community sector infrastructure' – local hubs, community anchors, local funding pots and local coordination.

The challenge, however, remains to turn this form of empowerment – alongside the others listed above – into shared and local strategies for developing preventative approaches to working with wicked (social) problems. Local hubs and community organisations could then provide the sorts of public service and community sector infrastructure that can engage locally and realistically with NHS Scotland's preventative evidence-base (Craig, 2014; see 3.6), for example:

- supporting *income maximisation* – welfare advice, employment and training
- improving the *local environment* e.g. advocacy on traffic safety, greenspaces
- supporting *vulnerable groups* in accessing services, resources and social capital
- supporting *early years work* – working with schools, children and families
- supporting *local advocacy and change* – building local understanding of 'prevention'.

Crisp et al. (2016) illustrates some of the existing evidence base on the potential of community organisations and other community approaches to impact on local poverty in smaller ways.

The Community Empowerment (Scotland) Act 2015 puts emphasis on 'community bodies' providing the potential for multiple roles, for instance, in strategic discussion, locality plans, local provision and asset transfer. CPP partners could work together to build their support for, and investment in, local community anchor organisations – such as community development trusts and community housing associations – and other community organisations, enterprises and groups. It is important to recognise that the community sector is not part of the state, with organisations having their own governance structures, ethos and purposes. Yet such community sector infrastructure would be well-placed to provide the multiple roles that 'community bodies' could play with CPP structures and

⁶⁰ View at: <http://whatworksscotland.ac.uk/publications/review-of-first-generation-participatory-budgeting-in-scotland/>

public services. And crucially, they can provide sources of external investment for preventative approaches where community ownership of assets and trading activity generates surplus ('profits') for re-investment in local community social and economic development.

6.3 What others are learning... and what next?

6.3.1 Neil Craig, NHS Health Scotland: reflections on the Learning Day

A key theme from the discussion during the Collaborative Learning Day on Prevention (May 2016) – see section 3.0 – was the need to find ways to support the use of evidence at a local level. There is often a call for more evidence, but much of the evidence available comes from reviews of national or even international studies based on experience in other areas or even other countries. This poses further questions:

- Does this evidence apply at a local level? Is it relevant?
- Does it address the particular policy and service choices faced by local practitioners and local populations?
- Are the needs of local people different from those of the people using services studied in the wider evidence base?
- If so, will the costs and impacts differ if we try and implement the same services in local areas?

The apparently simple solution of getting more local evidence is not that simple as resources – skills, time, capacity, money – may not be available to gather evidence at a local level on whether services are effective and cost-effective. Projects carried out on a relatively small scale at a local level may not lend themselves to carrying out *robust* studies that provide valid results that can be transferred to other settings.

My key reflection, then, would be that what is needed is *not* just more evidence. In addition, what is needed is decision-making support at a local level to help decision-makers translate evidence from the wider literature on 'what works and what is cost-effective' into *useful* knowledge, using *local* intelligence on needs, costs and the practicalities of local contexts. This, of course, has its own implications for skills, resources and time. However, the discussion at the Learning Day suggest to me that it may offer a more constructive way forward than repeating the constant refrain of "more evidence please". Just producing more evidence without involving those who want to use it and those affected by the decisions taken, is unlikely to get evidence of what works into practice.

A final thought. I was particularly struck by Ally Birkett's presentation at the Collaborative Learning Day of the Fire Service's efforts at a shift to prevention – see Appendix 2.1. These seemed to have been successful and offered a good example of the shift required, not just in health care, but in other parts of the public sector. It was interesting to reflect on what factors may have encouraged and enabled this shift to take place.

Overall, it was a fascinating day. It underlined the benefit of dialogue between national and local bodies to understand better each other's perspectives and to put into practice more evidence on what works in prevention.

6.3.2 George Howie, Aberdeenshire HSCP: LOIP Priority – Child Poverty

This report notes the emphasis by Marmot and Wilkinson & Pickett (see p.8) on the need for upstream action to address inequality, and much of this action is outwith the preserve of CPPs, lying with Scottish and Westminster governments. However, I think it's also worth emphasising that there is still considerable scope for preventive action to be implemented by partners at a local/regional level and within the context of community planning. Indeed LOIPs require CPPs to focus on issues and geographical communities where outcomes are poorest so there is a recognition by Scottish Government that partners at a local level have a crucial role to play in addressing inequality.

