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Working with communities to improve the quality of life for all in Argyll and Bute

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7 August 2018

NOTICE OF MEETING

A meeting of the **BUTE AND COWAL COMMUNITY PLANNING GROUP** will be held in the **TIMBER PIER BUILDING, DUNOON** on **TUESDAY, 14 AUGUST 2018** at **10:00 AM**, which you are requested to attend.

BUSINESS

1. WELCOME AND APOLOGIES

2. DECLARATIONS OF INTEREST

3. MINUTES

(a) Bute and Cowal Community Planning Group - 1st May 2018 (Pages 5 - 10)

4. MANAGEMENT COMMITTEE UPDATE

Report by Community Planning Manager (Pages 11 - 14)

5. AREA COMMUNITY PLANNING ACTION PLAN

(a) Strachur Hub (Pages 15 - 94)

Update by Heather Grier

(b) Update on Opportunities available for local businesses to engage with the Argyll and the Isles Tourism Co-Operative

Update by Colin Moulson, PA23 BID Manager

(c) Transformation Projects and Regeneration (Pages 95 - 106)

Presentation by Senior Development Officer

(d) Update on great places heritage bid
Update by Senior Development Officer

(e) Feeling Safe in Dunoon
Update by Superintendent Brian Gibson, Police Scotland

6. COMMUNITY FOCUS

(a) Maxie Richard's Foundation - King's Court
Update by Brian Leech

7. ARGYLL AND BUTE OUTCOME IMPROVEMENT PLAN 2013-2023 - OUTCOME 5 (PEOPLE LIVE ACTIVE, HEALTHIER AND INDEPENDENT LIVES)

(a) Health and Social Care Strategic Plan (Pages 107 - 142)
Report by Argyll and Bute Health and Social Care Partnership

(b) Health and Well Being Annual Report (Pages 143 - 172)
Report by Argyll and Bute Health and Social Care Partnership

8. ARGYLL AND BUTE OUTCOME IMPROVEMENT PLAN 2013-2023 - OUTCOME 6 (PEOPLE LIVE IN STRONGER AND SAFER COMMUNITIES)

(a) Scottish Fire and Rescue - Annual Update
Update by Stuart McLean

(b) Police Scotland - Annual Update
Update by Inspector MacLean

(c) ACHA (Pages 173 - 182)
Update by Iona McPhail

9. PARTNERS UPDATE

(a) Highlands and Islands Enterprise (Pages 183 - 184)
Report by HIE Representative

(b) Gateway Project
Update by Kyle Wilson, Youth Worker

Opportunity for verbal updates by Community Planning Partners

10. DATE OF NEXT MEETING - TUESDAY 6 NOVEMBER 2018 AT 10:00AM IN EAGLESHAM HOUSE, ROTHESAY

Discussion facilitated by the Area Governance Manager on items for inclusion on the Agenda for the next meeting.
Outcomes to be discussed:

OUTCOME 1: THE ECONOMY IS DIVERSE AND THRIVING

OUTCOME 2: WE HAVE INFRASTRUCTURE THAT SUPPORTS SUSTAINABLE GROWTH

Bute and Cowal Community Planning Group

Willie Lynch (Chair)   Alistair McLaren (Vice-Chair)

Contact: Andrea Moir, Senior Area Committee Assistant - 01369 708662

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MINUTES of MEETING of BUTE AND COWAL COMMUNITY PLANNING GROUP held in EAGLESHAM HOUSE, ROTHESAY on TUESDAY, 1 MAY 2018

Present: Willie Lynch (Chair)
Alistair McLaren, Argyll Third Sector Interface
Councillor Audrey Forrest
Councillor Jean Moffat
Councillor Jim Anderson
Councillor Bobby Good
Stuart McLean, Area Committee Manager, Argyll & Bute Council
Samantha Somers, Community Planning Officer, Argyll & Bute Council
Sharon MacDonald, Community Development Officer, Argyll & Bute Council
Blair Moglia, Caledonian MacBrayne
Paul Duffy, Bute Island Alliance
Sergeant Neil Grant, Police Scotland
Bobby Tourish, Scottish Fire and Rescue
Catherine Russell, Colintraive and Glendaruel Community Council
Brian Leitch, Maxie Richards Foundation
Patrick White, Maxie Richards Foundation

1. WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and general introductions were made.

No apologies were intimated

2. DECLARATIONS OF INTEREST

No declarations of interest were intimated.

The Chair ruled and the Group agreed to take Police Scotland's partner update at the start of the meeting to facilitate officer attendance. This update was taken after item 2. Declarations of Interest of the agenda.

8. PARTNER UPDATE - POLICE SCOTLAND

Sergeant Grant informed the Group that this quarters crime statistics were down from the previous quarter with no major incidents to report.

Sergeant Grant also highlighted some of the ongoing community engagement activities which included a school poster competition on how to tackle dog fouling and an ongoing campaign to recruit youth volunteers which was being taken forward by the Youth Engagement Officer for the Cowal Area.

3. MINUTES

(a) Bute and Cowal Community Planning Group – 6th February 2018

The minute of the Bute and Cowal Community Planning Group meeting of 6th February 2018 was approved as a correct record.

4. MANAGEMENT COMMITTEE UPDATE

The Group considered a briefing note outlining the matters of concern which had been raised by Community Planning Group Chairs at the Argyll and Bute Community Planning Partnership Management Committee which was held on 13th March 2018.

Decision

The Group noted the contents of the briefing note.

(Ref: Briefing Note by Community Planning Manager, dated 1st May 2018, submitted).

5. AREA COMMUNITY PLANNING ACTION PLAN

(a) Timetable for Area Community Planning Action Plan items

The Group considered a briefing note that outlined the timetable for Area Community Planning Action Plan items and the ongoing work to determine how the actions would be progressed and presented to the Area Community Planning Group.

Decision

The Group:

1. Noted the contents of the report; and
2. Agreed the timetable for those items listed and note that those currently not scheduled into an upcoming meeting would be when an appropriate timescale has been agreed with those involved in the action.

(Ref: Briefing Note by Community Planning Officer, dated 1st May 2018, submitted).

(b) Rothesay Pavilion Update

The Group considered a briefing note that outlined the progress of the Rothesay Pavilion renovation programme as well as the background and future plans of the Rothesay Pavilion Charity Group.

It was noted that once the renovation process was complete the Rothesay Pavilion Charity Group would be looking to actively engage with the Bute and Cowal Community Planning Group.

The Chair noted the ambitious plan for the Pavilion and that once completed it would be an asset to Bute.

Decision

The Group noted the contents of the briefing paper.

(Ref: Report by Rothesay Pavilion Charity dated 1st May 2018, submitted)

(c) **Strachur Hub**

Alistair McLaren provided a verbal update on the Strachur Hub, the following points were noted:

- The Hub was established two years ago with an aim to engage with older members of the community.
- The HUB had grown to include social activities, lunch clubs and exercise classes.
- The Health and Social Care Partnership had identified the Strachur Hub as a successful model and are looking to replicate this across the Argyll and Bute area

Decision

The Group:

1. Noted the verbal update; and
2. Noted a full report/ presentation would be brought to the August meeting of the Bute and Cowal Area Community Planning Group.

(Ref: Verbal update by Alistair McLaren dated 1st May 2018, submitted)

6. COMMUNITY FOCUS

(a) **Bute Island Alliance**

The Group considered a presentation by the Bute Island Alliance which provided a background to the formation of the Alliance and the key purposes of the Charrette, which was not only to retain people on the island but also to attract new residents.

The presentation also highlighted:

- How the project fits into the 6 single outcome agreements.
- The progress of the project in the last 12 months.
- The objectives moving forward, including securing office and manufacturing space that would allow prospective small business's to grow.

It was noted that the Bute and Cowal Area Community Planning Group had a role to play in helping to maximise local investment and should help the alliance to integrate into the local area action plan.

Decision

The Group:
1. Noted the presentation; and
2. Agreed that this item would be added to the June meeting of the Community Planning Partnership.

(Ref: Presentation by Bute Island Alliance dated 1st May 2018, submitted)

7. ARGYLL AND BUTE OUTCOME IMPROVEMENT PLAN 2013-2023 - OUTCOME 3 (EDUCATION, SKILLS AND TRAINING MAXIMISES OPPORTUNITIES FOR ALL)

Bobby Tourish on behalf of Scottish Fire and Rescue informed the Group that they were currently delivering a series of fire skills courses in the Bute and Cowal area and are looking to roll this course out across Argyll and Bute.

Mr Tourish also informed the Group that a real crash scenario involving multiple agencies would be taking place in Dunoon stadium at the end of May.

Decision

The Group noted the contents of the verbal update.

(Ref: Verbal update by Scottish Fire and Rescue dated 1st May 2018, submitted)

(a) Education Quality and Standards Report

The Group considered the Argyll and Bute Education Annual Plan for 2017/2018 ‘Our Children, Their Future’.

Decision

The Group noted the contents of the report.

(Ref: Report by Head of Education dated 1st May 2018, submitted)

(b) Secondary School Education Reports

The Group considered the Dunoon Grammar School and Rothesay Academy education reports which provided an update on the schools achievements for the 2017 session.

Decision

The Group noted the contents of the reports.

(Report by Head Teacher, Dunoon Grammar School and Rothesay Academy dated 5 December 2017, submitted)

8. PARTNERS UPDATE

CalMac Ferries

Blair Moglia informed the Group that Caledonian MacBrayne were rolling out a range of initiatives to celebrate 2018 being the year of the young person, including

- 28 modern apprenticeships.
- Workshops for vulnerable youngsters.
- Collaboration with Young Scot and Transport Scotland to roll out a ticketing pilot scheme which would include discount's and incentives.
- Cadet sponsorship via Clyde Marine

Ms Moglia also explained that the company were raising awareness of corporate social responsibility and would be introducing a work shadowing scheme to allow younger members of staff to gain more experience in the workplace and their Human Resources department would also be running employability workshops in schools.

Third Sector Interface

Alistair McLaren tabled a written update to the Group regarding Historic Kilmun and Scottish Rural Action.

Historic Kilmun was now open, a range of activities and projects were now available until 31 October 2018, including Oral History and Art Therapy projects. Historic Kilmun had also submitted an application to Creative Scotland for funding to help make this season really special.

Mr McLaren reported that the location and date for the Scottish Rural Parliament in 2018 would be issued shortly. A recently released report, FareEnough?, highlighted the impact of transport costs on access to education and employment for young people. A free rural transport conference was taking place in September, which would feed into the National Transport Strategy 2.

(Ref: Briefing note Third Sector Interface, dated 1st May 2018, tabled)

Scottish Fire and Rescue

Mr Tourish from Scottish Fire and Rescue advised that there had been 33 recorded incidents in Bute and 43 in Dunoon. Incidents recorded included primary fires, secondary fires, chimney fires, special service call outs, car accidents and false alarms.

Mr Tourish also informed the Group that 57 home fire safety inspections had been carried out in Dunoon and 33 in Bute.

The Chair noted the excellent services that the retained fire fighters offer in both Bute and Cowal.

9. CPG AGENDA COMPILATION

The Group considered a report which outlined a development in the compilation of agendas for meetings, linking to and progressing the work which has been carried out in developing Area Community Planning Actions Plans and enabling groups to focus on a regular basis on local matters related to the various Outcomes in the Argyll and Bute Outcome Improvement Plan (ABOIP) 2013-2023.

Decision

The Group:

1. Noted the contents of the report; and
2. Agreed the proposed agenda compilation for meetings.

(Ref: Report by Area Governance Manager dated 1st May 2018, submitted)

10. DATE OF NEXT MEETING

The Group noted that the next meeting of the Bute and Cowal Area Community Planning Group would take place at 10.00am on Tuesday 14th August 2018 in the Timber Pier Building, Dunoon.

Agenda Item 4

Argyll and Bute Community Planning Partnership

Bute and Cowal
Area Community Planning Group

14th August 2018

Briefing Note: Community Planning Partnership Management Committee update

This briefing relates to the meeting of the Community Planning Partnership (CPP) Management Committee on 27 June 2018, and its consideration of issues raised by Area Community Planning Group Chairs. The briefing is for noting and relevant discussion.

Summary

The CPP Management Committee met on the 27 June in Kilmory, Lochgilphead.

Area Community Planning Group chairs raised matters of concern within their local areas with the CPP Management Committee, and these matters were taken on board and actioned where relevant. A report outlined the main issues from the last set of Area Community Planning Group meetings. The Chair of Bute and Cowal have an update on the work of Bute Alliance.

Further information is available in the *meetings, minutes and agendas* section of: https://www.argyll-bute.gov.uk/council-and-government/community-planning-partnership

Highlights

- Partners agreed there is a need to support the promotion of Argyll and Bute. The following were highlighted at the meeting:
  - #abplace2b is the Instagram account of the council which has many followers and excellent images submitted by people showcasing Argyll and Bute. Please promote and link to this.
  - www.wildaboutargyll.co.uk is an excellent website that everyone can use to promote the area.

- Anne Paterson, Head of Education, updated on the new Early Years Strategy to meet the requirement for an increase in the number of hours of free Early Years provision.

- Partners were asked to contribute their case studies for the annual report of the CPP.

- Excellent and informative presentations were made by:

- Kirsteen Murray, CEO of Argyll and Bute Third Sector Interface, gave a presentation detailing the specific functions mandated of the Third Sector Interface (TSI) by the Scottish Government and outlined some of the changes being implemented in the future months.

- Laura Stephenson from the Public Health team within NHS Highland gave a presentation on the Tobacco Strategy. The CPP agreed the adoption of the strategy in principal.

- Argyll Coast and Countryside Trust (ACT) and Argyll and the Isles Tourism Cooperate (AITC) gave a joint presentation on the work of the two organisations and their partnership activity. ACT have been successful in creating employment, generating income and bringing in £1.5million of external funds. AITC spoke of the wildaboutargyll website showcasing Argyll as a great place to live and visit. AITC also spoke of an ongoing project mapping the tourism infrastructure to identify opportunities for potential community enterprises or businesses.

Matters Raised by Area Community Planning Group Chairs

The points raised from the previous meetings of the area community planning groups and the action response to these is below:

1. Recognise the work of the Strachur Hub and keep the effective model of working in mind when considering service development and enhancement in other communities.
    a. **Strachur Hub will be invited to a future meeting of the Management Committee**
2. Note and discuss the concerns of the MAKI CPG in regards the lack of attendance by key partners at MAKI CPG meetings.
    a. **Partners to commit to attend MAKI meetings with the knowledge that video-conference facilities always be available**
3. Note the request from the MAKI CPG that mental health first aid training be provided on the island of Islay
    a. **Request sent to Health and Social Care Partnership colleagues**
4. Note the difficulties experienced in Oban regarding access codes for defibrillator units and consider if there is support at strategic level which can be put in place to resolve this issue quickly
    a. **SuperIntendent Gibson from Police Scotland to coordinate an approach to access codes and defibrillators across the area.**

Concluding Point for Action

Communicating Community Planning is a priority for the Partnership and we welcome issues raised at Area Community Planning Groups, where these cannot be resolved locally, to be highlighted to the Argyll and Bute Management Committee meetings. The next formal meeting of the Community Planning Management Committee is 20 November 2018.

We welcome partners at Area Community Planning Groups sharing and linking to #abplace2b Instagram account of the council which has many followers and excellent images submitted by people showcasing Argyll and Bute. And, www.wildaboutargyll.co.uk

For further information please contact: Rona Gold, Community Planning Manager, rona.gold@argyll-bute.co.uk. 01436 658 862

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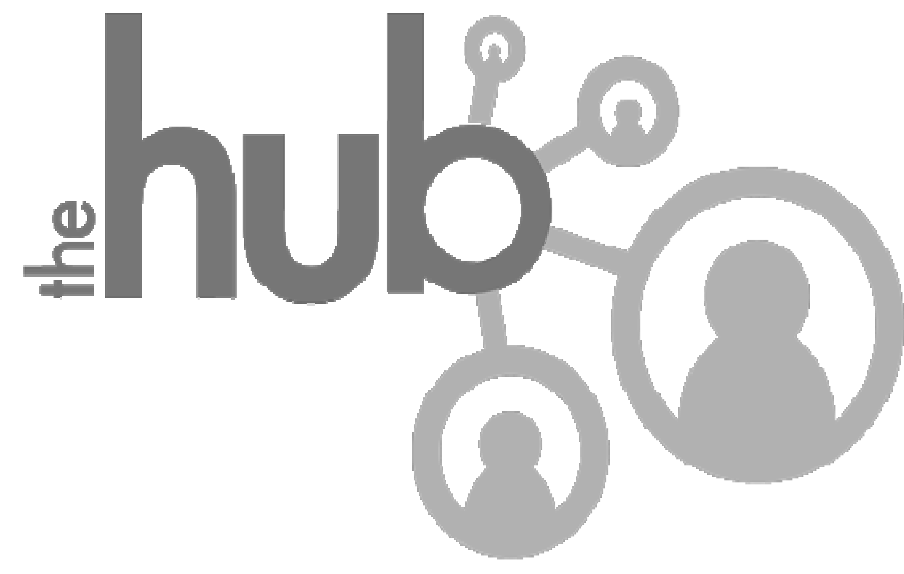
strachur



A COMMUNITY PROJECT SUPPORTED BY THE INTEGRATED CARE FUND

THE STRACHUR HUB WAS THE IDEA OF KATE PATON, THE PRACTICE NURSE OF THE STRACHUR MEDICAL PRACTICE. (SMP)

Kate's objective was to bring something into the community to:

- **Ensure that older people had the opportunity to live independent lives in their own home for as long as possible**
- **Reduce social isolation**
- **Improve their quality of life**
- **Provide some respite to carers and family members**
- **Improve mobility**
- **Prevent falls.**

In June 2015 an application for funding was submitted by the SMP's Patient Participation Group to the Integrated Care Fund of the Health and Social Care Partnership (HSCP).

In February 2016 we were granted the funding of £12.8kpa.

Together with Heather Grier, Ian Asher and a group of very dedicated volunteers, the Hub started on its journey at the beginning of March 2016.

SETTING UP

- **Between the date of our application and granting of the funding we :**
- **Planned how we would implement our ideas.**
- **Received support from TSI in this set up.**

- **During this time we sought to:**
- **Employ a qualified Otago trained instructor**
- **Seek a deputy to be locally trained.**

- **We originally envisaged around 16 people attending each week, based on Kate's 'sounding out' of patients.**

- **A problem however: Transport. People had expressed an interest to come but could not get there.**

- **A solution: We entered into a co-production with Cowal Elderly Befrienders from whom we hire a specially adapted vehicle.**

WHAT ARE WE TRYING TO ACHIEVE?

As well as Kate's 'local' goals, we seek to have positive impact on some of the criteria laid down by the Scottish Government on improving health and well-being in Scotland.

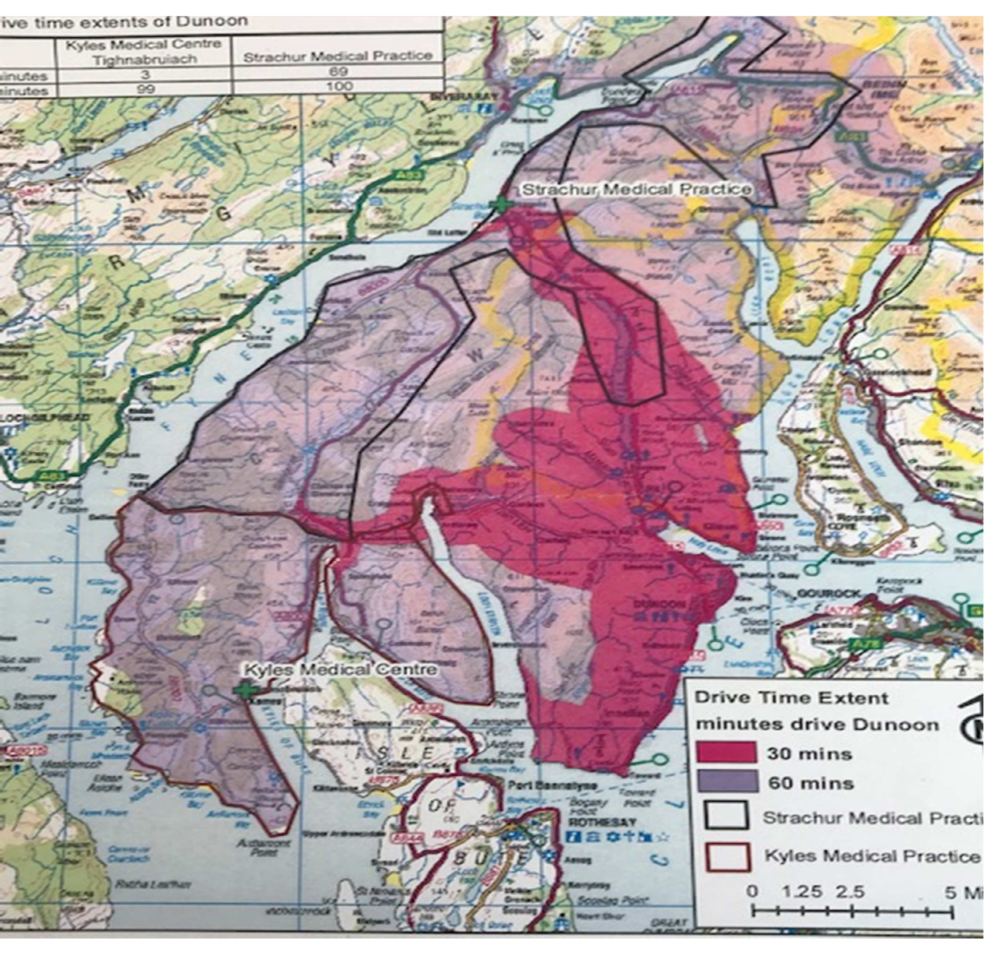
- **Healthier Living**
- **Independent Living**
- **Positive Experience and Outcomes**
- **Maintained and Improvement Quality of Life**
- **A reduction in Health Inequalities**
- **Carers are supported**
- **People are safe in their environment**

These remain our target areas

THE STRACHUR MEDICAL PRACTICE

- **Covers a large geographical area**
- **Has 892 patients.**
- **269 of them are over 65 years of age**
- **121 of over 65's have long term conditions**
- **87 of them live alone**
- **Limited access to transport, so the expectation that older people travel to Dunoon is just not working for them.**
- **Older people were becoming isolated, less mobile, and prone to falls.**
- **Cairndow to Dunoon: 28 miles, so a 56 mile round trip**
- **From Dunans, nr Glendaruel to Dunoon: 32 miles so an 64 mile round trip**

COVERAGE – KYLES AND STRACHUR PRACTICES



WHAT HAVE WE ACHIEVED?

- **The continued co-production with Cowal Elderly Befrienders.**
- **An Involvement with Interloch Transport**
- **Support and encouragement from Dr Coull and the Strachur Medical Practice**
- **A Hub running every Thursday 10.30 to 1.30 for our 'older' community members**
- **An average attendance each Thursday of 37**
- **4148 attendees to end of May 18 since the start.**
- **A maximum in any one week was 48**
- **Regular Strength/Balance and Tai Chi Classes**
- **Less mobile attendees enjoy playing the ball game 'Boccia'**
- **Purchased the equipment required to undertake all activities**

CONTINUED

- **Supplying a lunch for all our attendees each week, with soup provided by the Bay Cottage Tea Room as a contribution to our community and sandwiches and baking from our group of supportive volunteers**
- **Not charging but asking for donations instead**

As well as our regular Thursday daily activities we have organised:

- **Diabetes Management Courses**
- **Chronic Pain Management Courses**
- **Falls Prevention through Exercise, Strength and Balance**
- **Mindfulness classes - on-going**
- **Counterweight classes - on-going**
- **Conversational French Class – working with ‘Takeaway Creative’**
- **Defibrillator Training and CPR Course**
- **First Aid Class – on-going**
- **Choir for Lauder Memorial Concert**
- **Country Dancing**

the hub

Country Dancing at the Hub – 26th July 2018

Continued

- **Co- production also with the Creggans Hotel, and Manse Gardens' common room. We also use the Sports Pavilion and the Strathlachlan Hall when necessary.**

- **Our locally trained instructor also carries out an exercise programme monthly in the local ' Friendship Club' another group of elderly people.**

- **Instrumental in the installation of a defibrillator at the Village Hall, supported by the SMP, available 24/7.**

- **New loading and unloading bay at the Village Hall car park leading to easier access for more frail participants.**

- **Acquired equipment for the local primary school 5 aside football teams**

- **Preventative fitness class for a 'younger age' group – on-going, together with an outside walking group.**

Continued

- **We made a dvd with the story of the Hub, with film of activities and interviews with participants,**
- **On the 30th June 2018 we ran a successful 'Roadshow' to showcase our activities with 'taster' sessions for visitors to participate in all our activities.**
- **Part of the roadshow included a display to explain to our community and visitors the difficulties currently being encountered at our HSCP and Council with cost and budget issues.**
- **We have had many visitors to both the Hub and the Roadshow and these include:**
- **Brendan O'Hara, MP**
- **Michael Russell, MSP**
- **Cleland Sneddon, CEO, Argyll and Bute Council**
- **Councillors Audrey Forrest, Jim Anderson and Alan Reid**
- **Elizabeth Higgins, Lead Nurse from the HSCP**
- **Alison McGrory, Lead Public Health from the HSCP**
- **Dr Christine McArthur, Lead on Falls Prevention from the HSCP**
- **Jayne Lawrence-Winch, Local Area Manager from the HSCP**

We have had excellent publicity and support from the local press.
All visitors have endorsed the Hub's success.

A recent Independent Assessment for
the strachur hub

By Student Doctor Fiona McKirdy.

Fiona carried out an assessment in July 2018 on 24 of the participants who attend the Hub. They were given a questionnaire on their experiences, how they felt about the Hub, and permission to look at their medical records with the objective of seeing what direct health benefits could be evidenced.

