1. **PURPOSE OF REPORT**

1.1 The purpose of this report is to update members on the progress of the Community Health Improvement Partnership (CHIP) following the mainstreaming of the initiative in 2008 and completion of the second year of the Service Level Agreement between NHS Ayrshire & Arran and East Ayrshire Council.

2. **BACKGROUND**

2.1 The Community Health Improvement Partnership (CHIP) was established in 2001 to directly address health inequalities within East Ayrshire’s most deprived communities with a particular emphasis upon coronary heart disease.

2.2 The services delivered by CHIP very quickly developed from the original CHIP Van in line with local priorities to incorporate an extensive range of programmes which focused on reducing health inequalities and in 2008, following seven years of temporary external funding, CHIP was mainstreamed by East Ayrshire Council and NHS Ayrshire & Arran and became a permanent service.

2.3 The NHS Ayrshire & Arran funding arrangements necessitated the development of a Service Level Agreement which has now been in operation for two years.

2.4 The Community Health Improvement Partnership is managed and delivered by the Council’s Leisure Development Services section within the Department of Neighbourhood Services. The other services in this section include Community Play Development; Sports Development and Children’s Health Development (Recreation Partnership Service). Working together all of these provide a coherent, whole population approach to improving health and wellbeing, and reducing health inequalities within East Ayrshire Communities.

3. **PROGRESS / PERFORMANCE**

3.1 **Healthy Communities and Workplaces**

<table>
<thead>
<tr>
<th>Target(s)</th>
<th>Performance</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,000 attendances through outreach services such as CHIP van, events &amp; groups</td>
<td>4,446 attendances via outreach services</td>
<td></td>
</tr>
</tbody>
</table>
The CHIP van remains a popular visitor in communities and is an important first point of contact with individuals in terms of anticipatory care. The CHIP van attendances represent an increase of over 200 from last year’s results. Similarly there is a slight increase on last year’s workplace interventions which have this year included greater focus on the importance of a healthy workforce to improve productivity.

3.2 Lifestyle Referral Scheme (LRS)

<table>
<thead>
<tr>
<th>Target(s)</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>700 new referrals per year</td>
<td>1,109 new referrals</td>
</tr>
</tbody>
</table>

This element of the CHIP Service continues to be the fastest growing and the results demonstrate continued development in relationships and trust with medical professionals who make referrals. These results show an increase of nearly 200 individual referrals on last year’s performance. The LRS also represents CHIP’s highest impact service and most recently a snapshot evaluation of those completing a year’s involvement in the service indicated:

- 97% used other CHIP Services as prescribed by the LRS consultant
- 88% had achieved some (61%) or all (27%) of the goals set for them since referral; and most importantly
- 83% intend to continue with the range of activities upon leaving the LRS

3.3 Programmes to treat specified Illnesses, Long Term Conditions, and the Frail Elderly Population

<table>
<thead>
<tr>
<th>Target(s)</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum of 900 classes per year</td>
<td>747 classes delivered</td>
</tr>
<tr>
<td>8,000 attendances per annum</td>
<td>11,321 Attendances at classes</td>
</tr>
</tbody>
</table>

A range of interventions have been delivered including provision of rehabilitation and confidence building for patients with Chronic Obstructive Pulmonary Disease (COPD) and Cancer as well as prevention and rehabilitation programmes for the frail and elderly population more susceptible to falls.

The numbers attending classes this year is over 1,000 more than performance in 2009/10 and it should be noted that in terms of actual delivery some classes span up to 3 hours and therefore whilst the target for classes was not achieved the number of class hours increased to 1,004 in this period.
Over and above these performance measures, the CHIP team have commenced a pilot Older Person’s Play programme in partnership with colleagues in Outdoor Amenities and the Council’s Community Care team at Rosebank Centre. This has resulted in the installation of a range of fitness and therapeutic play equipment being installed and will result in the publication of easy to use exercise cards, training and led-classes at the centre.

### 3.4 Equalities

<table>
<thead>
<tr>
<th>Target(s)</th>
<th>Performance</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support 3 wellbeing events held within Kilmarnock Prison - 200+ attendances per visit</td>
<td>2 events supported</td>
<td>Not Achieved</td>
</tr>
<tr>
<td></td>
<td>200+ Attendances at each event</td>
<td>Achieved</td>
</tr>
<tr>
<td>Deliver 10 health awareness sessions within homeless facilities - 50+ attendances per year</td>
<td>12 sessions delivered</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>158 Attendances in total</td>
<td>Achieved</td>
</tr>
<tr>
<td>Deliver 4 weeklong Men’s Health Events - 300 participants per year</td>
<td>4 events delivered</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>254 Attendances in total</td>
<td>Not Achieved</td>
</tr>
<tr>
<td>Provide information on healthy living at 2 mental health events</td>
<td>3 events supported</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

The work of CHIP is driven by the reducing health inequalities agenda and whilst this section of the SLA relates specifically to equalities the vast majority of CHIP services are focused on achieving this outcome.