For instance, following the CPP Board's approval of *Reducing Child Poverty in Aberdeenshire* as one of our LOIP priorities in March 2017, [the Poverty Alliance](#)⁶¹ and [the Scottish Poverty Information Unit](#)⁶² at Glasgow Caledonian University were commissioned (June 2017) by Aberdeenshire Council (on behalf of the CPP) to undertake research in Aberdeenshire to inform the development and ultimately the delivery of our local strategic approach to child poverty. The research will follow four phases:

- A focused literature review looking at poverty/child poverty and strategies to prevent and mitigate its impact within a rural context.
- An online survey of practitioners across a wide range of sectors/partner agencies to attitudes to poverty/child poverty, current practices and barriers to action, and generate ideas for action moving forward.
- Focus group discussions and one-to-one interviews to develop a better understanding of the lived experience of poverty and child poverty in Aberdeenshire.
- Partner event – an opportunity for senior managers and practitioners with an interest in child poverty to consider the findings and the feasibility of the key research recommendations.

The recently published [What Works Scotland child poverty evidence review](#)⁶³ for councils and their community planning partners also provides a helpful overview of high impact actions that can be taken in relation to income maximisation, employability, education, childcare etc. Whilst the Council's Community Planning Team is also now working with CPP partners to identify data partners routinely collect which may assist in measuring and monitoring the CPP's ambitions to effectively prevent and mitigate the impact of child poverty in Aberdeenshire.

The LOIP priorities that CPPs are developing will be expected to continue over a ten-year period, with key milestones articulated for 1 and 3 years. Once the Child Poverty (Scotland)

⁶¹ <http://www.povertyalliance.org/>

⁶² <http://www.gcu.ac.uk/research/researchcentres/scottishpovertyinformationunit/>

⁶³ <http://whatworksscotland.ac.uk/events/preventing-and-mitigating-child-poverty/>

Bill has been approved by the Scottish Parliament (Dec 2017), this will also place a number of duties on councils, NHS boards and other partners to develop a series of local action plans seeking to eradicate child poverty in Scotland by 2030.

6.3.3 Dawn Brown, Garioch Partnership: considers community-led solutions

My key reflections from the report:

- Everyone is challenged by Christie – multi-agency working will be difficult until structures and policies change to enable cross-agency working and information sharing.
- Using evidence to support spending decisions on preventative approaches may not happen as given tightening budgets for services, decisions to divert spend become hard to make/justify however, we shouldn't shy away from these conversations.
- There is sometimes a mismatch between strategic plans to work across boundaries and understanding at a delivery level of how that can actually happen.
- The move towards more community influence on budgets, e.g. local government reforms and participatory budgeting, can see money being spent meeting local needs in more preventative, cross-cutting ways, and targeted on local good practice.
- There are no easy, quick fixes. There are issues of equality across sectors, and sometimes a view that communities and third sector can deliver free or cheap alternatives to statutory service.

Moving towards genuinely community-led approaches

As we become more aware that the underlying cause is rarely one-dimensional, and therefore needs a multi-faceted approach to be managed effectively, collaboration is essential for responsive services that are fit for purpose. In my experience, local creative approaches make a difference, with people feeling engaged and able to influence but we are still guilty across agencies of confusing consultation with different stages on Arnstein's *Ladder of Participation*⁶⁴, and often 'badge' information giving as consultation after decisions and priorities have been set. The power debate about controlling budgets and obligations to deliver services will continue but local government reform and the Community Empowerment Act will move power down to locally accountable levels which is good for increasing collaboration and improving performance.

We need to encourage and support community interest in developing, designing and delivering effective, local solutions in partnership with agencies, or as an alternative delivery method. There is definitely desire within communities to be part of this, but we do need caution that it is not just the already empowered, and continue to support effective capacity and skill building, to ensure that we are not widening gaps that exist. By placing more relevance on local research and supporting people to find ways to capture impact, but without burdening people with difficult processes to manage on top of delivering effective services, we can effectively evidence change.

⁶⁴ Find out more about Arnstein's thinking at: <http://www.gov.scot/resource/doc/49303/0122794.pdf>

6.3.4 Other reflections from Aberdeenshire: ideas, comments and responses

Some of the other feedback from participants in the consultation on the full report from staff from CPP partners is given below.

