



Aberdeenshire
Health & Social Care
Partnership

Health and Social Care Locality Plan Kincardine & Mearns

2018 – 2021



Aberdeenshire
COUNCIL



NHS
Grampian

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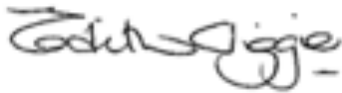
WELCOME

South Aberdeenshire is a great place to live and work and we want to make it even better by supporting people, and our communities, to live life to the fullest. We will encourage people to live healthy, safe and active lives by promoting a culture of personal independence and growth.

Our aim in South Aberdeenshire is to provide services at a local level that will empower people to actively participate in how their community is developed, allowing them to have input into decisions relating to their health and social care. By giving people the opportunity to participate in these decisions it gives them ownership of how they live and how they access the services they require.

As the area demographic changes and our communities becoming more diverse in nature, it is important that we capture the needs of all people, of all backgrounds, and provide a service that is equitable for all.

Your Locality Plan provides details on where we are now and how we are going to achieve our objectives moving forwards. This document is to be used as a guideline as to how we are going to improve services at a local level for the benefit of all, to ensure people live happily and healthily in their communities for longer.



Edith Criggie
Location Manager, Kincardine & Mearns

1.0 INTRODUCTION

1.1 What is a locality?

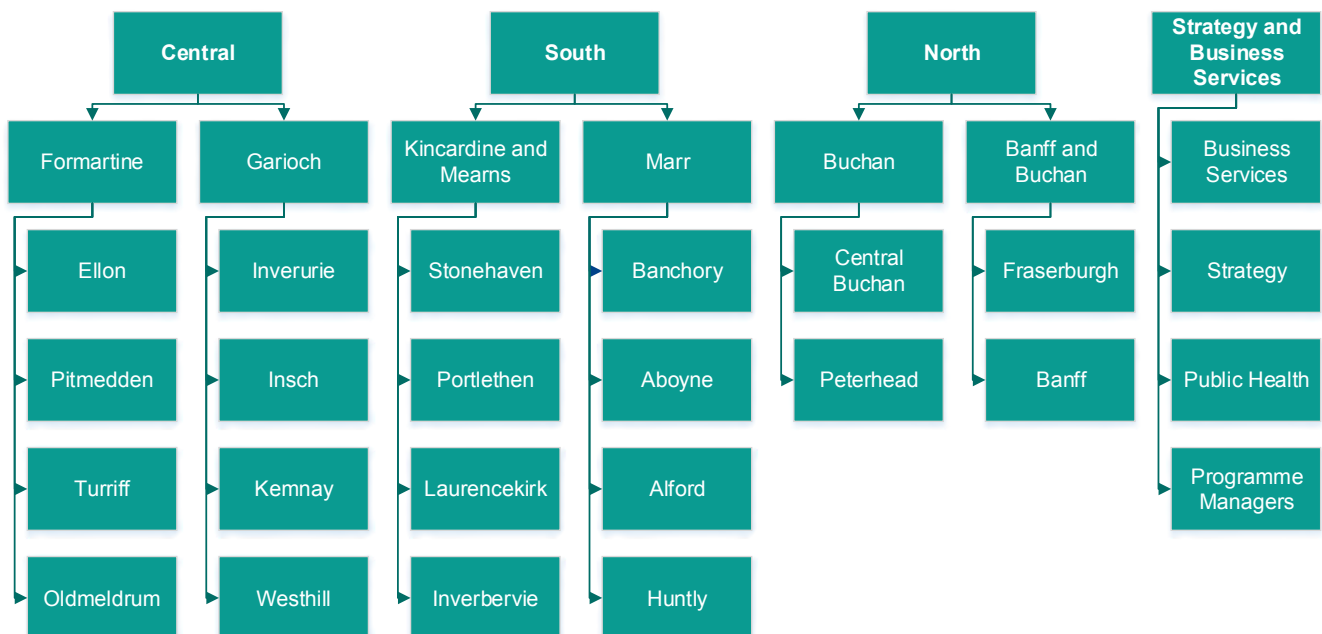
A locality is described as a small area within the Integration Authority borders. In Aberdeenshire our localities are organised so that health and social care teams and the people in the area they serve can have a clear influence on the resources that are available and the development of new services and support. Localities are defined by geography, the people that live and work in the area, the characteristics of the population and to some extent by existing services such as the location of community hospitals, health centres and social work offices.

Aberdeenshire Health and Social Care Partnership has four Partnership managers, one for Strategy and Business Services and three Partnership Managers who cover South, Central and North Aberdeenshire. The South, Central and North Partnership Managers each have overall responsibility for two of the six administrative areas in Aberdeenshire. Within each administrative area lies Aberdeenshire’s localities. There are 20 localities in Aberdeenshire which vary greatly in geography, size and characteristics.

The organigram below demonstrates the links between localities, administrative areas and partnership areas.

1.2 What is Locality Planning?

Locality planning is a way for Aberdeenshire’s localities to come together to look at and prioritise the needs of



its people. A Locality Planning Group has been established in South Aberdeenshire to develop locality plans for Kincardine and Mearns and for Marr.

This plan covers Kincardine and Mearns which includes the localities of:

- Auchleven
- Portlethen
- Laurencekirk
- Inverbervie
- Stonehaven

1.3 Who is the Locality Plan for?

This plan is for people living within the Kincardine & Mearns area of Aberdeenshire who currently have access to health and social care services and also for those who may require care and support in the future. Furthermore, it is aimed at people who are well and want to maintain or improve their health and wellbeing.

1.4 What is included in the Locality Plan?

Throughout this plan we will make reference to health and social care services, primary care services, housing services, acute services and some elements of children's services where we are beginning to see integrated working.

1.5 How Locality Planning fits into the bigger picture

This plan will be one of six plans for Aberdeenshire Health and Social Care Partnership and will align with our wider strategic priorities and the nine national health and wellbeing outcomes.



The strategic plan sets out our high level priorities which provides direction for the Partnership. The commissioning plan ensures funding is aligned to the projects that are linked to the strategic priorities. The locality planning and community planning groups engage with communities to prioritise local need. Moving forward the locality plan will help to inform future strategic direction.

The national health and wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services. The suite of nine national health and wellbeing outcomes focus on improving the experience and quality of services for people using integrated health and social care services, carers and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for individuals.

The Aberdeenshire Health and Social Care Partnership Strategic Priorities

1. The most appropriate and effective use of acute and community resources.
2. Involving people as partners with early identification, management and appropriate support to promote recovery and achieve their potential.
3. Active engagement with all stakeholders to optimise the best planning and use of resources.
4. Development of services that are fit for the future.
5. Quality.
6. Support the contribution of an individual's network of support.
7. Empowering the workforce.
8. Prevention.
9. Public Protection.
10. Reducing inequalities to provide equitable outcomes for the population.

1.6 The benefits

- It gives the locality the opportunity to play an active role in service design and improvement.
- The process of locality planning raises awareness of current services and celebrate successful partnership working
- Identifies local priorities, which ensures that the needs of the locality are being address by those who know it best.
- Creates a culture where these local relationships can lead to real change.

1.7 The Locality Plan

This Locality Plan will set out specific information about the locality, identifying what is working well and some of the main challenges the Health and Social Care Partnership needs to tackle.

1.8 Locality Planning in Kincardine and Mearns

In order to develop the locality plans, a Locality Planning Group was established in South Aberdeenshire which includes representatives from Kincardine & Mearns and from Marr. The locality team membership for Kincardine & Mearns includes:

Title & Organisation	Role
Partnership Manager, Aberdeenshire HSCP	Chair
Deputy Clinical Lead (South) Area Lead (K&M)	Provide links with clinical services both in terms of priorities and through engagement with staff teams
Location Manager (Stonehaven), Aberdeenshire HSCP	Link with all Aberdeenshire HSCP teams in Stonehaven
Location Manager (Portlethen, Laurencekirk & Inverbervie), Aberdeenshire HSCP	Link with all Aberdeenshire HSCP teams in Portlethen, Laurencekirk & Inverbervie
Head of Nursing, Aberdeenshire HSCP	Link with nursing teams across South Aberdeenshire
Advanced Public Health Coordinator, Aberdeenshire HSCP	Provide Public Health Information to support health improvement for populations across all age groups
Lead Physio, Aberdeenshire HSCP	Link with Allied Health Professional Teams
Continuous Improvement Officer, Aberdeenshire HSCP	Provide support to SLPG
Strategic Development Officer, Aberdeenshire HSCP	Provide support to SLPG
Area Manager for K&M, Aberdeenshire Council	Provide steer on priorities and need in K&M
Community Planning Officer for K&M, Aberdeenshire Council	Part of Aberdeenshire Council's Community Planning Department, links with the Local Community Planning Groups and partners including Police, Fire and Ambulance Service. Responsible for the Local Outcomes Improvement Plan (LOIP), Local Community Plans and Locality Plans
Finance, Aberdeenshire Council	Provide support with budget information
Housing, Aberdeenshire Council	Provide link with Aberdeenshire Council Housing Service, including tenant engagement
Finance, NHS Grampian	Provide support with budget information

Title & Organisation	Role
Service User/Carer Representative – position currently vacant	Currently, all locality planning documents are shared by the CHIP officer with the Patient Participation Groups in Laurencekirk and Stonehaven, Quarriers Carers Service and the Older People's forum facilitator for dissemination and comment.
Community Health in Partnership Officer for K&M, Aberdeenshire Voluntary Action	Develop strong & sustainable relationships by connecting Third Sector to Health & Social Care services.