The outcomes are as follows:

OUTCOMES

- **15% of responders live alone.**
- **80% of those responded who attend the Hub said it had given them more confidence.**

- **79% of the responders reported having long term conditions including COPD, heart problems and hypertension. Of this subset 79% felt their health condition had improved since joining the Hub.**

- **87.5% felt that their overall health had improved since joining the Hub**

Continued

83.3% felt they were stronger since joining the Hub

16.6% admitted to previously feeling lonely and isolated. 75% of this subset felt that attending the Hub has improved this. 25% of the overall group reported previous low mood with 66.6% reporting an improvement since joining the Hub.

100% of the group reported and increased quality of life since joining the Hub and all (100%) would recommend friends to join.

Continued

Falls: 34 patient records were accessible. A filtered search on the EMIS system indicated 14 of the 34 patients had a history of falls, with 37 falls amongst them.

Since each member had joined the group, the overall numbers of falls had dropped from 34 to 3, a reduction of 91%. The number of patients falling pre and post joining the Hub fell from 14 to 3, a reduction of 79%. Whilst other factors need to be taken into account, this indicates the work at the Hub is very likely to be a positive contributor to this reduction.

In 2010, falls in the 65 + was estimated to cost the NHS UK wide £4.6 million per day, equating to more that £1.7b pa. This is about the same amount required to fill the funding gap in councils for adult social care by 2020.

OBAN TIMES – 26 JULY 2018

Bid to reduce number of falls in Argyll

Health chiefs are aiming to help older Argyll and Bute residents to Move and Improve, according to a new report.

Plans are in place to provide exercise programmes in the community which will help elderly people reduce the risk of being hospitalised due to a fall.

These will take place under the Move and Improve project launched by the NHS last year, which consists of three levels of standing and balancing exercises.

The document, which went before a meeting on Tuesday, revealed that the area has a quarter of the population aged over 65 – far higher than the Scottish average.

The report was delivered on Tuesday at a meeting of NHS Highland, which runs Argyll and Bute Health and Social Care Partnership (HSCP) together with the council.

Stephen Whiston, head of strategic planning and performance with the HSCP, said: 'It has been identified by the HSCP that we require falls admission data at a hospital and locality level to understand who is being admitted, where and why.

'We have work starting this year with the national falls programme, the Information Services Division and Active and Independent Living and Improvement Programme to develop a quality dashboard for falls for incidences of admissions due to hip fracture and falls.

'Argyll and Bute is taking action to reduce falls and each locality has an action plan based on the national minimum standards.

'We are working with partners to provide evidence-based exercise programmes in our communities for older people to improve strength and balance which reduces the risk of falls.'

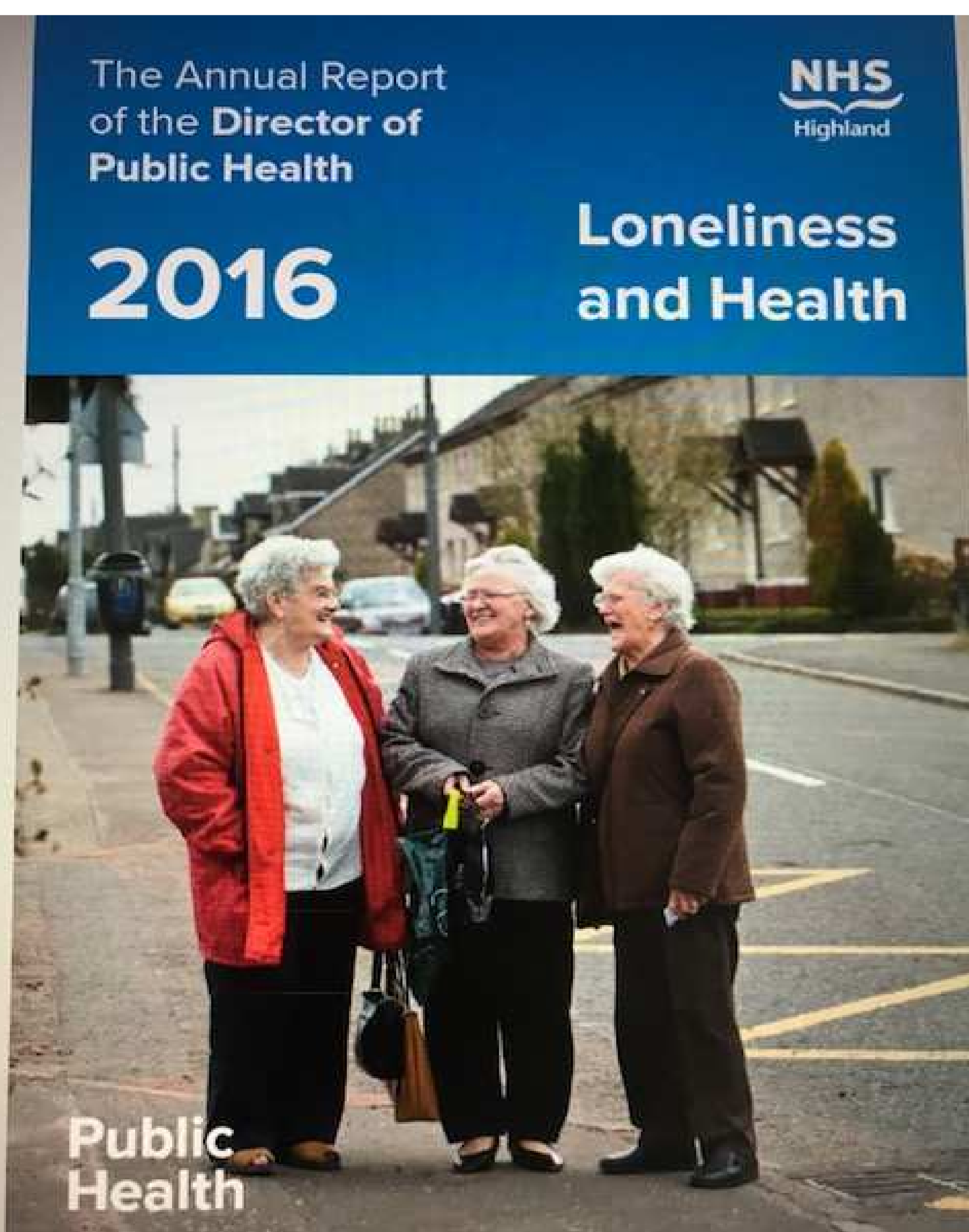
Continued

100% also felt that this should be used as a template for setting up similar groups in other rural areas.

The last question asked was about their favourite things about the Hub with no pre-printed answers. 96% reported that the socialisation, exercise or both were the most enjoyable aspect. The remaining respondent answered that what they enjoy most is the ability to watch fitness improve week to week.

All participants in this audit responded positively towards all aspects of the Hub. Enabling 80% of those living alone to feel more confident in their own homes by meeting once a week and having the support of the GP practice is invaluable in the community. This could lead to further benefits to health and social care but was outwith the scope of this audit.

In her conclusion Fiona said that the evidence gained from her audit supports the use of this model to provide further health services tailored to the elderly where access to such services can be problematic and limited.


The Annual Report
of the Director of
Public Health
NHS
Highland
2016
Loneliness
and Health
Public
Health

Daily Mail
27/03/18

You can die of loneliness

Social isolation could raise chance of a premature death by 50%, study warns

By **Kate Pickles**
Health Reporter

LONELINESS may raise the risk of a heart attack by more than 40 per cent.

A major study published today also suggests that social isolation can increase the chance of a stroke by 39 per cent and premature death by up to 50 per cent.

The analysis is based on the health records of 480,000 Britons – making it the largest study of its kind. Those who already had cardiovascular problems were far more likely to die early if they were isolated, suggesting the importance of family and friends in aiding recovery.

The research team, which included British academics, said lonely people had a higher rates of chronic diseases and smoking and showed more symptoms of depression.

Christian Hakulinen, the University of Helsinki expert who led the study, concluded that having few social contacts was a risk factor for early death, particularly among those with pre-existing cardiovascular disease.

'The message is that if we target the conventional risk factors then we could perhaps reduce the cardiovascular disease among those who are isolated or lonely,' said Dr Hakulinen. 'It is also important we show that those who are socially isolated might have a worse prognosis after a heart attack or stroke.'

Scientists from University College London and Finland tracked the 480,000 Britons, aged 40 to 69, for seven years.

Social isolation was associated with a 43 per cent higher risk of first-time heart attack when age, gender and ethnicity were factored in.

Once lifestyle and socio-economic factors were taken into account, this explained 84 per cent of the increased risk, suggesting the lonely and isolated were most vulnerable to well-known risks.

Similarly, social isolation was associated with a 39 per cent heightened chance of a first-time stroke, but the other conventional risk factors accounted for 83 percent of it.

The results were similar for loneliness and risk of first-time heart attack or stroke, according to the study in the medical journal Heart. Those who already had cardiovascular problems were 50 per cent more likely to die if socially isolated and still a quarter more likely to die once known risks had been accounted for.

More than half of all people aged 75 in Britain live alone and more than a million are believed to be suffering from chronic loneliness. Helen Stokes-Lampard, who chairs the Royal College of GPs, said loneliness could have a devastating impact on long-term health.

'Facing intense pressure'

The professor said: 'The reality is that loneliness and social isolation, particularly for older people, can be on a par in terms of its impact on health with suffering from a chronic long-term condition and, as this study shows, increase the likelihood of developing serious conditions, such as heart attacks and strokes.

'On the front line, GPs and our teams report seeing patients on a daily basis whose underlying problems are not primarily medical, but who are feeling socially isolated or lonely.

'As well as being distressing for patients, loneliness can also have a real impact on general practice and the wider NHS, at a time when the whole system is facing intense resource and workload pressures.'

The college said it was working with charities, community and voluntary groups to draw up a manifesto to present to Government to tackle loneliness.

DAILY MAIL – 27 MARCH 2018

FUNDING

Our total budget for a year has been in place since February 2016. The amount is £12,827 pa and this does not allow for any cost and demand pressures or inflation. Running for 51 weeks per annum, that's a weekly cost of £251.50, with the average attendance per week of 45 (including the preventative class) is £5.58 per session per person. With each session lasting 3 hours (plus 1 hour for the preventative class), that is a cost per hour of £1.40 per person.

This project is certainly delivering value for money in our view.

A community project supported by the Integrated Care Fund

AND FOR THE FUTURE?

- **We are now drawing up plans to seek alternative funding as there is no guarantee that the HSCP Cowal Locality will continue to support this project beyond March 2019, the end date for the current ICF grant funding.**
- **It is our belief this project has been a success and should continue to be HSCP ‘core’ funded.**

If funding discontinues and we are unable to raise adequate alternative inflow, the project may have to cease. This will have a substantial negative impact on this rural community, and the health and wellbeing outcomes would not be met unless services were supplied from Dunoon up to our community at a substantial increase cost per person per week. Many participants would be unlikely to attend a similar venture in Dunoon, for some due to age and frailty, and others transport issues.

CHRISTMAS PARTY 2017

strachur hub

THANK YOU FOR THIS OPPORTUNITY TO SHOW CASE

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The Annual Report of the **Director of Public Health**

2016

Loneliness and Health

Public Health

"The most terrible poverty is loneliness, and the feeling of being unloved."

Mother Teresa

"In the silence of night I have often wished for just a few words of love from one man, rather than the applause of thousands of people."

Judy Garland

"Hello darkness, my old friend. I've come to talk with you again."

Simon and Garfunkel "The Sound of Silence."
Songwriter: Paul Simon
Lyrics © Universal Music Publishing Group

"A great fire burns within me, but no one stops to warm themselves at it, and passers-by only see a wisp of smoke"

Vincent Van Gogh

"And they'll all be lonely tonight and lonely tomorrow."

Del Amitri "Nothing Ever Happens."
Songwriter: Justin Currie
Lyrics © Universal Music Publishing Group

Acknowledgements and list of contributors

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Introduction

Over the last six months, NHS Highland has been running a campaign to tackle social isolation and loneliness. It therefore seemed appropriate to focus this year's public health report on this important topic.

Loneliness is an increasingly important public health issue, as social relationships are central to personal well-being and are crucial for maintaining physical health, mental health and a holistic sense of meaning and purpose. Whilst loneliness can be a problem across all age groups, it is a significant and growing issue, particularly for older people because the risk factors for loneliness such as bereavement, reduced income and poor physical health occur more frequently in older age. This report recognises that there are different terms in use including social isolation, emotional loneliness and social loneliness. This is an emerging topic and it is understandable that different terms should be used to emphasise different aspects of the problem.

This report also builds on the concept of salutogenesis, recognising that there are a range of factors that may protect individuals and communities from loneliness, including a sense of coherence, meaning and purpose in life. A sociologist, Antonovsky, proposed that the belief that things in life are interesting, 'a source of satisfaction and worthwhile' and that there is 'good reason or purpose to care about what happens' may improve health. It may also help to protect against some aspects of loneliness.

Public health should be based on facts and figures and this year's report is therefore based on a survey of 3000 individuals aged 65 years and older. The survey assessed some of the above issues in Highland and Argyll and Bute.

I am very conscious that the public health department on its own cannot address this issue and I am very grateful for the commitment that Community Planning Partnerships in the Highland Council area and Argyll and Bute Council area have made to working together to address this challenge.

I look forward to continuing to work with many of you as we take this work forward.

Yours sincerely

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Chapter One - Why Focus On Loneliness?

Loneliness is increasingly recognised as a significant public health concern, affecting wellbeing, quality of life, premature death[1] and contributing to diseases such as dementia[2], heart disease and depression[3].

Loneliness can occur at any age but is particularly associated with periods of change such as moving home or job, childbirth, and experiences common to older age such as retirement and death of a spouse.

"...if you are on your own the problems become magnified and you imagine things are wrong with you.

You're sitting on your own, there was maybe nothing wrong with you, but you imagine there are things wrong with you [..] that's what isolation does to you." [5]

Focus group participant

This year's Public Health report focuses on loneliness and social isolation in older age and sets out recommendations that would take us forward as a society in addressing this challenge. This report is based on published literature and local research in those over 65 years who live in the NHS Highland area.

Loneliness has to do with the extent and quality of our relationships[4]. Most of us have experienced loneliness at some time or another, but it is particularly challenging when it becomes a long standing and painful experience.

Having weak social relationships increases the chance of an early death to the extent that it is:

- **Equivalent to smoking up to 15 cigarettes a day**
- **greater than not exercising**
- **twice as harmful as being obese.**

There are a variety of different but overlapping aspects of loneliness and social isolation. Loneliness can be defined as the subjective emotion felt by people who are unhappy with their levels of social relationships. This is sometimes called 'emotional loneliness'.

Social isolation relates to a more objective measure, which is the number of relationships a person has and is sometimes referred to as 'social loneliness'.

It is important to recognise that it is possible to be socially isolated and to experience 'social loneliness' without feeling 'emotional loneliness'. Similarly, it is possible to have regular interaction with other people, and to fall outside the definition of 'social loneliness', but still experience significant 'emotional loneliness'.

There are other related concepts including social relationships, social ties, social support, social connectedness, friendship networks, civic participation and social capital, which are valuable concepts but are beyond the scope of this report.

> 'Loneliness is a negative emotion associated with a perceived gap between the quality and quantity of relationships that we have and those we want.' [6]

There are environmental and personal characteristics that buffer the effects of social isolation and loneliness. One of the aims of the research underpinning this report has been to examine the relationship between a sense of coherence, loneliness and health. This work is ongoing and it is intended that the results will be published elsewhere in due course.

How common is loneliness?

> **'Lonely people, in talking to each other, can make each other lonelier'**
>
> Lillian Hellman, cited in Age UK Oxfordshire, 2011

The prevalence of loneliness is very dependent on how it is measured. In the survey which has informed this report, we have used a six item loneliness scale, with three items to measure 'social loneliness' and three items to measure 'emotional loneliness'.

The sub-scales can be used separately or combined into a total loneliness score[7].

Studies have suggested that loneliness increases with age, and one study, using a slightly different definition of loneliness, found that over 50% of those aged over 80 years experienced some loneliness[8].

Another study of the general population, using yet another definition, reported that 31% of the population felt lonely sometimes and 5% often felt lonely[9].

The trend for increasing family dispersal and the rising elderly population mean that loneliness is likely to be an increasing societal challenge over the coming decade[10].

Around 20% of the population in the UK are currently over 60 years and this proportion is expected to rise to 24% by 2030[11].

Across NHS Highland, 29% of the population are currently over 60 years. This figure is expected to rise to 38% by 2035. The higher elderly population across the area, both now and in the future, emphasises the importance of this issue for local public sector planning.

> 'In the next 20 years, in Britain, the number of people aged 80 years and over will treble and those over 90 will double'. [12]

Those living in institutional care are also susceptible to loneliness. One study found more than half of nursing home residents reported feeling lonely[13] and an association has been identified between loneliness and dementia[14].

Risk factors for loneliness

The Campaign to End Loneliness report summarises some of the risk factors for loneliness and social isolation[15]. Disability is associated with loneliness[16], particularly in older people who have sensory impairment or a significant health condition[17].

Reduced mobility can prevent people from getting out and limit their opportunities to socialise[18]. Sensory impairment can limit their ability to communicate and can lead to a sense of being isolated even from other people in the same room. Limited disposable income, or loss of access to a car, can reduce access to transport and limit opportunities to socialise[19].

The prevalence of each of these factors rises substantially as individuals become very elderly. The presence of several of these factors has a compounding effect on the risk of social isolation.

There has been little comparison of levels of loneliness between urban and rural communities. A small-scale survey found that twice as many people in urban areas mentioned isolation and loneliness as an issue compared to those in rural areas, which may be related to better networks of support[20].

When combined with factors such as disability or poor health, living remotely may increase the likelihood of being lonely. The survey we have undertaken has sought to address this question in

some detail.

Social stigma and discrimination can have a negative impact on individual and community health and wellbeing, for example arising out of racial or other personal characteristics. This has the potential to lead to people being excluded or isolated.

The Campaign to End Loneliness also flags specifics of ageing that can cause loneliness, for example adjusting to life after retirement can be difficult due to changes in identity, role and daily routines that perhaps involved regular contact with work colleagues.

A weak sense of coherence has been linked to an increased risk of mental illness and mortality[24,25] and sense of coherence is implicated in levels of loneliness[26].

Similarly, many older people have a caring role and becoming a carer can be a life changing event that can increase the risk of becoming isolated.

Often carers have fewer opportunities to socialise, as their caring responsibilities take up most of their time. Working unsocial hours can also affect social networks and increase the risk of social isolation, not only for the individual working the unsocial hours, but also for those who depend on that person.

There is a case for employers minimising unsocial hours and weekend work because of its societal effects[21].

Bereavement, particularly if it is in relation to the loss of a partner or spouse, is associated with loneliness and social isolation.

Many people find it difficult to socialise following the loss of a loved one and can be left with long standing feelings of loneliness. However, this is a complex area and there is some research to suggest supportive friends and communities rallying around can help to minimise the length of distress.

There is some evidence to suggest that our sense of loneliness is linked to the experiences of others in our social networks. Those who are close to someone experiencing loneliness are at increased risk of becoming lonely themselves[22].

Salutogenesis and sense of coherence

The survey we have undertaken to support this annual report has also measured an aspect of salutogenesis called ‘sense of coherence’. This relates to a person’s ability to cope with challenging and stressful situations and is related to research on resilience and hardiness.

The concepts of salutogenesis and sense of coherence were developed by a psychologist who worked with holocaust survivors and who wanted to understand why some individuals had survived concentration camps whereas others had not.

The psychologist, Antonovsky, suggested that those individuals who had survived the holocaust had a strong sense of coherence, which had three components – comprehensibility, manageability, and meaningfulness.

Comprehensibility is ‘the extent to which events are perceived as making logical sense, that they are ordered, consistent, and structured’.

Manageability is ‘the extent to which a person feels they can cope’.

Meaningfulness is ‘how much one feels that life makes sense, and challenges are worthy of

commitment.' [23]

These characteristics can be captured in a simple three item questionnaire, which we have used in the survey underpinning this report.

Counting the cost

Loneliness and social isolation have a significant human and financial cost. Loneliness has been associated with an increased risk of death. In one study, 22.8% of the participants classified as 'lonely' died over the six years between 2002 and 2008 compared to 14.2% of participants who were 'not lonely'[27].

Similarly, social isolation has been significantly associated with mortality in men. In another study, over an eight year follow-up period, 7% of those classed as 'low social integration' died compared with 1.4% of those classed as 'high social integration'[28].

Loneliness also affects the demand for NHS services. Lonely people are more likely to visit their GP and to use other health services. Loneliness is a predictor of the use of accident and emergency services, after adjusting for the presence of other factors such as chronic illness[29].

Recommendations

- Increased publicity and awareness of the strong links between loneliness and poor health outcomes, mortality and increased service utilisation.
- Better awareness of the risk factors of loneliness and consideration of these risks during patient assessments and consultations.
- Public sector bodies should invest in interventions to reduce loneliness
- Employers should consider the potential impact of working unsocial hours and weekend shifts on the families and personal networks of their staff.

Chapter Two - Evidence From The Literature

Wider context

Loneliness is a societal challenge that has received increasing attention from researchers and policy makers across the developed world including the USA, France, Norway, Denmark, Sweden, Australia, Taiwan, Japan and the UK.

In the UK, the societal challenge has been led by the Campaign to End Loneliness[30], which was launched in 2011. The campaign aims to develop the research base, facilitate learning & understanding, and lead a national call to action on this important topic.

The third sector has provided much of the leadership to date, with the charity *Silverline*[31] launched in 2013, to provide a helpline for older people in distress. The extent of loneliness is demonstrated by the fact that the helpline has since received more than one million calls, among whom 53% have said that they had no-one else to talk to.

Prevention better than cure

"It was about 2am, I couldn't sleep and I felt very lonely so I called the helpline. You can't understand loneliness until you go through it yourself."

Silverline caller

In Scotland, the Christie Report (2011), 'Commission on the Future Delivery of Public Services', which has had significant influence on Scottish policy, made reference to loneliness[32]. The report recognised that, 'Public services find great difficulty in prioritising preventative approaches to reduce long-term future demand. Services often tackle symptoms not causes, leading to "failure demand" and "worsening inequalities".'

The report also stated that, 'as much as 40% of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach.'

The Scottish Parliament has been aware of the importance of loneliness and published a report on the topic in 2015[33]. The Committee recognised that tackling loneliness requires a multi-pronged approach. The report's recommendations included:

- developing a national strategy and the incorporation of social isolation and loneliness into all policy considerations, for example, mental health, housing, and family & early years strategy
- conducting national research into the extent of the issue in Scotland
- developing a national promotional and marketing campaign with the public
- developing the approach of social prescribing to formally link up people who are lonely with sources of support
- joining up the loneliness agenda with community transport.

The Scottish Government has also published a Fairer Scotland Action Plan, with 50 actions to help tackle poverty, reduce inequality and build a fairer and more inclusive Scotland. Part of this plan is focused on social isolation, and the intention is that the topic will be a priority in the 2017 part of the national action plan.

Providing solutions

Asking people if they feel lonely and putting them in touch with social support has the potential

to enable people to live in good health for longer; and improves their quality of life[34]. Initiatives to prevent loneliness are cheaper than treating the subsequent ill-heath.

However, the evidence for what works is not widely known or understood[35]. There are many examples of upstream investment to prevent more costly interventions or treatments later that have been collated in a systematic review.

One study identified savings of up to £300 per year from individuals receiving befriending support compared to the intervention cost of only £80[36]. Similarly, in selected groups, arts-based community activities significantly reduce the need for acute hospital care[37].

The third sector is well placed to deliver activities to tackle loneliness and isolation as they are often closer to communities and more responsive to local needs[38].

Public Health teams can play a role in further developing partnership working between the public and third sectors, for example, supporting robust evaluation and monitoring to ensure the benefits of interventions to reduce loneliness are quantified and scaled up.

Co-production and capacity building

Empowering people and working in partnership with others are key ingredients for improving health; the Ottawa Charter for Health Promotion laid this foundation in 1986[39].

Over the past 10 years this has evolved in Scotland into an approach called 'co-production'. Co-production, which is further explored in chapter 5, is defined as the collective 'doing with' rather than 'doing to' communities and recognises the equal value of contributions from the public. Local people know their communities best and often know how to solve problems where they live.

Prevention programmes require a long term focus, which is challenging in a modern context. Historically, a lot of community development has been built on short term funding, with projects constantly being created, abolished and then re-invented.

For example, seven full-time Public Health Community Development posts in Highland have had their funding withdrawn over the last year, whilst new government monies continue to emerge for fresh initiatives.

Locality planning

In recent years, Scotland has seen an increasing legislative drive towards localism of service planning and service delivery. This is known as locality planning and could play an important role in coordinating services to reduce loneliness and strengthen a sense of coherence at individual, family and community level.

Locality plans could help by putting people who are lonely in touch with appropriate support; identifying gaps in services; and working with communities to co-produce services to fill service gaps that are identified.

Empowering individuals to self-manage their health

Empowering people with knowledge and skills about what keeps them well is key to effective self care of long term health conditions.

Addressing loneliness and increasing a sense of purpose and meaning in life may play a part in helping people live better with their health conditions.

Self-management programmes are provided by the health and social care partners to enable people to take charge of their own health, rather than be passive recipients of care.

Given the link between loneliness and many long term conditions there is a need to address issues of loneliness and social isolation overtly in self management programmes and to build a sense of coherence.

The policy context

A number of national policy initiatives that are relevant to loneliness are summarised in the following text.

The Public Bodies (Joint Working) (Scotland) Act 2014 came into effect on 1 April 2014 and requires health and social care services to come together in each area of Scotland in a process of 'Integration'[40].

At its heart, this change is about shifting the balance of care from hospitals to the community. It relies on building capacity in communities for people to be able to lead the healthiest lives possible, self manage their own health, and address issues such as loneliness.

Reshaping Care for Older People (RCOP) is Scotland's national strategy, covering 2011 – 2021, to improve health outcomes and services for older people[41].

In anticipation of an ageing population, this strategy promotes self-management, better joint planning and delivery across the range of health & social care partners, and building resilience for communities to support healthy living of increasing numbers of older people.

This includes recognition that older people's engagement in volunteering and/or caring activities can bring benefits to individuals, and also help to sustain communities.

The Community Empowerment (Scotland) Act 2015 will give communities more control over how services are delivered[42]. The Act includes support for asset transfer of public sector buildings and land to community groups, and gives communities more influence in how services are planned and delivered.

