Health Inequalities in Stirling

Forth Valley Health Improvement/Health Inequalities Group

1 Introduction

The strategic approach and initiatives to tackle health inequalities in Stirling sit within the context of the strategy for Forth Valley which in turn fits within the National picture. This paper brings together all these perspectives into a life stages approach.

2 Brief Overview of Health Improvement and Health Inequalities

Health has been defined as physical, psychological and social wellbeing. As such it encompasses:

- “Determinants of Health” – relating to, for example, housing, education, employment, income, social support etc
- Risk factors – such as behaviour or clinical risk factors
- Disease/Long Term Conditions – cardiovascular disease, cancer, mental health problems, etc., and their impact on and relationship to, wellbeing.

Health inequalities relate to the difference in health associated with differences in health determinants – deprivation (some of which is attributable) experienced by individuals and communities.

3 National Context

There are many relevant national policy documents and initiatives. These include:

- Equally Well
- The Early Years Framework
- Achieving our Potential
- Keep Well
- Reshaping Care for Older People
- Quality Strategy
- Christie Commission

The emphasis is increasingly on early intervention and better integration of public services, particularly health and social care. This includes early intervention across the life stages to prevent or anticipate ill health or increasing care needs before the situation becomes too serious. The Christie Commission emphasised the importance of shifting resources into prevention and away from fire fighting.
Most recently Equally Well is being reviewed and we await the outcome of this piece of work.

4 Tackling Health Inequalities – The Forth Valley Approach

Forth Valley adopts an overarching approach which has 2 complementary approaches;

- Undertaking initiatives which specifically target disadvantaged areas or groups with many of these linking to national priorities and targets for ‘health improvement and wellbeing’ e.g. alcohol, smoking cessation.
- Ensuring that all services address the issue of inequalities to maximise potential benefits to disadvantaged groups and minimise any negative consequences through the provision and planning of ‘care and services’.
  (Health Board paper 2008).

4.1 Priorities in Forth Valley

In 2011, the evidence for effectiveness was considered and 3 areas were prioritised (paper available on request).

Based on the evidence presented, it was agreed to prioritise the following 3 areas, for improving health and reducing inequalities in Forth Valley:

- Early Years, including parenting, and health improvement in schools. This is based mainly on the high rates of return – small improvements early on can lead to cumulative and on-going improvement across the life course.
- Anticipatory care. Taking a broadly preventative approach, and linking a clinical approach to addressing risk factors to a community development approach can be very powerful. The Forth Valley approach also aims to be holistic and person-centred. Currently measured on activity in 40-65 year olds, there is scope to develop a more formal policy to target younger adults, especially parents.
- Employability. Referring to the national purpose targets, and recognising that health can usefully be defined as “the ability to work and love”, employability in its broadest sense (including volunteering and caring), when focussed on general progression (rather than paid employment as the only goal), is key to improving health and reducing health inequalities.

4.2 Recent Developments

The Forth Valley Health Improvement/Health Inequalities Group is presently reviewing our approach in the light of recent evidence of what works in terms of tackling health inequalities. We are now developing a
framework for how we build on the strong Community Planning Partnerships to progress our work. This might involve a shift of emphasis away from health improvement towards tackling health inequalities.

4.3 Asset Based Approach

We are also developing a strategic approach for how we take forward the asset based approach and co-production. This will consider both the community orientated asset-based approach along with the adoption of asset-based principles.

5 Tackling Health Inequalities in Stirling

The Stirling Council area is home to around 90,000 people, 65% of which are in the City of Stirling and its urban neighbouring settlements and 35% in the rural area.

On many measures of health and its determinants, the area as a whole compares favourably to national averages. Parts of Stirling, Dunblane, Bridge of Allan and much of the rural area are some of the most affluent and successful communities in the country with high incomes, good health and excellent quality of life. In contrast and in relatively close proximity, there are communities of concentrated deprivation where worklessness is very significant and indicators of health and its determinants are worse than the Scottish average.