*"... There is a fear that services will be overwhelmed by demand. This has appeared in many policy documents, and has done for over ten years now. We are hearing of examples everywhere, from NHS staff shortages, recurrent winter crises, increased waiting times, care management teams struggling to cope with demand, shortages of care at home and so on. This doesn't really change the main findings of the report about what *may* work at a local level, but we may have to act much faster, and genuinely try approaches for which there is little available evidence but which may seem 'right' at a local and community level."*

"... There are different motivations for entering into preventative activities and investing in prevention. We are all so well versed in what Christie recommends, perhaps we feel we are all speaking the same language when we talk about prevention. Yet whilst they talk about the same thing, the fact that there are different drivers creates an impression of difference or distance between partners. This difference or distance can be hard to overcome. There is a role for leadership here and we need to explore what this type of leadership is."

"... Culture change and learning to work with our community partners presents a considerable workforce development challenge if this is to be effective and not tokenistic. The Community Empowerment (Scotland) Act provides a context within which this can happen and the key challenges for partners include: coordinating their engagement work with communities; staff within partner agencies leading on community engagement work having the required expertise; and, CPP partners seeing community engagement as worth investing in and adding value to their services as opposed to something they have to do."

"... I see better how the shift to prevention could and should fit into local democratic structures. At first, I thought it was about local people being able to inform the agenda. Now, I still consider this local involvement important: it is a valuable part of the information at hand, as is the published evidence and health statistics. However perhaps the role of local democracy is that these choices are about compromises and as such, those making them should be accountable to the people they serve, not just Scottish Government."

"... There is a need to develop a powerful alternative 'narrative' to drive the major policy and cultural change required to tackle inequality, climate change etc; a narrative that would draw on people's capacity to collaborate and co-operate at a community level for change."

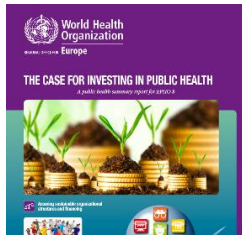
"... I found Neil Craig's (p15) observations thought-provoking and certainly helped me consider that there may be other perspectives, other narratives which are important. I was working on the assumption that there were 'right ways forward'. In reality these do not exist, just a series of compromises and foreseen and unforeseen consequences. Neil, in his report (Craig, 2014) on the best preventative investments for Scotland, gives six priorities. I think these form the start of what would be an accountability framework that can give a clearer steer on the improvements that we are looking for."

Appendices

Appendix 1: further resources and evidence on prevention



The King's Fund [Improving the Public's Health](https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf)⁶⁵: this report fills the gap by providing information and resources in nine key areas to help councils answer crucial questions. It brings together a wide range of evidence-based interventions about 'what works' in improving public health and reducing health inequalities. It presents the business case for different interventions and signposts to further resources.



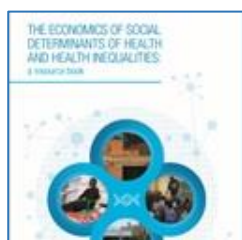
This World Health Organisation's [Public Health Summary](http://www.euro.who.int/_data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf)⁶⁶ outlines quick returns on investment for health and other sectors for interventions that promote physical activity and healthy employment; address housing and mental health; and reduce road traffic injuries and violence. Population-level approaches are estimated to cost on average five times less than individual interventions.



The [Marmot Review](https://www.gov.uk/dfid-research-outputs/fair-society-healthy-lives-the-marmot-review-strategic-review-of-health-inequalities-in-england-post-2010)⁶⁷ into health inequalities in England was published on 11 February 2010. It proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities.



[Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities](http://www.healthscotland.scot/media/1053/1-healthinequalitiespolicyreview.pdf)⁶⁸ written by NHS Health Scotland to provide evidence to the 2013 Scottish Ministerial Task Force on Health Inequalities. It reviews the current policy and the evidence about what works to address health inequalities.



[The Economics of the Social Determinants of Health and Health Inequalities](http://apps.who.int/iris/bitstream/10665/84213/1/9789241548625_eng.pdf)⁶⁹ World Health Organisation resource book establishes the economic arguments to support partnership working for health equity across the range of relevant policy-making fields and sectors.