This legislation gives weight to the co-production approach and empowers community members to take responsibility for local services. This in turn has potential to reduce loneliness and isolation.

Community Planning Partnerships, involving statutory bodies working together on identified priorities, have a role in addressing isolation and loneliness.

The partnerships have already demonstrated their commitment to reducing loneliness by signing up to Reach Out, a social media campaign launched by NHS Highland that aims to tackle loneliness through encouraging individuals, communities and workplaces to sign a pledge to take action to make a difference to someone who is lonely.

Community planning partners could help take this to the next level by:

- Continued commitment to the Reach Out campaign;
- Raising awareness amongst their staff of the risks of loneliness for themselves and their service users;
- Supporting joint community planning activity on loneliness;

- Pooling resources to invest in reducing loneliness;
- Addressing wider community planning agendas that impact on isolation and loneliness, the main example of this is community transport but could also include responding to and supporting people in distress.

Recommendations

- Service providers should regularly ask people they come into contact with if they feel lonely and signpost to local sources of support.
- Embed social prescribing in health and social care delivery to ensure people with underlying social problems get referred or signposted into appropriate sources of support by their health professional or care giver.
- Reshaping Care for Older People should be refreshed to reflect the issues of loneliness and social isolation.
- Locality plans developed as a result of the Community Empowerment Act should consider loneliness and help build a sense of coherence within communities.
- Community Planning Partnerships should consider how they can contribute to reducing the risks of loneliness and isolation.
- Ensure people experiencing, or at risk of loneliness, are able to access appropriate services. Practical barriers may be present for those who have difficulty using their own or public transport. Access to community transport should therefore be considered.
- Wherever possible, those who award grants should minimise the risk of stop/start funding cycles for preventative activity.

Chapter Three - Investigating Levels of Loneliness Across Highland

The reason for the survey

In July 2016, the public health department undertook a survey of loneliness across NHS Highland. Following ethical approval, a random sample of 3,000 people, aged 65 years and over were sent a survey called 'Keeping Connected'. The main aim of the survey was to identify the prevalence of loneliness across NHS Highland.

The survey was issued by postal questionnaire with Freepost return envelopes. Fifteen questions were asked, including demographic variables, a set of six validated loneliness questions, three 'sense of coherence' questions, and a general health question.

Loneliness has two parts; social loneliness and emotional loneliness.

- **Social loneliness is the feeling of missing a wider social network (for example, feeling we lack friends and family).**
- **Emotional loneliness is a feeling of missing an intimate relationship (for example, feeling we lack a personal relationship like that of a partner).**

Within the loneliness questions, three of these assessed emotional loneliness and the other three assessed social loneliness. The loneliness subscales could only be calculated if a response was present for each of the three questions and a total loneliness score was dependent on responses to all six questions.

We were also interested in sense of coherence (SoC) which provides insight into our ability to cope with adversity. This was measured from responses to three questions.

Finally, we asked for information about the responders such as their year of birth, postcode and their living arrangements. All responses were anonymous.

Of the 3,000 surveys issued, 1,539 (51.3%) responses were returned by the August closing date.

Of those returned, 1,119 (73%) provided valid loneliness scores, which were used to estimate the prevalence of loneliness by age, gender and other characteristics.

Survey results

The overall survey results indicated that two thirds of the sampled population aged 65 years & over are lonely and that 8% were intensely lonely.

The groups with higher rates of loneliness were:

- Those living alone
- Those with more than one long-term condition
- Those with a disability
- Those providing 20 or more hours of care per week
- Those with a weak sense of coherence

The following sections present the results in more detail.

Loneliness and age

22% of NHS Highland's population are aged 65 years and over

67% of those aged 65 and above, feel loneliness on some level

8% of those aged 65 and above, feel intense loneliness

66% of those aged 75 and above, feel loneliness on some level

10% of those aged 75 and above, feel intense loneliness

The prevalence of loneliness was higher in those aged 80-84 years, with 71% experiencing some degree of loneliness.

For all age groups, the prevalence of social loneliness (55%) was higher than the prevalence of emotional loneliness (35%).

Loneliness and gender differences

70% of men felt lonely

9% of women felt intense loneliness

Our results show that slightly more men felt lonely; (70%) compared to women (63%) although more women (9%) than men (7%) felt intense loneliness. Social loneliness was experienced by 51% of women and 58% of men.

Emotional loneliness was experienced by 38% of women and 31% of men. Other research on loneliness and gender suggests that women over 85 years old and men who have low life satisfaction, resilience and depression are more likely to experience loneliness[37].

In addition, these researchers reported that those with poor social networks were more likely to experience loneliness, especially women.

Urban and rural loneliness

10% in 'very remote small towns' feel intense loneliness

5% in 'accessible rural' feel intense loneliness

Table 1 - Emotional and social loneliness by urban/rural location

Scottish 8-fold urban/ rural classification	Emotional loneliness	Social loneliness	Combined loneliness
Urban areas	35% (7%)	45% (19%)	60% (9%)
Accessible small towns	32% (7%)	60% (19%)	71% (7%)
Remote small towns	48% (3%)	51% (24%)	66% (7%)
Very remote small towns	33% (6%)	58% (25%)	67% (10%)
Accessible rural	32% (4%)	52% (12%)	63% (5%)
Remote rural	37% (6%)	54% (21%)	65% (8%)
Very remote rural	34% (4%)	59% (19%)	72% (8%)
Undisclosed	15% (5%)	48% (24%)	67% (8%)
Total	**35% (5%)**	**55% (19%)**	**67% (8%)**

Figure in brackets denotes percentage experiencing intense loneliness

The prevalence of some degree of loneliness was highest in 'very remote rural areas' (72%) and 'accessible small towns' (71%) and lowest in urban areas (60%), as found in Table 1.

The prevalence of intense loneliness was greatest within 'very remote small towns' (10%), and lowest in accessible rural areas (5%).

The prevalence of social loneliness was highest in 'accessible small towns' (60%), 'very remote rural areas' (59%), and 'very remote small towns' (58%). It was lowest in urban areas (45%).
The prevalence of emotional loneliness was highest in 'remote small towns' (48%) and lowest in accessible rural areas and in accessible small towns (32%).

The prevalence of social loneliness was higher than that of emotional loneliness in every residential category.

Loneliness and living arrangements

75% of those living alone feel lonely

15% of those living alone feel intense loneliness

62% of those living with others feel lonely

5% of those living with others feel intense loneliness

Partnership status		
Divorced/separated and living alone	Widowed and living alone	Married and not living alone
75% feel lonely	**74%** feel lonely	**26%** feel lonely
20% feel intensely lonely	**12%** feel intensely lonely	**2%** feel intensely lonely

Table 2 - Emotional and social loneliness by living arrangements

Living arrangement	Emotional loneliness	Social loneliness	Combined loneliness
Alone, divorced/ separated	45% (16%)	66% (37%)	76% (23%)
Alone, widowed	57% (11%)	55% (21%)	76% (13%)
Alone, never married/ SSCP*	37% (4%)	70% (38%)	73% (12%)
With others, married	26% (2%)	52% (16%)	62% (5%)
With others, widowed	52% (7%)	43% (17%)	64% (7%)
With others, divorced/ separated	33% (5%)	65% (30%)	68% (9%)
Undisclosed living arrangement	80% (40%)	83% (17%)	100% (20%)
Total	**35% (5%)**	**55% (19%)**	**67% (8%)**

Figures within the brackets indicates the percentage of people experiencing intense loneliness

SSCP= Same-Sex Civil Partnership

In line with evidence from previous research, living arrangements have an effect on levels of emotional and social loneliness. A higher proportion of those ‘living alone’ (e.g. divorced, widowed etc) reported some degree of loneliness (73-76%) compared to those living ‘with others’ (62-68%), see Table 2.

This also applies to intense social loneliness where those divorced or separated and living alone reported a higher prevalence of intense social loneliness (37%) compared to those divorced or separated and living with others (30%) and compared to the figure for NHS Highland as a whole (19%).

Those ‘living alone and divorced or separated’ recorded the highest percentage of intense loneliness (23%). The other two groups who lived alone were also associated with higher proportions of intense loneliness than the overall for the NHS Highland sample (8%).
We would expect that ‘living with others’ makes us less likely to experience loneliness. Our local findings support this in terms of those who experienced some level of loneliness.

However, for social loneliness, this is not the case for those separated or divorced where the prevalence of loneliness was higher (65- 66%) compared to the prevalence for NHS Highland as a whole (55%).

Being married and not living alone was associated with a lower prevalence of emotional loneliness (26%; 2% intense loneliness), compared to the overall prevalence for NHS Highland as a whole (35%; 5% intense loneliness).

Although marriage reduces loneliness for many, the effect was not universal. This may reflect the fact that most of us require a social network that is wider than one person.

Long term health conditions (LTCs) and loneliness

80% of those living with one or more LTC feel lonely

18% of those living with one or more LTC feel intense loneliness

Chart 1 - Loneliness by long term condition

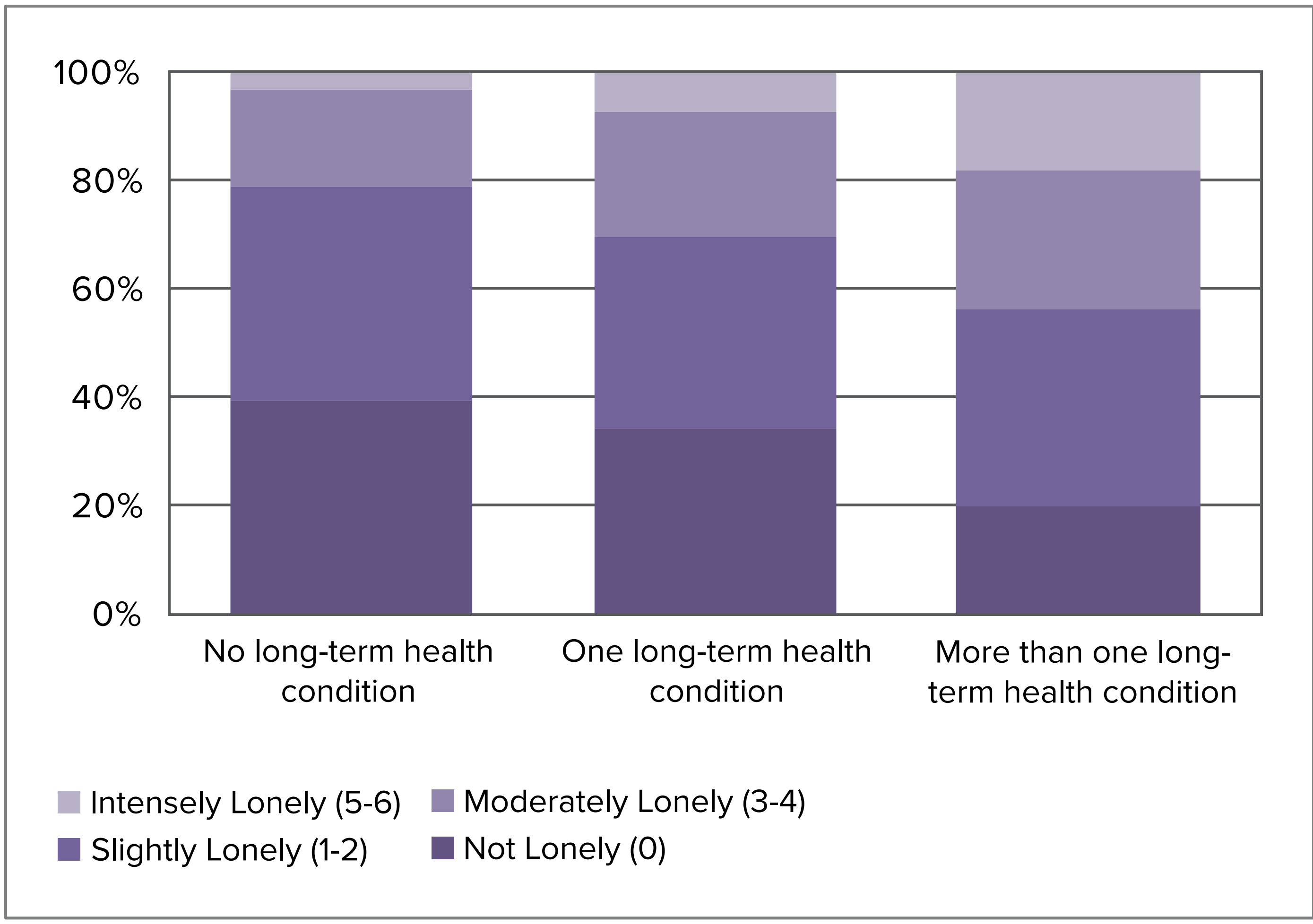


Table 3 - Emotional and social loneliness by long term condition

Number of long term conditions	Emotional loneliness	Social loneliness	Combined loneliness
No long term condition	24% (2%)	49% (15%)	60% (3%)
One long term condition	34% (5%)	53% (19%)	66% (7%)
More than one long term condition	53% (12%)	68% (27%)	80% (18%)

Figures within brackets indicate the percentage of people experiencing intense loneliness

The relationship between loneliness and long term conditions (LTC) is shown in Chart 1. Those with one or more LTC were more likely to feel some degree of loneliness than those with no LTC.

Those with more than one LTC were more likely to experience intense loneliness (18%) than either those with one LTC (7%), or those with no LTC (3%), see Table 3.

A higher proportion of those with more than one LTC experienced intense loneliness than was the case across NHS Highland as a whole (8%).

Previous research has similarly shown that those with poor health are more likely to experience loneliness[43].

Those with more than one LTC have the highest levels of emotional (53%) and social loneliness (68%). The prevalence is higher than that for NHS Highland as a whole in the case of both emotional loneliness (35%) and social loneliness (55%).

Our results support previous research which has highlighted that experiencing one or more LTC is a risk factor for loneliness[44]. This may be because it limits a person's ability to socialise and stay connected with others in their community.

Disability and loneliness

29% of sampled population are living with a disability

77% of those living with a disability, feel loneliness on some level

16% of those living with a disability, feel intense loneliness

Blind/visual impairment	Deaf/hearing impairment	Physical disability	Other disability
82% feel lonely	72% feel lonely	76% feel lonely	82% feel lonely
26% feel intensely lonely	12% feel intensely lonely	15% feel intensely lonely	22% feel intensely lonely

Chart 2 - Loneliness by disability

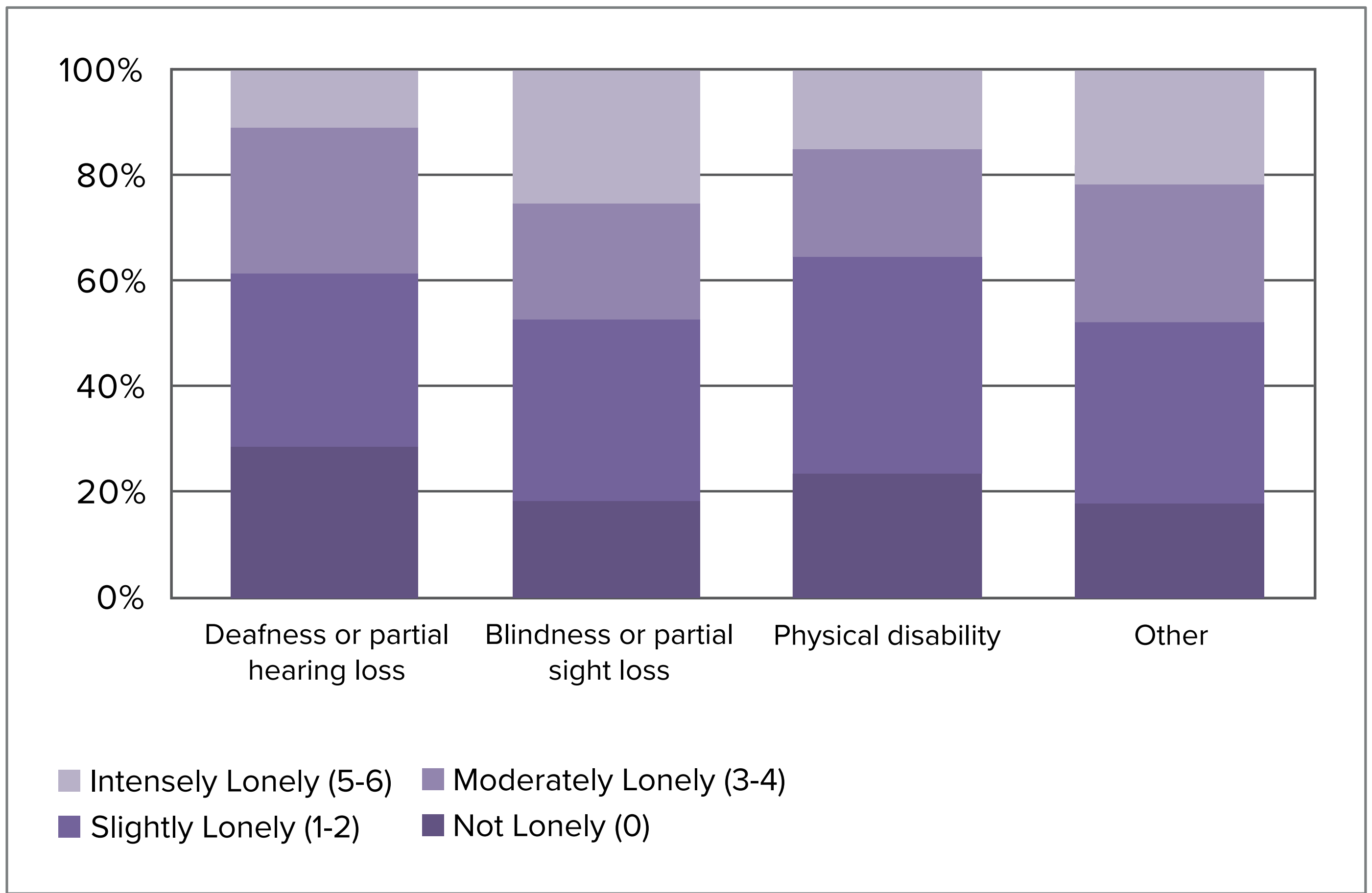


Table 4 - Emotional and social loneliness by disability

	Emotional loneliness	Social loneliness	Combined loneliness
Deaf/hearing impairment	44% (10%)	58% (25%)	72% (12%)
Blind/visual impairment	68% (11%)	59% (32%)	82% (26%)
Physical condition	51% (13%)	58% (22%)	76% (15%)
Other disability	56% (16%)	70% (35%)	83% (21%)
Living with a disability or long term condition	46% (11%)	61% (26%)	76% (15%)

Figures within brackets indicate the percentage of people experiencing intense loneliness

Those with a disability were more likely to experience some degree of loneliness (77%). This is in line with previous research, which has found that those with either physical disability or sensory impairment were at greater risk of loneliness[45].

Chart 2 indicates the prevalence of the degree of loneliness in those who have disabilities. The proportion of those with disabilities who experience intense loneliness (16%) was higher than the average for NHS Highland as a whole (8%).

Experience of loneliness and intense loneliness varied depending on the type of disability (Table 4).

Those with a visual impairment or physical disability were more likely to experience some degree of loneliness (82% and 76% respectively), whilst 72% of those with a hearing impairment reported some degree of loneliness.

Those with a visual impairment were most likely to feel intense loneliness with 26% reporting this compared with 12% of those with a hearing impairment and 15% of those with a physical disability.

The prevalence of some degree of emotional loneliness in those living with a disability was 46%, compared to 35% in the overall NHS Highland surveyed population.
This group also experienced greater levels of intense emotional loneliness (11%) compared to the overall NHS Highland surveyed population (5%).

A similar pattern was seen in relation to social loneliness with 61% of those with a disability reporting some degree of social loneliness compared to 55% in the overall sample.

More than a quarter (26%) of those with a disability experienced intense social loneliness compared to 19% of the overall population sampled.

The results show those living with a disability are more likely to experience loneliness (76%) than the overall population of older people across NHS Highland (67%). This is in line with previous research[46].

Furthermore, those with a disability were more likely to experience intense loneliness (15%) than the overall population sampled (8%).

Carers and loneliness

9% of sampled population provide care (paid and/or unpaid) for another

79% of those providing 20 hours or more of unpaid care feel loneliness on some level

14% of those providing 20 hours or more of unpaid care feel intense loneliness

Chart 3 - Loneliness by amount of unpaid care provided

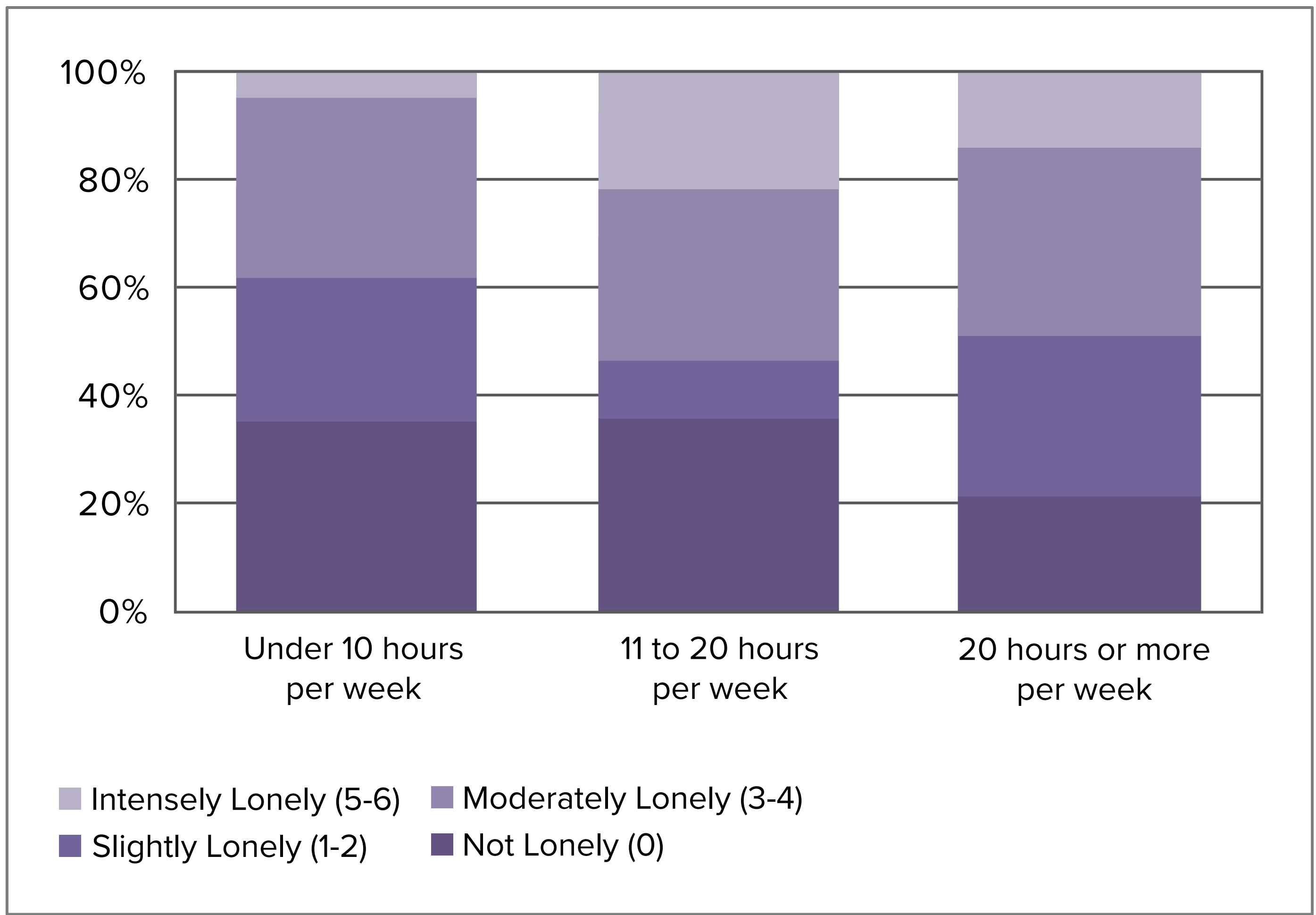


Table 5 - Emotional and social loneliness by hours of unpaid care provided

Number of hours of unpaid caring	Emotional loneliness	Social loneliness	Combined loneliness
Under 10hrs per week	36% (0%)	64% (23%)	65% (4%)
11-20 hrs per week	54% (8%)	64% (36%)	58% (17%)
20hrs + per week	42% (9%)	69% (34%)	79% (14%)
Unpaid carers combined	44% (8%)	67% (32%)	74% (13%)

Figure in brackets denotes percentage experiencing intense loneliness

We found that 74% of all unpaid carers experienced loneliness with 13% feeling intense loneliness. Both these percentages were higher than those measured in the NHS Highland population (67% and 8% respectively), see Table 5.

Carers experienced greater levels of social (67%) and emotional (44%) loneliness than the overall Highland sample (55% and 35% respectively).

Those who provided over 20 hours of unpaid care per week were more likely to experience some degree of loneliness. Those who provided 11-20 hours per week of unpaid care report the most intense levels of loneliness.

Overall, those who provided care were more likely to experience loneliness, and more intense levels of loneliness, compared to those who did not provide care. Previous research has demonstrated that caring responsibilities reduce carers' ability to maintain social networks including relationships with friends and family[47].

All categories of carers experienced a higher prevalence of social loneliness (67%) compared to emotional loneliness (44%).
10% of the respondents to our survey provided paid or unpaid care for someone else; of these 10% provided invalid responses and were excluded from the analysis.

As almost all of the valid responses were from those providing unpaid care, the results presented here relate to unpaid carers.

Chart 3 shows that the prevalence of some degree of loneliness was highest in those who provided 20 hours or more of care per week (79%) compared to the NHS Highland population (67%).

Those who provided 11-20 hours per week experienced the highest prevalence of intense loneliness (17%) compared to the prevalence in the NHS Highland population (8%).

Previous research shows that carers are more likely to have experienced loneliness, with Carers UK suggesting that 83% of carers feel lonely or socially isolated.