1.9 What are we hoping to achieve?

The plan is centred on the Aberdeenshire Health and Social Care Partnership Vision:

“Building on a person’s ability, we will deliver high quality person centred care to enhance their independence and well-being in their own communities”

For the people in our community this means that services are designed around the needs of the person. People are entitled to expect the best possible advice, care and support from our staff in a timely manner and in the right place.

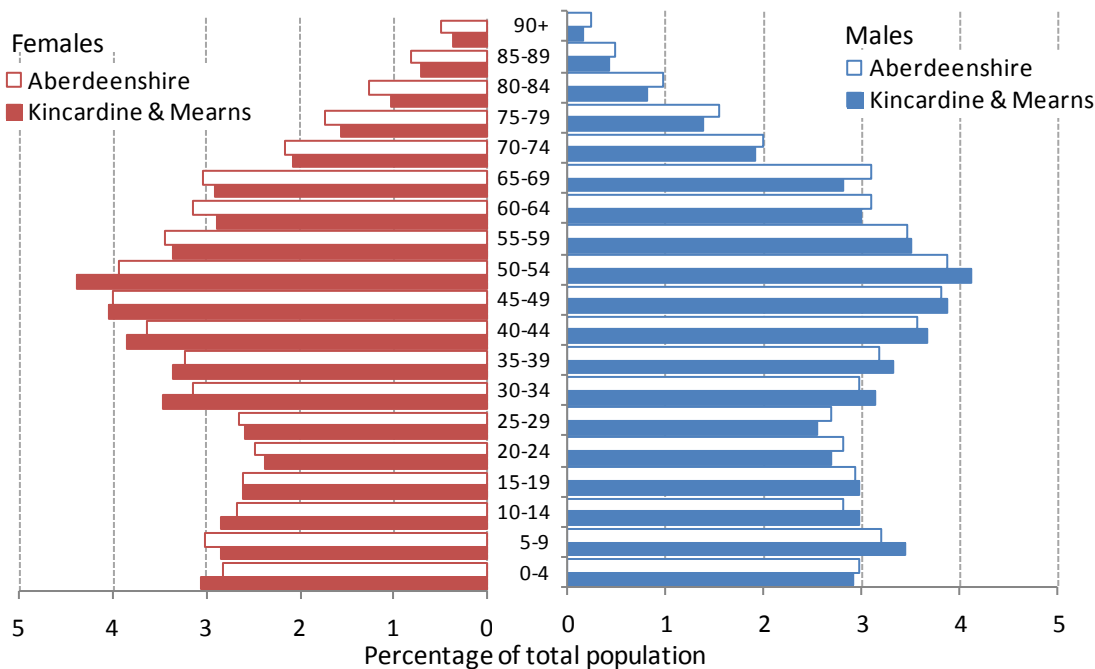
Every individual is able to contribute to their own health and wellbeing, make their views known and participate in their own care. A person’s family, their social network and their close community all have a part to play to achieve healthy lifestyles and to support those who need help to continue to live in their own homes.

Within Kincardine & Mearns we are committed to developing our services to meet local need. We plan to achieve this through ongoing local community consultations and engagement events, helping us to understand and evolve the local community resources to achieve better outcomes.

2.0 ABOUT KINCARDINE & MEARNS

Kincardine & Mearns is located in South Aberdeenshire. The largest town in Kincardine and Mearns is Stonehaven. Portlethen is also a significant settlement and both benefit from railway stations with good connections to Aberdeen city. Just over 45,000 people are resident in the area. The growing population of older people represents both opportunities and significant challenges for the area.

Kincardine & Mearns and Aberdeenshire - Percentage of persons by 5 year age band and gender



Life expectancy in Kincardine & Mearns is on the whole better than the Scottish average. Men have an average life expectancy of between 78 and 81 years (compared to an average of 77 years across Scotland). An average woman can expect to live between 80 and 86 years (compared to an average of 81 years across Scotland).

Across the area, more residents are being encouraged to take part in social, leisure and support activities that promote positive health and wellbeing, and helping older people to plan better for their future needs is a priority. There are a number of health initiatives in Kincardine & Mearns to encourage people to get active including health walks and gentle exercise classes. There is also a Wellbeing Network and Welfare Solutions group. These multi-agency groups support partnership working to meet local need. The area also has two Patient Participation Groups, three older people's forums, and an active Dementia Friendly community group in Portlethen.

Kincardine & Mearns is well served by a community hospital, five GP practices and four Health Centres. The area has seven care homes and good availability of sheltered housing but the area has no Very Sheltered Housing to provide additional support for older people who want to retain their own tenancy whilst receiving 24 hour care and support. It is estimated that 8% of the people living in Kincardine & Mearns provide unpaid care. Just over 1% of children under 16 reported providing care to another person. The majority of carers in Kincardine & Mearns are aged 50 or over.

Some areas of Kincardine & Mearns are extremely remote with no local services and for people living in these areas access to services can be difficult. Issues relating to social inclusion have been specifically highlighted for those towns that have rapidly expanded and where the lack of any central focus or community facilities is becoming apparent.

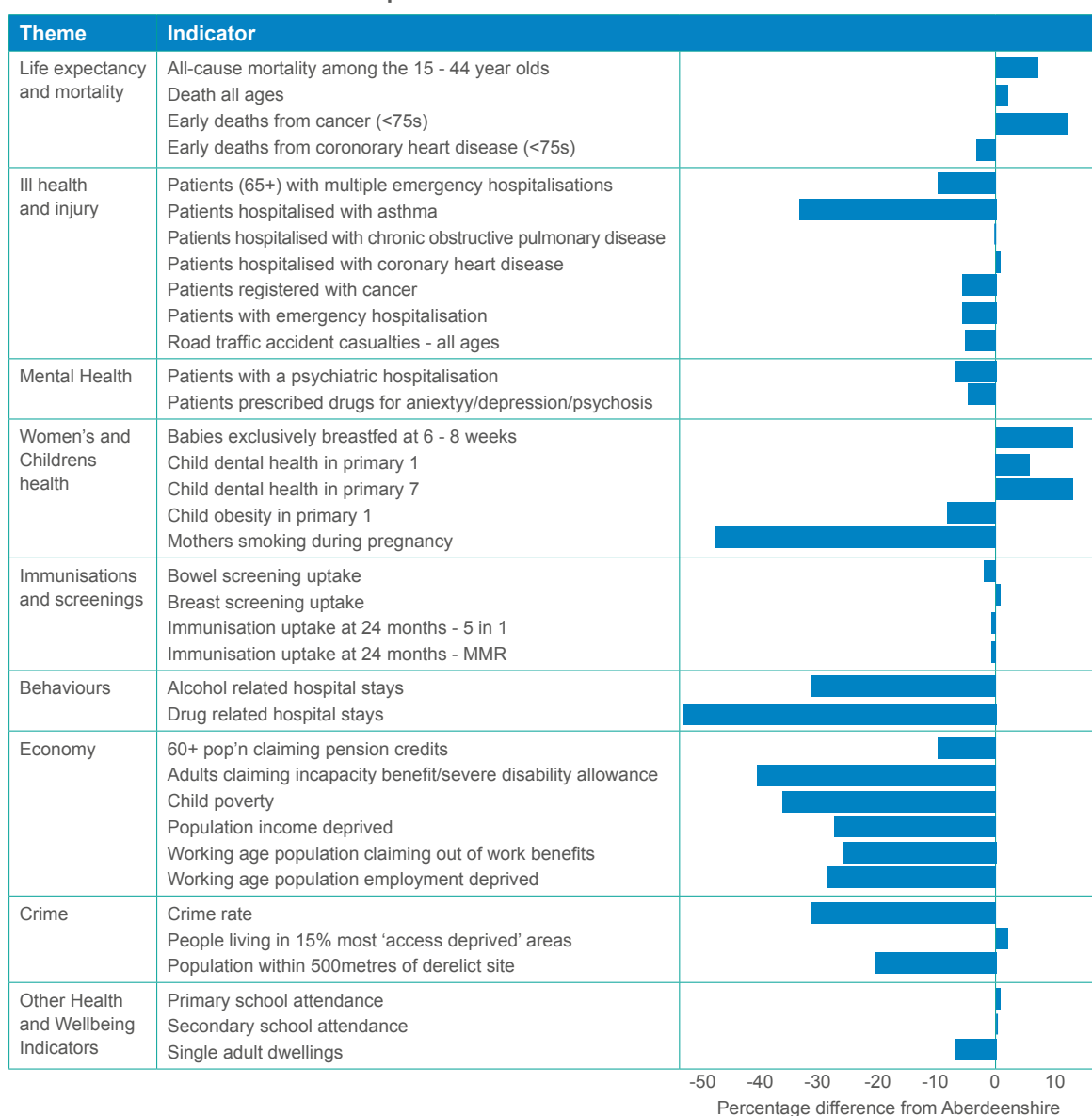
There are a number of organisations that provide supported accommodation for people with learning disabilities and additional support needs in K&M and there is some respite support available to carers through day services which are mainly community based but some buildings based provision does remain in the area.