⁶⁵ https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf

⁶⁶ http://www.euro.who.int/_data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf

⁶⁷ <https://www.gov.uk/dfid-research-outputs/fair-society-healthy-lives-the-marmot-review-strategic-review-of-health-inequalities-in-england-post-2010>

⁶⁸ <http://www.healthscotland.scot/media/1053/1-healthinequalitiespolicyreview.pdf>

⁶⁹ http://apps.who.int/iris/bitstream/10665/84213/1/9789241548625_eng.pdf

Appendix 2: further learning and examples referred to in this report

1. Scottish Fire and Rescue Service: culture change and prevention

Note: The background to Ally Birkett's presentation at Collaborative Learning Day, May 2016

The [Scottish Fire and Rescue Services strategic plan 2016-2019⁷⁰](http://www.firescotland.gov.uk/media/1005163/scottish_fire_and_rescue_service_strategic_plan_2016_2019.pdf) builds on a decade-long practice of preventative approaches to delivering its services. The introduction of the Fire (Scotland) Act in 2005 led to a legislative responsibility to balance activities across intervention, prevention and protection.

Prevention is a constant practice that is continuously happening. It is about anticipating future risks through knowledge-sharing and building common understanding of risks, partnership-building with communities and other public services, collaborative working culture and ongoing evaluation to determine impact and contribution to social value. Against the backdrop of more than ten years of developing preventative approaches, the strategic plan outlines its **key strategic objectives** for the three coming years.

Sharing knowledge across public sector services: "Individuals who have died as a result of fire were, more often than not, known to other agencies such as health, social care or criminal justice. This highlights the absolute need to share knowledge between services about those most vulnerable in our society and to work together better to reduce their risk from harm." (Strategic plan, p:15)

Building understanding: "by increasingly understanding the social make up of each community - its individuals, behaviours, vulnerabilities and inequalities – we will be able to better integrate and coordinate our plans with our local partners" (Strategic plan, p:15)

Local multi agency action teams: "A common understanding between agencies and communities of local priorities will allow for better integration of plans, co-production and coordination of services to target prevention activity where it will be most effective. We will increasingly deliver our broad prevention work as part of local multi agency action teams." (Strategic plan, p:16)

Changing behaviour: "Building an awareness of risks and consequences is a key prevention technique used to influence and change behaviours. For a number of years, we have used education and targeted public safety messages to motivate and empower people to take responsibility for their safety and wellbeing. (examples: [Ageing Safely⁷¹](http://www.firescotland.gov.uk/media/975765/ageing_safely_framework.pdf) and [Youth Engagement⁷²](http://www.firescotland.gov.uk/media/975769/youth_engagement_framework_2016_2019.pdf) Frameworks)." (Strategic plan, p:16)

Anticipation on risks associated with changing policy: "Changes in health and social care place a greater emphasis on enabling people to stay in their homes safely. Working with our partners, including social housing landlords, we need to better understand the risks that

⁷⁰http://www.firescotland.gov.uk/media/1005163/scottish_fire_and_rescue_service_strategic_plan_2016_2019.pdf

⁷¹http://www.firescotland.gov.uk/media/975765/ageing_safely_framework.pdf

⁷²http://www.firescotland.gov.uk/media/975769/youth_engagement_framework_2016_2019.pdf

people will face as a community if we are to successfully achieve this ambition.” (Strategic plan, p:16)

A learning organisation and a collaborative approach. “We adopt a collaborative approach. We see local Health and Social Care Integration Boards, and their multi agency delivery groups, as being the key local forums which we will contribute to, and work closely with.” (Strategic plan, p:16)

Provide advice and enforce fire safety regulations. “We take a highly active role in the collaborative Scottish Business Engagement Forum. We not only seek to promote fire safety in existing premises, we aim to get involved in the early planning stages of new innovative building design proposals and construction projects. We have specialist officers qualified in fire risk engineering working closely with local authority building standards officers as well as the project design team to offer practical guidance to ensure fire safety compliance at an early design stage.” (Strategic plan, p:17)

2. Beyond Action Learning: empowerment, learning and improvement

Note: The report was co-produced by Fiona Soutar (NHS Grampian) and Jane Warrander (Aberdeenshire Council) with James Henderson, What Works Scotland.