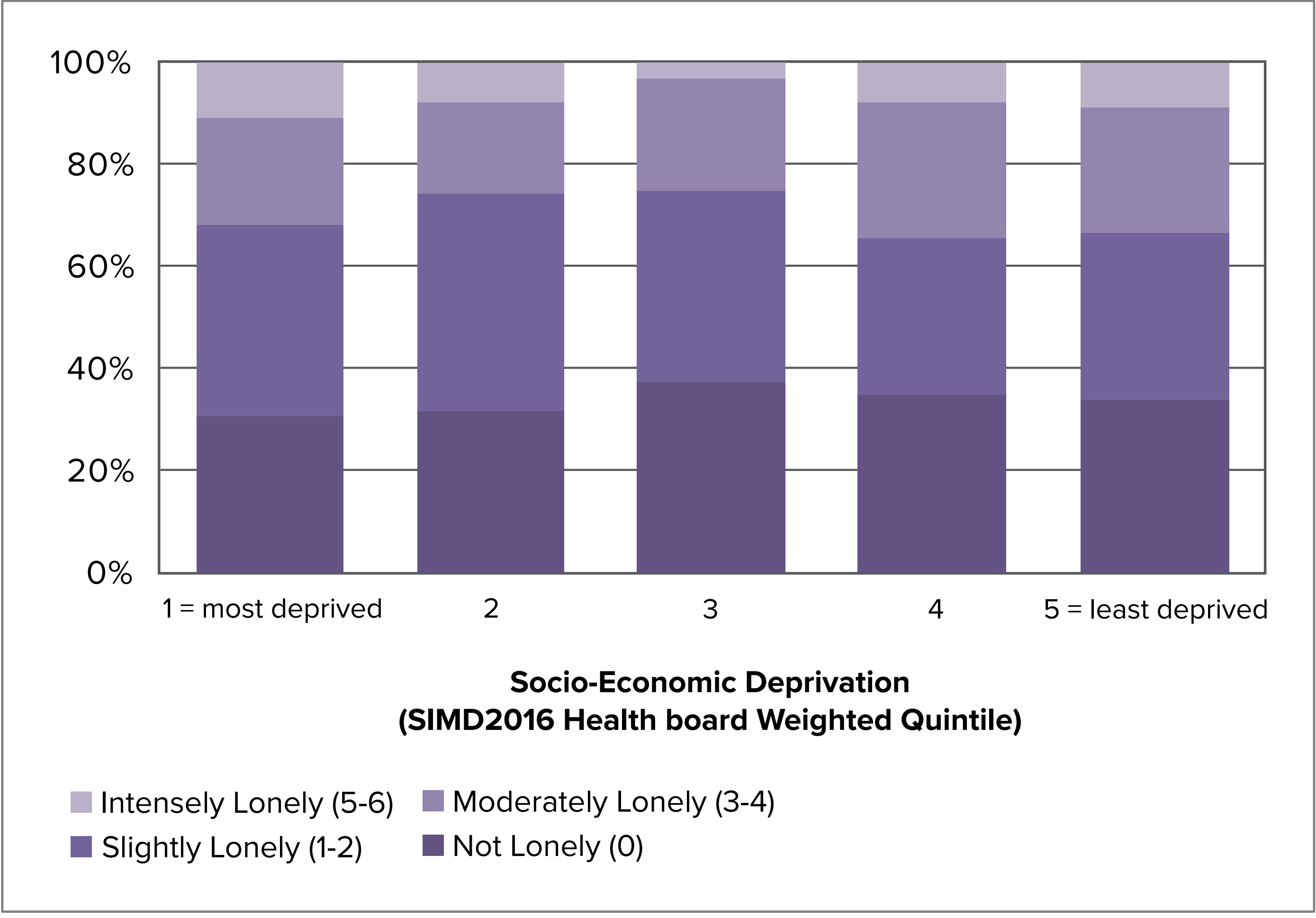
Deprivation and loneliness

79% of sampled population reported a 'good' or 'excellent' quality of life

Similar levels of loneliness were evident whether living in least or most deprived areas

Living in least deprived areas	Living in most deprived areas
67% feel lonely	69% feel lonely
10% feel intensely lonely	11% feel intensely lonely

Chart 4 - Loneliness by socio-economic deprivation



Research indicates that deprivation and loneliness are linked, and that higher levels of deprivation increase the likelihood of loneliness[8].

However, we found little difference in the prevalence of loneliness between those living in our least deprived areas (67%) compared to our most deprived areas (69%).

This was also the case for those experiencing intense loneliness, with 10% reporting intense loneliness in our least deprived areas compared to 11% in our most deprived areas (Chart 4). This suggests that in the context of NHS Highland, factors other than social-economic deprivation are key drivers of loneliness.

Sense of coherence

95% of those expressing a weak sense of coherence feel lonely

40% of those expressing a weak sense of coherence feel intense loneliness.

Table 6 - Emotional and social loneliness and level of sense of coherence

Level of sense of coherence	Emotional loneliness	Social loneliness	Combined loneliness
Strong sense of coherence	23% (2%)	48% (14%)	58% (4%)
Intermediate sense of coherence	39% (5%)	55% (19%)	69% (7%)
Weak sense of coherence	77% (29%)	87% (54%)	95% (40%)

Figures within brackets indicate the percentage of people experiencing intense loneliness

A weak sense of coherence (SoC) has been linked to increased risk of mental illness and mortality[24,25]. There is limited research on the link between a sense of coherence and levels of loneliness. This study, therefore, provided an opportunity to examine this relationship.

Of the valid loneliness scores in our survey, 95% had a valid SoC score. These cases were used in the analysis below.

Our results indicated that 95% of those with a weak SoC experienced some degree of loneliness, whereas the figure was 58% in those with a strong sense of coherence. The overall NHS Highland figure was 67%.

The relationship between SoC and the likelihood of feeling lonely, also applied to feelings of intense loneliness. In those with a weak SoC, 40% experienced intense loneliness compared to 8% of the overall sample and 4% in those with a strong sense of coherence.

In addition, those with a weak SoC experienced the highest levels of emotional (77%) and social (87%) loneliness – higher than the NHS Highland sample figures of 35% and 55% respectively.

Only 2% of those with a strong SoC experienced intense emotional loneliness compared to 29% of those with a weak SoC. Similarly those with a weak SoC were more likely to report intense social loneliness (54%), compared to those with a strong SoC (14%).

Previous research has demonstrated higher prevalence of a low sense of coherence in females, older people, those most socio-economically deprived, and in those with more than one long-term health condition. Our findings are consistent with that found in younger adults[25].

Key messages

67% of people aged 65 and over in the NHS Highland area experience some degree of loneliness and 8% experience intense loneliness

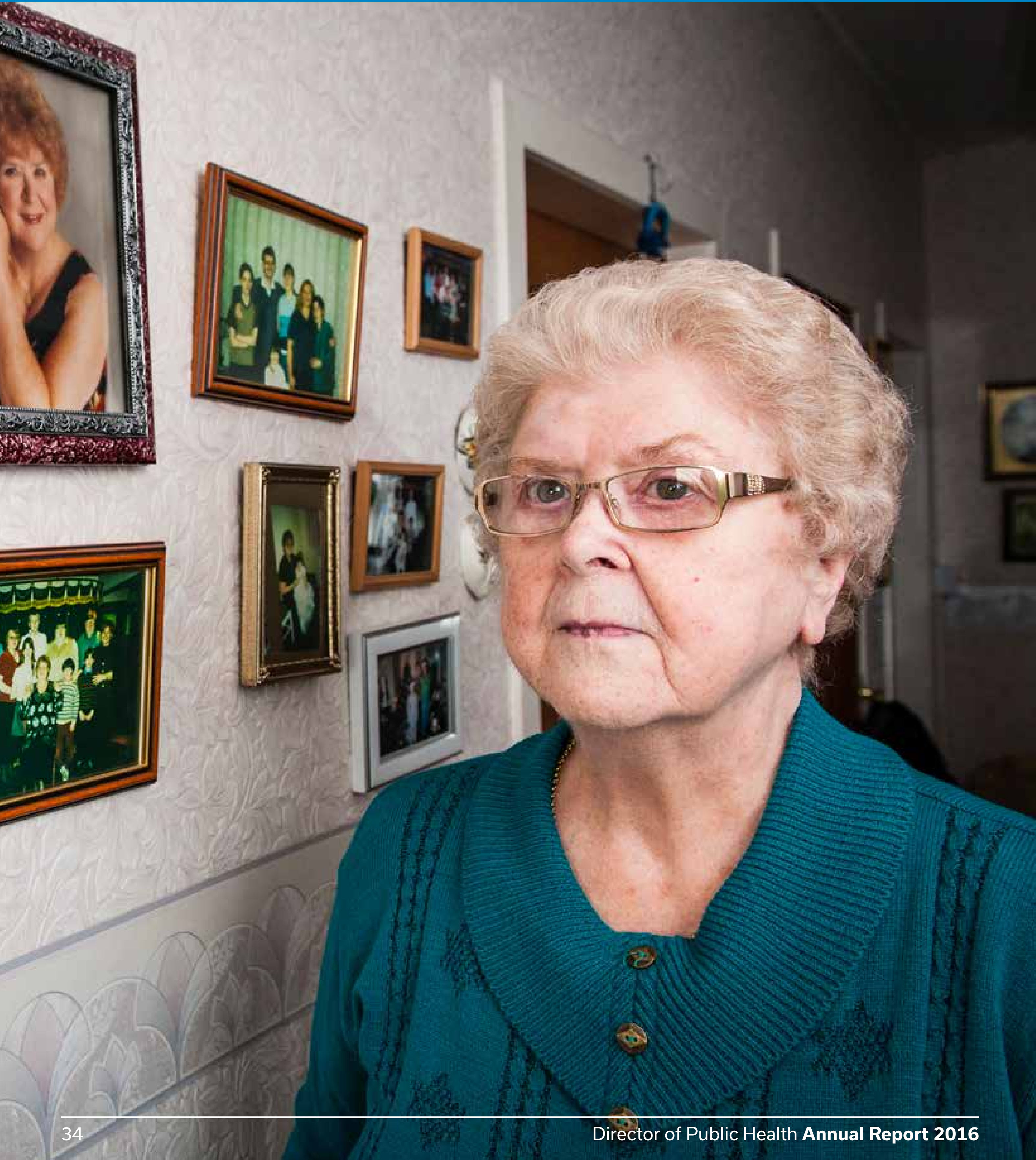
Risk factors for loneliness in those aged 65 years and over include:

- living alone
- living in very remote rural areas or very remote small towns
- having a disability
- having one or more long-term conditions
- providing more than 10 hours per week of unpaid care

Protective factors for loneliness in those aged 65 years and over include:

- a strong sense of coherence
- living in a town or accessible rural area
- married and living together

Chapter Four - What Older People Think



In 2014, three focus groups were undertaken in the Cowal area to investigate older people's views of social relationships and health.

The focus groups took place at:

- A sheltered housing complex, where six residents took part
- a community befriending group, where seven members took part
- a third sector community resilience project, where seven participants took part.

Participants ranged in age from 60 to 99 years and although men and women were invited, only women took part.

Although this may limit the generalisability of the findings, it still provides significant insight into the experiences of older people within NHS Highland.

Focus group discussions were recorded and transcribed word for word. This was analysed using a technique called thematic analysis, which involves looking for common ideas and themes.

The required approvals were obtained for this project, which was undertaken as part of a Masters dissertation.

Identified themes

1. Relationships:
   a. Family
   b. Peers

2. Maintaining social relationships:
   a. Opportunities for meeting people
   b. How ageing affects the maintenance of relationships

3. Loneliness
   a. Alluding to loneliness or talking about loneliness in others
   b. Explicit loneliness

Focus group findings

The focus group findings are summarised as per the quotations in the following content.

Whilst quotes have been used to illustrate these themes, the names of those involved have been changed to preserve confidentiality.

Theme 1 - Relationships

Participants spoke in vivid terms about their relationships. One participant, Mauve, spoke about the high level of value she placed on social relationships with friends and family.

> "There's a circle of people with whom I'm in touch about once a month and they're people that have known me a long time and I can talk to them about absolutely anything..."

Nessie also referred to the importance of relationships to her:

> "I've got loads of, loads of friends, more friends than I had when we lived in Lanarkshire and they're just wonderful, wonderful people."

a. Family

Relationships with family members were particularly important[48]. Several participants had contact and support from their children. Annette explained how her daughter gave practical support:

> "I'm very fortunate because my daughter just stays across the road and she tends to help out a lot and do things for me, [..] I know that if there's anything wrong you just need to pick up the phone..."

Mavis mentioned practical barriers affecting family support:

> "...the family are all down in Reading, my daughter comes up when they can but they're starting to depart a bit 'cause they're getting more children themselves."

b. Peers

Peer relationships were expressed as spending time with people of a similar age, background or experience[49]. All groups spoke about relationships with peers. Mauve described the closeness that can come from knowing someone well:

> "...the long term friends possibly know me better than my family."

With increasing age, peer groups got smaller, for example, friends may have died[50]. Mavis spoke about being the only surviving member of her bridge group:

> "...there are 12 of us and every 12 met every Wednesday [ ] all of them have died, which is a bit of a shock, suddenly every single one..."

Peer support was apparent when Mavis talked about her close friendship with Maggie who attended the same activity as she did:

> "Maggie is my godsend, because I'm usually on the telephone 'Oh Maggie I'm not feeling very well.'..."

In the sheltered housing group where the participants knew each other well, peer support was described by Muriel:

> "In this community everyone cares about everyone else, and that goes a good deal towards good health if you like, if no one ever chaps on your door it's a very lonely existence..."

Theme 2 - Maintaining social relationships

The second theme identified in the discussions was maintaining social relationships.

a. Opportunities for meeting people

Participants gave many examples of how they established and maintained social relationships. These included neighbours, churches, and wider community activities like evening classes and volunteering.

Elsie talked about neighbours:

> "I find too, good neighbours, I mean the house I'm in is far too big for me but I really don't want to move because I've got good neighbours and .... I'm really quite happy where I am."

On a practical level Elsie knows her house is too big but she does not want to leave. Conversely, Alice's neighbour moved away:

> "...she used to just knock my door [..] and then she moved up to Edward Street and do you know it's quite funny because you're waiting on her coming to your door or you go to knock her door and you realise – 'Oh she's not there'..."

Several participants mentioned activities specifically for older people, examples included social clubs, a structured befriending service and social activities organised by sheltered housing. Maggie spoke about her participation in the community befriending group:

> "The best thing that happened to me was the day I joined the befrienders [..] I never looked back. I look forward to this special day every week."

There was evidence of community resilience, and the ability to withstand problems and overcome adversity[51]. Mona spoke about her clubs:

> "Well I go to three clubs [..] I have done for the last 20 years. It doesn't seem like that but it is. But that's not everyday and some days it is pretty boring, but on the whole [..] you're meeting people, joining in whatever's going on."

This comment about clubs being 'pretty boring' is interesting. Research on interventions to reduce loneliness has found that active involvement from participants in the planning of activities is likely to achieve the most benefit[52]. Her comment suggests that this may have been lacking in the activity she was attending.

Several participants spoke about volunteering, working in charity shops or church activities. There is considerable evidence that community participation and specifically volunteering is beneficial, for example, meeting other people or developing social networks often provides a 'sense of purpose' and of 'doing something worthwhile'[53].

b. Ageing and relationships
Ageing is associated with failing health and reducing capability. Participants in all three groups spoke of decreasing ability. Annette said her physical health had deteriorated:

> "I wasn't very well early on in the year and now I've got a zimmer and a walking stick, which I try to avoid using...."

There is evidence that physical decline stops older people maintaining social relationships[54]. Eleanor recognised the limiting effect her capability has on social interactions and said:

> "Yes. I can't go out on my own. My sight you know, I'm registered blind."

Some participants were less confident about taking part in social activities as they got older. In Betty's case a connection was made to failing health:

> "...when you're on your own, the older you get, I think you get more cautious [..] I might fall, I might have a stroke or a heart attack or something it's being pessimistic but it's possible..."

A number of participants spoke about the challenge of continuing to drive. Elsie said:

> "I was perfectly competent but I didn't have all the confidence in the world, you know it takes years of driving to build up your confidence. When my husband died just over a year ago I gave the car up."

Mavis also stopped driving:

> "I, erm, bashed the car, which was a pity so I had no car..."

Transport affects the ability of older people to get to activities, especially in rural areas where transport options may be limited[55]. Giving up driving was found to be a significant factor in contributing to loneliness in a Canadian study of loneliness in older people[56].

Theme 3 - Loneliness

The challenge of loneliness was well described. Elsie expressed her sense of isolation as follows:

> "... if you are on your own the problems become magnified and you imagine things are wrong with you. You're sitting on your own, there was maybe nothing wrong with you but you imagine there are things wrong with you [..] that's what isolation does to you."

Betty gave the following reply to Elsie:

> "Yes that's right, you've got no-one to bounce things off..."

a. Recognising loneliness
Loneliness was expressed as having stigma attached to it[57]. This could be the reason Sarah spoke about loneliness in the second person:

> "...if you are lonely and you've got nothing to do, you sit there and feel even more lonely and depressed, but if you've got something on the go, knitting or something and you're concentrating on that, you're not so lonely."

Participants spoke more about loneliness in others, for example Maggie talked about her friend:

> "I have a friend like that and she is always lonely especially when she draws the blinds at night puts on the light and it's a long, long evening and a long, long night."

Alice remarked about feeling lonely, although she is married:

> "I've got a husband and still sometimes you can feel lonely [..] he'll sit at his computer [..] for hours and you'll say to him 'I want to go out' [..] I say to the dog 'I wonder how long the 5 minutes will last this time, come on we'll just get ready and go ourselves' and then he'll say 'Are you not waiting on me' and you feel like choking him."

b. The effect of loneliness

Notwithstanding the sensitivities of discussing personal experiences of loneliness in a focus group and acknowledging this was not a specific question asked of participants, two people in different groups spoke about the effects of loneliness. Betty told the group:

> "Sometimes I just can't be bothered doing anything and then I'll sit and watch the soaps but I don't think that's where my loneliness comes from."

Loneliness is often experienced by people following the death of a spouse[58]. Molly also spoke of the effect on her:

> "I would like to say how lonely I am and there is a reason, I'm not long widowed and I've never been on my own in my life and I feel it, but I'm getting better. I nearly went into a black hole but I'm getting better because I'm determined to do it, but I have been very lonely..."

Conclusion

This qualitative research provided an insight into what loneliness and social relationships mean for older people in the context of their everyday lives.

It is clear that older people are not a homogeneous group, and that a range of community based services and activities are required to reduce their isolation and loneliness.

The groups also brought to light the importance of co-production and the importance of involving older people in the design of the services that they receive.

Chapter Five - Reducing Loneliness

Developing and maintaining social relationships

The logical answer to reducing the incidence of loneliness is to increase opportunities for social interaction for people who feel lonely, or who are at risk of loneliness.

However, this is easier said than done. The assumption amongst some older people that it is normal to be lonely in old age should be challenged, as new friends can be made[59].

Having frequent contact seems to be more important than the number of friends that someone has.

"Professionals and citizens making better use of each others' assets, resources and contributions to achieve better outcomes or improved efficiency." [62]

Bovaird & Loeffler, 2012

A small number of meaningful relationships may be better than a large number of acquaintances. Support in developing or refreshing the social skills required to make new friends is key, as is encouragement to 'give it a try'.

Evidence suggests that interventions which support people to become active participants in group activities rooted in their communities is one of the most successful ways of reducing loneliness.

A review of the evidence undertaken in 2014, about what works to prevent social isolation and loneliness in older people, suggests the following characteristics are relevant for any successful intervention to enable the development of meaningful relationships:

- older people are active participants rather than passive recipients[60]
- older people are involved in the planning and implementation of support[61]
- support is flexible and adaptable to the needs of the participants[61]
- support consists of group activities, particularly those with a defined goal[37]
- support is rooted in the community[37]
- the intervention has a theoretical basis (i.e. is evidence informed)[12].

These characteristics are key to a co-production approach, which may be defined as:

Contact with children is a particularly effective antidote to loneliness. This appears to apply to cross-generational contacts in general, i.e. contact with children and young people as well as contact with one's own (grown-up) offspring.

Asset mapping

Asset mapping is a term used to find out what is going on in communities, for example, what services and activities there are as well as having good up to date contact details so that people are able to easily access them.

Information from asset mapping can be provided in a variety of ways including posters in community locations; through word of mouth; and increasingly online information sharing on websites and social media.

Asset mapping can help signpost people who are lonely to appropriate support and activities.

Social prescribing

Social prescribing is the process of referring people to appropriate sources of support for social problems within their community. For social prescribing to be effective, health professionals need to know where to refer people to by having accurate lists of community activities and services.

There is a key role for primary care in undertaking social prescribing.

Solutions to reducing loneliness need to be multi-faceted and include more than one of the following:

Information and signposting services

- websites or directories including information about social support services
- telephone helplines providing information about social support services
- health and social support needs assessment services (postal or web-based questionnaires or visits)

Support for individuals

- befriending – visits or phone contact; may include assistance with small tasks such as shopping
- mentoring – usually focused on helping an individual achieve a particular goal, generally short-term
- buddying or partnering – helping people re-engage with their social networks, often following a major life change such as bereavement
- Wayfinders or Community Navigator initiatives – helping individuals, often those who are frail or vulnerable, to find appropriate services and support

Group interventions – social

- day centre services such as lunch clubs for older people
- social groups that aim to help older people broaden their social circle, and possibly focusing on particular interests, such as reading

Group interventions – cultural

- initiatives that support older people to increase their participation in cultural activities (e.g. use of libraries and museums)
- community arts and crafts activities
- local history and reminiscence projects

Health promotion interventions

- walking groups for people over 50
- healthy eating classes for people over 50

Wider community engagement

- projects that encourage older people to volunteer in their local community (for example, local volunteer centres and Time Banks).

Source: Loneliness and Isolation: a toolkit for health and wellbeing boards, The Campaign to End Loneliness (www.campaigntoendloneliness.org.uk/toolkit/)

Loneliness is not often spoken about and many people experiencing loneliness are reluctant to admit they feel lonely. It can even be viewed as a personal failing.

Front line health and social care staff may not ask people if they feel lonely due to a lack of understanding of what to do to support them. There also seems to be no systematic or consistent approach to raising the issue during routine contact with services. However, there is a case for health and social care staff to regularly ask about loneliness and social isolation and signpost people to opportunities to develop stronger social networks.

Community-led interventions often cost less than treatment of conditions that are linked to loneliness. For example, this is the case in dementia. However, building ongoing local solutions requires sustained funding to ensure the longevity of services and activities. Currently third sector funding is short term and fragile and by consequence, so are many of the services delivered by this sector.

Examples across NHS Highland

The following information describes some of the initiatives across the NHS Highland area that help to tackle loneliness and social isolation.

Shopper Aide

Shopper-Aide is a social enterprise delivering services to people aged 60 years and over, to help them remain as independent as possible in their own homes.

Their client base is made up of people receiving statutory services, such as home care, but needing additional help, and also people living independently with no health and social care input. The initiative is highly valued by service users and by health and social care practitioners as one that keeps people socially connected.

Shopper Aide clients, staff and volunteers enjoying a day out at a local tea-room in Kintyre.

Community Resilience Workers

Argyll and Bute Health and Social Care Partnership invest in the Third Sector Interface (TSI) to pay for seven community resilience workers for older people across Argyll and Bute.

These staff work very closely with their local communities to provide support for individuals on a one-to-one basis and in addition, develop group based activities.

Members of the Kintyre community group on a recent trip to the Corrivrekan whirlpool.

Befrienders Highland

Befrienders Highland offers befriending to people across the Highlands including those who live with mental health issues or dementia, as well as carers of people with dementia who are socially isolated.

Volunteers now support 100 people who are known as 'friends' across the length and breadth of NHS Highland. Befriending increases wellbeing, social connectedness and a sense of belonging within the community.

Volunteer walk leader, TJ, who has provided support to a number of walking groups in the Inverness area.

Step It Up Highland

Step It Up Highland co-ordinates a network of volunteer-led health walk groups throughout the Highland Council region. Many participants say that the social interaction aspect is their main reason for joining a walking group. A number of those who joined a walking group have gone on to become walk leaders, starting their own groups in other areas.

Community Transport Schemes

There is a range of Community Transport Schemes across NHS Highland that operate with volunteer drivers.

Schemes meet the needs of people who cannot get out and about and fills gaps in existing public transport, either with volunteer drivers using their own car or using the scheme's own vehicles, which can be hired and are fully accessible to those with disabilities.

> "I think it is so handy and it gives me my independence. If there was no car scheme I would be stranded in my own home"

Living it Up

Living it Up is a web-based health and well being self management hub, which supports people aged 50 years with long term conditions and their carers.

Living it Up facilitates peer support though the use of inspirational user stories and experiences and users are asked to contribute to 'experience guides' and online articles.

The scheme supports the development of digital skills and health literacy. One of the popular aspects of Living It Up is the activity logs and community challenges that it organises. It also contains information on local activities and services. These tools encourage and motivate people to get out and about more.

Living It Up provides motivation for people over 50 to get out and increase their physical activity.

Reach Out

'Reach Out' provides an overarching framework for a wide range of initiatives to address loneliness and social isolation across NHS Highland. The scheme has been very well supported.

The local press have done an excellent job of promoting the campaign, resulting in extensive coverage of the campaign in local newspapers and radio channels. It has also been backed by a wide range of local organisations.