Figure 1 describes the diversity that exists across the different parts of the Stirling Council area, looking at a range of indicators through different life stages on health, economy, education, crime etc.
Figure 1: Stirling: Community and Life Stage ‘Traffic light’ comparison chart

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Years</td>
<td>Mothers smoking during pregnancy:</td>
</tr>
<tr>
<td></td>
<td>Domestic violence</td>
</tr>
<tr>
<td></td>
<td>Teenage pregnancies</td>
</tr>
<tr>
<td></td>
<td>Low weight live births</td>
</tr>
<tr>
<td></td>
<td>Babies exclusively breastfed at 6-8 weeks</td>
</tr>
<tr>
<td></td>
<td>Immunisation uptake at 24 months excl MMR</td>
</tr>
<tr>
<td></td>
<td>Child dental health in primary</td>
</tr>
<tr>
<td>School Age</td>
<td>Average tariff score of all pupils on the S4 roll</td>
</tr>
<tr>
<td></td>
<td>Primary school attendance</td>
</tr>
<tr>
<td></td>
<td>Secondary school attendance</td>
</tr>
<tr>
<td>Youth Transition</td>
<td>Positive Destinations % 2009/10 Follow-up</td>
</tr>
<tr>
<td>Behaviours</td>
<td>Smoking prevalence %</td>
</tr>
<tr>
<td></td>
<td>Hospitalised with alcohol conditions</td>
</tr>
<tr>
<td></td>
<td>Hospitalised with drug related conditions</td>
</tr>
<tr>
<td>Ill Health and Injury</td>
<td>Patients registered with cancer</td>
</tr>
<tr>
<td></td>
<td>Patients hospitalised with COPD</td>
</tr>
<tr>
<td></td>
<td>Hospitalised with Coronary Heart disease</td>
</tr>
<tr>
<td></td>
<td>Hospitalised with cerebrovascular disease</td>
</tr>
<tr>
<td></td>
<td>Patients hospitalised as an emergency</td>
</tr>
<tr>
<td></td>
<td>Patients (65+) with multiple hospitalisations</td>
</tr>
<tr>
<td></td>
<td>Road traffic accident casualties</td>
</tr>
<tr>
<td></td>
<td>Prevalence of diabetes</td>
</tr>
<tr>
<td>Working Age</td>
<td>Prescribed drugs for anxiety/depression/psychosis</td>
</tr>
<tr>
<td></td>
<td>Patients with a psychiatric hospitalation</td>
</tr>
<tr>
<td></td>
<td>Claims: incapacity benefit/severe disability allowance</td>
</tr>
<tr>
<td>Social Care and Housing</td>
<td>Single adult dwellings</td>
</tr>
<tr>
<td></td>
<td>Population income deprived</td>
</tr>
<tr>
<td></td>
<td>Working age popn employment deprived</td>
</tr>
<tr>
<td></td>
<td>Working age popn claiming Jobseeker's Allowance</td>
</tr>
<tr>
<td></td>
<td>Dependence:out of work benefits / child tax credit</td>
</tr>
<tr>
<td>Crime</td>
<td>Crime rate</td>
</tr>
<tr>
<td></td>
<td>Prisoner Population</td>
</tr>
<tr>
<td>Retired Stirling</td>
<td>Life expectancy - males</td>
</tr>
<tr>
<td></td>
<td>Life expectancy - females</td>
</tr>
<tr>
<td></td>
<td>Deaths all ages</td>
</tr>
<tr>
<td></td>
<td>Early deaths from coronary heart disease (under 75)</td>
</tr>
<tr>
<td></td>
<td>Early deaths from cancer (under 75)</td>
</tr>
<tr>
<td></td>
<td>People claiming pension credits (60+)</td>
</tr>
</tbody>
</table>

Source: Adapted from Scottish Public Health Observatory Health & Wellbeing Profiles 2010
Stirling’s new Single Outcome Agreement (SOA) provides the strategic framework for the collective reform of public services in Stirling. It prioritises the main changes that need to be made in Stirling’s communities over the next ten years, and commits community planning partners to harnessing collective effort, in partnership with our communities, to delivering the step change required.

The Agreement is based on an understanding of the needs and aspirations of Stirling’s communities. It will be implemented through a series of annual prevention action plans that will be developed with our communities and will show how all partners, including communities themselves, can contribute to progress.

Stirling Community Planning Partnership (CPP) is committed to essential change to improve wellbeing, and to enabling the capacity of communities, families and individuals to deliver change in their own communities, working alongside effective and efficient public services when required.

The outcomes in the SOA have been developed through a comprehensive process of evidence gathering, analysis and partner and community engagement.

The outcomes reflect the diversity of Stirling; its inequalities, is mix of urban and rural communities; its rich heritage, environment and high level of community involvement and ambition. They also reflect the challenging context in which this SOA will be implemented-encompassing public service reform, financial hardship, welfare reform and economic uncertainty and changing demographics.