The *Beyond Action Learning* project ran from July 2011 to March 2013 and sought to support the integration of health and social care across the then Aberdeenshire Community Health Partnership and Aberdeenshire Council Social Care Services – both now integrated as Aberdeenshire Health and Social Care Partnership. It involved over 170 staff members from across a range of health, social care and other public services. Two facilitators led the process and adapted an ‘action learning set’ approach – which supports shared learning and problem solving – to suit local needs and policy aspirations for collaborative partnership working. They also drew on tools and thinking from ‘improvement methodologies’ to support staff in using data to improve service practice and policies for example

“By actually doing some data gathering and asking questions, we worked out how many of the people going back home in the last six months it would have been reasonable to transfer from the ARI to this Community Hospital. And if the physio or OT had been there, how much more quickly would they have been discharged; what would have been the financial savings; and what would have been the likely outcome of them getting home earlier. We demonstrated that there was a huge saving to be made and that it was worth funding more OT and physio hours in the community hospital and working with colleagues in the acute sector to get people through the system much more quickly.”

“You can sound like you're moaning that you don't have enough hours if you haven't actually put it together in a paper. So together the group wrote a paper. GPs added to it. Care Managers added material about what happens when somebody is ‘mobilised’: when they go home they may need fewer hours of input or fewer people, and so fewer resources to support them. We had all of these contributions which made quite a powerful read and ended up with them being granted funding for more physio hours to see what difference it would make. It was very powerful for them”.

The report highlights both the potential for ‘bottom-up’ staff empowerment through collaborative learning that could support a focus on ‘systems change’ and preventative spend – in this case in relation to delayed discharge, unplanned (emergency) hospital admissions, and community-based care and support. But, also the need for on-going and ‘underlying’ commitment from senior management across key partners.

For more on the learning from the project, view [here on the What Works Scotland website](http://whatworksscotland.ac.uk/publications/learning-about-community-capacity-building-from-community-links-worker-approach-aberdeenshire/)⁷³.

3. Developing a Brief for Community Linking Inquiry Cycle 2: Community Linking and working to reduce poverty and inequality (draft 20.01.17)

1. Introducing this brief

This is a developing draft Brief for a Cycle 2 Inquiry into the role of ‘Community Linking’ in improving community health and wellbeing in Aberdeenshire. It would have relevance to the HSCP’s development of its approach to community capacity-building; to the CPP’s development of its Local Outcomes Improvement Plan, Locality Plans and other community engagement work in relation to the Community Empowerment (Scotland) Act 2015; and to supporting ongoing third sector dialogue on community development approaches.

The Brief builds on Cycle 1 Inquiry work into the role of the Community Links Worker approach developed in Inch (2013-16): see the Executive Summary and Full report at: <http://whatworksscotland.ac.uk/publications/learning-about-community-capacity-building-from-community-links-worker-approach-aberdeenshire/>

Those involved in the development of this Brief (thus far) – across four discussions in July, August, September and November – have included: Alison McPherson, Community Health in Partnership Team (AVA); Jude Richards, Children & Families Development Officer (AVA); Paul Gleisner, Improvement, Aberdeenshire HSCP; Sophie Humphries and Erin Wood, Community Planning Partnership; Nick Bland and James Henderson, What Works Scotland.

This Brief provides an opportunity for those in strategic and operational management across the CPP, HSCP and third sector in Aberdeenshire to consider the value to their development work of:

- **Either** a second cycle of inquiry into the role of a Community Links Worker in reducing poverty and inequality in Aberdeenshire.
- **Or** how to best further use ‘the resources’ established through the Cycle 1 inquiry and the development of this Cycle 2 Brief – namely, the Report and the Inquiry Team members (above) – in supporting strategic and operational development work within Aberdeenshire’s HSCP, CPP and third/community sectors.

⁷³ <http://whatworksscotland.ac.uk/publications/collaborative-learning-research-and-action-in-public-service-reform/>

2. Key elements of a developing focus for inquiry

Our developing discussions have focused on: how can the ‘community linking’ approach to health and wellbeing – and other related ‘community approaches’ – support Aberdeenshire CPP, HSCP and third sector seek to support reduction in poverty and inequality in Aberdeenshire. For instance, through supporting:

- work to develop the proposed LOIP priority focus on ‘Child Poverty’ – and related family poverty and inequality
- the generation of CPP Locality plans aiming to reduce poverty and inequality
- HSCP’s development of strategies aiming to reduce health inequalities (National Outcome).

Note: see Annex A for early thinking on definitions and 2.3, below.