Reach out has its own online presence on Facebook, Twitter and Instagram and has a dedicated website: www.reachout.scot.nhs.uk

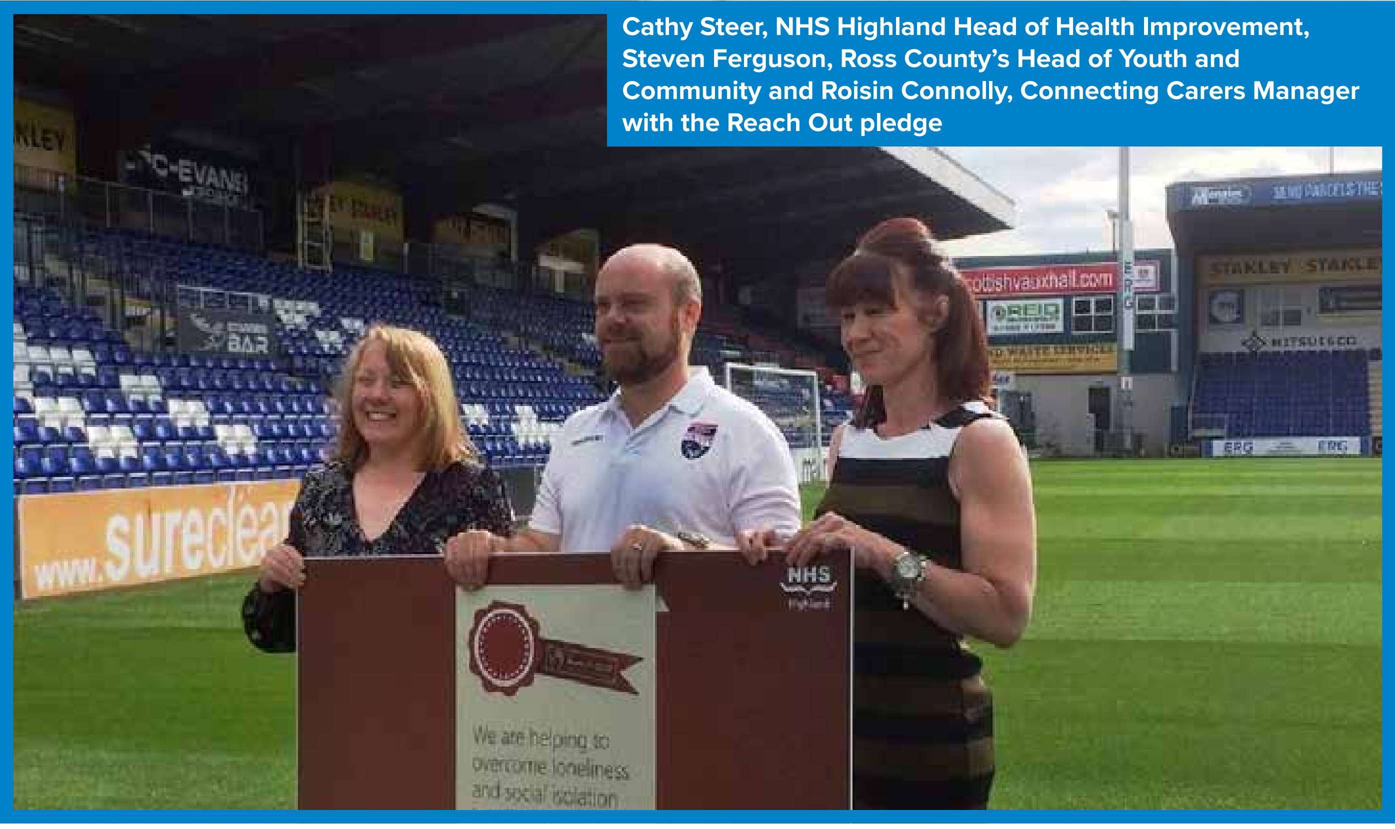
Many pledges have been signed online. Examples of personal pledges include:

- Smiling and talking to people in the street
- telling friends and family about the pledge and encouraging them to sign up
- knocking on your neighbour's door to get to know them better
- inviting people you know who live alone to have a meal with you.

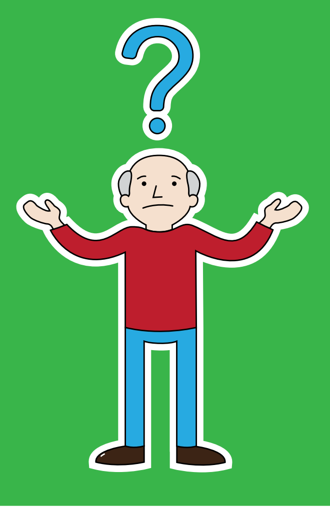
Employer pledges include:

- Raising awareness of the pledge with all staff emails and web links
- encouraging staff to volunteer with community groups
- providing information on local social support for staff who may be feeling lonely.

In summary, Community Planning Partners across Highland and Argyll & Bute have made major strides in developing a sustainable platform for addressing social isolation and loneliness via the Reach Out campaign, but much more remains to be done.



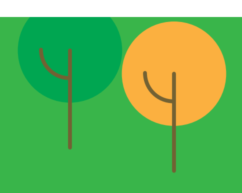
Cathy Steer, NHS Highland Head of Health Improvement, Steven Ferguson, Ross County's Head of Youth and Community and Roisin Connolly, Connecting Carers Manager with the Reach Out pledge



Accessing community activities and support

Some people who are lonely may be able to access their own support with appropriate signposting but others need more help to do so. In the case of people who are already lonely it is very likely they will need help and encouragement to be able to take part in community activities.

Places of Worship

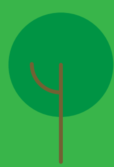


Colleagues at Work

Community Centres

Places of Education

Family and/or friends



Recommendations

- Build capacity in the Third Sector so they can further invest in community based support. Careful consideration of funding models is required here due to the fragility of long term funding solutions for these services.
- Showcase examples of what is working in local communities to reduce social isolation and loneliness.
- Ensure the principles of co-production are fully embedded in service design and delivery i.e. older people informing and shaping the services they want.
- Enable people to access these services, considering community transport for those who may have difficulty using their own or public transport.
- Embed the principles of social prescribing to ensure people with underlying social problems at the root of their health problems get referred or signposted into appropriate sources of support.
- Local ownership and value of Third Sector community support for loneliness and isolation by Health and Social Care partners.

Chapter Six - Conclusion

This report has drawn together a range of published and local evidence regarding the importance and impact of loneliness and social isolation.

The costs associated with loneliness are significant in terms of mortality and morbidity and in relation to the cost to public services. Additionally, the significant human impacts of distress and poor quality of life for people experiencing loneliness are recognised.

A number of factors have been identified in the published literature that increase the risk of being lonely including having a disability, a long term health condition or being a carer.

Conversely, there are protective factors against loneliness including having a strong sense of coherence, regular opportunities to socialise and good social and family structures such as living together or being married.

The published evidence indicates that a range of measures to reduce loneliness are cost effective, can reduce health service costs and represents value for money for the public purse. Some of these approaches are being provided across NHS Highland.

The risk of feeling lonely increases as we get older. The proportion of older people is expected to increase over the next decade; this will have a bearing on the impact of loneliness on our communities and the requirement for interventions to reduce loneliness delivered by communities themselves, public sector and third sector organisations.

A 2016 survey in Highland indicated that 67% of the population over 65 years experienced some degree of loneliness. Living in very remote rural areas or very remote small towns was associated with an increased prevalence of loneliness compared to urban or accessible rural areas. Those who reported having a strong sense of coherence had a lower prevalence of loneliness.

This report makes ten recommendations for implementation by the NHS as well as wider health and care partners and the general public, these are outlined below:

1. Increase awareness of the strong links between loneliness and poor health, mortality and increased service utilisation. In order to achieve this:
   - The Public Health Department will continue to raise awareness of the risks of loneliness and isolation.
   - There will be comprehensive promotion and marketing to showcase examples of what is working in local communities to reduce social isolation and loneliness.
   - The community nature of the problem of loneliness and the need for a partnership approach to finding solutions will be advocated. This is an ideal topic for Community Planning.
2. Health and social care services should consider the risk factors of loneliness and raise the issue during patient assessments and consultations. Staff should regularly ask people they come into contact with if they feel lonely and signpost to local sources of support.
3. Embed social prescribing in health and social care delivery to ensure people with underlying social problems get referred or signposted into appropriate sources of support by their health professional or care giver.
4. Ensure people experiencing or at risk of loneliness are able to access appropriate services. There may be practical barriers present so consider community transport for those who may have difficulty using their own or public transport.

5. Public sector bodies should invest in interventions to reduce loneliness as part of a wider focus on preventing health problems before they arise. The promotion of a preventative approach to loneliness should focus on building capacity in the third sector so they can further invest in community based support. Careful consideration of funding models is required, due to the fragility of long term funding for these services.
6. Ensure the principles of co-production are fully embedded in service design and delivery so that older people inform and shape the services they want.
7. Those who award grant funding should minimise the risk of stop/start funding cycles for preventative activity and recognise the financial difficulties of sustaining third sector services.
8. Employers should consider the potential impact of working unsocial hours and weekend shifts on the families and personal networks of their staff.
9. Work on Reshaping Care for Older People should be refreshed to reflect the issues of loneliness and social isolation.
10. Locality plans developed as a result of the Community Empowerment Act and the integration of health and social care services should consider loneliness and help build a sense of coherence within communities.

The Reach Out campaign is an exciting new approach to health improvement and provides NHS Highland with an overarching framework for addressing loneliness and social isolation.

Since May 2016, a wide range of local community support initiatives have signed the pledge to make a difference to someone who is lonely.

Investment in community services needs to be sustained over the long term. This is challenging in a tight financial context, but represents an important opportunity when one considers the overall wellbeing of our population and the potential for improving public service delivery.

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ransformation Projects and Regeneration

COMMUNITY PLANNING GROUP

14 August 2018
Timber Pier, Dunoon

Lorna Pearce, Senior Development Officer
for Bute and Cowal and Helensburgh and Lomond

BUTE & COWAL COMMUNITY PLANNING GROUP

AREA COMMUNITY ACTION PLAN

5 c) ONGOING ACTIVITY IN THE DUNOON AREA

5 d) GREAT PLACES BID

ONGOING ACTIVITY IN THE DUNOON AREA

TOWN CENTRE REGENERATION

- Dunoon CARS

PROJECT DEVELOPMENT

- Dunoon Area Alliance
  - Doors Open Day
  - Dunoon Mod SLA

DUNOON CARS

Heritage-led regeneration – safeguards, restores and celebrates
Partnership Project – HES and ABC
Project value - £1.89m
2017-2022

- Comprehensive repair of 4 properties in multiple ownership
- Restoration of 3 shopfronts
- Facilitation of a training and skills programme
- Facilitation of events to celebrate the unique culture and heritage of Dunoon

DUNOON CARS

BOUNDARY

- Enhance the principal thoroughfare
- Links and adds value to the other regeneration projects
- Attract higher footfall

PRIORITIES

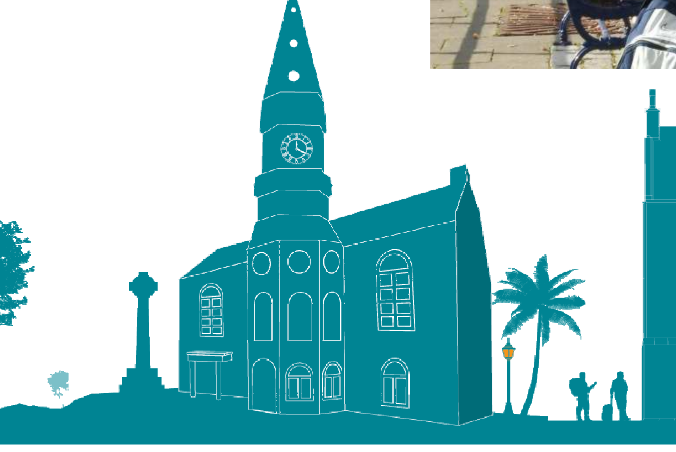
Level of disrepair / structural repair required
Oldest buildings in the street
Architectural merit
Visual impact

RTHCOMING EVENTS

RCHANDISING MASTERCLASS

ase contact:

rgal De Buiteleir, CARS Project Officer
01546 604 549



WAL DEVELOPMENT PROJECTS

lyn Rieley, Bute and Cowal Development Officer

Dunoon Area Alliance

- Formed in August 2016
- Presently incorporating as a SCIO
- Membership from all walks of the Dunoon Area community
- Dunoon Harbour Masterplan
- Digital Dunoon
- Living Streets Scotland

WAL DEVELOPMENT
OJECTS

Arg
Bu
COUN

Doors Open Day 2018

- Taking place September 22nd/23rd
- Buildings will open their doors to the public at no charge
- Participating this year:
  - Queen's Hall
  - Dunoon Pier
  - Castle House Museum
  - Burgh Hall
  - Historic Kilmun
  - Cowal Open Studios
  - Kirn and Sandbank Church

WAL DEVELOPMENT
OJECTS

Dunoon Mod 2018

- Taking place October 12th – 20th
- Torchlight Parade on Friday 12th October on High Street
- Full Programme of events across Dunoon including Opening Concert at Queen's Hall and a Fiddler's Rally ending with a Masses Choir event on the final evening
- Venues will include the newly opened Queen's Hall, the Burgh Hall, the High Kirk and Dunoon Grammar School

Great Places

- Unsuccessful second-round bid to HLF in 2017
- Connected Cowal ambition
- Networked heritage – using the peninsula's rich and varied heritage to stimulate tourism growth and better alignment of strategic areas of focus
- Benmore and Kilmun Community Development Trust are developing a bid to pick up on these themes to submit to HLF Heritage Grants programme

THANK YOU

Argyll and Bute Community Planning Partnership

Bute and Cowal
Date: 14 August 2018

Title: Health & Social Care Partnership Strategic Plan Refresh 2019 – 22 and Community Engagement Process

1. SUMMARY

The Health & Social Care Partnership (HSCP) is seeking feedback from service user and carer representatives, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022), specifically on eight strategic areas of service change required to deliver the ambitions of the HSCP over the life of the Plan. This will take place during summer and early autumn 2018.

2. RECOMMENDATIONS

Community Planning Partnership Area Groups should consider their role in health and social care and what their collective response on the HSCP Strategic Plan engagement proposals. Individual partners can also provide their own response.

3. BACKGROUND

3.1 Strategic Plan

The current HSCP Strategic Plan runs from April 2016 to March 2019 and is available to view here - http://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/SP%202016-2019%20%20Final.pdf

This includes the following vision and areas of focus:

Vision

- People in Argyll and Bute will live longer, healthier, independent lives.

Areas of Focus

- Promote healthy lifestyle choices and self-management of long term conditions
- Reduce the number of avoidable emergency admissions to hospital and minimise the time that people are delayed in hospital.
- Support people to live fulfilling lives in their own homes, for as long as possible.
- Support unpaid carers, to reduce the impact of their caring role on their own health and wellbeing.
- Institute a continuous quality improvement management process across the functions delegated to the Partnership.
- Support staff to continuously improve the information, support and care that they deliver.
- Efficiently and effectively manage all resources to deliver Best Value.

3.2 Financial Challenges

The HSCP receives funding from NHS Highland and Argyll and Bute

Council for delivering health and social care to the people of Argyll and Bute. There is a significant budget shortfall (£5.2 million in 2018/19) and this means that health and social care delivery must change. There are eight proposed areas for service change:

1. Children's Services
2. Care Homes and Housing
3. Learning Disability Services
4. Community Model of Care
5. Mental Health Services
6. Primary Care Services
7. Hospital Services
8. Corporate Services

3.3 Engagement Process
The HSCP engagement process involves three stages, with stage 1 taking place from summer 2018 to early autumn 2018:

Stage 1 – Informing and Consulting on the Strategic Plan

- Informing people about what the HSCP is going to do
- Inviting comments on the key service change areas that are required
- Inviting suggestions around what we need to do to make sure we involve people as we make these changes
- Use the information gathered in this stage to inform what we do next

Stage 2 – Involving and Collaborating on service redesign

- Developing the areas of work around the 8 key areas for service change
- Involve staff, citizens and partners as we take forward this work
- Publicise what we have found out and how this information will be used to make service changes

Stage 3 – Involving and Collaborating on implementing service change

- Involve people who use services, carers, staff and partners in how we implement service change

Feedback on stage 1 can be done on handouts that will be collected at the end of the meeting or via this Survey Monkey link - https://www.surveymonkey.co.uk/r/AB-HSCP2019-23

4. CONCLUSION

The view of Community Planning partners is important in ensuring there is appropriate consultation and engagement to inform the new HSCP Strategic Plan.

For further information contact: Sandra Cairney
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Argyll and Bute Health and Social Care Partnership

Email: sandra.cairney1@nhs.net
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STRATEGIC PLAN (2019/22)

ENGAGEMENT PROCESS

The Health & Social Care Partnership (HSCP) is seeking feedback from service user and carer representatives, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022), specifically on eight strategic areas of service change required to deliver the ambitions of the Partnership over the life of the Plan.

The Challenging financial position means the Health & Social Care Partnership cannot do everything to meet the public's expectations of care. The ageing population and increasing health and care demands mean it is not possible to continue to provide services in the same way. Simply we need to utilize our staff, buildings and money differently to achieve the best impact.

Delivering services within a balanced budget will require a shift of focus to delivering high quality and effective services for people with a complex range of needs and investing in communities, enabling and supporting people to enjoy the best quality of life possible, informed by choices they make for themselves.

The HSCP engagement process involves three stages, with stage 1 taking place from summer 2018 to early autumn 2018:

- **Stage 1 – Informing and Consulting on the Strategic Plan**
- Informing people about what the HSCP is going to do
- Inviting comments on the key service change areas that are required
- Inviting suggestions around what we need to do to make sure we involve people as we make these changes
- Use the information gathered in this stage to inform what we do next
- **Stage 2 – Involving and Collaborating on service redesign**
- Developing the areas of work around the 8 key areas for service change
- Involve staff, citizens and partners as we take forward this work
- Publicise what we have found out and how this information will be used to make service changes
- **Stage 3 – Involving and Collaborating on implementing service change**
- Involve people who use services, carers, staff and partners in how we implement service change

The key service change areas are outlined below. We welcome and value your feedback to better inform the Strategic Plan and the transformational service changes required over the next three years and beyond.

Please could you complete your response to the following five questions online via

https://www.surveymonkey.co.uk/r/AB-HSCP2019-23

Alternatively, you can post your response to:

Caroline Champion
Public Involvement Manager

Argyll & Bute Health & Social Care Partnership FREEPOST RRYT-TKEE-RHBZ
Blarbuie Road
LOCHGILPHEAD
Argyll
PA31 8LD

1. CHILDREN'S SERVICES

What do we Know?

Data for 2017 shows 13,163 children aged 0-15 years live in Argyll& Bute (6705-males and 6458 females). The children and young people population is declining. The number of children with complex needs is increasing. The single biggest challenge is the recruitment and retention of midwives, health visitors and social workers. £844K of savings will need to be delivered over the next year.

Being exposed to adverse and stressful experiences (ACEs) can have a negative impact on children and young people throughout their lives. Trauma-informed and resilience-building practices should be embedded within services.

What do we plan to do?

- Provide continuity of midwifery care.
- Increase visits by health visitors.
- Prevent children and young people coming into care.
- Increase the number of fostering and kinship placements.
- Place children close to their families and communities.
- Reduce youth and adult reoffending rates.
- Preventing problems through early intervention such as breastfeeding support and reducing poverty.

2. CARE HOMES AND HOUSING

What do we Know?

The number of older people is set to rise significantly in the coming years with the steepest rises being in the over 75 year age group. 10.7% of the current population is aged 75 and over. There is an increasing demand for adapted properties as more older people are enabled to stay at home.

The challenge is to provide suitable housing and sustainable 24 hour care and care at home services for people with high levels of need in the context of workforce recruitment difficulties. As service demand rises there is a requirement to make £0.1 million of saving over the next year from this service.

A Health and care housing needs assessment has been undertaken to inform need and a Care & Nursing Home Modelling Tool is being developed to better assess future needs.

What do we plan to do?

- Understanding current scale and profile of nursing, residential care & supported accommodation for older people.
- Working across health, social care, housing and independent sector to determine future demand.
- Plan future provision around 24 hour care and housing.

3. LEARNING DISABILITY SERVICES

What do we Know?

Argyll & Bute has a growing number of people living with learning disabilities who are living healthier for longer. There is an increasing demand for Learning Disability services, both internal and external, with this trend not predicted to slow given the population profile. The challenge will be to deliver community based supported living services with a reducing resource, increasing need while meeting quality standards.

Other models of care will be required which will involve moving away from individual tenancies which are unsustainable. Engaging with Third Sector providers will enable the development of new opportunities for supported living with a view towards delivering alternative models of care and support.

What do we plan to do?

- Further develop service and resources that will support individuals to return from out of area placements.
- Review and evaluate current 'sleepover' services and increase usage of Telecare whilst maintaining service user safety and wellbeing.
- Work with housing services to develop 'Core and Cluster' models of care.
- Develop HSCP internal services that are able to support individuals with complex needs.
- Sustain and further improve on the positive feedback from external regulators regarding the quality of service provision.
- Increase the uptake of Self Directed Support.
- Support the co-production of community based services for families living with learning disabilities.

4. COMMUNITY MODEL OF CARE

What do we Know?

There are more elderly people living in Argyll and Bute and it is anticipated this will increase significantly in future years. There will be more people living with care needs in our communities and some of these care needs will be complex. It is also predicted that more people will be living with dementia requiring support and care in our communities. There are a number of challenges to meeting service demand including recruiting care workers; high public expectation of care provision; the availability of appropriate homes/housing for people with care needs; and the delivery of care across a large geographical area.

Evidence suggests that a multi disciplinary team provides more efficient and effective community care, reducing hospital admissions and supporting discharges. Focussed re-ablement following a period of ill health can improve health and wellbeing outcomes for people and reduce the demand on homecare. A team approach to falls prevention and frailty supports people to continue to stay at home.

What do we plan to do?

- Develop and implement multi-disciplinary community care teams
- Develop a multi skilled care worker role to work within the multi-disciplinary community care teams.
- Ensure anticipatory care planning is adopted to reduce the incidence of emergency hospital admissions.
- Prioritise the prevention e.g. empower people to self manage long term health conditions and connect people with sources of support in their community such as

opportunities to be more physically active.
- Further develop the use of technology to support people living at home who have health and care needs.

5. MENTAL HEALTH SERVICES

What do we Know?

There are increasing numbers of people living with mental health problems in our communities. Demand for support and care services centre around in-patient beds for people with severe and acute episodes of mental ill health and community services to support people living at home. There continues to be an increasing demand for services and recruitment to specialist mental health professionals and care support workers remains challenging. The nature of the large geographical area presents difficulties in delivering care and support, particularly responding to acute episodes of care out with normal working hours.

It is well recognised that anticipatory and crisis care planning reduces admission to a hospital bed and a positive therapeutic environment supports recovery. A multi disciplinary team approach provides more efficient and effective care in the community and new technologies can support care delivery.

What do we plan to do?

- Establishment of the in-patient beds within Mid Argyll Community Hospital.
- Review of the community mental health teams.
- Explore new technological ways of delivering therapy.
- Implement the Locality Based consultant model of care.
- Further develop the WRAP approach to enable people to self manage their mental wellbeing (Wellness Recovery Action Planning).
- Mitigate the impact of problems such as debt and loneliness on mental health through connecting people to community based support.

6. PRIMARY CARE SERVICES

What do we Know?

There are 33 GP practices in Argyll and Bute, with a registered patient population of 88,657 as at 1 April 2018. The national priority is to reduce the future workload on GPs and practices and to transfer work to HSCP to deliver services through other clinicians such as Pharmacy, Physiotherapy, Advanced Nurse Practitioners.

The new GP Contract was implemented in April 2018. Sustainable services delivered by wider teams are being planned within the context of Primary Care Service Redesign. This will see extra funding over the next 3 years in Argyll and Bute - £848,000 in the first year expected to rise to £2.9 Million.

What do we plan to do?

- Musculoskeletal (MSK) Services - More physiotherapists employed so that patients can benefit from quicker access and treatment reducing unnecessary referrals to GPs.
- Community Mental Health - Increasing the number of community mental health nurses better placed to support up to 25% of patients who currently see GPs.
- GP Workload - Free up time and support the changing role of GPs so they can concentrate on patients with more complex health and care conditions. Make the role more attractive to recruit to.

7. HOSPITAL SERVICES

What do we Know?

There is one Rural General Hospital in Oban and six Community Hospitals all with Accident & Emergency departments.

As more people live longer there is more demand on services. The number of A&E attendances continues to increase; more care is now being delivered in the community and hospitals are being used for more day care services. A challenge is that the general population decline in Argyll and Bute is also mirrored in the workforce impacting on the ability to recruit a sustainable workforce.

International and national evidence advises that people have better outcomes when they receive care as close to home when it is safe and possible to do so; hospital care should be used when needed for acute care; and A&E departments should only be for urgent care.

What do we plan to do?

- Standardise role and function of each community hospitals.
- Bed model each in-patient area to ensure we make best use of all resources.
- Workforce review to ensure we are utilsing the full potential of all individuals.

8. CORPORATE SERVICES

What do we Know?

HSCP corporate services include finance, planning, IT, HR, pharmacy management, medical management and estates, as well as all IT and corporate asset infrastructure. Demands are increasing alongside new corporate demands of health and social care integration. There is a requirement to make corporate services more efficient and integrated for front line managers.

There are a number of challenges in improving the effectiveness and efficiency of these services. These include less people and buildings; not all corporate support services from Council are delegated to the partnership; the balance between efficiencies and reduced level of service; and more efficient use of technology and systems requires significant investment. The recurring budget is expected to reduce, requiring savings of £1.3m over the next year. However, if efficiency and effectiveness are to be achieved non-recurring investment may be required.

The National health and wellbeing outcome indicators require HSCPs to use resources effectively and efficiently and to integrate support services to provide efficiencies. The HSCP will model corporate efficiencies on those already realised by the Council.

What do we plan to do?

- Health and social care corporate staff (eg finance, planning, IT, HR, estates) are co-located to work together in the same locations and in the same teams.
- Integrate health and social work administration and implement digital technology.
- Efficiencies in catering and cleaning services through shared services.
- Rationalise estates and properties by co-location of staff.
- Efficiencies in travel and subsistence costs.

YOUR VIEWS ARE IMPORTANT AND WE WELCOME YOUR FEEDBACK.

Q1:	What is your understanding of the types of services that are provided by the Health & Social Care Partnership?

Q2:	What are your thoughts about the 8 key areas of service change?

Q3:	What do we need to do to make sure we involve people as we go about making these changes (effective engagement)?

Q4:	How can individuals, communities and our partners work with us to help people stay healthy and well?

Q5:	What would help communities to work with us and play an active role in developing and delivering future services?