The seven related outcomes, which will help to reduce health inequalities, are:
• improved outcomes in children’s early years
• improved support for disadvantaged and vulnerable families and individuals
• communities are well served, better connected and safe
• improved supply of social and affordable housing
• reduced risk factors that lead to health and other inequalities
• improved opportunities for learning, training and work
• a diverse economy that delivers good quality local jobs

The focus of the SOA is on prevention and intervention. The six areas prioritised for preventative activity to deliver the outcomes are:
• early years, including early learning
• support for vulnerable individuals and families including early intervention to prevent neglect and harm
• appropriate community support, care and housing for older people
• alcohol misuse, particularly in relation to antisocial behaviour and offending
• business growth, enterprise, investment and connectivity
• employability, tackling barriers to employment and increasing skills

Areas that will embed the prevention and intervention activity are:
• accessibility of facilities and services
• maintaining the quality of the environment and adapting to climate change
• tackling inequalities in health, income and housing

6.1 The Healthy Stirling Partnership

As part of the Stirling Community Planning Partnership, the multi-agency Healthy Stirling Partnership (HSP), chaired by the Stirling CHP General Manager, facilitates a strategic, co-ordinated and targeted approach for tackling health inequalities and improving health in Stirling.

To facilitate an integrated partnership approach the HSP membership links in to a number of key strategic planning partnership groups e.g. the Community Safety Partnership, the Stirling Alcohol and Drug Partnership, the Environment Partnership, Local Employability Partnership, the Tackling Poverty Group, the Early Years Group and the Reshaping Care for Older People Group.

The Single Outcome Agreement is the main vehicle through which the impact of action plans developed by the HSP will be measured. The work of the HSP will contribute to all SOA outcomes, prioritising outcome 5, namely Reduced risk factors that lead to health and other inequalities. The changes we expect to see through progress of this outcome include: - healthier lifestyles including improved diet and levels of physical activity; higher levels of wellbeing; increased financial inclusion and capability; improved ability to access employment; a reduction in the effects of substance misuse; communities making the best use of public and open space.

6.2 Stirling Alcohol and Drugs Partnership

The Stirling Alcohol and Drug Partnership (SADP) is the lead partnership addressing substance misuse for the Stirling Council area as well as being a contributing member of the area wide Forth Valley Alcohol & Drug Partnership. The interface between the Forth Valley partnership and local ADPs is vital to the delivery of the area wide strategy. There is also a Forth Valley Needs Assessment to support strategy planning.

As well as the Forth Valley strategy, the SADP addresses the priorities within national strategic documents such as The Road to Recovery and Changing Scotland’s Relationship with Alcohol. Each of these strategies
recognises the impact that drugs and / or alcohol can have on health inequalities and the importance of working in partnership to address these issues.

Developments such as reduction in waiting times and alcohol brief intervention should help to address problematic drug and alcohol use quicker which should in turn help to address health inequalities. As per national strategy and direction, the SADP supports a whole population approach in relation to tackling alcohol misuse.

Stirling ADP continues to be integral to Stirling’s Community Planning Partnership. The ADP has actively contributed to the new SOA and effectively tackling substance misuse is going to be instrumental in achieving many of the identified outcomes.

7 Early intervention and prevention across the lifecourse

Action on health inequalities in Stirling is informed by evidence of need and effectiveness and through targeted early intervention and prevention activity at both a geographical/ community level and at key life stages and transition points.

The 2012 iteration of the Scottish Index of Multiple Deprivation showed that more of Stirling’s population has fallen into relative poverty, and that deprivation continues to be concentrated in certain geographical communities. Whilst this may seem to favour a geographical approach to implementation, there is evidence that people living in more deprived communities tend to have poorer experiences throughout their life stages. Moreover, understanding and intervening in an earlier life stage and at key transition points has the potential to improve outcomes and prevent further harm.

The SOA recognises that key services tend increasingly to be responding on a life stage basis. It therefore suggests that an approach to implementing activity towards our key outcomes that is planned and resourced around life stages would in fact target activity towards our most vulnerable geographical communities, whilst at the same time not allowing needs in all our communities to go unrecognised.

Figure 2 provides highlights of evidence for key life stages in Stirling

Figure 3 outlines how the groups visited by Committee and the case studies offered as evidence examples impact on particular life stages.
Concentrations of very young (16/17) mothers in areas of deprivation
A higher proportion of under-threes live in our most deprived areas than of the population in general.
A growth of around 5% in under threes is expected to 2020.
16% of under 4s live in households dependent on benefits. In Bannockburn HS catchment this is 24%, in Dunblane it is 3%.
18% of P1 children are overweight (down from 24% in 05/06). 5% are severely obese

Almost 90% of school leavers achieve positive destinations, ranging from 78% to 95% across high schools. Girls do better.
Those from deprived areas achieve 60-70%, except those from St. Modan’s (92%).
Jump in 18-24 claiming job-seekers allowance since 2008. Biggest increases in areas with the highest numbers previously. Overall still 3 percentage points below Scotland figures.
Costs of activities and transport/access remain key concerns for this age group, especially in rural areas.
3600 new students (under- and postgrad) arrive at University in Sept 2012. Net in-migration of around 500 16-19 yr olds.