Kincardine & Mearns has good support from the third sector. As well as a number of commissioned services providing support and activities there are a large number of organisations and groups providing low level support to people to help reduce social isolation and maintain their own health and wellbeing. There are also volunteer-run First Responder services in Laurencekirk, Johnshaven and Stonehaven which provide immediate assistance to people in need.

The table below was produced by the Local Intelligence Support Team (LIST) and provides an overview of health in Kincardine and Mearns. In general, the indicators of health and wellbeing are favourable for people living in Kincardine & Mearns, comparing well against similar indicators for Aberdeenshire as a whole.

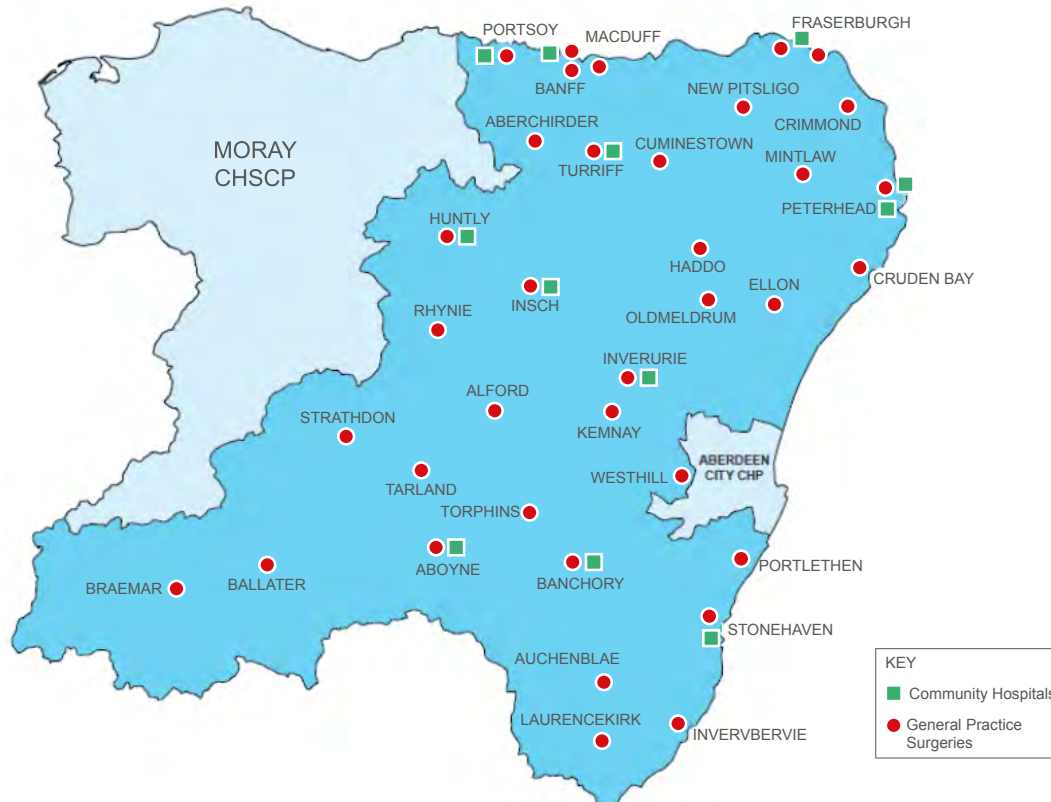
It is not clear why Kincardine & Mearns has an apparently higher rate of premature deaths from cancer. It requires further investigation to uncover what the reason or reasons for this are and subsequently develop an improvement plan. Whilst we have not included any specific actions against this in this Locality Plan, Public Health leads for the Kincardine & Mearns area have identified this as an area to investigate as part of the broader Public Health programme for the locality. Subsequent locality plans may include further work specifically to support this.

Selected ScotPHO Indicators: Comparison of Rates for Kincardine & Mearns with Aberdeenshire rates



Relative to Aberdeenshire, areas of concern for Kincardine & Mearns include the lower rates for 'Bowel Screening Uptake', and the higher levels of 'All-cause mortality among the 15-44 year olds' and 'Early deaths from cancer (<75s)'. There are a number of areas of encouragement, including the low levels of 'Deaths from suicide', 'mothers smoking during pregnancy', 'alcohol-related hospital stays', 'Deaths from alcohol condition' and 'Drug-related hospital stays'.

3.0 KINCARDINE & MEARN'S RESOURCES



<p>Adult Services</p> <ul style="list-style-type: none"> • Mental Health Services • Learning Disability Services • Physical Disability Services • Substance Misuse Services • Criminal Justice Services • Shared Lives Service • Care Management Team 	<p>Older People’s Services</p> <ul style="list-style-type: none"> • 7 Care Homes • Older People Services • Specialist Dementia Services • Care Management Team 	<p>Primary Care Services</p> <ul style="list-style-type: none"> • 1 Community Hospital • 5 x GP practice • 4 Health clinics • District Nursing Services • AHP Services – Physiotherapy, Podiatry, Occupational Therapy, Dietetics • Dental Services
<p>Cross Sector Services</p> <ul style="list-style-type: none"> • Adult Protection Services • Carers Support Services • Health Improvement Services • Housing Support Services • Day Services • Respite Services • Palliative Care Services • Alcohol and Drugs Partnership 	<p>Third Sector Services</p> <ul style="list-style-type: none"> • Community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers provide a diverse range of services supporting the wider community. • First Responders • Commissioned services 	

3.1 The process for local engagement

A wide variety of engagement and consultation activities have taken place across Kincardine & Mearns, including community and staff integration events, community action surveys and community planning events. These events have enabled us to gather meaningful and relevant information about what matters to the people of Kincardine & Mearns when it comes to the health and wellbeing of their communities and the type of health and social care services they want to be able to access.

In addition, as part of the Locality Plan development process, five stakeholder workshops were held with the South Locality Group, which was made up of staff from both within and outwith the partnership, third sector, community based organisations, and service user representatives. The members of this group used their knowledge of the area to identify the initial priorities for the Locality Plan and each member of the group shared these with their own wider network for comments and feedback. Following every workshop, the outputs were circulated around the wider network. This approach enabled us to ensure that the Locality Plan was developed with ongoing input from the people who are best placed to identify the priorities, objectives and measurable actions against which we can measure our performance and progress.

Consultation and engagement will be an iterative process and we will continue to seek feedback and comments from people living and working in Kincardine & Mearns as the Locality Plan is delivered. The Locality Plans will run from 2018-21, with a review of the action plans after 18 months. This timeframe will ensure that they inform the next Strategic Plan (2019 – 2022). The timeframe will also ensure that subsequent locality plans fit into the planning landscape.

The action plan, Section 10 below, details activity which will be carried out over the first eighteen months of that period. The action plan will then be updated to reflect activity which has been completed and any follow up action required, in addition to any new actions arising from feedback from ongoing public engagement and consultation in the locality.

4.0 KINCARDINE & MEARN'S PRIORITIES

In Kincardine & Mearns three priorities were identified as important over the next 18 months. These priorities were identified drawing from a number of sources including feedback from staff and service users, information contained within other local plans, local and national internal and external data and new legislation which impacts the services provided by the Health and Social Care Partnership.