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A&B HSCP | Transforming Together

STRATEGIC PLAN (April 2019- March 2022)

STAKEHOLDER ENGAGEMENT

Health & Social Care Partnership

- The Integrated Joint Board was established as a new public body on the 1st April 2016.
- First Strategic Plan (2016/19) identified key areas of focus to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and require support from both health and social care.
- There have been some notable successes in the first two years.

Successes in the first 2 years

- Developed Community Care Teams with a single point of access in Kintyre and Mid-Argyll.
- Developed a single point of access for health community referrals in Dunoon.
- Development of an extra care housing unit in Lorn Campbell Court Campbeltown.
- Relocation of in patient mental health facility in Mid Argyll.
- Embedding a re-ablement approach to care that enable a people to reach their highest level of independence, reduce the need for continued care at home.
- Developing process to improve referral into a community team, how referrals are triaged and allocated, to reduce the time and simplify the process.
- Working with the carer centres and respite providers to implement the Carers Act which gives carer rights to be assessed and supported in their caring role.
- Graded VERY GOOD for children's residential and fostering services.
- More Looked After Children placed in family type placements.
- Implemented 'Attend Anywhere' within Maternity Services.

2nd Strategic Plan (April 2019 - March 2022)

- The Challenging financial position means the Health & Social Care Partnership cannot do everything to meet the public's expectations of care.
- The ageing population and increasing health and care demands mean it is not possible to continue to provide services in the same way. Simply we need to utilise our staff, buildings and money differently to achieve the best impact.
- Delivering services within a balanced budget will require a shift of focus to:
  - delivering high quality and effective services for people with a complex range of needs, and
  - investing in communities, enabling and supporting people to enjoy the best quality of life possible, informed by choices they make for themselves.

Engagement Process

➢ Stage 1 – Informing and Consulting on the Strategic plan

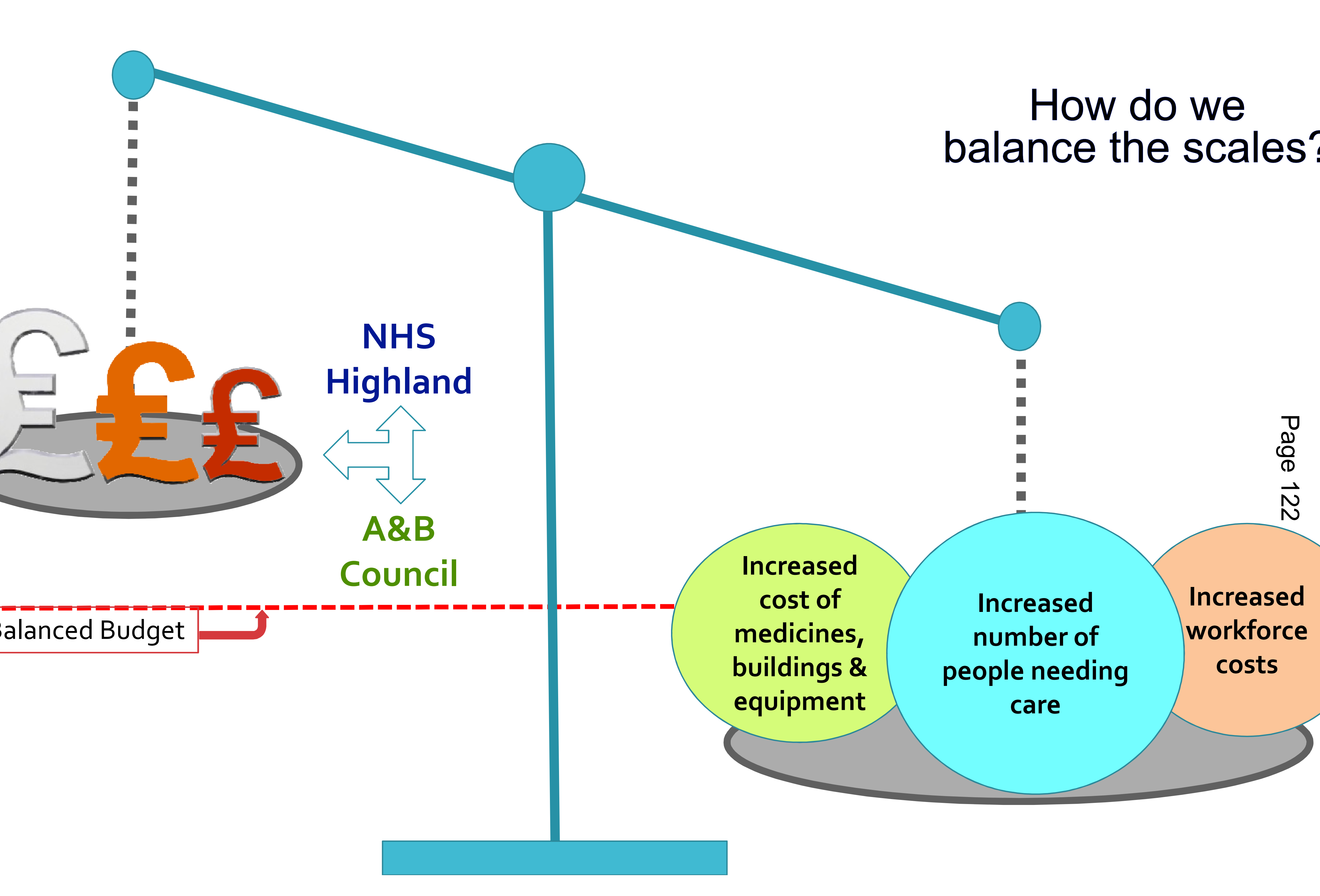
- Informing people about what the HSCP is going to do
- Inviting comments on the key service change areas that are required
- Inviting suggestions around what we need to do to make sure we involve people as we make these changes
- Use the information gathered in this stage to inform what we do next

➢ Stage 2 – Involving and Collaborating on service redesign

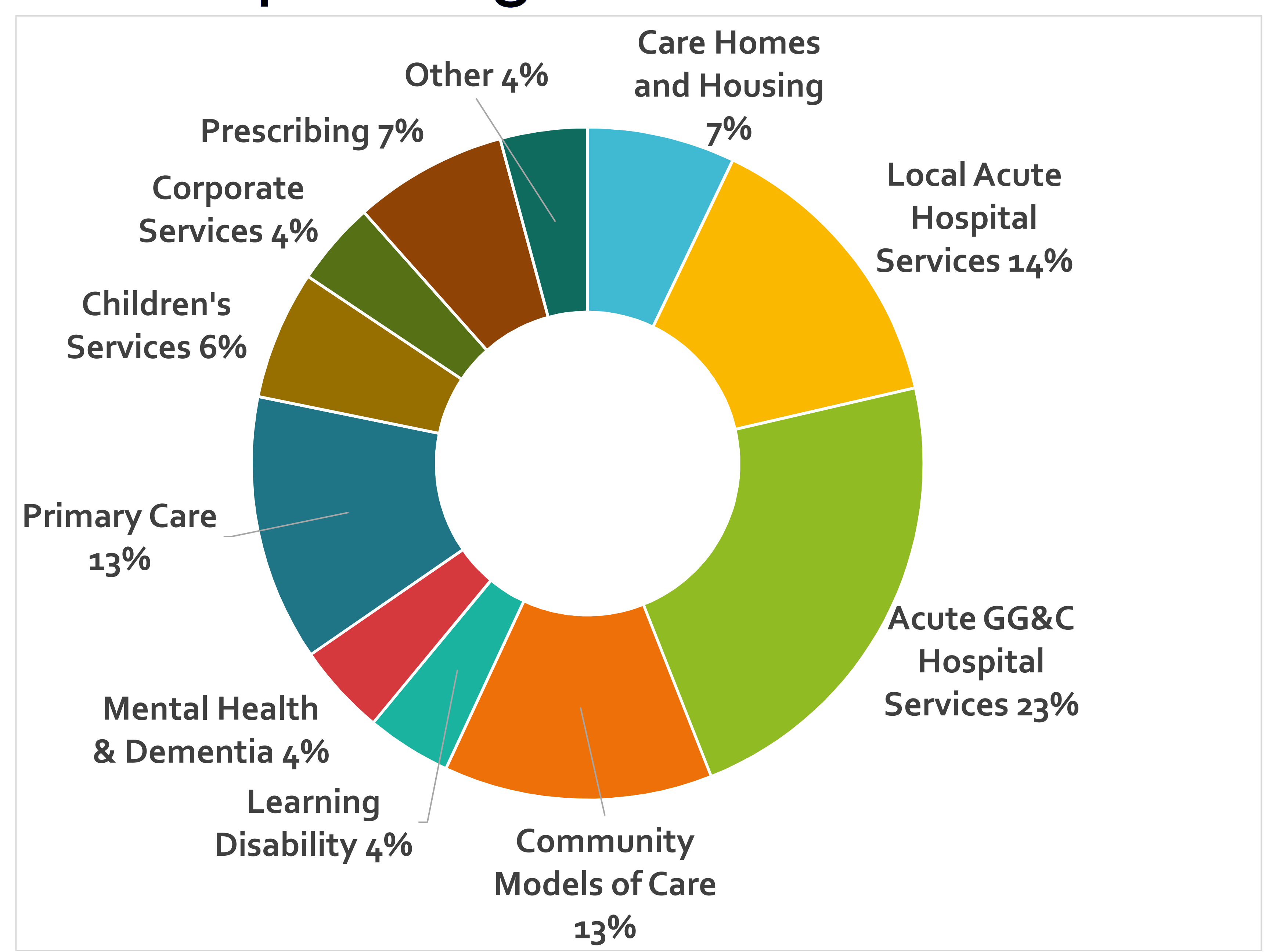
- Developing the areas of work around the 8 key areas for service change
- Involve staff, citizens and partners as we take forward this work
- Publicise what we have found out and how this information will be used to make service changes

➢ Stage 3 – Involving and Collaborating on implementing service change

- Involve people who use services, carers, staff and partners in how we implement service change.


How do we
balance the scales?
NHS
Highland
A&B
Council
Balanced Budget
Increased
cost of
medicines,
buildings &
equipment
Increased
number of
people needing
care
Increased
workforce
costs

Current Spending



Spending Shortfall

Year			Shortfall
2017/18	Income	£258.9m	£6.4m shortfall
	Spending	£265.3m	
2018/19	Income	£263.1m	£5.2m shortfall
	Spending	£268.3m	
2019/20 (estimated)	Income	£265.7m	£6.2m shortfall
	Spending	£271.9m	

High Level Service Changes

1. Children's Services
2. Care Homes and Housing
3. Learning Disability Services
4. Community Model of Care
5. Mental Health Services
6. Primary Care Services
7. Hospital Services
8. Corporate Services

Each of the high level Service Changes will involve a major area of work, needing their own improvement plan and engagement process.

1. Children's Services

Population Profile

Data for 2017 shows 13,163 children aged 0-15 years live in Argyll& Bute (6705-males and 6458 females). The children and young people population is declining.

Service Demand

The number of children with complex needs is increasing.

Challenges

The single biggest challenge is the recruitment and retention of midwives, health visitors and social workers.

Evidence Base

Being exposed to adverse and stressful experiences (ACEs) can have a negative impact on children and young people throughout their lives.
Trauma-informed and resilience-building practices should be embedded within services.

Current Service Cost

£19.1 million

Estimated Savings

Required to make
£0.8 million
savings over the next year.

Service change

1.1	Provide continuity of midwifery care.
1.2	Increase visits by health visitors.
1.3	Prevent children and young people coming into care.
1.4	Increase the number of fostering and kinship placements.
1,5	Place children close to their families and communities.
1.6	Reduce youth and adult reoffending rates.
1.7	Preventing problems through early intervention such as breastfeeding support and reducing poverty.

2. Care Homes & Housing Services

Population Profile

The number of older people is set to rise significantly in the coming years; with the steepest rises being in the over 75 year age group. 10.7% of the current population is aged 75 and over.

Service Demand

Increasing demand for adapted properties as more older people are enabled to stay at home.

Long-term sustainable solutions for high level needs (24 hour care).

Challenges

Our challenges are providing suitable housing and sustainable 24 hour care and care at home due to our workforce difficulties.

Evidence Base

A Health and care housing needs assessment has been undertaken to inform need.

A Care & Nursing Home Modelling Tool is being developed to better assess future needs.

Current Service Cost

£18.8 million

Estimated Savings

Required to make

£0.1 million

savings over the next year.

Service change

2.1	Understanding current scale and profile of nursing, residential care & supported accommodation for older people.
2.2	Working across health, social care, housing and independent sector to determine future demand.
2.3	Plan future provision around 24 hour care and housing.

3. Learning Disability Services

Population Profile

Argyll & Bute has a growing number of people living with learning disabilities who are living healthier for longer.

Service Demand

There is an increasing demand for Learning Disability services, both internal and external, with this trend not predicted to slow given the population profile.

Challenges

The challenge will be to deliver community based supported living services with a reducing resource, increasing need while meeting quality standards.

Evidence Base

Engaging with Third Sector providers will enable the development of new opportunities for supported living with a view towards delivering alternative models of care and support.

Current Service Cost

£10.8 million

Estimated Savings

Required to make
£1.4 million
savings over the next year

Service change

3.1	Further develop service and resources that will support individuals to return from out of area placements.
3.2	Review and evaluate current ‘sleepover’ services and increase usage of Telecare whilst maintaining service user safety and wellbeing.
3.3	Work with housing services to develop ‘Core and Cluster’ models of care.
3.4	Develop HSCP internal services that are able to support individuals with complex needs.
3.5	Sustain and further improve on the positive feedback from external regulators about quality of service provision.
3.6	Increase the uptake of Self Directed Support.
3.7	Support the co-production of community based services for families living with learning disabilities.

4. Community Model of Care

Population Profile

There are more elderly people living in Argyll and Bute and it is anticipated this will increase significantly in future years.

Evidence Base

A multi disciplinary team provides more efficient and effective community care, reducing hospital admissions and supporting discharges.
Focussed re-ablement can improve outcomes for people and reduce demand on homecare.
A team approach to falls and frailty supports people to continue to stay at home.

Service Demand

There will be more people living with care needs in our communities and some of these care needs will be complex.
There will be more people living with dementia requiring support and care in our communities.

Challenges

Recruiting care workers.
High public expectation of care provision.
The availability of appropriate homes/housing for people with care needs.
The delivery of care across a large geographical area.

Current Service Cost

£34.2 million

Estimated Savings

Required to make
£1.7 million
savings over the next year

Service change

4.1	Develop and Implement Multi-disciplinary Community Care Teams.
4.2	Develop a multi skilled care worker role to work within the Multi-disciplinary Community Care Teams.
4.3	Ensure anticipatory care planning is adopted to reduce the incidence of emergency hospital admissions.
4.4	Prioritise the prevention e.g. empower people to self manage long term health conditions and connect people with sources of support in their community such as opportunities to be more physically active.
4.5	Further develop the use of technology to support people living at home who have health and care needs.

5. Mental Health Services

Population Profile

There are increasing numbers of people living with mental health problems in our communities.

Evidence Base

Anticipatory and crisis care planning reduces admission to a hospital bed.
A positive therapeutic environment supports recovery.
A multi disciplinary team approach provides more efficient and effective care in the community.
New technologies can support care delivery.

Service Demand

In patient beds for people with severe and acute episodes of illness.
Community services to support people living at home.

Current Service Cost

£11.6 million

Challenges

Increasing demand for services.
Recruitment to specialist mental health professionals.
Recruitment to care /support workers.
Delivery of care in a large geographical area.
Ability to provide a response to acute episodes of care out with normal working hours.

Estimated Savings

Required to make
£0.6 million
savings over the next year

Service change

5.1	Establishment of the in patient beds within Mid Argyll Community Hospital.
5.2	Review of the Community Mental Health Teams.
5.3	Explore new technological ways of delivering therapy.
5.4	Implement the Locality Based consultant model of care.
5.5	Further develop the WRAP approach to enable people to self manage their mental wellbeing (Wellness Recovery Action Planning).
5.6	Mitigate the impact of problems such as debt and loneliness on mental health through connecting people to community based support.

6. Primary Care Services

Population Profile

33 GP practices in Argyll and Bute, with a registered patient population of 88,657 as at 1 April 2018.
Practice populations range from 11,200 in Oban to 130 on the Isle of Colonsay

Service Demand

To reduce the future workload on GPs and practices, services will be provided by other clinicians such as Pharmacy, Physiotherapy, Advanced Nurse Practitioners.

Challenges

GP Practices across Scotland provide Out Of Hours Cover, in Argyll and Bute.
Vacancies and turnover GPs
Transfer of GP work to HSCP.

Evidence Base

New GP Contract Implementation (April 18).
Sustainable services delivered by wider teams in the context of Primary Care Service Redesign.

Service Investment

New GP contract will see extra funding over the next 3 years- £848,000 to £2.9 Million in Argyll and Bute.

Changes

The HSCP is to take over some services currently provided by GPs e.g. Vaccinations, prescribing, Practice nursing tasks .

Service change

6.1	Musculoskeletal (MSK) Services - More physiotherapists employed so that patients can benefit from quicker access and treatment reducing unnecessary referrals to GPs.
6.2	Community Mental Health - Increasing the number of community mental health nurses better placed to support up to 25% of patients who currently see GPs.
6.3	GP Workload - Free up time and support the changing role of GPs so they can concentrate on patients with more complex health and care conditions. Make the role more attractive to recruit to.

7. Hospital Services

Population Profile

One Rural general Hospital in Oban.

Six Community Hospitals all with Accident & Emergency departments.

Contract with NHS GG&C for acute health services and specialities .

Service Demand

More care now being delivered in Community.

Hospital used for more day care services.

Number of A&E attendances increasing.

Challenges

People living longer, more demand on services.

Population decline mirrored in workforce.

Recruitment difficulties.

Increasing costs of acute health care and negotiation with NHS GG&C to reduce payment.

Evidence Base

People have said they want to receive care as close to home where it is safe and possible to do so.

Hospital services there when needed.

A&E departments should only be for urgent care .

Current Service Cost

Local Hospitals
£37.8 million

GG&C Hospitals
£60million

Estimated Savings

Required to make
£2.1 million
savings over the next year from local hospitals

£1.2million
reduction in use of GG&C services

Service Change

7.1	Standardise role and function of each Community Hospitals.
7.2	Bed model each inpatient area to ensure we make best use of all resources.
7.3	Workforce review to ensure we are utilising the full potential of all individuals.
7.4	Further improve discharge planning to reduce readmissions.

8. Corporate Services

Profile

Corporate services teams – including finance, planning, IT, HR, pharmacy management, medical management and estates
Includes all IT and corporate asset infrastructure.

Evidence Base

Audit Scotland - integrating support services will provide efficiencies.
Evidence of corporate efficiencies in Council services can be replicable within the Partnership.
National health and wellbeing outcome indicator to use resources effectively and efficiently.

Service Demand

Customers of support services are front line health and social care services
Demands are increasing, new corporate demands of health and social care integration alongside requirements of Council and Health organisations requirement to make corporate services more efficient and integrated for front line managers.

Future Budget

Recurring budget is expected to reduce, but non-recurring investment may be required.

Challenges

Inevitably less people and buildings
Not all corporate support services from Council delegated to the partnership
Balance between efficiencies and reduced level of service
More efficient use of technology and systems may require significant investment.

Estimated Savings

The HSCP is required to make £1.3m of saving over the next year.

Service change

8.1	Health and social care corporate staff (eg finance, planning, IT, HR, estates) are co-located to work together in the same locations and in the same teams.
8.2	Integrate health and social work administration and implement digital technology.
8.3	Efficiencies in catering and cleaning services through shared services.
8.4	Rationalise estates and properties by co-location of staff.
8.5	Efficiencies in including travel and subsistence costs.

Stakeholder Engagement

The HSCP is engaging service users, carer, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022). Your views are important and we welcome your feedback specifically on the 8 key service changes required to deliver the ambitions of the Partnership over the life of the Plan.

Q1:	What is your understanding of the types of services that are provided by the Health & Social Care Partnership?
Q2:	What are your thoughts about the 8 key areas of service change?
Q3:	What do we need to do to make sure we involve with people as we go about making these changes (effective engagement)?
Q4:	How can individuals, communities and our partners work with us to help people stay healthy and well?
Q5:	What would help communities as partners to play an active role in developing and delivering future services?

Agenda Item 7b

Argyll and Bute Community Planning Partnership

Bute and Cowal
Date: 14 August 2018

Title: Health and Wellbeing Annual Report for 2017 - 2018

1. SUMMARY

The Health and Wellbeing Partnership is a strategic partnership of the CPP that leads and supports the delivery of activity for health and wellbeing in Argyll and Bute.

2. RECOMMENDATIONS

The four area community planning groups should note the health and wellbeing activity taking place across Argyll and Bute and consider their role in supporting the promotion of health and wellbeing in their local area.

3. BACKGROUND

3.1 Health and Wellbeing Partnership

This group meets four times per year to lead the promotion of health and wellbeing activity across Argyll and Bute. Ways of doing this include:

- Engaging partners from a range of sectors
- Working with local communities via the Health and Wellbeing Networks
- Developing policy and strategies informed by local needs, evidence and national direction.

The Partnership is also responsible for implementation of the CPP Outcome 5 – People lead active, healthier and more independent lives

3.2 Annual Report

An annual report of activity is published each year and is published at – www.healthyargyllandbute.co.uk

3.3 Joint Health Improvement Plan (JHIP)

The JHIP is the strategic document that sets out the intentions of the Health and Wellbeing Partnership. It has four high level themes which are:

- Theme 1 – Getting the best start in life
- Theme 2 – Working to ensure fairness
- Theme 3 – Connecting people with support in their community
- Theme 4 – Focusing on wellness not illness

4. CONCLUSION

Better health and wellbeing in the people of Argyll and Bute has the potential to make Argyll and Bute a better place to live. Health improvement is a partnership requirement rather than being the sole responsibility of the Health and Social Care Partnership.

For further information contact: Alison McGrory
Health Improvement Principal
Argyll and Bute Health and Social Care Partnership

Email: alison.mcgrory@nhs.net
Telephone: 07766 160 801

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Being the Healthiest we can be in Argyll and Bute

HEALTH & WELLBEING ANNUAL REPORT 2017-2018

Connected
Healthy
Vibrant Equality
Argyll Well Support
Health
Empower Strong
Wellbeing
Community
People

Health and Wellbeing in Argyll and Bute Annual Report 2017 - 2018

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Introduction

Alison McGrory
Health Improvement Principal, Argyll and Bute Health & Social Care Partnership

Welcome to our annual report for 2017 - 18. This year has seen the team really focus on what it means to prevent health and social care problems from arising and helping our partners to do this. Prevention is really important as 40% of public sector spending is on things that could have been avoided with an earlier intervention.

As public sector spending continues to be stretched it is essential that every penny is spent wisely. We are especially proud that the health and wellbeing grant fund continues to support local projects to deliver excellent health and wellbeing projects that are designed by and for local people.

The Health Improvement Team in Argyll and Bute also works with the Health Improvement Team in Inverness. Their annual report is at: http://www.nhshighland.scot.nhs.uk/Pages/Welcome.aspx

We've had a busy year working to build healthier and stronger communities across Argyll and Bute. Please tell us what you think on Facebook: **www.fb.com/healthyargyllandbute**

If you would like a copy of this report in a different format or in large print please contact us at: High-UHB.ABHealthImprovement@nhs.net

Health and Wellbeing Networks & Health and Wellbeing Grant Fund

Health and Wellbeing Networks

There are eight Health and Wellbeing Networks across Argyll and Bute which work in a co-productive way to support healthy living at a local community level. Each network has a part time co-ordinator funded by the Public Health Team. The coordinators are responsible for running the networks and administering the Health and Wellbeing Fund.

Co-ordinators produce an annual report in May of each year and these are available at: www.healthyargyllandbute.co.uk

Sharon Erskine from the Cowal Network said: "Our local network helps a wide range of people with an interest in healthy living to come together and share ideas. We meet 4 times per year and everyone is committed to making our community better."

Over the last year, two Health & Wellbeing Networks have welcomed new coordinators:

Helensburgh & Lomond: *Audrey Baird*

Kintyre: Ailsa Wilson

Health and Wellbeing Small Grant Fund

The Health & Wellbeing Fund provides an opportunity to help get local health improvement projects off the ground or to expand. **£115,000 was available across the eight networks in 2017-18.**

The funds are allocated using a formula based on the National Resource Allocation Committee (NRAC). This considers factors known to affect health care usage and need, for example, the age-sex profile of the population; additional cost of service provision across different geographical areas; and the additional needs of a population due to morbidity and life circumstances.

Grant applications must meet the strategic priorities of the Joint Health Improvement Plan (JHIP) and decisions on how to spend the grant fund is devolved to local, community led scoring panels to ensure network members agree with how the money is spent.

A total of 100 local projects received a grant ranging from £250 to £2,000. All projects complete a Project Case Study at the end of the funding period and these are published at http://healthyargyllandbute.co.uk/case-study/

The JHIP is the strategic plan for health improvement in Argyll and Bute; the latest edition covers the period 2017 – 2022 and includes the following 4 themes:

- Theme 1 – Getting the best start in life
- Theme 2 – Working to ensure fairness
- Theme 3 – Connecting people with support in their community
- Theme 4 – Focusing on wellness not illness

The allocation of the Health and Wellbeing Fund across Argyll & Bute is shown below:

Area	Funding Amount (£)
Bute	£10,173
Cowal	£19,922
Helensburgh and Lomond	£28,303
Islay and Jura	£5,441
Kintyre	£11,210
Mid Argyll	£12,778
Mull, Iona, Coll, Tiree and Colonsay	£6,042
Oban Lorn and Inner Islands	£21,131
Total	£115,000

Overview of Spend	
Main health theme	Number funded
Getting the best start in life	36
Working to ensure fairness	13
Connecting people with support in their community	33
Focusing on wellness, not illness	18
Total number of projects funded:	100
Average award (£):	£1,150

Children enjoying the new Lismore play park that received a Health and Wellbeing grant of £2000

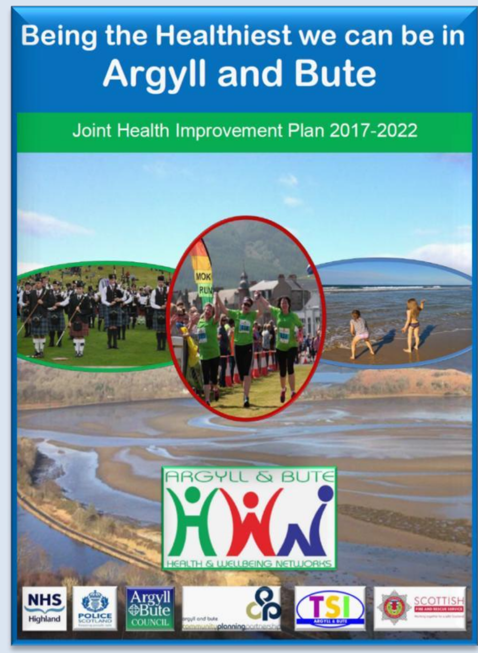
Health and Wellbeing Partnership

The Health and Wellbeing Partnership is a strategic partnership of Argyll & Bute's Community Planning Partnership, which meets quarterly throughout the year. Membership of the Partnership consists of Health Improvement Team staff; NHS Leads with a health promoting role; strategic partners, such as, Police, Fire and Rescue; and the eight local Health and Wellbeing network co-ordinators.