Employment levels in the area generally high. Although pockets of unemployment where it can exceed 30%
Local jobs reliant on public sector or lower paid sectors.
Housing costs are high relative to Scotland, especially for ‘entry-level’ housing to buy.
Quality of life high with vast majority pleased with area as a place to live. Housing, public transport and environmental improvements are key.
9% of households in extreme fuel poverty
Civic participation / volunteering is generally high, although lower in more disadvantaged communities

Around 2000 more 65-74 year olds predicted in the next 15 years as life expectancy grows.
Higher proportion of retirees in rural areas with accessibility and service provision issues.
Lower proportion overall claiming pension credits but again significant variations across the area.
Care at home for those with intensive care needs (21%) is lower than Scottish average (32%)

10% of children are defined as living in poverty. Indiv. zones range from 0 to 55% for this indicator. 14% of children in out of work families, again with similar range.
24% of children in lone parent families ranging from 7% (Dunblane) to 59% (Raploch).
In 2010, 85% of primary children attained appropriate levels in reading, 77% in writing and 86% in maths.
Overall attainment is well above comparator and national averages. Challenges remain for the lowest performing 20%.
Compared with Scotland, Stirling has a significantly higher rate of child protection referrals.
15 year old smoking prevalence is higher than Scotland
10% growth expected in under 16s by 2035

Almost 90% of school leavers achieve positive destinations, ranging from 78% to 95% across high schools. Girls do better.
Those from deprived areas achieve 60-70%, except those from St. Modan’s (92%).
Jump in 18-24 claiming job-seekers allowance since 2008. Biggest increases in areas with the highest numbers previously. Overall still 3 percentage points below Scotland figures.
Costs of activities and transport/access remain key concerns for this age group, especially in rural areas.
3600 new students (under- and postgrad) arrive at University in Sept 2012. Net in-migration of around 500 16-19 yr olds.

Employment levels in the area generally high. Although pockets of unemployment where it can exceed 30%
Local jobs reliant on public sector or lower paid sectors.
Housing costs are high relative to Scotland, especially for ‘entry-level’ housing to buy.
Quality of life high with vast majority pleased with area as a place to live. Housing, public transport and environmental improvements are key.
9% of households in extreme fuel poverty
Civic participation / volunteering is generally high, although lower in more disadvantaged communities

Well over 200% increases in numbers of 85+ by 2035
Increasing numbers of single person households
Average life expectancy a couple of years above Scotland, but as low as 67 for males in some areas. Rural and affluent area expectancy much higher.
Figure 3  ADDRESSING INEQUALITIES OVER THE LIFE STAGES: OUR VISITS AND CASE STUDIES

Outcomes for Stirling: Single Outcome Agreement

Pre-Birth & Early Years
- COP 4 FAMILIES
- PLUS
- HOME START
- TIME 4 US

School Age
- MAX IN THE MIDDLE
- TIME 4 US
- COP 4 FAMILIES
- HOME START

Youth Transition
- COP 4 FAMILIES
- LEP/OPPORTUNITIES FOR ALL
- LEGAL HIGHS APP
- PLUS
- CARER’S CENTRE

Working Age
- KEEP WELL
- LEP
- ‘SKINT’
- CITY CENTRE NORTH
- CARER’S CENTRE

Retired Stirling
- RSVP
- TOWN BREAK
- CITY CENTRE NORTH
- CARER’S CENTRE
- U3A
- ‘SKINT’

85+
- TOWN BREAK
- RSVP
- U3A

WHOLE COMMUNITY ASSET BASED APPROACH
CULTENHOVE/FALLIN
CASE STUDIES

1 Stirling ADP – Stirling City Centre North

This initiative represents the Community Planning Partnership’s first attempt at ‘total place’ activity, in a particularly complex and challenging area of Stirling city centre. Senior members of Stirling’s Community Planning Partnership identified that a relatively small area of Stirling city centre had a range of well-documented issues, which included:

- Complaints from business over drug use inhibiting trade
- Inappropriate waste presentation, illegal dumping and graffiti
- Antisocial behaviour
- Acquisitive crime, particularly from student residences
- Highest rate of robbery in Forth Valley area.
- Transient nature of residences, including relatively high numbers of short term private sector rents and tenancies
- Drug dealing
- Drug and alcohol misuse
- Highest rate of opiate non fatal overdoses in Forth Valley
- Poor property and estate maintenance
- Low income households
- Worklessness

Despite the high level of resource expended on a number of interventions, from both statutory community planning partners and local community organisations, the area remained problematic and outcomes for residents poor.

