OLI Health & Wellbeing Network (Oban, Lorn & Inner Isles of Lismore, Kerrera, Easdale, Seil and Luing)
Joint Health Improvement Local Action Plan
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Argyll and Bute has a good track record for prioritising working in a preventative way to identify and solve health problems before they arise. The new Joint Health Improvement Plan (JHIP) covers a 5- year period to 2017-2022 sets out what we want to achieve for a healthier Argyll and Bute. Our outcomes are informed by National Outcomes and locally agreed measures in Argyll and Bute's Community Plan. The JHIP plan can be viewed on our website:

http://healthyargyllandbute.co.uk/wp-content/uploads/2013/03/JHIP-2017-22.pdf

The health improvement approach favoured in Argyll and Bute centres on building better communities with a wide range of services and activities in these communities. This is in the knowledge that people live good lives in vibrant communities. We call this an "assets based approach" to health which is different to a "deficits approach" i.e. looking for a health problem and then trying to find the solution.

This local action plans sets the objectives for 2018-19 . This plan has been developed with support of OLI Health & Wellbeing membership and will focus on the 4 Themes identified in the strategic Joint Health & Wellbeing Plan 2017-22

It should be noted that health inequalities is relevant to all of the priorities and we should all be asking how "inequalities sensitive" our health improvement practice is, for example, are those most in need benefiting from the activity.
Throughout our plan areas to consider are:

- An "assets" based approach to investing in healthy communities
- Social determinants of health eg housing, access to employment, access to services, transport, income, remoteness etc.
- Protected characteristics – age, gender, race etc
- Physical health eg long term health conditions, disability, mental wellbeing, etc.
- Areas of deprivation
- Health literacy individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. e.g Self directed support
- Identified gaps in service provision noted by our local membership

This action plan will support the Local Health & Wellbeing network objectives to promote healthy lifestyles. Each year Argyll and Bute's Public Health Department allocates a budget for a small grant fund. This is administered by the Health and Wellbeing Networks to support local health improvement activity. Grant recipients must demonstrate their project is able to demonstrates that it meets at least one of the locally agreed strategic priorities. Awards are usually in the region of several hundred pounds up to a maximum of £2000.

Theme 1 – Getting the best start in life

JHIP PLAN

Giving children a good start in life enables them to go on to be healthy adults. Ways of giving children a good start in life include: pre and during pregnancy support; breastfeeding and healthy weaning; active lifestyles; and alleviation of poverty.

What assets do we have locally which support this outcome ? OLI Local activity/ Member Sharing:ALISS System/ ABAN;Local network activity/Service delivery range of partners

Local Outcome : Activity which increases the number of vulnerable families able to access, engage and receive provision which gives children a good start in life.

What are the key target groups for our local area?

Vulnerable families (adverse effect to lifestyle)

Gaps identified : whole family activity; young vulnerable adults (carers) - practical help; activity - preventative work; post birth – not on radar/isolation / loneliness; face to face support;

Planned /anticipated activity which will support outcome? Are there additional resources/activities /interventions which would assist ? What methods will we adopt/support to achieve outcome?

Network knowledge of existing services- updates and communication via members/links to other local partnerships - **Themed meeting children services** - Invite to team lead children & families service- update to August meeting (service plan 2017-2020); Carer Act update MML

Children Services staff attendance - Regular attendance social work staff.

Member feedback from attendance at practitioner locality meetings – Children & Families (GIRFEC) **- Feedback from members attendance- 3rd sector C &F and Girfec practitioner meets**

Support activities which increase engagement and address "gaps" in key target groups noted above -

Is our outcome being achieved/progressed? (e.g Numbers/ Case studies/ Monitoring reports/ Network activity)

What activity have we funded 2018 which supports this outcome

Theme 2 Working to ensure fairness

JHIP PLAN Health inequalities continues to be a priority. One of the best ways to improve health is to increase income levels. Other areas of fairness include: race, religion, disability, age, gender, sexual orientation, marital status and pregnancy. Our rural geography will also be noted as a barrier to engagement.

What assets do we have locally which support this outcome ? OLI Local activity/ Member sharing:ALISS System/ ABAN;Local network activity

Local Outcome
More individuals engaging in activity which supports healthy lifestyle choices

What are the key target groups for our area?
All ages; Isolated ;Invisible elderly;Rural – access to services

Planned /anticipated activity which will support outcome? Are there additional resources/activities /interventions which would assist ? What methods will we adopt/support to achieve outcome?

Activities which support " active" lifestyle; self motivation addressing behaviour change
Transport review - receive updates on pilot plans - Sue Pagan_
Listening / Sharing session – Local Health & Social Care Partnership – Locality Manager – Attendance to be requested
Support activities which increase engagement to address "gaps" in key target groups noted above
Theme Meet _ July - Alison Hardman – Fairer Scotland Guidance
Invite HSC Manager –Update Locality - July/ Sept

Is our outcome being achieved/progressed? (e.g Numbers/ Case studies/ Monitoring reports/ Network activity)
What activity have we funded 2018 which supports this outcome?

Theme 3 - Connecting people with support in their community

Health problems can be caused or made worse by social issues like loneliness, relationship breakdown, debt or homelessness. Enabling people to access community and support is called social prescribing.-

What assets do we have locally which support this outcome ? OLI Local activity/ Member sharing:ALISS System/ ABAN;Local network activity

Local Outcome : To support activity which improves wellness and well-being in Oban Lorn & Inner Isles area

What are the key target groups for our area?
Look beyond fitness for wellness; Reducing isolation ; teenagers that do not connect with services; Mental Health service provision (particularly young people); Transport (all ages);

Planned /anticipated activity which will support outcome?
Are there additional resources or activities /interventions which would assist? What methods will we adopt/support to achieve outcome?

Increase awareness - Promote local interventions/ healthy villages - Oban Health Town support to Health Fayre
Awareness and information sharing sessions
Activity which promotes positive mental health
Support activities which increase engagement to address "gaps" in key target groups noted above
**** This theme is likely to have activity which will crossover with other themes identified in local plan**

Is our outcome being achieved/progressed? (Numbers/ Case studies/ Monitoring reports/ planned network activity)
What activity have we funded 2018 which supports this outcome?

Theme 4 Focusing on Wellness not illness

Enabling people to be as healthy as possible and focus on wellness instead of illness. Doing this by building capacity in communities for healthy living and continuing to focus on assets for health i.e. what keeps us healthy

Local Outcome

Increase the focus on "wellness" building capacity of individuals and communities to encourage healthy lifestyle choices

What are the key target groups for our area?

Isolated by place; mobility; vulnerability; Social generic participation**;** Transitions

Areas/individuals – below the radar/ not on system; remoteness, isolation/ loneliness

Planned /anticipated activity which will support outcome?
Are there additional resources/activities /interventions which would assist ?
What methods will we adopt/support to achieve outcome?

Signpost /Network knowledge and links to existing activities/ partnerships -

Services/ activity which supports maintenance of independent lifestyles – community led initiatives; co –production of service -

Support activities which increase engagement to address "gaps" in key target groups noted above

Speaker invite to Pauline Jesperson/ Derek Laidlaw- Frailty project

Is our outcome being achieved/progressed? (Numbers/ Case studies/ Monitoring reports/ planned network activity)
What activity have we funded 2018 which supports this outcome?