The three identified priorities are:

1. Provide and support workforce to meet the needs of people of Kincardine & Mearns
2. Enhance and promote support at moderate and low level need to support mental wellbeing
3. Equality of Access to Health and Social Care Services

Each top level priority is broken down into smaller, specific, measurable objectives which identify the actions which will be taken in order to meet the identified priority. The next few pages provide further detail on each priority and a summary of all the priorities and actions is available in the Kincardine & Mearns Locality Action Plan at Section 10 of this document, below. These priorities will be reviewed after 18 months, and the Action Plan will be refreshed to reflect action which has been carried out and any new activity that needs to be delivered for the last 18 months of this Locality Plan's timeframe.

4.1 Theme one: provide and support workforce to meet the needs of people of Kincardine & Mearns

Health and Social Care recruitment and retention is challenging on a national scale and this is evident at a local level across Aberdeenshire as a whole, including within Kincardine & Mearns. To illustrate this situation, during November and December 2017, there were over fifty vacant posts in the Aberdeenshire Health and Social Care Partnership, the vast majority of which were for front line carer or service provider roles.

In order to support recruitment and retention Kincardine & Mearns have identified the importance of supporting the workforce in respect of wellbeing, training, and communication. Three objectives have been identified which can be pursued on a local level.

Develop appropriate inclusive shared learning for the wider partnership

There is a vast amount of training available within the Health and Social Care Partnership through various methods including face to face and online training. Some work has already been done around training need analysis both by the NHS and Aberdeenshire Council training team. Aberdeenshire Voluntary Action also undertakes an annual training needs analysis for the Third Sector and has a number of themed sessions each year which enable information sharing. The Kincardine & Mearns locality felt it was important to develop appropriate shared

training resources in order to reduce duplication and where possible make all training available within the partnership more accessible.

A number of shared training courses have already taken place already including Best Practice in Dementia Care, Making Every Opportunity Count (MEOC) People Handling Induction.

In order to support a mentally healthy workplace the Mentally Healthy Workplace Training programme for manager, supervisors and team leaders has been developed by the Scottish Centre for Healthy Working Lives in partnership with the Scottish development Centre for Mental Health. The partnership is also rolling out the new Promoting Resilience training for all staff to create a greater understanding of how to build personal resilience in the workplace.

This work is being directed by the workforce plan and will be fully supported by Management Teams in Kincardine & Mearns.

		
<ul style="list-style-type: none"> • 563 accounts created for staff outside of Aberdeenshire Council • 966 courses completed by external applicants 	<ul style="list-style-type: none"> • Over 15,000 external users • Accessed by Scottish Fire & Rescue Service, Police Scotland, Aberdeen University, RGU University, Care Homes and the Third Sector 	<ul style="list-style-type: none"> • 30 thematic training events annually • Bespoke training • Integrated training opportunities across sectors

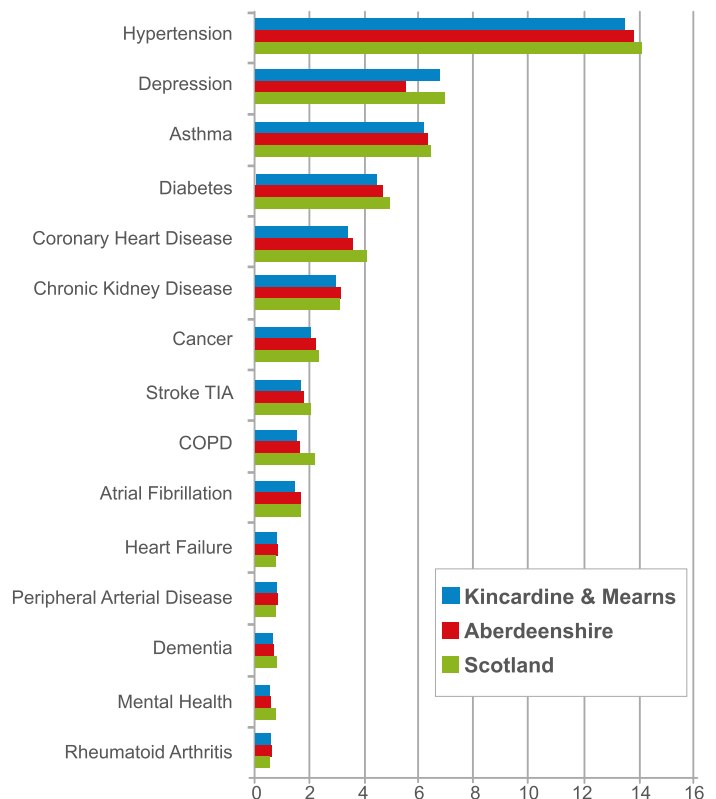
Promote better working relationships at a local level to share information between Public Health, Local Authority Corporate Team and the Third Sector with regards to Healthy Working Lives.

A healthy workforce can have a positive effect on retention, absence and employee sickness and participation in the Healthy Working Lives programme allows an organisation to invest time in employees' health and wellbeing in a structured and supported way. Currently both Aberdeenshire Council and NHS Grampian hold the formal accreditation however it is recognised more can be done in order to share good practice and work on joint health focused initiatives in order to uphold and improve the status of both organisations in respect of this accolade. Close working between NHS Grampian Public Health, Aberdeenshire Council's Wellbeing Team and Locality Managers to promote participation on a local level from staff in Kincardine & Mearns will contribute towards improvements in this area and has the ability to lead to reduced sickness absence and improve staff retention.

4.2 Priority theme two: Enhance and promote support at moderate and low level need to support mental health and wellbeing

In Kincardine & Mearns prevalence of mental health conditions are close to the Aberdeenshire average but rates of depression are much higher which may be indicative of a particular issue in the area. The figures for mental health conditions may not include those people who require lower level interventions or those who self-manage or access third sector providers. Therefore the true figure may be higher.

Kincardine & Mearns - Prevalence Rate per 100 people



A few pieces of work have been commissioned recently around Living with Hope and Loneliness which may help to identify some of the causes and what local supports can be put in place to support positive mental wellbeing.

A summary of the number of people receiving a mental health service from the local authority in 2016 showed that requirements in South Aberdeenshire are reasonably high however it is worth noting that some of the clients attributed to South may not live there but are in receipt of services there and this is due to a lack of availability in their own area.

Summary	
Assigned To Team	Total
Central Community Mental Health Team	166
North Community Mental Health Team	288
Older People's Mental Health Team	43
South Community Mental Health Team	211
Grand Total	708

Given the high demand in the area and the requirements of local services to support those who cannot access services locally it is important to ensure the support is there for people who require low level interventions as this preventative work may help to reduce the number and complexity of future demand on mental health services in the area.

1. Tier 2 Community Psychologist for K&M post who will provide support to people with low to moderate depression and anxiety

At time of publication of this plan (February 2018) this post is currently vacant. When it is filled the person will be providing a peripatetic service via GP practices in Kincardine & Mearns.

2. Widen access to Carers Awareness training to all Health and Social Care staff including those in the third sector to support identification of carers and enable people to be signposted to appropriate support services.

The Carers (Scotland) Act 2016 legislation will come into effect from April 2018 and this places a statutory obligation on Health and Social Care Partnership's to support carers. In order for carers to be supported they must identify themselves as carers. It has been recognised that frontline staff and those in the third sector have a responsibility to help identify carers and signpost them to appropriate support.

Through completing the 'Carer Aware' course staff will have a basic level of understanding regarding how to identify someone as a carer and how to help signpost them to appropriate support services. This is the first step in ensuring we can support carers to continue in their caring role without putting their own physical and mental health at risk.

- 241 people completed the 'Carer Aware' course in 2017

3. Raise profile and uptake of low level community services and support to promote mental wellbeing and reduce loneliness and isolation

The Kincardine & Mearns community wellbeing network commissioned the Living with Hope community research project which identified need for more joined up working across all partner agencies to support communities. Public feedback from research identified a need to support mental wellbeing and Aberdeenshire viewpoint survey identified loneliness in older people living in Kincardine & Mearns.

4. Map third sector service provision in K&M to identify and promote services that support health and wellbeing

Following on from the Living with Hope research, the Kincardine & Mearns community wellbeing network, as a multi-agency partnership, is working with third sector groups and local agencies to map existing services to identify current levels of support for health and wellbeing in Kincardine & Mearns. By mapping the different support services available we can identify opportunities for organisations to work together, reduce duplication and highlight any gaps, to improve the availability of support services for the local community.