The CPP therefore piloted an alternative, structured interventionist approach, firmly founded in community planning, to more effectively resolve both the presenting issues and their root causes. The City Centre North Action Plan was developed and this captured a range of activity intended to begin a process of regeneration within that community.

City Centre North action planning was essentially a total place approach. It sought to engage community planning partners to work together to agree a series of connected activity designed to tackle both immediate infrastructure issues, and more intractable socio economic concerns. The work sought to encourage partners to work out with departmental and agency boundaries; to intervene earlier in the delivery of services to prevent escalation, and to raise the capacity of staff to work in a more collaborative, ‘outside the box’ manner.

The process is currently being evaluated and a Phase II considered.
2 Stirling ADP – Time 4 Us

Time 4 Us is a service commissioned by the Stirling ADP and is delivered by the third sector. The aim of the service is to provide support to families affected by substance misuse and the interventions particularly focus on children affected by parental substance misuse. Time 4 Us offer a unique model of service delivery within Stirling and is not commonly available throughout Scotland.

The service is staffed by a Senior Addictions Worker, Lead Family Worker and Lead Children’s Worker who support individual family members in their own right as well as the family unit. Each family member will have a care plan tailored to his / her own individual needs rather than the adults been seen by one service and the children by another.

Time 4 Us has been developed in line with the Integrated Assessment Framework and with the Getting it Right for Every Child (GIRFEC) principles guiding its work. The service is compatible with a number of local and national strategies such as:

- Scottish Government (2012 revision) Getting Our Priorities Right
- Mental Health Strategy for Scotland 2012 - 2015
- Forth Valley Alcohol & Drug Partnerships Strategy Documents (currently being revised)
- Stirling Alcohol & Drug Partnership Delivery Plan 2012 – 2015

The Time 4 Us service fits with a number of the Stirling ADP priorities namely:

1. Earlier & Intervention
2. Family Support
3. Children Affected by Parental Substance Misuse

Time 4 Us also fits with a number of strategic priorities identified by Stirling Council and also the main theme of Early Years identified for Community Planning Partnerships and Single Outcome Agreements.

The work provided by Time 4 Us can be very intense with some families having daily contact for a period of time. This intensity most certainly contributes to the success of the project.
3 Stirling ADP – Legal Highs App

The Stirling ADP worked with Stirling Council Youth Services and Police Scotland to develop an app for smart phone devices which provided up to date and accurate information about legal highs and the associated dangers.

The aim is to take a harm-reduction approach and ensure that young people can quickly and easily access the correct information about substances so that they are then able to make informed choices about whether they intend to use drugs or not. Local services were finding that increasingly young people are using their mobile phones to access information but that there wasn't a mobile site that provided relevant health promotion information about legal highs. As a result, partners have taken a local approach to filling the gap and develop a source of information that is primarily targeted at young people but which may also be of use to parents and practitioners.

The app is designed into 4 sections:

1. Substances – up to date information about a range of legal highs.
2. Emergency overdose – basic information on what to do in the event of an overdose and a link straight to calling the emergency services.
3. Lower the Risk – harm reduction advice in terms of reducing risk to self.
4. Need to talk? – links and information on services that can provide support if an individual is worried about drug / alcohol use.

The app can be found at:

http://m.hi5stirling.com/ (best viewed on a smart phone or Google Chrome browser on desktop)

4 Stirling Carers Centre

Stirling Carer’s Centre provides practical and emotional support to carers in the Stirling Council area

Stirling Carers Centre Offer the following Support for Carers:

- **TAG GROUP**: Trossachs Area Support for Carers (TASC) is a rural support group for Carers.
- **My Time**: These sessions aim to provide an informative, relaxed evening for carers; an opportunity to learn, socialise, and simply take some time out from caring responsibilities.
• **1-1 Carer's Support Service**: Free, confidential and impartial advice to all unpaid carers. This includes a benefits advice service

• **Information Services**: A one stop shop of information, from how to access a disabled parking permit to how to find out about aids for the home and other community services.

• **Young Carers Group**: fortnightly and annual residential social opportunities for young people with unpaid care roles in the home.