2.1 Initial areas of scoping: questions, knowledge, existing resources and strategic relevance.

(1) Community linking, ‘community approaches’ and reducing ‘poverty and inequality

What do we know already about ‘community linking’ and other ‘community approaches’ in relation to ‘poverty and inequality’ from our Cycle 1 Inquiry work?

- Work done in Inch by CLW re. accessible/affordable transport and services; fuel poverty.
- *Need to consider:* will this (Inch) CLW model work be relevant in areas of higher deprivation as well as more affluent areas? (spread)

What else do we know from our various individual fields of work and expertise about ‘community approaches’ that would be relevant to this Cycle 2 Inquiry? (including resources)

- **Possible case study areas** that could be used for further action inquiry: Fraserburgh, Peterhead, Huntly, Edzell Woods
- **Children and Families – different CLW approach:** would need a different approach to work with older people as often only a small one year of opportunity to link to a family – dangers of isolated parents/families
- **Going beyond ‘mapping the mapping’ – sustainable information sharing:** seeking to establish more sustainable approaches to information that can support community linking work (e.g. three web-based examples Jude has tracked down) ... and seeking to avoid duplication.
- **Avoiding duplication:** how to share data on communities from across different ‘systems’: ALISS; HSCP; Children and Families; Children Services and mental health.

(2) Existing knowledge on level of poverty and inequality in Aberdeenshire

What do we know about poverty and inequalities (economic, social, health) in Aberdeenshire already?

- Risks of hidden pockets of poverty in Aberdeenshire: people and families in dire straits and those with marginal incomes.
- Even in areas with lower levels of child poverty – Gordon and West Aberdeenshire – there are still significant levels of child poverty e.g. unlikely to be below 4-5%; and pockets where levels are much higher e.g. Huntly (17-18%).
- Poverty and inequality creates stigma, social exclusions, social isolation and mental ill-health too – there is material and non-material poverty. Importance then of myth-breaking around poverty, inequality and related stigma.
- Factual, statistical and strategic information has been produced by CPP in relation to LOIP Priority: Child Poverty

What else do we know that is happening that feels relevant in relation to seeking to reduce 'poverty and inequality' in Aberdeenshire?

- Exercise; early interventions; 'passport' example in Portlethen, Health and Social Care integration could impact
- Dementia: seeking dementia friendly approaches – supporting active minds and social contact – link to work of Alzheimers Scotland
- Link to 'children and families' work – information and community linking work with this focus would have much wider benefits including community and mental health.
- What Works Scotland Evidence Review on Child Poverty, [available on the What Works Scotland website](#)⁷⁴
- Resource: End Child Poverty website: www.endchildpoverty.org.uk/
- *Sources of data: GIRFEC in Aberdeenshire; Intelligent Data Group; Grampian Care Data*

(3) Current areas of strategic and/or operational development that might learn from such inquiry work

Areas of current strategic development that could learn from existing and further inquiry work:

- Aberdeenshire HSCP's developing strategic approach to 'community capacity-building' – already an initial contribution at Discussion Group (01.12.16) organised by HSCP/ What Works Scotland.
- Aberdeenshire CPP's LOIP work:
 - LOIP Priorities on Child Poverty and Reducing Alcohol Consumption
 - other LOIP foci – community cohesion, affordable transport, homelessness, obesity
 - also relevant to CPP Locality planning work
- Aberdeenshire Tackling Poverty and Inequalities Strategy Group
- Aberdeenshire Early Years Strategy Group
- Third sector forums – AVA and Rural Partnership

⁷⁴ <http://whatworksscotland.ac.uk/publications/tackling-child-poverty-actions-to-prevent-and-mitigate-child-poverty-at-the-local-level/>

- National (Scotland-wide) research into ‘community linking’ to support Scottish Government development programme for 250 Community Links Workers (note: both AVA and What Works Scotland have had some early contact with this research).

Key strategic questions raised by the consultation work on Community Linking Cycle 1 Research Report that would need attention in further inquiry work:

- What evidence-base is there for community capacity-building generating actual (‘cashable’) reductions/savings in health service provision or wider public service provision? And, if there is one, how could this be usefully applied in Aberdeenshire?
- How can and should limited public sector investment in community capacity-building be targeted – which communities – the most deprived? what size population per worker? What about those in poverty in more affluent communities and across the Shire?
- How can different public services pool their resources and staff to build an effective community capacity-building strategy?