This year a new approach to Men’s Health Promotion was implemented which whilst resulting in lower uptake successfully attracted men who participated for the first time. Similarly, the methods of engaging with the homeless population have been to encompass a wider section of the community including working with voluntary sector partners which has led to a sharp increase in numbers benefiting.

### 3.5 Healthy Eating

<table>
<thead>
<tr>
<th>Target(s)</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver a minimum of 25 programmes / events focussing on healthy eating including Cookwell, healthy buffets &amp; weight management programmes</td>
<td>25 healthy eating sessions</td>
</tr>
</tbody>
</table>

A range of healthy eating interventions are delivered within the community including Cookwell, cookery demonstrations, healthy buffets and weight management sessions. The focus across all of these is on awareness raising and providing practical input to promote healthy food purchase and preparation.
3.6 Keep Well

Following completion of year one of the SLA, NHS Ayrshire & Arran as commissioners requested an addendum to the existing agreement requiring CHIP to deliver specific elements of the national Keep Well programme. This was agreed late 2009 and the performance below covers only February and March of this reporting period.

<table>
<thead>
<tr>
<th>Target(s)</th>
<th>Performance</th>
<th>Not Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 days per year of outreach visits by the CHIP van will be allocated to Keep Well Communities:</td>
<td>14 days were allocated</td>
<td>Not Achieved</td>
</tr>
<tr>
<td>- including offering a minimum of 600 Keep Well checks to people who have not received one</td>
<td>1,700+ households offered health checks</td>
<td>Achieved</td>
</tr>
<tr>
<td>- monitor uptake of offers and review at end of 1st quarter</td>
<td>14 health checks have been completed</td>
<td>Achieved</td>
</tr>
<tr>
<td>2 health and activity classes will be delivered per week for adults with a learning disability</td>
<td>2 classes delivered per week</td>
<td>Achieved</td>
</tr>
<tr>
<td>5 walking groups per week will be delivered within Keep Well communities</td>
<td>5 walking groups delivered</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

Keep Well is a national anticipatory care programme targeting those aged 45 - 64 years living in the 0-15% most deprived data zones. The programme aims to deliver comprehensive health checks which are used to identify and thereafter reduce the risk factors associated with the development of coronary heart disease.

In order to attract the target group, the CHIP team are provided with postcodes, not actual names and addresses, of individuals who meet the criteria for Keep Well. Therefore when promoting the service whole streets are targeted in an attempt to capture the specific individuals. Whilst this approach is slightly scatter-gun in nature, it has resulted in increased uptake of health checks for the general population over and above the 12 Keep Well clients checked.

3.7 Healthy Weight Community Pathfinder – “C’mon Catrine”

The existing strong commitment to partnership working between CHIP and NHS Ayrshire & Arran was a key component of the bid to host a Scottish Government Healthy Weight Pathfinder in Catrine. This partnership has subsequently expanded and been strengthened by the addition of a range of
other public and third sector agencies and in particular by the commitment of all to leave logos and egos off the agenda in taking forward “C’mon Catrine”.

Progress on the pathfinder in the last year has been rapid including an extensive audit of community activities and resources; identification of key groups in the community; door step awareness raising and evaluation, a community celebration; and the production of a single leaflet incorporating all community provision. There has also been extensive fitness and wellbeing testing in the primary school and clear baseline data established to help measure success.

The Scottish Government has appointed Rocket Science as the national evaluation team and early feedback in relation to East Ayrshire progress using survey monkey are exceptionally positive when compared nationally. It is highly likely that these early positive results are a direct result of the strong partnerships in place alongside a clear focus on actual delivery of services. Further more in-depth evaluation will take place in the year ahead, the results of which will be a key determinant of future roll-out of this initiative.

4. BEST PRACTICE / ACHIEVEMENTS

4.1 CHIP is currently involved in a research study with Glasgow University which includes a pilot rehabilitation programme for patients who receive treatment for Multiple Sclerosis. The approach to CHIP was made for a number of reasons including the Service’s track record in providing disease specific rehabilitation programmes, on-going support and continued activity opportunities for patients.