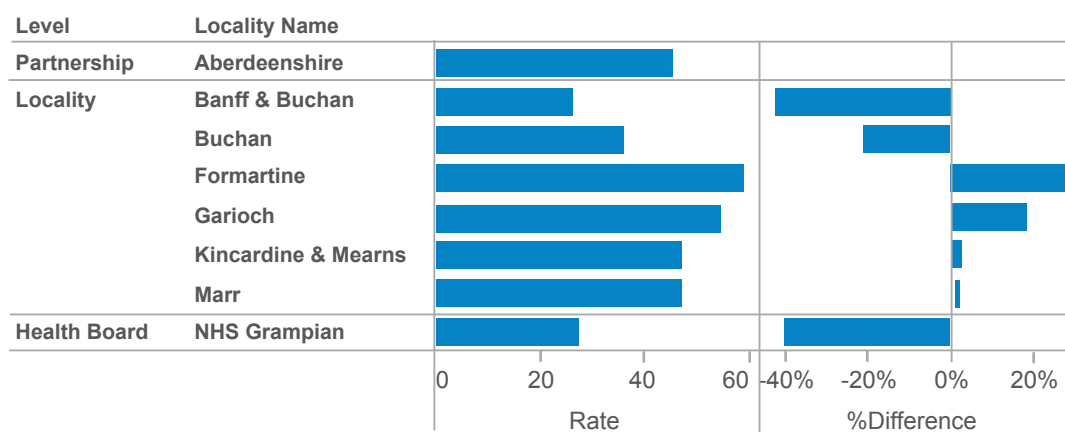
4.3 Priority theme three: equality of access to health and social care services

Kincardine & Mearns has specific challenges in relation to the rural nature of its geography. This in turn can lead to difficulties accessing services, particularly in communities which have no local resources and poor transport and communication links with the rest of the area.

From the table below you can see that Kincardine & Mearns has a significant proportion of people who are considered 'access deprived' and this is higher than the Aberdeenshire average.

People living in 15% most 'access deprived' areas, Percentage Rate and % Difference from Aberdeenshire Rate,

Single Calendar year: 2014



In addition to this there are specific challenges in Kincardine & Mearns with regards to access to specialist types of accommodation, and a lack of availability of appropriate accommodation has the potential to lead to other challenges. There is a particular difficulty in Kincardine & Mearns currently around a gypsy traveller population in South Esk and in the coming months it will be critical to ensure support for the people in this community.

1. Identify a space which can be used as a hub to gain access to service information

Given the challenges around accessing services in Kincardine & Mearns the group felt that the creation of a hub where people can go to access service information would likely be of great benefit to the area. This hub could be used to enable local people to access information on a number of different support services. A Community Asset Transfer has identified a potential venue in the old Stonehaven Courthouse and Stonehaven Town Partnership are pursuing the options available.

The Hub has the potential to be a well-used resource for people living in, and with good access to, Stonehaven. However for many out-lying communities in K&M with poor transport links further exploration, including identification of need, support required and organisational capacity to deliver increased outreach services such as currently supplied by KAMCAB and Aberdeenshire Signposting Service.

In support of improving access to services there are other activities ongoing for example South Aberdeenshire Accessibility Event, organised by PAMIS, Kincardineshire Development Partnership and Crossreach which aimed to explore how towns could be more accessible to people of all ages with disabilities. Actions from this event will be explored by the local teams. Intelligence from this activity and the recent Living Streets consultation and audit should be shared to avoid duplication.

2. Increasing the supply of appropriate housing in K&M

Waiting lists in Kincardine & Mearns for various types of accommodation are high and it has been identified in the Housing Strategy that there is a need for new housing to be built.

Area	1 Bed	2 Bed	3 Bed	4 Bed	5 Bed	Other	Total
Banff and Buchan	642	228	128	52	30	20	1099
Buchan	613	223	143	58	12	67	1116
Formartine	528	183	145	47	16	8	927
Garioch	1124	388	277	91	32	16	1928
K&M	611	315	209	67	25	35	1262
Marr	513	191	136	41	14	51	946
Other	1						1
Aberdeenshire Total	4032	1528	1038	356	129	197	7280

The strategy is to deliver new affordable housing in Stonehaven (106 units), Portlethen (31 units), Newtonhill (28 units) and Marykirk (9 units). Some of these will be suitable for people with particular needs.

3. Improve access to services for gypsy travellers

The Scottish Government decision to refuse planning permission for the gypsy traveller site in North Esk (St Cyrus) will potentially identify demand for support for this group of people whether that be people presenting as homeless or requests for other health and social care services which may present as a result.

5.0 FINANCIAL RESOURCES

The revised budget for Aberdeenshire Health and Social Care Partnership is £277,402,000. The split of this budget can be seen in the table below.

While a good proportion of the budgets are split to a locality level many of them are still running Aberdeenshire wide and expect to see these split out across the localities as progress is made into the coming years.

It is the responsibility of the Partnership Manager to review our budget and ensure it is fit to meet the pressures which are faced. The resources must be managed to the best effect to ensure positive outcomes across localities.

With continuous rising demand and restricted resources efficient use of the budget must be made to meet challenging demand and current priorities.

Current pressures are particularly high in areas of home care, care packages, prescribing and community hospitals.

Combined NHS & Council Revised Budgets as at 31st October 2017				
	Pay	Non-Pay	Income	Total
	£'000	£'000	£'000	£'000
Locality Based Services				
Banff and Buchan	12,971	7,585	(1,630)	18,926
Buchan	8,733	8,273	(1,170)	15,836
Garioch	9,006	10,751	(1,878)	17,879
Formartine	8,352	8,636	(1,939)	15,048
Kincardine and Mearns	6,276	5,617	(1,100)	10,794
Marr	10,328	5,272	(1,019)	14,581
Area Based Services				
North	4,976	20,199	(1,532)	23,642
Central	2,386	12,588	(291)	14,683
South	9,580	7,577	(1,192)	15,965
Aberdeenshire Wide Services				
Aberdeenshire Wide	12,141	8,161	(5,147)	15,154
Business Strategy	1,220	1,796	(95)	2,921
Community Mental Health	6,536	997	(122)	7,411
Dental	1,952	490	(236)	2,206
Management and Administration	1,934	666	(499)	2,101
Nursing	748	55	(17)	786
Out of Area	0	1,782	0	1,782
Prescribing	0	43,649	0	43,649
Primary Care	0	36,990	0	36,990
Primary Care Support	838	151	(10)	980
Inw Rech Hosted Services	0	12,559	0	12,559
Partnership Funds	0	3,508	0	3,508
	97,978	197,303	(17,878)	277,402

6.0 HOW ARE WE DOING?

6.1 Measuring Performance

It is important that we evaluate our performance to ensure we are delivering against the actions that we have set out in the Locality Plan. Performance Indicators will be aligned to the two themes and ten priorities outlined in the Aberdeenshire Health and Social Care Partnership, Integrated Joint Board Strategic Plan, these priorities are shown on page 5 of this document.

The primary purpose of measuring performance against the actions in the Locality Plan is to provide information on progress and current status. The Kincardine & Mearns Locality Group which was formed to develop the Locality Plan will continue to meet to review progress against the plan, and to ensure that the actions agreed are delivered. Location Managers will report to the Kincardine & Mearns Area Committee as requested, in line with Aberdeenshire performance reporting requirements.

The Integration Joint Board (IJB) will have the responsibility for checking the performance information whilst the Kincardine and Mearns locality planning group will review and monitor the actions to ensure they are being progressed, led by the responsible team members. From this information the IJB will be able to ascertain the effectiveness of integration for service users.

There will be an annual report developed each year of the plan as required by law.

7.0 COMMUNICATING PROGRESS

Effective and timely communication is essential in ensuring that people and communities remain well informed. We will work with all stakeholders within the Kincardine & Mearns Community to ensure that progress against the Kincardine & Mearns Locality Plan is reported appropriately and effectively. This including:

- Service Users
- Partnership Staff
- Unpaid carers
- AVA / Third sector personnel
- Community Groups
- Anyone within Kincardine & Mearns who wants to become involved in making Kincardine & Mearns a better place to live

8.0 WORKFORCE



Aberdeenshire Health & Social Care Partnership continues to hold discussions with key partners and stakeholders across health and social care, developing our workforce plans across our integrated teams. Evidence shows that staff who are valued, treated well and supported to give their best will deliver better outcomes for people.

We commit to valuing our workforce and developing the changes that need to be made to ensure a high quality of service is provided, ensuring a healthy organisational culture from a capable workforce who are then able to deliver integrated services, supported through effective leadership and management.