Annex A: Notes on potential meanings

‘community linking’: used here to mean the ‘model 1’ community development based model – as piloted in Inch (2013-16) – rather than ‘the model 2’: social prescribing (although this is relevant to ‘community approaches’ see below).

‘community approaches’: a broad range of community-based practices community development; community capacity-building; community organising; local volunteering; community/social action; community networking; community enterprise; community anchors and so on.

‘poverty and inequality’: broad scope of material and non-material deprivation generated through inequalities via income and class; gender; race and ethnicity; age; sexuality; disability; culture and belief.

‘health inequalities’: differences relating to people’s health and wellbeing e.g. lifespan, and generated by the range of inequalities given above.

4. What Works Scotland Evidence Review on Partnership Working (Cook, 2015)

Summary of areas to consider in developing good practice.

Inputs / Resources for partnership:

- Adequate and secure funding
- Effective IT systems that enable information sharing
- Partnership specific management structure
- Sufficient staff
- Previous experience of joint working

Partnership activities:

- Develop and articulate shared aims and objectives
- Clarify roles, responsibilities and lines of accountability at operational and strategic levels
- Establish performance management systems that reflect complexity of partnership, capture range of activity and have focus on outcomes

Engagement / involvement / reach:

- Key staff working at operational and strategic levels are included
- Local communities and voluntary and community sector organisations meaningfully involved
- Relevant private sector organisations relate to the partnership in appropriate ways

Stakeholder reactions and awareness:

- The need for the partnership is recognized
- There is commitment to the partnership at operational and strategic levels
- Strategic managers/funders/central government are realistic about what partnership can achieve

Knowledge, attitudes, skills and aspirations for effective partnership:

- Different professional approaches and expertise are valued
- Partners are trusted and respected
- Partners feel that relationships are mutually beneficial
- Partners take time to understand the contexts in which each other are working
- There is expertise in project and change management within the partnership
- Staff believe other partners and the partnership as a whole will deliver on objectives

Practices and behaviours for effective partnerships:

- A flexible approach to developing the work, using resources and determining roles and accountability.
- Regular and effective communication and information sharing between partners at operational and strategic levels
- Regular opportunities for joint working, including meetings, joint training and co-location
- Effective and visible leadership at strategic and operational levels
- Involvement of wider partners and staff in development of procedures and policies

- Services/interventions are holistic and responsive, meeting broad needs of populations/clients
- Services provide specialist support where required
- There are appropriate ways of achieving conflict resolution and consensus building
- The partnership engages in continual reassessment of processes and procedures

Final outcomes of effective partnerships:

- Improved health and wellbeing
- Reduction in inequalities
- Reduction in offending
- Equitable access to services
- Avoid inappropriate service use
- Reduction in costs
- Responsive service meeting needs and preferences of clients

View the full Evidence Review [on the What Works Scotland website](#)⁷⁵

⁷⁵ <http://whatworksscotland.ac.uk/publications/creating-effective-partnerships-to-deliver-public-services/>

Acknowledgements

Many thanks to all those who've had input into the co-production of the report and its case studies and the related activities that inform them. Co-production in this case is taken broadly to mean an active involvement in any of these activities: discussing material relevant to the report or supporting case studies; drafting text; taking part in the consultative work.

Section 2:

2.3: The Aberdeenshire Submission to Scottish Parliament Finance Committee was developed by: George Howie, Principal Health Improvement Officer, Aberdeenshire Health & Social Care Partnership; Chris White, Buchan Area Manager & Tackling Poverty & Inequalities Group, Aberdeenshire Council; Gillian Robertson, Commissioning & Performance Manager, Aberdeenshire Alcohol and Drug Partnership; Ally Macleod, Housing Strategy Manager, Aberdeenshire Council; Catriona Tulloch, Community Planning Officer (Marr), Aberdeenshire Council; Philip McKay, Head of Roads and Landscape Services, Aberdeenshire Council; Erin Wood and Sophie Humphries, Strategic Development Officers, Aberdeenshire CPP; Amanda Roe, Service Manager, Aberdeenshire Council.

Approximately 40 people participated in Collaborative Learning Day 1 from across Aberdeenshire CPP. A full list is not given due to the space required, but their input has been crucial to developing this report. Ed Garrett (Mearns and Coastal Health Living Network) presented on community-led health and wellbeing.