Stirling Carers Centre also offer support and training to health, social work and care professionals and work to raise awareness of and represent the interests and needs of carers in service planning and community planning forums.

After using Stirling Carers Centre Services, Carers report feeling: 90% happier, 60% more informed, 30% less stressed, 60% more able to cope, 80% more supported.

5  **PLUS**

PLUS was founded in 1988 by parents who had children with disabilities. Parents continue to be the driving force behind the organisation, with involvement at all levels - from the board of directors, as trainers, staff and volunteers.

PLUS works across the Stirling Council area to give children and young people with disabilities the support they need to get out and have fun with people their own age. This also gives parents and carers some time for themselves.

PLUS supports over 250 children and young adults to take part in age appropriate social activities of their choosing, giving them the opportunity to personalise their service by influencing the development of the activity programme, then selecting events that meet their needs.

Plus’ services allow young people to be themselves, to feel safe, to know they are supported, and will have their needs met. For a short period of time, they are not labelled by their disability; they are an individual who is able to access activities of their choosing, with the support of staff to ensure that their disability is no barrier to fun.

Age: 3 - 5 years old: a weekly play session for children, and supports parents through the provision of information, advice and a natural break.
Age: 5 - 11 years old: support to attend holiday, weekend and occasional evening play activities.

Age: 12 - 17 years old: holiday, weekend and evening community based activities. Young people choose from a wide range of activities.

Age: 18 - 25 years old: supports young adults in maintaining existing friendships and making new ones. Young people are supported to meet friends and pursue activities of their choice.

Supports young people to access mainstream groups across Stirling, such as youth clubs, Guides, Anchor Boys etc. The project aims to increase the capacity of organisations to work inclusively by providing information, advice, training and practical help.

An opportunity for families of PLUS members to exchange information and support each other through meetings, Facebook and an electronic forum.

'I think it’s something I didn’t realise before having Z, just how isolating it can be having a child who’s got difficulties. So to be able to come somewhere where you can be yourself,....not being on high alert, not having to defend your position, or justify things, or explain why your child isn’t like everybody else’s. You just talk about ordinary things, or your frustrations or whatever. It is really valuable.” - A Plus parent

6 Home Start

Home-Start Stirling offers friendly, informal support to families experiencing difficult times or stress by matching families with a suitable volunteer who will visit them in their own home. Volunteers are carefully matched to a family and then visit for approximately three hours per week.

Volunteers help by listening and offering companionship, as well as practical help. They may help with things like: keeping appointments, playing with the children or simply providing another pair of hands.

There is no time limit to support. Volunteers receive full training and staff will visit families regularly to review the service until everybody agrees that the family is able to cope on its own.

Home-Start Stirling works alongside other agencies from both the statutory and voluntary sector and families can refer themselves. Referral reasons vary and sometimes there is more than one reason for referral. However, they often include one or more of the following:

- Multiple Births
- Disability/ ill health
- Loneliness/ isolation
- Depression / post natal depression
- Help with parenting skills
- Relationship problems
- Domestic Abuse
- Families affected by alcohol /substance abuse

Support for families in the Stirling in the following circumstances:
- The family have given their consent
- The family has at least one child under the age of five
- The family is suffering stress or experiencing difficulties (whatever the reason)
- The family feels valued and in control of the decision to accept the support offered.
- The family must live in one of the following areas: Stirling, Raploch, Cornton, Bridge of Allan, Dunblane, St Ninians, Bannockburn, Fallin, Cowie or Plean.

7 Retired and Senior Volunteer Programme
RSVP, the Retired and Senior Volunteer Programme is a project within the volunteering and learning charity CSV and encourages the growing number of those aged over 50 to volunteer in their local area. RSVP Forth Valley manages a range of volunteering programmes across Stirling, Clackmannanshire and Falkirk and since its launch over 10 years ago has helped hundreds of older people enjoy the many benefits of volunteering.

Volunteer Organisers give up their time to recruit and support other volunteers to help in schools, hospitals, volunteer led walks, knitting groups and a handy person service. The volunteering is facilitated by a paid member of staff, and supported by a volunteer Advisory Board. In 2011 RSVP Forth Valley were awarded the Queen’s Golden Jubilee Award for voluntary services by groups in the community, recognising the achievements of local older volunteers.

It is recognised that volunteering keeps older people happier and healthier for longer.

The Handy Person project supports personal safety in the home where volunteers carry out a range of essential odd jobs in the homes of older and vulnerable people. Many of the jobs tackled are of a nature that may have risked the safety of the individual. RSVP Handy Person volunteers tackle a range of odd jobs that the individual can no longer do safely. This is all done free of charge.