8.1 Summary of Key Information

Delayed Discharge

Delayed discharge is the term used to describe an instance where a person in hospital is medically fit to be discharged but is unable to do so. This can be due to inability to identify suitable care at home support, waiting for adaptations or equipment in the home or a lack of availability of community hospital resources.

Reducing the number of delayed discharge patients is a priority for the Aberdeenshire Health and Social Care Partnership as it is both physically and psychologically detrimental to the wellbeing of a patient if they are delayed in hospital. Research has shown that a patient's wellbeing deteriorates and their confidence and independence can be compromised if they remain in hospital beyond the point they are medically fit to leave.

Through the introduction of sustainable improvements such as increasing care at home, falls prevention and a rehabilitation approach, progress has been made in getting people discharged from hospital earlier and avoiding readmission. Historically, Kincardine & Mearns has had a relatively low rate of delayed discharges and this remains the case at the present time.

Virtual Community Wards

The Virtual Community Ward creates a system which can rapidly identify and meet the needs of individuals who have acute illness, exacerbation of chronic illness, terminal phase of an illness or complexity associated with social care needs. The intervention is therefore aimed at the group of individuals most likely to suffer an otherwise avoidable hospital or care home admission, or to come to harm due to a lack of organisation of, and consistency of, health and social care.

Individuals who could benefit from this approach are identified by any member of the health and social care team. Individuals are "admitted" and their names entered on a whiteboard. GPs, social work staff, community nurses and where appropriate other team members meet each morning around the whiteboard for about 15 minutes, checking rapidly on progress of individuals and deciding on actions needed that day. Once individuals have recovered they are then "discharged" from the ward to normal or if necessary enhanced care.

Face to face meetings help to build good working relationships and trust within our teams and patients benefit from a proactive whole team response. We have been very effective at supporting patients to recover at home and avoid admission to hospital. We have greatly benefited from the introduction of the Aberdeenshire Responders for Care at Home (ARCH) service who have been able to step up or introduce care to patients as soon as it is required.

Adult Protection

Aberdeenshire Health and Social Care Partnership has undertaken a considerable amount of work around raising awareness of the importance of adult protection among staff within the Partnership and the wider community.

Adult Protection is everyone's responsibility and the Health and Social Care Partnership is working hard to support and encourage staff to work together to identify when people may be at risk. A multi-disciplinary approach, involving relevant professionals as well as their family and/or carers can ensure the best outcome for the person.

Carers



A carer is someone of any age who provides support to a member of their family or a friend who is affected by long-term illness, disability, age or addiction. Based on the 'Scotland's Carers' report published by the Scottish Government in March 2015, it was estimated that there were 759,000 adult carers in Scotland. This equates to 17% of the adult population. In Aberdeenshire, this would give us an estimated 36,228 adult carers and for Kincardine & Mearns an estimated 9,366 adult carers. The total number of carers is likely to be higher as many people do not identify themselves as carers.

Following a health & social care carer survey in early 2016, carers in Kincardine & Mearns reported the following:

- 83% of Kincardine & Mearns respondents say that they are satisfied with the health, social care and social work services they receive.
- 93% of Kincardine & Mearns respondents say that caring has a negative impact on their health and wellbeing which is higher than Aberdeenshire as a whole, which is 70%.
- 87% of Kincardine & Mearns respondents say that they are offered support for their caring role, this is significantly higher than the Aberdeenshire average, which is 69%.

A separate adult carer strategy for Aberdeenshire is currently being developed which details the full local plan to support carers in Aberdeenshire from April 2018 to April 2020.

Alcohol & substance Use

The latest rate of alcohol-related hospital stays puts Kincardine & Mearns as the lowest of all the localities and below the rates recorded for Aberdeenshire and Grampian generally. There has been a general decrease in the rate of alcohol-related hospital stays since 2010/11 and the rate for 2014/15 is the lowest reported for the past thirteen financial years. Data from community pharmacies suggests that Kincardine & Mearns has the lowest prevalence of potential harmful drug use across all of Aberdeenshire.

Learning Disability



In 2017, there were 23,186 adults with a learning disability known to local authorities across Scotland. Care Inspectorate reports say most services in Aberdeenshire are "good" or "very good" and there is high satisfaction of both health and social care services. More people are supported to live in the community, to be active citizens and to achieve their goals and aspirations.

Promoting a More Inclusive Society

(PAMIS) Grampian is a third sector provider of support to those with profound and multiple learning disabilities, who are some of the most vulnerable and excluded in our communities.

PAMIS Grampian have identified what they believe to be the priorities for our localities in Aberdeenshire which are detailed below and have been embedded within our locality planning process:

- Family carers feel supported and involved in services being delivered to their family member.
- Transitions, especially to adult services are person-centred, safe and effective.
- Disabled people can access meaningful and accessible activities which helps meet their potential.
- Partnership staff are supported to meet the outcomes of vulnerable groups.

Mental Health

What do we mean when we talk about mental health? It does not only relate to mental health problems or illness. Everyone has mental health and maintaining this is just as important as having good physical health. Mental health relates to:

- Our ability to have positive relationships with others
- How we feel emotionally about ourselves and the people around us
- Our ability to develop psychologically and make the most of our potential
- Our resilience – the ability to overcome the difficulties in life that we all face at time

It is normal to feel worried or upset at times when we encounter difficulties in life. If these feelings are persistent, to the extent that they are seriously interfering with how you manage everyday activities such as work, domestic tasks and relationships it is important to seek advice.

In Kincardine & Mearns your mental health. A primary care mental health worker, is attached to our GP practices and can provide short-term early interventions for mild to moderate mental health problems. There is also a wide variety of services and groups available in the third sector.

Our community mental health team is a multi-disciplinary team consisting of psychiatry, nursing, occupational therapy, psychology and social work. The team support people in the community who have significant or complex mental disorders. Severe mental health problems can involve a combination of changes in thinking, emotions or behaviours that can lead to significant distress and difficulties in managing everyday life. The majority of mental disorders are treatable and even individuals with a severe condition can learn to manage their symptoms well and live a fulfilling life.

Kincardine & Mearns has several groups that are run in partnership with the mental health team, third sector and peer led support and there is a particular focus on developing groups that support physical fitness as exercise can be beneficial in improving your mental health.

Prescribing in Primary Care



In addition to GP practices, primary care covers dental practices, community Pharmacies and high street optometrists. Prescribing is the most common action the NHS undertakes for people across all sectors of health care – primary, hospital, public and community. It is the second highest area of spending in the NHS, after staffing costs.

About two-thirds of all prescribing costs in NHS Grampian are associated with primary care. It is important that we continue to work with and support prescribers to analyse and review prescribing in line with cost effective guidelines and best practice. This includes supporting people in our communities to make informed decisions about their medication and promote self-care where appropriate.

The overall cost and volume of prescribing has continued to increase. Moving forward we plan to increase public awareness, explore how we can improve prescribing processes and expand the range of non-medical support so we can meet the needs of local people.

We also want to make sure that prescriptions, particularly repeat prescriptions are managed effectively by the public to help avoid unnecessary costs and inappropriate storage of medication and waste.

Community Justice



The Aberdeenshire Community Justice Outcomes Improvement Plan sets out the Community Justice priorities for 2017/18 and the actions that statutory and other partners will take collectively to prevent and reduce reoffending and to improve outcomes for community justice. The National Outcomes for Community Justice that must be adopted locally are:

Structural Outcomes:

- Communities improve their understanding and participation in Community Justice.
- Partners plan and deliver services in a more strategic and collaborative way.
- Effective interventions are delivered to prevent and reduce the risk of further offending.
- People have better access to the Services they require, including welfare, health and wellbeing, housing and employability.

Person-Centric Outcomes

- Life chances are improved through needs, including health, financial, inclusion, housing and safety being addressed.
- People develop positive relationships and more opportunities to participate and contribute through education, employment and leisure activities.
- Individual's resilience and capacity for change and self-management are enhanced.

As part of the development of the Community Justice Outcomes Improvement Plan, we consulted with service users to find out about their experience of the justice system, what they thought worked well, what didn't and what should be a priority for improvement. These views have been incorporated into the plan. We are currently looking at ways in which we can evidence how delivery of the actions within the plan has led to improvements in the three person-centric national outcomes for Community Justice.

9.0 CASE STUDIES

Men's Shed

The Shed is a Scottish Charity established to promote general wellbeing, continuing education and healthy lifestyles for retired and unemployed men and those who seek to enhance their lives constructively and enjoyably. We have converted a public toilet block into a 'shed' where men can share skills, actively pursue hobbies, work on community projects or simply just relax.