Section 3:

3.5: Approximately 50 people participated at Collaborative Learning Day 2 from across Aberdeenshire CPP, North-East Scotland and beyond. A full list is not given due to the space required, but their input has been crucial to developing this report. Presenters and keynote listeners are listed in section 3.

Section 4: Case Study 1: A Changing Relationship with Alcohol

2: Evidence research paper – Wayne Gault, Aberdeenshire Alcohol and Drug Partnership

3: Participants in the workshop included: Dawn Brown, Garioch Partnership; James Henderson, What Works Scotland; Wayne Gault, Aberdeenshire Alcohol and Drug Partnership; John Scott McCullough, Scottish Ambulance Service; Carol Muir, NHS Grampian; Tara Shivaji, Consultant in Public Health, NHS Grampian; Elaine Sinclair, Aberdeenshire Voluntary Action; Elaine Wilson, Lloyds TSB Foundation Scotland; Kevin Wallace, Scottish Police Service; Erin Wood, Aberdeenshire CPP.

4: Summary by James Henderson, What Works Scotland, of various discussions or consultation feedback.

Section 5: Case Study 2: Community Capacity-building for Health & Wellbeing

1: Participants in the workshop included: Philippa Berry, Aberdeenshire Health and Social Care Partnership; Nick Bland, What Works Scotland, Dawn Brown, Garioch Partnership; Andrea Fraser, CAIR Scotland; James Henderson, What Works Scotland; Kevin McDermott, Community Learning and Development, Aberdeenshire Council; Alison McPherson, Aberdeenshire Voluntary Action; Doug

Milne, Garioch Area Manager, Aberdeenshire Council; Isobel Moir, Friends of Inch Hospital and Community; Carolyn Lamb, Public Health, NHS Grampian; Kim Penman, Aberdeenshire Health and Social Care Partnership; Naida Sneddon, Aberdeenshire Alcohol and Drug Partnership; Bill Stokoe, Older Peoples' Service, Aberdeenshire Health and Social Care Partnership.

2: Community Links Worker Partnership Innovation Team team⁷⁶

3: Summary by James Henderson of various discussions or consultation feedback.

Section 6:

6.3: Commentaries from Neil Craig, NHS Health Scotland; Dawn Brown, Garioch Partnership; and others who gave feedback. The case studies are available on the What Works Scotland website at: whatworksscotland.ac.uk/publications/inquiring-into-multi-layered-preventative-partnership-working

Appendix 2:

(1): Material provided by Ally Birkett, Scottish Fire & Rescue Service.

(2): Material from *Beyond Action Learning* report co-produced by Fiona Soutar (NHS Grampian), Jane Warrander (Aberdeenshire Council) and James Henderson (What Works Scotland).

(3): *Draft Brief for Inquiry work on Community Linking and inequality (Cycle 2)* Initial discussions involved: Alison McPherson, Community Health in Partnership Team, and Jude Richards, Children & Families Development Officer, Aberdeenshire Voluntary Action; Paul Gleisner, Improvement, Aberdeenshire HSCP; Sophie Humphries and Erin Wood, Community Planning Partnership; Nick Bland and James Henderson, What Works Scotland.

Participants in the consultation on the full draft document

Nick Bland, What Works Scotland; Dawn Brown, Garioch Partnership; Wayne Gault, Aberdeenshire Alcohol and Drug Partnership; George Howie, Aberdeenshire Health and Social Care Partnership; Tara Shivaji, Consultant in Public Health, NHS Grampian; Bill Stokoe, Older Peoples' Service, Aberdeenshire Health and Social Care Partnership.

Editing, research, other text and What Works Scotland commentaries

Editing, research and other text: James Henderson, Cleo Davies (What Works Scotland)

What Works Scotland commentaries (2.4; 3.6; 5.2, section 4 in Case Study 1 and section 5 in Case Study 2): initially drafted by James Henderson (What Works Scotland researcher) and then further developed through the consultation work across the individual sections and the full report. The final responsibility for these commentaries, and the report as a whole, remains with the researcher.

Layout, design and graphics: Dawn Cattanach (What Works Scotland); with further graphics and layout by Cleo Davies (What Works Scotland) on 3.2, 3.3, 3.4 and Appendix 1.

⁷⁶ Full team is listed in this report whatworksscotland.ac.uk/publications/learning-about-community-capacity-building-from-community-links-worker-approach-aberdeenshire/