Similarly older volunteers receive training and lead around 120 outdoor walks per year, departing from over 25 different meeting points across Stirling and Clackmannanshire. RSVP helps over 100 regular walkers get regular
exercise, and enjoy the social and physical benefits from their participation. The main benefits of physical exercise and overall general mental health and wellbeing are matched by the benefits of social interaction walkers’ experience.

8 University of the Third Age (U3A)

The University of the Third Age (U3A) encourages older people to keep active minds by discovering the pleasure of learning in friendly surroundings.

Forth Valley U3A was set up in 2004 and has around 240 members, mainly from Stirlingshire or Clackmannanshire. The objectives of Forth Valley U3A are:

- To advance the education of the public and in particular the education of older people no longer in full employment in the Forth Valley and its surrounding locality

- Provision of facilities for leisure time and recreational activities with the object of improving the conditions of life of the above persons in the interests of their social welfare

U3A describes it as coming after the ‘first age’ of youthful growth and education and the ‘second age’ of maturity, career and/or home making and child care responsibility.

Members are often retired but there is no age limit. The only specification is that members should no longer be in full-time employment.

Interest groups run from September until April/May each year, led by a group leader and often held in members’ homes. General meetings are held during the year, usually with a speaker. There is also a Coffee Club held most Saturday mornings.

Cultural Activities in Care Homes (CACH) is an innovative project within Forth Valley U3A which aims:

- to provide stimulating activities and a broad range of cultural and leisure opportunities to residents of local care homes and other long term care settings for older people;

- to enhance the quality of care home residents’ lives and encourage their inclusion in meaningful activities;

- and to promote learning between younger and older generations.
The Financial Capability Advice Project service aims to improve the financial and independent living skills, and the financial wellbeing, of people on low incomes living in disadvantaged areas of Stirling. The project started in Plean and has now also expanded to Cowie and other disadvantaged areas in the Stirling Council area.

The project targets people who have poor financial skills, low incomes and personal debt and who are often exploited by commercial lenders with high interest rates or targeted by loan sharks. Many of the clients also suffer from fuel poverty and lack of access to key financial products including basic bank accounts.

Support is provided via weekly drop-in surgeries in the local community and one-to-one appointments in the home to ensure that people with illness, disability, childcare commitments and poor access to public transport would be able to access the service.

A three-stage process offered is designed to: maximise income / resolve indebtedness; increase financial literacy / financial capability; and finally increase access to appropriate key financial products and services.

Some of this is offered through workshops with follow up 1-1 support on financial literacy, budgeting, money management, fuel poverty and preparing for welfare reform. Staff and volunteers also ensure clients are aware of independent consumer credit advice to support the informed acquisition of key financial products.

In its first year, the project realised financial gains for its clients of over £384,365; tutored 1021 local people in financial literacy issues; gave sessions on banking products to 721 clients and visited 398 families in their homes.

A key element of the service is that it is run in partnership with communities and it works co-productively with clients to give them the skills to address their own financial inequalities.

In Plean, this led to some clients addressing inequality issues of their wider community as well. The advice project has co-created a Work Club, which has in turn led to the recent development of a community fruit Barra. The Plean Work Club is hosted and facilitated by the Financial Capability Advice Project staff but for the most part is run by local volunteers.

The project’s asset building approach supported 5 work club members to turn a casual conversation into a new service. With help from the Financial Capability Advice Project staff and the NHS, Pop’s Fruit Barra launches with a list full of pre-orders. They will also be promoting the use of the NHS healthy Start vouchers.
10 Local Employability Partnership

Stirling Local Employability Partnership (LEP) is part of the Community Planning Partnership.

The LEP provides an important opportunity to bring together key organisations to develop a common purpose to work together to strategically and operationally align employability provision across the Council area.

The organisations involved in the LEP are:
- NHS Forth Valley
- Stirling Council
- Forth Valley College
- Skills Development Scotland
- Stirlingshire Voluntary Enterprise
- Jobcentre Plus
- Raploch Community Enterprise
- Scottish Government

The importance of the LEP has been recognised in developing and ensuring an effective seamless provision between organisations, clearly identifying gaps and minimising duplication in activity.

The LEP allows for a focus on partner resources, activities and outcomes that will to create opportunity for progression for individuals and between organisations across the Skills Pipeline with the aim of delivering a motivated and skilled workforce and supporting local employers to develop and grow their business.