Our vision for the benefit to the community from the 'Shed' will be as a focal point for community projects that improve the local environment. The benefit to other community members will be as a resource where they can get advice and/or assistance to benefit from skills and experience of the members of the shed with an onus on support with home improvements and DIY for those most in need within our community.

The benefits for the participants in the Men's Shed are:-

- Improve self-esteem, learn new skills and practice old ones thus improving purpose and building self-worth and confidence.
- Having a welcoming place to go to spend time outside the home, members will overcome isolation.
- By improving members' awareness of health and social issues important to ageing men through display of relevant information and invited expert talks.

We have the support of the local Social Work department and Medical Centre, and have very good links with other community projects in the area.

We have refurbished the 'Shed' and are in the process of renovating a portacabin as our social area with disabled access, doorway and toilet facilities. We currently meet every 2 weeks for a coffee and blether, hold regular "progress update" meetings once a month and host a monthly "soup and sweet".

For more information please visit our website - www.portlethenmensshed.co.uk

People in Kincardine & Mearns speak up about their experience of mental illness in a bid to end stigma.

The Journey – Navigating a route to wellness is a short video produced by local people supported by Pillar Kincardine, a mental health charity based in Stonehaven. The idea for the video came about as Pillar members considered ways to support local wellbeing forums that had identified the stigma around mental health as a barrier to people coming forward for help. Those who benefit from the advice & information, groups & activities run by Pillar share their personal journeys in a bid to achieve real change in attitudes to mental illness.

The aim is to encourage others experiencing mental health difficulties to seek help by making it acceptable to speak about mental health openly.

Pillar believes that educating everyone in our communities about mental health is the key to ending the stigma that continues to exist. The video is included in Pillar's Mental Fitness Workshops which are learning opportunities that help participants understand the impact mental illness can have on families and how, with the right help and support, people can indeed navigate a route to wellness.

Where to find the video: www.pillarkincardine.co.uk

Alzheimer Scotland South Aberdeenshire

Background

A 72 gentleman, Jim* was referred, by a concerned friend for support in January 2017. He had a diagnosis of Alzheimer's, lived alone and had very little support in way friends and no family in the area. He had lost a lot of self-confidence and was reluctant to go out.

Support

Jim was visited by a member of the South Aberdeenshire Alzheimer Scotland team. The groups and activities we have in the local area were discussed. Jim felt groups were not his thing, he said he preferred to be on his own. We continued to visit and suggested that Jim may like to come and visit day care for one of our musical memory afternoons. Jim agreed to this and said he surprised himself how much he enjoyed it and agreed to come back again. With Jim's permission we contacted Social work department as a result of this he now has a care manager and self-directed support is in place. We also assisted Jim to apply for Attendance Allowance and his application was successful.

Outcomes

After several visits to day care Jim asked if he could put his name on the waiting list. A place became available in February 2017 and settled immediately, quickly making friends and he grew in confidence every week.

One year on Jim says he "has never felt better". He now attends our Stoney Stompers walking group, our musical memories group, our curling class, our weekly yoga group, our exercise class, our football memories group and has never missed a day at day care. He has been on outings to Banchory, Gourdon, Pittodrie and is a regular at the monthly cinema club at Woodend Barn and also a regular at Boogie in the Bar in Portlethen.

Feedback

When asked what he likes about the support he receives he said, "I love the company, the catch up on the news from everyone, always something different each week. It means I get out more and now have something to get out of bed for, I have made a lot of new friends"

When asked if there is anything else we could support him with he said, "I would love to play for Aberdeen Football Team" - we are working on that!

*names have been changed

Kincardine & Deeside Befriending

A project funded by the Aberdeenshire Health and Social Care Partnership has benefited a befriending service in Kincardine & Deeside.

The Aberdeenshire Health and Social Care Partnership awarded £30,000 to Kincardine & Mearns to be utilised through a participatory budgeting method through Your Voice Your Choice. This is a project involving local people in the South Mearns Coastal Strip where residents had to decide for themselves what projects are needed to improve Health, Wellbeing and Community Links in their area and be involved in delivering these.

One of the successful applicants was Kincardine & Deeside Befriending. Their project was befriending in the South Mearns Coastal Strip with an aim to reduce loneliness and isolation for five older people living in the area. K & D Befriending is a local registered charity which aims to reduce social isolation and loneliness in older people by matching them on a one-to-one basis with a volunteer befriender. A regular visit from a befriender can provide companionship, practical and emotional support, and generally improve physical and mental wellbeing; in many cases, a carer also benefits from the welcome respite provided.

Brigitte said: "I just explained to voters what befrienders do for their befriendees and the difference that is making to older people who feel lonely and isolated. The credit for winning the funding has to go to our volunteer befrienders for doing such a fantastic job."

Mary is one of the people benefiting from the befriending service. She was feeling very lonely and suffered from depression and anxiety after the death of her husband. She was his full-time carer for many years. Working closely with Aberdeenshire Council Care Management and the NHS Grampian CNP support worker, the regular befriending visits provide Mary with much needed companionship and outings, and offer her practical and emotional support. Mary has benefited a lot from the service. She said "I always look forward to Liz's visits. She takes me out and helps me with my messages. She and the support worker are the only people I see and talk to. I wouldn't know what to do without them, particularly since I am no longer able to go out by myself."

Scottish Association for Mental Health – service users’ experiences

“I used your My Life Dynamic services for several months this year, I chose the cultivate project and got to work with the wonderful Fiona*. We focused on my garden, I really wanted to grow vegetables, so Fiona helped me with a variety including leeks, potatoes, spring onions and strawberries. We also found rare Orchids in my garden so focused on orchid management and wildflowers. The experience helped me learn so much and gave me something to look forward to each week. I couldn’t have asked for a better person to learn from. I couldn’t leave my house for months and struggled with any social interaction before this program and this has really helped build my confidence and social skills. And now I am studying conservation and have learned so much useful information from Fiona. I really don’t think I would have come this far so fast without her help.”

“A client was being told from others who supported her to go into bereavement counselling and said it would fix a lot of things for her and she point blank didn’t want to do it because felt like it wouldn’t fix anything. After meeting with her a couple of times she is now going to attend bereavement counselling and is actually going to refer herself. She said yesterday that SAMH has already made a difference by listening to her and not assuming that bereavement counselling will fix all her problems.”

“A client that’s a little complex. She has delusional psychosis, has had no psychotherapy that we know of, no medication changes for an extremely long time and cannot leave the house without support. The client has previously not walked further than the end of their street. With techniques employed in conjunction with the Resilience Coach, the client successfully walked beyond the end of the street with the Resilience Coach walking a few paces behind for reassurance. This is the furthest walked in almost three years.”

“Mary* entered the Listening Project very sceptical, she had had poor experiences of counselling before and so thought it wouldn’t help. She was hesitant, stressed and prone to anger outbursts. In sessions offering a consistent therapeutic relationship, Mary began to trust in the sessions. Her attendance and engagement increased. Because of this, issues of the demands and stress placed on Mary was discussed and she began to learn to say no to the demands of others. Mary left with more hope, positivity and groundedness. “

“Mark* found it difficult to manage his stress and anger, and believed it was due to his childhood/past. In sessions, Mark discussed past issues and their impact on the present. This helped to facilitate some degree of resolution of these and learn to repeat past experiences into the present. At the end of sessions Mark was more hopeful but was concerned that his progress would be lost without further engagement and support. It was agreed to engage with a Resilience Coach to continue progress in Marks life.”

*Names have been changed

Living with Hope – A Kincardine & Mearns Wellbeing Network project

Professor Karen McArdle, University of Aberdeen, undertook research on behalf of the Kincardine & Mearns Wellbeing Network. Funded was kindly provided by the Health Improvement Fund and Local Community Planning Group budget.

“The Kincardine and Mearns Well Being Network proposed that research be undertaken in Kincardine and Mearns to explore factors that contributed to (lack of) engagement with activities that sought to promote individual and community wellbeing.”

The following Research Questions were established in a participatory workshop with Network members, where research questions were discussed and summarised by the researcher:

1. Is, and why is Kincardine and Mearns different from other areas of Aberdeenshire in terms of community engagement?
2. What are barriers to engagement?
3. What will encourage people from diverse groups to engage in activities linked to wellbeing?
4. How can services better meet the engagement needs of people in Kincardine and Mearns?

To summarise the main findings of this study, the reasons for a problem with engagement in the area are:

- Culture
- Social Isolation, for those who have lived in the community for many years and newcomers.
- Lack of Community Empowerment.