The Partnership oversees the implementation of the Health & Wellbeing Grant Fund and the Joint Health Improvement Plan (JHIP). The Partnership also provides leadership for health and wellbeing and keeps up to date with national policy and strategy. They also review developments and examples of best practice in health improvement across Argyll & Bute with a view to up-scaling good practice.

During 2017-18 the Partnership addressed the following:

- Responded to national consultations:
    - Well Connected Scotland to reduce the impact of loneliness and isolation on health and wellbeing outcomes for people.
    - Diet and Healthy Weight to reduce the incidence of obesity in our population and promote healthy weight.
- Launched the Joint Health Improvement Plan in April 2017.
- Carried out an evaluation of the Health and Wellbeing grant fund which is available to view here: www.healthyargyllandbute.co.uk
- Led Argyll and Bute's Community Planning health priorities – Outcome 5: People live active, healthier and more independent lives.
- Considered a range of topics to provide leadership for their dissemination across the local networks. These topics included:
    - Physical activity
    - Self management
    - Social prescribing
    - Equality Outcomes
    - Smoking cessation
    - Healthy weight
    - Diabetes
    - Mental wellbeing in young people



Health and Wellbeing Networks Highlights

Bute Network
Caroline Gorman (*hwnbute@ab-rc.org.uk*)
Health & Wellbeing Network Coordinator

This was Argyll and Bute Rape Crisis's (ABRC) first year and we have really enjoyed the opportunity to be part of the Health and Wellbeing Network, promoting prevention and building links with local organisations. Our quarterly meetings are well attended and supported by local groups and organisations. Each meeting focuses on one of the themes in the Joint Health Improvement Plan. In January, we facilitated an action planning day to capture information and local priorities to be included in the Bute Local Plan.

Our main highlight for us was the grant funding as through our fund allocation we were able to fund nine projects last year. It was an amazing to be able to support smaller, local organisations to see their plans come to fruition. The groups funded are detailed below:

Butefest – training volunteer costs & fruit snacks/water for volunteers
Achievement Bute – counselling support for children with disabilities and their families
A & B Adult Learning – 'Come and Try' sessions for adult learners – offering workshops in IT, literacy, etc.
Rothesay pre-5s – 'Warm and cosy and out to play' - outdoor clothing to enable all children to enjoy outdoor play and learning.
Tiddlers – outdoor storage and repairs, music sessions
North Bute and St Andrews Primaries – 'Healthy Lives in Primary School Project' – growing vegetables to encourage healthy eating and cookery classes in school.
Fyne Futures – 'Future Growth' project – funding towards growing fruit, veg and herbs healthier lifestyle and access to the outdoors.
Appletree Nursery – A bubble wrap greenhouse to grow their own fruit and veg.
Bute Advice Centre – 'Supporting the Elderly – provide advice and information to elderly members of the community.

We have been delighted to hear their successes and look forward to seeing the legacy of these projects as time goes on.

Cowal Network
Sharon Erskine (Sharon@homestartmajik.eclipse.co.uk)
Health & Wellbeing Network Coordinator

Cowal Health and Wellbeing Network have been working on connecting the NHS Health Improvement Strategy with the wider community throughout 2017/2018. We have a strong and cohesive membership who have committed to ensuring that there is equity for the residents of Cowal in NHS services and that we meet the needs of each individual group.

We have met at Cowal Community Hospital to Plan for the coming year and have identified potential gaps in service and ways in which we can work on wellness and not illness for our population and for future members of our community.

Last year we funded several Community Groups to deliver projects which we felt would have a positive impact on the wellbeing of Cowal Residents and would potentially create lasting change.I have listed below some of the activities rolled out over 2017/18:

Step up Innellan: A community who have invested hugely in the regeneration of their village came up with the idea of having working groups to support with regeneration which was inclusive of all ages and abilities. It encouraged residents to access their pathways and had an educational element for younger residents. Getting out and about locally for our smaller, more isolated communities we felt also encouraged a system which would potentially reduce social isolation and create links between residents which may well not have happened without this piece of work.

Dunoon Grammar School Additional Support Swimming Lessons:Used in conjunction with some money which was raised by the Department in DGS the CHWN awarded a grant for the Pupils with Additional Support Needs to access swimming lessons at our local pool. The lessons were tailor made for our pupils and meant that they could access a sport which has many health benefits for them now and into old age.

We look forward to inviting all of the organisations who were awarded funding last year to join us and present their project reports. This includes Dunoon Schools Pipe Band who were awarded £2,000.

Helensburgh & Lomond (H&L) Network
Audrey Baird (*audreyabhwn@gmail.com*)
Health & Wellbeing Network Coordinator

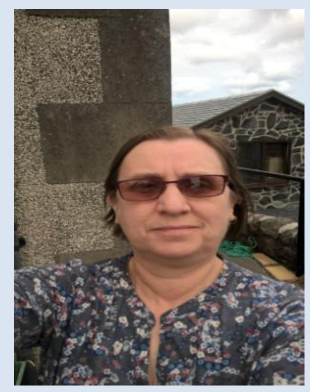
The Helensburgh & Lomond Network underwent a significant change in April 2017 when its long-standing coordinator of nearly 10 years, Morevain Martin, stepped down and handed over to a new coordinator, Audrey Baird. Thankfully Morevain continued to have a significant role in the Network representing a number of local community organisations and the H&L office of Argyll & Bute Third Sector Interface. Audrey previously coordinated the Mid Argyll HWN and knows the Helensburgh & Lomond area well through working in a community development role for four years. Two significant pieces of work in 2017-18 were creating a new 2018-22 work plan for the network and establishing a new database of members.

The Work Plan was the main focus of two of the quarterly Network meetings and the final version was published on the Healthy Argyll & Bute website in March 2018. Top priorities identified by members included supporting young people and families in areas of higher deprivation, boosting physical activity and 'free' exercise for people of all ages in our outstanding environment and tackling loneliness.The membership of the Network rose steadily to more than 150 people and invitations to participate were extended to community councils and local churches in the area. Average attendance at the four annual Network meetings was around 20 people and we were pleased to welcome guest speakers, including a representative from the Community Health Exchange (CHEX) who delivered a half day training programme to members on health inequalities. One training participant said: *"This should be a training opportunity that all services provide and access. [This] topic [is] very emotive and applicable to all service providers."*

Another important development was a pilot partnership arrangement with the H&L Substance Misuse Forum which saw both networks meeting on the same day and sharing a joint networking lunch. The arrangement boosted participation at both meetings and the partnership will continue into 2018-19.

Lastly, **the Network had a grant fund of more than £28k to distribute and 22 diverse and exciting projects were supported over the year**, ranging from a summer programme for young people through to community empowered beach cleaning and community gardening. This included £950 for Helensburgh's Tai Chi group who are pictured below.

Islay & Jura Network
Sandra MacIntyre *(sandra.macintyre@addaction.org.uk),*
Health & Wellbeing Network Coordinator



The Islay and Jura Network has 44 members, we meet regularly along with Islay and Jura SMF. This year Addaction took up HWBN on Islay and Jura in April for the next two years when Gill Chasemore, TSI, resigned due to other work commitments. Gill left a legacy of a lot of good work. My first meeting as new coordinator was well attended, we had a talk from Debra Nelson, Addaction's Volunteer Organiser about her work with recovery communities in Argyll. We discussed local interest news such as the Islay Hospital now has a Day Care Unit. We looked at our Local Plan for 2018.

A highlight from last year was two days of health and wellbeing events at Islay High School in March 2017 over a Friday and Saturday. The Friday was for High School pupils and offered Addictions, Sexual Health and Mental Good health workshops along with Yoga and Meditation taster sessions. The Mactaggart leisure centre offered a fitness instructor based in the leisure centre for the day. The Saturday was aimed at adults-parents and it was family orientated with entertainment for younger children such as bouncy castle and stalls which was well supported and conducted by the network membership and other groups and organisations. A good lunch was supplied by the Islay High School Expedition group.

Another highlight was the Islay Show in August 2017 where gave out 150 'goodie bags' filled with leaflets and give away materials from the Health and Wellbeing Network Membership. This was to let people know about health groups and organisations on Islay and Jura and how to access them.

In 2017 we distributed £5000 in grants to six groups for new projects.

This included £530 for the Jura lunch club to hold more social activities, they are pictured below.

Kintyre Network
Ailsa Wilson (*ailsaw@ab-rc.org.uk*)
Health & Wellbeing Network Coordinator

Ailsa ran the Kintyre Health and Wellbeing network from May 2017 – March 2018 and has now left to return to her other role with Argyll and Bute Rape Crisis. Ailsa lives in west Kintyre and during her time as co-ordinator spent a considerable amount of time building up relationships in communities throughout Kintyre and well as in Campbeltown. This is important as many people live in these communities and they often are unaware of health and wellbeing activity.

The network distributed £8,620 to 12 project including £1000 to the Monday Social Club pictured below at their strength and balance class.

Mid Argyll Network
Antonia Baird *(antonia.baird@argyll-bute.gov.uk),*
Health & Wellbeing Network Coordinator

The mid Argyll network has 150 members and regular bulletins are issued to them, packed with news.

We distributed 44 Health and wellbeing bags to attendees at "The Workshop". This is Argyll and Bute Council's job club – a hub for information and job hunting. The bags contained health based information from network members and some health based freebies provided by members.

The coordinator sat on the social prescribing working group to assist and understand how a Link Worker project would work in Argyll. From that, a draft of a prescription pad methodology was designed for use in rural areas. She also contributed to the Prevention and Diabetes group.

This year the coordinator worked to encourage a greater diversity onto the scoring panel, creating a task descriptor to recruit volunteers from all walks of life. The Mid Argyll Youth Forum collectively scored the bids for round one, and was represented by two young people at the scoring meeting. Their input and diligence were greatly valued and they admitted that they had learnt a great deal about what was going on locally.

We held a shopping project scoping meeting as the issue appeared occasionally on local consultations – it became clear that there was little need due to the preference to take housebound people out where possible and also that the local supermarkets had increased their delivery services in the area. It was therefore agreed not to progress with any shopping project in the mid Argyll area this year.

Working in partnership with the Kintyre network, a town hall participatory budgeting method for disbursing the grants was explored, and may be progressed at another time.

Mull, Iona, Coll, Tiree & Colonsay Network
Carol Flett (*tcmhwn@gmail.com*)
Health & Wellbeing Network Coordinator

The Health and Wellbeing Events continued with events in Tobermory, Derail and Salen on Mull, then an event on Iona in May. The Tiree event was in August. A larger and more varied group of mainland visitors came along to the 'Happy and Healthy' events to share information and offer support to Island residents. Organisations represented included North Argyll Carers Centre, Marie Curie Helper Service, Living it up, Alienergy, Argyll and Bute Council Community Development, Alzheimer Scotland, ACUMEN and Macmillan Cancer Information and Support Service. Also attendingg the events were NHS Senior Health Improvement Specialist, Argyll and Bute Council Home Energy Advisor, Smoke Free Officer and Public Health Dietician.

Over £5700 of Health and Wellbeing funding was allocated to 9 different projects, 6 of which were on the Isle of Mull (Homestart Mull, Baby Massage, Mull Triathlon, Swimming Lessons, Dervaig Cinema and Dervaig Outdoor Learning). Funding was given to Argyll Couple Counselling to support and promote Counselling sessions on the Islands. A joint Mindfullness training course took place on the Isle of Tiree for people from Tiree and Coll. Funding was given to Arinagour Primary School on the Isle of Coll to buy gymnastics mats. This culminated in the 7 children from the Isle of Coll taking part in Oban, Lorn and the Islands Gymnastics Competition and winning best girl and second placed team, a great achievement for such young children.

A day trip to Colonsay with North Argyll Carers Centre Manager is one of many examples of joint working and networking that have come about since the creation of the Islands Health and Wellbeing Network.

Oban, and the Inner Isles Network
Eleanor MacKinnon (*olihwn@gmail.com*)
Health & Wellbeing Network Coordinator

Themed topics remain in place this year. It has proven successful to have speakers usually at our first meeting of the new financial year. There is regular attendance from social work; fire service; public sector and voluntary sector. Speakers in 2017-18 included local healthy villages/ healthy town; children services plan; our children our future; SALI; Cool2 talk; Early Learning care model; Child protection committee- training support; Carers Act; HEEPs- Housing services/ Home Energy; Transport initiative reports; Paediatric Services.

We are delighted to hear on a regular basis about groups and activities we have supported over the years that remain active, are achieving results and filling gaps for their local communities. We are particularly pleased to have reached out to Lismore and Appin, both of which have gained funds to support local community capacity. We also have input in to the Oban Healthy Town Initiative.

We get regular feedback from members of earlier applications on advancement of projects. For example: Oban playpark now open; Lorn growers continues to expand; Oban walking group still ongoing; Fire service home call visit pointers still in use.

2017/2018 saw 12 applications for grants including our most unusual to date, compost toilet to enable older people to stay longer at a community garden.

Groups and Activities supported 2017/18 were:
Lismore playpark – community lead initiative - families
Homestart Lorn – sleep counselling training – enabling worker to support families, sleep deprivation in families (sleep Scotland training)
Dunollie Links – mental health outdoor initiative
Mindfulness – pilot with WHHA and local provider – mindfulness course
Appin Care and Appin Transport - 2 separate projects – Local community care provision
Ardchattan community council – further support to defibrillator in rural area
Healthy options – extending reach rural areas
Digital skills – Community Learning – accessing support
Youth Café – support project for young people additional needs
Lorn Growers – compost toilet- supporting attendance on site
Rape Crisis – extend service hours of support this year has supported 12 groups/ organisations

Oban people enjoying an exercise class delivered by Healthy Options.

Health Equalities

Alison Hardman, Health Improvement Lead
(alison.hardman@nhs.net)

Statutory Requirements for Equality

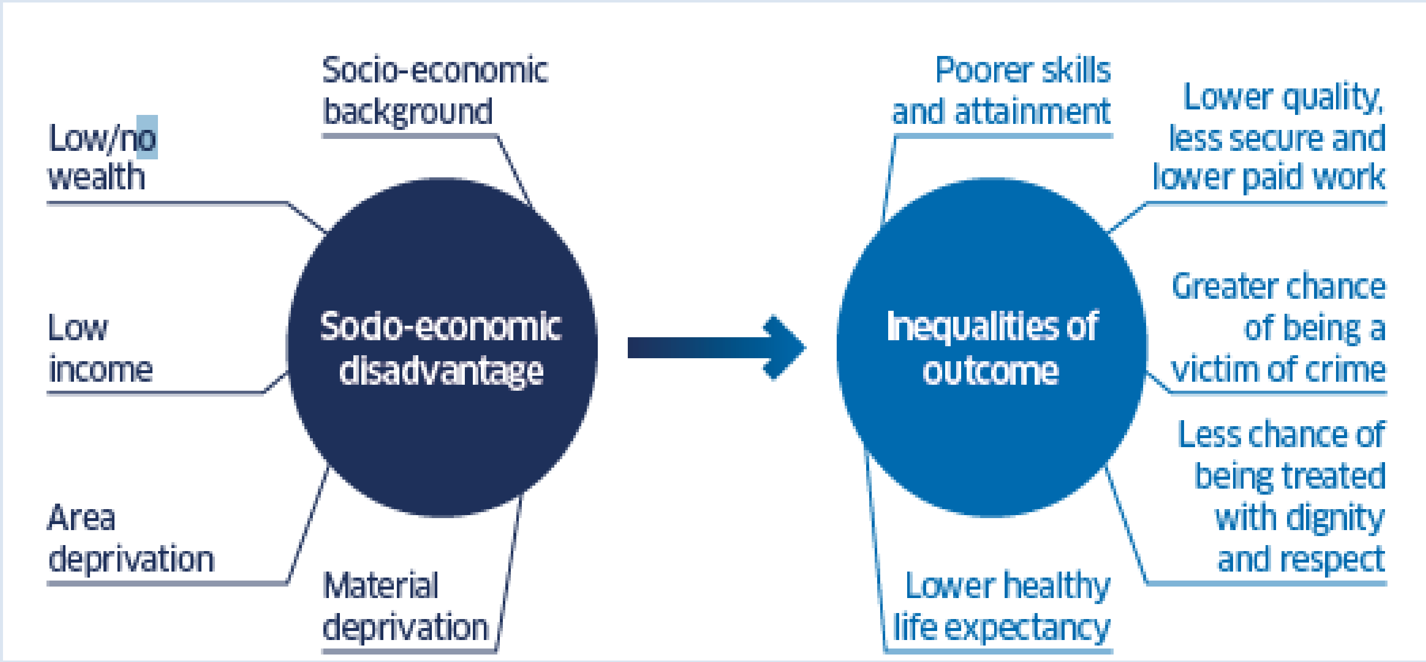
Equalities Outcome Framework
Over the last year Equalities work has gained an even higher profile fuelled by legislation, strategies and policies. The main piece of work was the Equalities Framework report to the Integrated Joint Board (IJB). This report looks at the first Equality Outcome Framework Measures for the period 2016-20 progress in 2016-18. Over the past year the existing set of equality outcomes have been reviewed and assessed against current evidence, data available, alignment against priorities and the progress made. A wide range of staff, managers and partners have been consulted.

As a Public authority Argyll and Bute must:

- Eliminate unlawful discrimination, harassment and victimisation and other prohibited conduct;
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

The report was presented and ratified by the IJB in March 2018. The 2016 framework and 2018 report can be viewed here:
http://www.nhshighland.scot.nhs.uk/YourHealth/Pages/Equalityanddiversity.aspx

Fairer Scotland Duty
Further legislation from April 2018 is the Socio-economic Duty (Fairer Scotland Duty). This will be implemented over the coming three years under guidance from the Scottish government, ensuring that inequalities are put at the heart of any strategic decision making with authorities required to undertake ‘due regard’. Many people in Scotland still experience significant socio-economic disadvantage, with over a million Scots living in poverty (1 in 4 children) contributing to wide health and education attainment gaps. Poverty and equality are not inevitable and can be reduced.



Source: The Scottish Government (2018:03) 'The fairer Scotland Duty Interim Guidance', Page 7.

(https://beta.gov.scot/publications/fairer-scotland-duty-interim-guidance-public-bodies/)

Welfare Reform Working Group
The Welfare Reform Working group is a forum of public and Third Sector agencies that are working together to support the residents of Argyll and Bute in all areas of finance, housing and wellbeing. Over the last year co-production and collaboration have been undertaken in many areas.
This group will oversee the implementation of Fairer Scotland and their priorities include:

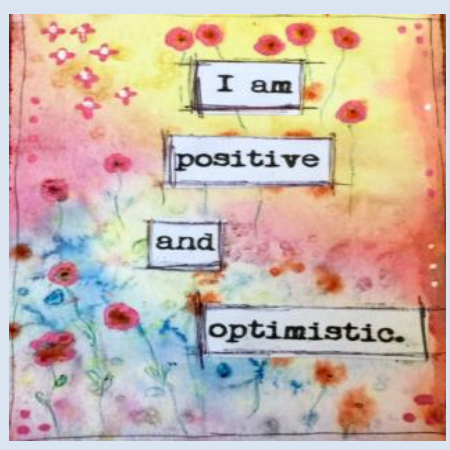
- Anti-poverty Strategy and action plan is now available on the Council website;
- Mitigating adverse impact of welfare reform – introduction of Universal Credit full service due Sept 2019 in A&B area;
- Monitoring use and impact of Scottish Welfare fund and discretionary housing payments, which currently pays the tax on behalf of the residents, especially since Under Occupancy Tax (bedroom tax);
- Responding to development of new Scottish Social Security Agency and its new benefits.

United Violence Against Women (VAG) Partnership
West Dumbarton and Argyll and Bute have merged to form the United VAW Partnership to plan, implement, co-ordinate and manage action to prevent and address violence against women. The aim is to improve outcomes for women affected by violence, to drive up quality standards, measure and report performance against agreed outcomes and targets. The Partnership will contribute to relevant national and local consultation exercises.

A **3 year action plan**, which will incorporate the Equally Safe Priorities is being developed. This will set clear outcomes that reflect the national framework and Local Outcome Improvement Plan priorities, including performance outcomes, indicators and targets identified.

Self Management

Yennie Van Oostende, Health Improvement Lead
(yennie.vanoostende@nhs.net)



'Successful self management is about working in partnership with family, friends, volunteers, peers as well as professionals to find the best route to your wellbeing. While health professionals will be knowledgeable in the field of medicine, people with long term conditions are the expert in how they are. Only they know how it affects their life, and what matters to them in their life.'

NHS Highland's Pain Management Toolkit
http://healthyargyllandbute.co.uk/wp-content/uploads/2018/04/self-management-toolkit-LGOWIT.pdf

The Living Well Self Management Programme

We have continued to work with Arthritis Care/Arthritis Research UK to deliver Self Management courses, Pain Toolkit workshops and Tai Chi programmes.

This year, we started the process of collaborating closer with 3rd sector organisations and volunteers to deliver the above programmes in a more sustainable way, which can build on their local connections and networks to increase referrals and signposting. This will also improve what can be offered to people with a long term condition in a supportive community

Often these organisations offer ongoing support programmes, helping people to make new friends and get involved with new activities which can combat social isolation and loneliness.

Participants of one of the programmes continued to meet, have set up a constituted group and have run a welcoming monthly "Stress Buster Coffee Morning" for the last three years. This offers a programme of activities, peer support, education and a place for people with long term conditions to continue to meet.

Self Management Toolkit & Personal Plan

Produced in collaboration with the "Let's Get On With It Together" (LGOWIT) Partnership, the newly produced **Self Management Toolkit** and Personal Plan, provides a helpful resource for people to work through on their own, with their health or support worker, or alongside the self management workshops. Access t*his resource via our "Your Health" tab under the healthyargyllandbute website (http://healthyargyllandbute.co.uk/your-health/).*

Training on Motivational Interviewing (MI)

Motivational Interviewing (MI) has continued to be delivered for staff supporting people to make positive changes. A Motivational Interviewing style of conversation encourages people to reflect on their situation and how they can best use their inner resources to help improve their wellbeing and life circumstances.

This training is delivered as blended modules with NHS Health Scotland's Health Behaviour Change, Level 1 on-line module and one or two days face-to-face training:

- 22 staff members attended 2-day training
- 5 staff members attended 1-day training
- 27 staff completed HBC Level-1 on line module

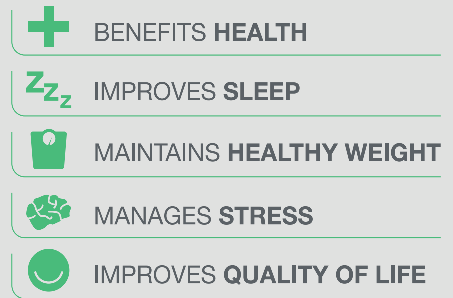
NHS Health Scotland continues to update and increase their on-line suite of courses, which can be accessed here: https://elearning.healthscotland.com/course/index.php?categoryid=108

Physical Activity

The benefits of physical activity as a means of maintaining good health are many, including improved mental wellbeing, reduced stress and better cardio-vascular health. The health improvement team has continued to support LiveArgyll's Leisure Services via a service level agreement to deliver an exercise referral programme for people to be referred to exercise by their GP or practice nurse. We are also forging close links, opportunities for referral and collaboration on physical activity programmes for frailer people and those with a long term condition. There is a clear evidence base to link increased physical activity in older people with a reduced risk of falling.

The benefits for older people being physical activity is explained well in the diagram on the next page.

Physical activity benefits for adults and older adults



REDUCES YOUR CHANCE OF

Condition	Reduction
Type II Diabetes	-40%
Cardiovascular Disease	-35%
Falls, Depression and Dementia	-30%
Joint and Back Pain	-25%
Cancers (Colon and Breast)	-20%

What should you do?

For a healthy heart and mind — **Be Active**

- VIGOROUS: RUN, SPORT, STAIRS
- MODERATE: WALK, CYCLE, SWIM

MINUTES PER WEEK: 75 VIGOROUS INTENSITY (BREATHING FAST, DIFFICULTY TALKING) OR 150 MODERATE INTENSITY (INCREASED BREATHING, ABLE TO TALK) OR A COMBINATION OF BOTH

Sit Less: TV, SOFA, COMPUTER

BREAK UP SITTING TIME

To keep your muscles, bones and joints strong — **Build Strength**: GYM, YOGA, CARRY BAGS

To reduce your chance of falls — **Improve Balance**: DANCE, TAI CHI, BOWLS

2 DAYS PER WEEK

Something is better than nothing.

Start small and build up gradually: just 10 minutes at a time provides benefit.

MAKE A START TODAY: it's never too late!

UK Chief Medical Officers' Guidelines 2011 **Start Active, Stay Active: http:bit.ly/startactive**

Alison McGrory, Health Improvement Principal
(alison.mcgrory@nhs.net)

Social Prescribing in Argyll and Bute

Social prescribing is connecting people with support in their community for social problems, such as relationship breakdown, debt, loneliness, caring responsibilities or housing difficulties. It is built on the premise that our health is affected by a wide range of social factors such as income, occupation, housing, environment etc.