4.2 Similarly, the service has piloted an NHS Ayrshire and Arran led programme encouraging patients who are receiving treatment for cancer to participate in physical activity. Evidence suggests that by taking gentle exercise some of the symptoms associated with treatment can be alleviated. Following completion of the pilot support will continue to be available to individuals via LRS and community based class programme.

5. FUTURE DEVELOPMENT AGENDA

5.1 The Services of CHIP will continue to take an outcome focused approach to reducing health inequalities and improving the health and wellbeing of our most vulnerable groups. In developing the service the following are priorities in the year ahead:

- Develop further innovative solutions to delivering the community element of the national Keep Well initiative.
- Enhance the work with the Long Term Conditions Collaborative and Community Rehabilitation staff in relation to Shifting the Balance of Care.
- Further develop partnership work with colleagues in NHS Ayrshire & Arran and Council Community Care to focus the frail elderly population including the development and roll-out of older person’s play areas.
• Develop CHIP services in line with the Council’s role as a corporate parent with a specific focus on care leavers.
• Continue the partnership focused development of the Healthy Weight Community initiative and identify sustainability / roll-out options following full evaluation of impact.
• Make increased use of the statistics recorded in relation to individuals who attend the LRS to identify health impact made, adherence levels, review the number of contacts made with each individual

6. RISK ASSESSMENT

6.1 The Service Level Agreement between NHS Ayrshire & Arran and East Ayrshire Council is now entering its final year it is imperative that a new agreement be negotiated early to avoid issues around staff retention and potential loss of services that are impacting on the health of most vulnerable sections of the community.

6.2 The health and safety risks associated with the work of CHIP are minimal. All working practices are risk assessed in line with authority regulations and the principles of managing safely including driver training, lone working arrangements and non-violent crisis intervention. Additionally all staff delivering intensive physical activity are appropriately qualified and only specialist staff are deployed to work with those with specific medical conditions.

7. LEGAL / AUTHORITY IMPLICATIONS

7.1 In order to secure mainstream funding a Service Level Agreement between NHS Ayrshire & Arran and East Ayrshire Council is in operation, a copy of this is available as part of the background papers.

7.2 The Service Level Agreement has been approved by legal services within both NHS Ayrshire & Arran and East Ayrshire Council and is subject to annual reporting through the Council Cabinet and the Committee of the Community Health Partnership.

8. FINANCIAL IMPLICATIONS

8.1 There are no further financial implications associated with this report.

9. POLICY / COMMUNITY PLANNING IMPLICATIONS

9.1 The Services of CHIP have been designed to reflect the most significant priorities of key national and regional strategies as they relate to the population of East Ayrshire including the National Physical Activity Strategy, Improving Scotland’s Health – The Challenge, Ayrshire & Arran Primary Prevention Strategy, Ayrshire Cancer Prevention Strategy, the Equally Well Implementation Plan and most recently the Scottish Government’s new Obesity Route Map.
9.2 CHIP delivers directly on aims one, two and five of the Improving Health & Wellbeing thematic Action Plan of the East Ayrshire Community Plan and is represented on the Community Health Partnership Officer Locality Group (Adults) and all appropriate sub groups.

10. CONCLUSION

The CHIP Service has performed well against all original targets set in the SLA and has adapted to incorporate several new areas of work in response to identified need. The work of CHIP is clearly outcome focused and now boasts an increasing range of evidence to suggest that services are having a clear positive impact, particularly on our most vulnerable groups.

11. RECOMMENDATIONS

It is recommended that the CHP Committee:

(i) Note the progress of the Community Health Improvement Partnership in respect of all aspects of the SLA and particularly in relation to new areas of work
(ii) Approve the identified future development agenda as priorities for the year ahead
(iii) Agree an early process to negotiate an extended Service Level Agreement to sustain services beyond March 2011.

12. GLOSSARY OF ACRONYMS USED

CHIP: is the Acronym for the Council’s Community Health Improvement Partnership Service which is based within Leisure Development Services;

LRS: is the Acronym for the Lifestyle Referral Scheme

LIST OF BACKGROUND PAPERS

1. Community Health Partnership Committee Report - Year 1 SLA Progress - 18th May 2009
2. East Ayrshire Council Cabinet Report - Year 1 SLA Progress - 17th June 2009
5. Community Planning and Partnership Board Meeting - Fairer Scotland Fund - 6th March 2008
7. Service Level Agreement with NHS Ayrshire and Arran – March 2008
8. Addendum to Service Level Agreement with NHS Ayrshire and Arran – Nov 2009

Any person wishing to inspect the background papers listed above should telephone 01563 578178 and ask for John Griffiths, Head of Leisure Services Implementation Officer – (john.griffiths@east-ayrshire.gov.uk)