The traditional rural barriers of lack of awareness of services, transport, and childcare or inappropriate provision were mentioned but were not as significant as the three factors outlined above.

Next Steps –

A sub-group has been set up to plan workshops to facilitate the Wellbeing Network and other local agencies and partners to come together and discuss the research findings and recommendations. Two workshops have been arranged to enable participants to explore, discuss and validate the 3 themes. There will also be an opportunity for participants to identify other themes as per their experiences. We will share local plans, Kincardine and Mearns and Shire-wide as appropriate, to discuss how and if local organisations and groups see their priorities align with those in the plans, and if common themes exist between the plans and those highlighted in the research as affecting engagement with services. We would like the workshops to promote and support a culture of partnership working across Kincardine and Mearns to address the needs summarised in the research, so we have also asked Wellbeing Network members and other local partner groups to identify where they work within Kincardine and Mearns, and which communities they support as part of an audit to increase knowledge, awareness and to promote partnership working.

The Haven

The Haven is a Social Enterprise that offers a wellbeing space in the heart of Stonehaven. The Haven is conceived from the inspirational people in our community who experienced benefit from the wellbeing services we offer.

We receive funding from Firstport to create social impact on the wellbeing of our community by focussing on:

- The Space: a central community space conducive to wellbeing' a fully equipped yoga studio. Mindful Room and Healing Room
- People who hire the Space: Affordable hire, guidance, support and mentorship for people who hire The Haven for their wellbeing services.

People who use the space: we fundraise internally as well as applying for funding grants to meet community wellbeing needs by listening to the community. This includes long-term projects, events, subsidised and free wellbeing opportunities.

10.0 KINCARDINE & MEARNS LOCALITY ACTION PLAN

Priority theme	Evidence of current status	Strategic Aims/ Objectives	Links to existing activity	Team	Actions
1. Provide and support workforce to meet the needs of the people of Kincardine and Mearns	<p>Identified through:</p> <ul style="list-style-type: none"> • Staff health & wellbeing surveys (Healthy Working Lives) • Workforce Planning • iMatter • Links with third sector • Absence and Sickness data • Staff numbers in K&M • K&M over 18 population 	<p>Provide training and support for the workforce.</p>	<p>AVA Training Needs Analysis; North East Learning Collaborative</p>	<p>AVA; NHS Learning and Development</p>	<p>Facilitate links between the work that is already ongoing in this area -</p>
1. Provide and support workforce to meet the needs of the people of Kincardine and Mearns	<p>Identified through:</p> <ul style="list-style-type: none"> • Staff health & wellbeing surveys (Healthy Working Lives) • Workforce Planning • iMatter • Links with third sector • Absence and Sickness data • Staff numbers in K&M • K&M over 18 population 	<p>Promote better working relationships at a local level to share information between Public Health, LA Corporate Team and the Third Sector with regards to Healthy Working Lives</p>	<p>Each team is working towards the goals of the initiative</p>	<p>Public Health, AVA</p>	<p>Facilitate shared access and better recording of shared activity</p>
2. Enhance and promote support at moderate and low level need to support mental health and wellbeing	<p>Identified through:</p> <p>Stonehaven and Portlethen LCPs,</p> <ul style="list-style-type: none"> • Living with Hope research • Loneliness data (Citizens' Viewpoint) • Carers Survey • Service User Survey • Health & Wellbeing Priorities (ISD data) • Commissioned Services • Citizens' Viewpoint (Wellbeing) <p>Non-commissioned services and organisations</p>	<p>Appoint to Tier 2 Community Psychologist for K&M post who will provide support to people with low to moderate depression and anxiety</p>	<p>Work is on-going to recruit to this post</p>	<p>Mental Health lead/ GP's/Secondary Care Team</p>	<p>Re-advertise and appoint to position</p>

Priority theme	Evidence of current status	Strategic Aims/ Objectives	Links to existing activity	Team	Actions
<p>2.Enhance and promote support at moderate and low level need to support mental health and wellbeing</p>	<p>Identified through: Stonehaven and Portlethen LCPs,</p> <ul style="list-style-type: none"> • Living with Hope research • Loneliness data (Citizens' Viewpoint) • Carers Survey • Service User Survey • Health & Wellbeing Priorities (ISD data) • Commissioned Services • Citizens' Viewpoint (Wellbeing) <p>Non-commissioned services and organisations</p>	<p>Raise profile and uptake of low level community services and support to promote mental wellbeing and reduce loneliness and isolation</p>	<p>Work is on-going with a third sector provider to evaluate the pop up (conversation) cafe's to assess if they meet the wellbeing needs of the people attending. Lunch and Learn pilot has taken place within 4 GP practices in K&M. HSC staff and partners invited to attend. Third Sector have supported PPG/GP events including Flu clinics, Educational evenings etc to raise profile of local support and services. CAB offer outreach appointments. CHIP officer promotes Third Sector/ community services within local partnership meetings including - CPG, AMT, GP cluster meeting, Joint Information meetings, team meetings, AHSCP locality meetings. Stonehaven and Portlethen LCPs have identified improving Mental Health and Wellbeing as a priority - ongoing actions to raise awareness, increase community participation with services as appropriate.</p>	<p>Wellbeing and Welfare Solutions Network, GP Cluster Lead</p>	<p>Evaluate and gather qualitative data on their use to influence future strategy.</p>

Priority theme	Evidence of current status	Strategic Aims/ Objectives	Links to existing activity	Team	Actions
2.Enhance and promote support at moderate and low level need to support mental health and wellbeing	<p>Identified through: Stonehaven and Portlethen LCPs,</p> <ul style="list-style-type: none"> • Living with Hope research • Loneliness data (Citizens' Viewpoint) • Carers Survey • Service User Survey • Health & Wellbeing Priorities (ISD data) • Commissioned Services • Citizens' Viewpoint (Wellbeing) <p>Non-commissioned services and organisations</p>	<p>Map third sector service provision in K&M to identify, support and improve services that support health and wellbeing</p>	<p>Living With Hope Research actions to be taken by K&M Wellbeing Network and partners. Links to Grampian Care Data, ALISS, Cornerstone SDS, Quarriers Mapping Project</p>	<p>K&M Wellbeing Network, Public Health and AVA Community Health in Partnership Officer.</p>	<ol style="list-style-type: none"> 1. Hold sessions to validate the research through speaking to third sector and local community groups in K&M. Ensure data mapped is shared with partners as appropriate. 2. Develop estimates/ models of need
3. Equality of Access to Health and Social Care Services	<p>Identified through:</p> <ul style="list-style-type: none"> • ISD data – community hospital • Admissions/discharge • SAG list for supported accommodation • CAB data • GP data • Data from Council Housing Service 	<p>Identify a space which can be used as a hub to gain access to service information. Explore need, support required and organisational capacity for outreach support and activities - potential to build on existing work.</p>	<p>Stonehaven Town Partnership has leader funding to convert the old courthouse in Stonehaven into a wellness hub. CAB and ASP currently offer outreach services in various K&M locations - current activities could identify if need to roll out.</p>	<p>Location Manager Stonehaven Town Partnership, Citizens Advice Bureau</p>	<p>Support development of wellness hub. Encourage use of Hub by range of multi-agency partners including HSCP staff. Identify need and support development (if required) of outreach 'hubs'.</p>

Priority theme	Evidence of current status	Strategic Aims/ Objectives	Links to existing activity	Team	Actions
3. Equality of Access to Health and Social Care Services	Identified through people on waiting list for social housing; people who are waiting for housing to meet their particular needs; number of homeless presentations	To ensure people have access to appropriate housing.	Strategic Housing Investment Plan 2018-2023	Affordable housing forum	To deliver new affordable housing in Stonehaven (106 units), Portlethen (31 units), Newtonhill (28 units) and Marykirk (9 units). Some of these will be suitable for people with particular needs and for older people.
3. Equality of Access to Health and Social Care Services	Existing work programme of Area Manager, Cross Service Group within Aberdeenshire Council and Health and Social Care Partnership, Gypsy Traveller Officer Group .	Improve access to services for gypsy travellers	Scottish Government decision to refuse planning permission for gypsy traveller site North Esk (St Cyrus) which will potentially identify demand for support for this group of people	Area Manager, Cross Service Group within Aberdeenshire Council and Health and Social Care Partnership, Gypsy Traveller Officer Group	CLD, Education, Health Visitors, GP's are all visiting to provide support. Link to work of Laurencekirk LCP as appropriate.

If you require this document in another format, or if you
require further information or would like to make comment
on any aspect of this plan please contact:
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