Someone who has money worries will very likely feel stressed and anxious. This may also make them feel physically unwell with things like headaches, insomnia or changes in appetite. A doctor can prescribe medication for these symptoms e.g. painkillers for the headaches, however, the underlying cause of the problem, which is debt, is still there. Linking this person up with a debt advice service will help them to feel better in the long run.
Carr Gomm Carer Outreach Service in Bute & Cowal

Two pilots for link workers took place in GP practices in Bute and Cowal during 2017. This was part of a two year commissioned project with CarrGomm called ***Connections for Wellbeing*** to develop awareness and understanding of social prescribing and investigate models for future delivery. Funding from NHS Highland Public Health, Technology Enabled Care and the Transforming Primary Care Fund enabled link workers to have a weekly clinic in each practice to see people referred to them by GPs and nurses.

The link workers followed a 'person centred model of care' seeing each person once or twice on average. Supportive conversations using motivational interviewing techniques focussed on linking people up with practical sources of help within their local community, for example debt advice for people in financial difficulty or community activities for people who were lonely. The link workers supported 65 people over a total of 89 appointments. The knowledge gained from the pilot work is being used to inform the roll out of the new General Medical Services contract from April 2018.

CONNECTIONS for Wellbeing

The diagram on the following page was part of a range of resources developed by the Carr Gomm development worker Amanda Grehan. She worked in a community led way to achieve this by linking with a range of partners and community representatives to ensure the material was relevant and accessible.

Hi, I'm Jenny and
I've just moved to Mid Argyll for
a fresh start after an accident
forced me to give up work.

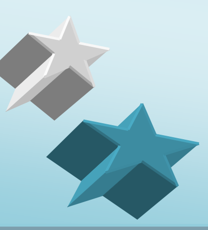
I take medication for back
pain but have noticed I'm putting
weight on and this is causing
me anxiety.

I met a new GP who suggested
less medication and some
physiotherapy might help.

I got on well with my
physiotherapist who invited
me along to a tai chi class.

I enjoyed the class and
met new friends and my health
began to improve.

I now teach tai chi
at a local volunteer centre and
I now take medication
occasionally. I feel great!



Adverse Childhood Events (ACEs)

Sam Campbell, Health Improvement Senior
(samanthacampbell@nhs.net)

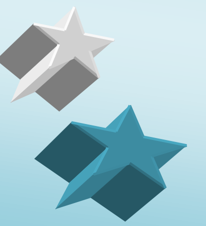
A successful Health and Wellbeing Development day was held in May 2017 attended by 130 people to better understand the topic of **Adverse Childhood Experiences (ACEs)** and to consider Argyll and Bute's response to this significant public health issue. A full report was published to consolidate learning from the event and share the key messages with those who were unable to attend which is available to view here - http://healthyargyllandbute.co.uk/ace-may17/

Attendees explored the negative effects of ACEs to physical and mental health outcomes. This was followed by reporting on evidence based interventions which mitigated the effects of ACEs and how to prevent these in the first place. Further presentations included information from local services which provide some of the support required to tackle ACEs in Argyll and Bute.

Workshops allowed partners to come together and share their thoughts about how to take forward the ACEs agenda and make Argyll and Bute ACEs aware. The recommendations included:

- Set up a dedicated ACEs steering group.
- Identify champions.
- Increase awareness & understanding of ACEs.
- Promote societal level solutions by supporting, facilitating and encouraging partnership working, sharing of information about services, support & training available.
- Promote the importance of resilience.
- Encourage the use of shared language.
- Implement routine enquiry about ACE procedures.
- Embed ACEs work & key performance indicators.
- Monitor & evaluate progress & ACE key performance indicators.

A working group has been established to support the progression of the ACEs agenda. A number of activities have taken place over the year, such as, screenings of the film 'Resilience' which focuses upon the negative impact of ACEs and what can be done to combat these. Around 80 people attended these two screenings from a wide variety of organisations such as Youth Projects, Family Mediation, Advocacy, Community Mental Health Services, Social Work, the Department of Work and Pensions, Addictions Services and Health Visitors.



Mental Health and Young People

Sam Campbell, Health Improvement Senior
(samanthacampbell@nhs.net)

Mentally Healthy Schools

A pilot project within three Secondary Schools in Argyll and Bute is underway. The schools undertook a self evaluation and with support from Health Improvement, Suicide Prevention and Educational Psychology have undertaken a variety of activities and training to address the challenges they identified. A further roll out is planned over the coming year.

Cool2Talk (http://www.cool2talk.org/)

Sam Campbell, Senior Health Improvement Officer

The Cool2Talk service launched in June 2017 and has received over 200 questions from young people aged 12-26 in Argyll and Bute, in the first year.

These questions were answered by our team of trained staff based in the Third and Independent Sector. The majority of questions posted by young people were about sexual health (69 questions), relationships (65 questions) and mental health (62 questions). There have been 9 questions about suicide and 16 about self harm. The majority (71%) of questions came from people who stated their gender as female and 18% male.

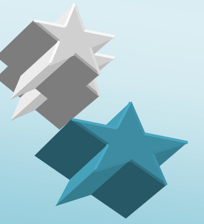
This pilot project is funded by the Alcohol and Drugs Partnership, Public Health and Children and Families until March 2020. A report detailing the activities of the first year was published in June 2018 and is available on the Healthy Argyll and Bute website http://healthyargyllandbute.co.uk.

Scotlands Mental Health First Aid - Young People (SMHFA-YP)

The 'SMHFA - Young People' courses took place in Lochgilphead and Inveraray in March 2017. This is the first time Public Health have made this course available in Argyll and Bute. Discussions with partners on the cool2talk project identified a funding opportunity which we utilised to finance the running cost.

Twenty-six people undertook the blended learning course however only 15 completed it. This significant non completion rate significantly impacts upon the likelihood this course will be supported by Public Health in the future and highlights an ongoing issue those who arrange training are experiencing.

Those who completed the course, which was co-ordinated by Sam Campbell and delivered by a Freelance Trainer enjoyed the training. Feedback from the course was positive with participants gaining a better understanding of issues that affect the mental health of young people, and how to support them. A full evaluation of this course, Scotlands Mental Health First Aid - Adults and all the Livingworks programmes will be initiated in partnership in August 2018.



S3 Health Drama Pilot

Laura Stephenson, Health Improvement Senior
(laurastephenson@nhs.net)

Following a needs assessment with young people, Laura Stephenson established and chaired a multi-agency steering group to provide an interactive health drama for S3 pupils in Argyll and Bute. The aim of the drama was to address the health issues highlighted through the needs assessment, raise awareness of available support services in relation to those health issues, and encourage young people to seek support from the services available. Topics included; social media and sexual relationships, sexuality, self harm, alcohol, smoking and peer pressure.

The powerful 60 minute drama toured Argyll and Bute delivering the production to all S3 pupils. It included three different scenarios to address the identified health issues. Immediately following the drama, local service providers worked with pupils to reflect on the play and consider what questions they had or what else they would like to know.

A question and answer session (Q&A) with the pupils and local service providers addressed 185 questions, the majority focussed on aspects of sexuality, sexual health, sexual material, explicit material, accessing help and self-harm.

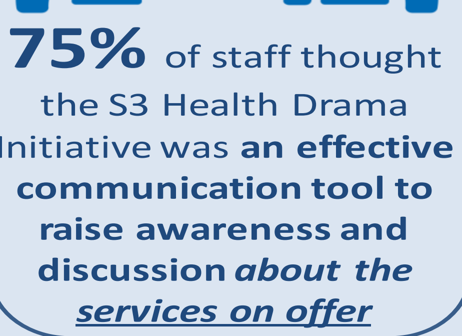
Each pupil was provided with a bespoke booklet containing exercises around self efficacy and resilience, useful information and details of services - around a quarter of young people shared this resource with their teacher. Bespoke lesson plans, for teachers to deliver, provided further follow up and learning for pupils.

Funding to support the project was sought from Smoking Cessation, Health Improvement, NHS Highland and Argyll and Bute Council.

Some local newspapers published an article about the initiative. Two pupils and Laura Stephenson were interviewed for BBC Alba who presented the article on their news programme. A full report of the event is available here - http://healthyargyllandbute.co.uk/wp-content/uploads/2018/03/S3-Health-Drama-Pilot-Project-2017-Report.pdf

Evaluation of the S3 Health Drama Pilot Project:

88% of staff thought the S3 Health Drama Initiative was **an effective communication tool to raise awareness and discussion *about these <u>issues</u>***



75% of staff thought the S3 Health Drama Initiative was **an effective communication tool to raise awareness and discussion *about the <u>services on offer</u>***

100% of staff thought their school would **be in favour of doing a similar drama initiative in future years**

63% of school staff thought the drama was a useful input to the curriculum whilst considering the Health and Wellbeing Social Benchmarks.

1 in 6 pupils self identified with at least one of the characters, or identified a friend in them.

Feedback from pupils was very positive with the majority expressing a similar project should be repeated.

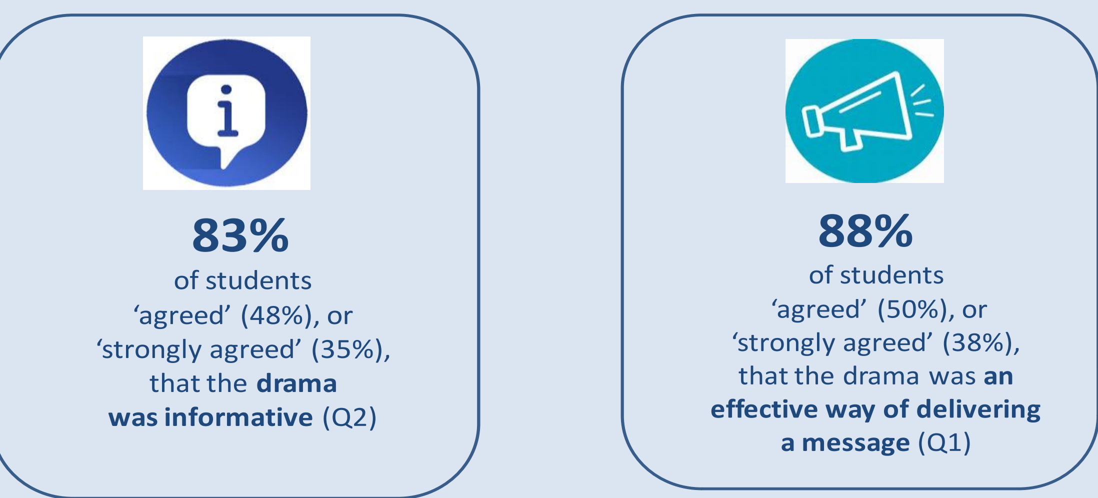


Fig. 4. Comments from the Young People who saw the S3 Health Drama

"I would never self-harm but there is a pressure with expectations"

"Trying to stop parents smoking"

"Sometimes I feel pressure in tests but it doesn't make me want to kill myself"

"Some of my mum's friends are gay"

"I believe I am like Rob but I don't feel strong emotions about failing because all my friends are supportive"

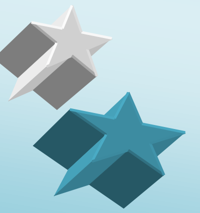
"It was hard for me to come out as gay and sometimes don't feel accepted but this play helped. I do feel stress and I put a lot of pressure on myself to do well but I am getting through it"

"Peer pressure to drink alcohol"

"Finally a section for others!"

"Someone I know pretended that they were going to commit suicide but then in the end told us most of the things she said were lies"

"No but if I experienced any of the topics I would know what to do"



Smoking Cessation

Laura Stephenson, Health Improvement Senior
(laurastephenson@nhs.net)

Scotland's strategy '**Creating a Tobacco Free Scotland'** aims to have a tobacco free generation by 2034. Yet smoking remains the most preventable cause of premature death and ill health.

Since the 1999 legislation, policy, health improvement and services have contributed to a decline in smoking prevalence in Scotland (19.6% for Scotland and 17.0% for Argyll & Bute in 2016). However, we need to keep working hard to support people to stop to reduce the adult smoking prevalence to **5% by 2034**.

This year the national logo ('Quit Your Way, with our Support') was launched and the Health Improvement Team promoted messages through a range of awareness raising methods including through the **Health & Wellbeing Network's Facebook page (**www.facebook.com/healthyargyllandbute**).**

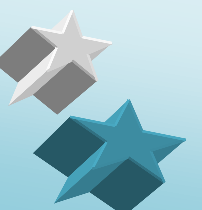
As well as the smoking cessation services provided through GP practises and pharmacies, two Health Improvement Officers (HIOs) with a Smoke Free remit supported people wishing to stop smoking, in Cowal, Oban and Lorn.

The HIOs raised awareness of support and services available and participated in education with schools. They also provided valuable one to one support for anyone in the local area wanting to stop smoking, and demonstrated how the use of 'Flo', the new texting service, could be used to provide added support for stopping smoking for good.

Smoking Cessation - Education

The primary school Smoke Free programme continues to evaluate very well and is considered a valuable and well established element of the health and wellbeing curriculum.

The Health Improvement team worked in partnership with Education colleagues to arrange and co-ordinate the programme. In 2017, 901 pupils from 52 schools participated in the programme, which includes five lessons delivered by teachers followed by a fun and interactive drama. This tours Argyll and Bute allowing pupils the opportunity to get together with other schools to reinforce the facts they've learnt and sing the songs they've practised in class.



Healthy Working Lives (HWL)

Angela Coll, Healthy Working Lives Adviser (angela.coll@nhs.net)

Argyll & Bute currently has 35 workplaces registered for the HWL Award Programme, including cross border HWL registrations (workplaces with sites throughout Scotland). Twenty-six of these workplaces have already achieved a HWL Award. This includes 14 Gold, three Silver and nine Bronze Awards. The organisations vary significantly in size, and come from all sectors.

Within Argyll & Bute HSCP, all seven NHS sites plus Argyll & Bute Council have achieved HWL Awards. NHS sites in Cowal, Islay, Kintyre, Mid Argyll and Oban all have a HWL Gold Award, Bute has a HWL Silver and the Victoria Integrated Care Centre, in Helensburgh, has a HWL Bronze Award. Argyll & Bute Council has a HWL Bronze Award.

In 2018 Healthy Working Lives launched its new website www.healthyworkinglives.scot, allowing organisations across Scotland to access personalised advice to improve the health, safety and wellbeing of their workforce.

The website is ideal for small to medium businesses, including Third Sector organisations. It is packed with interactive features and the new content structure makes it easier for businesses to find what they need, when they need it.

The website not only helps businesses with practical tasks, such as developing a health and safety policy or completing a return to work form - it also has simple guides on a range of topics, provides practical tips and advice on how to keep employees healthy and happy. In addition, there are policy templates, for example there is a smoke-free policy template, which can be downloaded in a ready to use format. One of the best ways to promote stopping smoking and protect people from the effects of smoking is by creating a smoke-free policy.

Take a tour of the new website now on www.healthyworkinglives.scot. If you would like more information on the Healthy Working Lives Award Programme then please contact angela.coll@nhs.net.

Stress Awareness and Stress Management Workshop

Angela Coll, Healthy Working Lives Adviser (angela.coll@nhs.net)

Health and Wellbeing in the Workplace

A **Stress Awareness and Stress Management Workshop** was held on the 9th November in Inveraray for all partners to attend. The workshop was well attended with 39 participants from a wide range of settings.

Two further half-day **Stress and Personal Resilience Workshops** were held in Lochgilphead, on 30th November, to include those who were unable to attend on the 9th November. Twenty more participants attended these workshops.

The aim of the workshop was to:

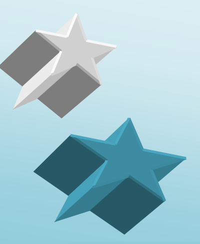
Identify attitudes and perceptions to mental health;

Increase knowledge of the most common mental health problems that affect people;

- Help understand the links between pressure, stress and performance and health;
- Recognise the effects of stress on physical as well as mental wellbeing;
- Increase understanding of how to recognise and manage stress related behaviours;
- Measure resilience and understand how to build resilience.

The workshop began with an introduction to mental health then highlighted different types of mental health problems, followed by introducing tools to help identify stress and increase personal resilience. Workshop activities allowed participants to consider their own stressors, how they deal with stress and potential ways to build their personal resilience.

Overall, the training was well received with the majority of participants. Most participants agreed that we should continue to increase the knowledge and understanding of stress and mental health. A full evaluation report, including a brief outline of the workshop presentations plus exercises undertaken, can be found via this link: Stress Awareness and Management Workshop 9 Nov 2017

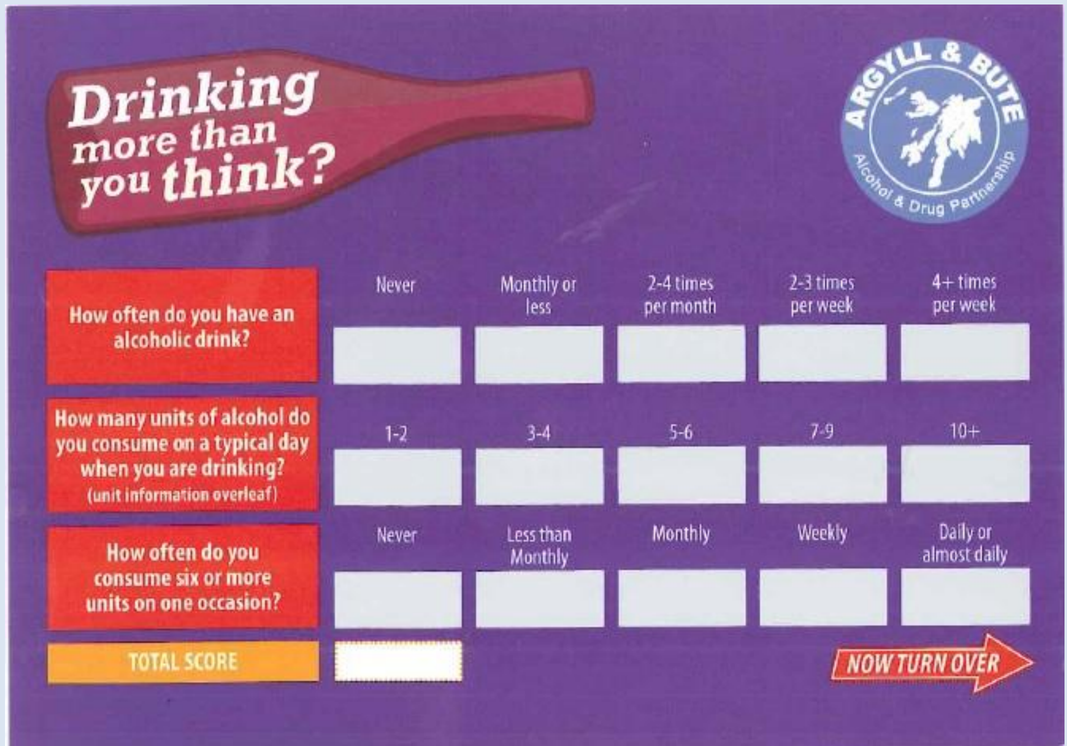


Alcohol Screening

Jenny Dryden, Health Improvement Senior (j.dryden1@nhs.net)

2017 saw the launch of the new Alcohol Screening Scratch Cards, a sample of which you can see below. The cards can be used to assess a person's alcohol drinking levels and therefore whether they may benefit from an Alcohol Brief Intervention (ABI).

Fig. 5. Alcohol Screening Scratch cards, Argyll & Bute



Many staff within the Health and Social Care Partnership plus our partners throughout Argyll and Bute have already started to deliver ABIs. However more work needs to be done in order help reduce the impact alcohol is having on our population.

Alcohol Brief Interventions are a simple way of supporting people who are currently drinking a bit more than is healthy to reduce their alcohol intake. Each ABI takes about 5-10 minutes and can be carried out by any trained member of staff. The training is easy and can be completed online.

NHS STAFF: **https://tinyurl.com/ycfut6rg**

NON-NHS STAFF: **https://tinyurl.com/yc23d3b7**

Please email joyce.ackroyd@nhs.net if you would like to order some scratch cards or contact the Argyll and Bute Alcohol & Drug Partnership Support Team, High-uhb.ArgyllandButeADP@nhs.net for more information.

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Bute & Cowal Community Planning Group

Presentation by Iona MacPhail

ACHA Regional Manager

Updates – 14 August 2018

- Snowmageddon!
- Stock rationalisation & Estate Management Action Plan
- ACHA Wins Award
- Community Action Funds

The Beast From the East!

1 March 2018

- Closure of office in Rothesay, partial closure Cowal
- Services to customers via free phone number unaffected
- Measures in place to ensure senior staff members can operate from home to ease and assist any future incidents

Dolphin Hall

Sandbank Primary School

Argyll Street

Updates
Rationalisation of Bute Stock

Progress since February meeting.

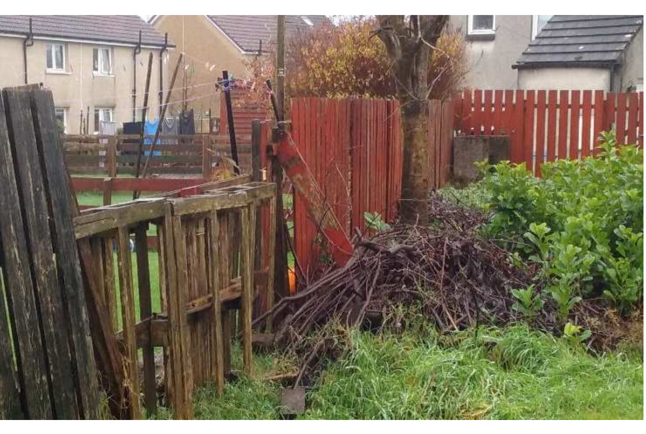
Watson Place – 32 properties. All tenants have been rehomed.

Columshill Higher Terrace – 8 properties. Private owner is moving out mid August leaving one ACHA tenant.

Columshill Lower Terrace – 6 properties. Our remaining tenant and the council's homeless department have both received offers for alternative accommodation.

Longhill Terrace – 3 tenants still to be rehomed.

Updates – ACHA's Estate Management Action Plan



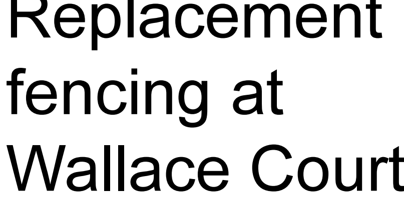
Before

After

Replacement fencing at Ardenslate

Before

After



Replacement fencing at Wallace Court

Updates – ACHA's Estate Management Action Plan

Further projects are planned…

…to remodel the grounds at Fairways Drive to improve pedestrian access and avoid damage to the landscaped areas

…and to improve the fencing at Machair Cottages, Toward

Most Inspiring Scrutiny Newcomer Award

- Sponsor: Glen Oaks Housing Association
- Presenter: Elaine McShane, Chairperson, Glen Oaks Housing Association

- **Winner: Your Voice Scrutiny Group, Argyll Community Housing Association**

- Finalist: Customer Scrutiny Group, South Lanarkshire Council
- Finalist: Hanover HEART, Hanover (Scotland) Housing Association

Community Action Fund

By way of reminder…

ACHA has a fund of £2500 available for local causes with a maximum award of £500 per cause.

Some causes that have benefited in the past include local volunteer groups and childrens' organisations.

Contact Garrick Collier at Dolphin Hall for an application form.

Questions?

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HIE CPP Argyll Update

July 2018

The infographic on page two shows an overview of HIE's activity across Argyll, April to June 2018.

All activity supports the strategic aims of Highlands and Islands Enterprise:

- Accelerating business growth—Supporting businesses to increase productivity and grow through investment, innovation and inward investment and exporting.
- Strengthening Communities—Supporting growth of social enterprise sector and enabling communities, particularly in remote a rural areas to make a significant contribution to local development
- Supporting growth sectors—Development of business sectors and supply chains
- Developing regional attractiveness—Making the Highlands and Islands a globally attractive region in which to live, work, study and invest.

In Argyll we are supporting this activity by aiming to:

⇒ Increase the number of permanent, skilled jobs in the area

⇒ Attract and retain a talented and innovative workforce.

⇒ Increase turnover of businesses across the area.

⇒ Assist community assets to generate income.

HIE's strategic aims

Accelerating business growth	Strengthening communities	Supporting growth sectors	Developing regional attractiveness

Activity across Highlands & Islands

⇒ 2018 Year of Young People–HIE has a regional survey underway into the aspirations and attitudes of the 16-30 age group regarding living and working in the Highlands. The findings, due October, will focus on what needs to be done to attract skilled and talented young people to come to work in the region, to support business growth.

⇒ Stimulating Housing Development–HIE is working with private and public organisations to address some of the issues identified by recently published research into the housing challenges the area faces and possible ways of solving these.

A snapshot of HIE support in Argyll Apr/June

Mid Argyll, Kintyre & the Islands

- Kiilmartin Museum —supporting the redevelopment & expansion
- Participation in Islay Summit organised by Brendan O'Hara MP.
- CS Wind—support to double production capacity making the business internationally competitive

Bute & Cowal

- Supporting multinational company, SYKES, to pilot remote working in Cowal and Bute
- Rothesay—development of land use feasibility
- Sandbank Business Park—marketing of development plots

Oban, Lorn and the Isles

- Glenshellach Oban— infrastructure development, releasing land for industrial use
- Oban A University Town—five year plan produced
- European Marine Science Park Phase II— feasibility study
- Work with community enterprises on Tiree and Mull to support key sector employment & to secure income generating assets

Activity planned for next quarter

- Co-Innovate events—supporting businesses to grow through innovation—Bute and Mull
- Rural Deal—participation in bid preparation with Argyll Bute Council
- Fit-out of 'The Moorings' - flexible workspace for marine businesses, Malin House, Oban
- Ulva community buy-out support
- Supporting the Dunoon Project Community Team to develop this community project & undertake an initial feasibility study.
- Argyll Housing Study—survey of local businesses & employers in Argyll & Bute into housing need and demand.