Key LEP successes to date have included:

- A comprehensive and shared mapping of all employability provision across the skills pipeline
- A successful “Skills for Success” programme designed and implemented by a number of partners and linked to Stages 2 and 3 of the skills pipeline
- An information and network exchange between willing and enthusiastic partners
- The proposal to introduce a co-ordinated approach to core skills profiling enabling all organisations to provide a consistent assessment of an individuals’ core skills level
- A developed referral process to ensure a seamless transition between organisations
• Supported a co-ordinated approach to give local best value from the Employability Fund

11 LEP: Opportunities for all Partnership
Opportunities for all Partnership is a sub group of the LEP, focussing on delivery positive employability outcomes for young people. The Health Development Worker (HDW) role within the Partnership is to provide early intervention health support and information on health priorities for young people post school, aged 16-25, who require additional support before they access employment or further education.

The aim is two fold. Firstly, to empower young people to take responsibility for their own health improvement and wellbeing. Secondly, to work with key partners to develop an effective model of primary anticipatory care (early intervention) for the target group, namely young people 16-25 (post school). The HDW works within the Public Health Nursing team in the Stirling CHP and works with a range of partners within the Opportunities for All setting.

The focus of activity is to build young people’s employability through identifying and addressing their health needs. Young people may be vulnerable for a variety of reasons e.g. homeless, emotional health issues, lack of support, early disengagement from school, who may be less likely to engage with formal health services.

The HDW links closely with partners who provide post school training opportunities to identify young people who may benefit from health input.

The HDW initially provides information sessions to the groups and strives to become a familiar face, establish relationships, which encourage the young people to feel comfortable to engage in a confidential health assessment.

Key workers or young people themselves can refer for individual health input and assessment. The health assessment is delivered in the setting of choice of the young person, usually where their group is being held and takes anything from half an hour to an hour.

A health assessment tool is used to encourage a therapeutic encounter and promote consistency. Young people were involved in piloting the tool and their feedback has shaped the final version.

Examples of outputs from health assessments:
• Brief advice on key health topics e.g. tobacco, alcohol, sexual health.
• Signposting to self help resources e.g. emotional health issues.
• Signposting to other services e.g. smoking cessation services, sexual health services.
• Referrals to other services e.g. Child Adolescent Mental Health Services.
• Ongoing input from the HDW e.g. to support health behaviour change, support to access and work through self help resources.
- Support to access other services e.g. register with GP, dentist, attend sexual health services.
- Partnership working with key worker to focus on confidence building etc.
- Immunisation check and support to receive outstanding immunisations.

12 Keep Well

Keep well Forth Valley is a health improvement programme which enables access to a person-centred health assessment and early intervention for people aged 40–65 who are at greatest risk of developing cardiovascular illness.

- Each year 2.3% of the Forth Valley population aged 40-65 attends for a keep well assessment lasting 1 hour
- The majority of those seen are living in areas of greater deprivation
- Keep Well has been successful in identifying people at high risk of developing cardiovascular disease (1 in 10 people having an ASSIGN score of 20 or above)
- Significant health gains are reported by those who attend e.g. the early detection of health conditions and lifestyle changes such as smoking cessation, weight loss, an increase in physical activity and reduced alcohol intake as well as improved mental wellbeing

Keep well builds an asset based approach with people and partners. Using the knowledge, skills and connections in a community in a joined up way helps to promote partnership and group work. This in turn can help to identify protective factors that support health and wellbeing.

Keep well Forth Valley Teams work in close partnership with GP practices. In most Health Board areas Keep well health assessments are delivered by and within GP practices. The Forth Valley model differs by providing the assessments and follow on services in a range of community settings and community health centres. GPs are involved through provision of the important information that allows their patients to be invited for a Keep well health assessment by letter and/or a telephone call. This personal service gives people the opportunity to discuss the assessment and puts them at ease prior to attending. It has contributed to a high attendance rate and supports any patients with literacy issues.

The Keep well team works closely with a range of health, local authority and third sector partners who help to engage individuals at greater risk to attend for a holistic health assessment. Vulnerable target groups include; homeless service users, substance users, prisoners, criminal justice clients, carers, gypsy travellers, ethnic minorities and people living in designated areas of deprivation. The contribution of volunteers and local champions has improved the engagement with these vulnerable groups. The introduction of 3 month recalls of assessment clients identified with medical and/or lifestyle issues has provided useful feedback on the positive impact of brief interventions in stimulating a range of health enhancing changes.
Keep Well Forth Valley builds on the strengths in each CHP, learned from the experience and rolled out this learning throughout Forth Valley. In Falkirk the emphasis is on gender, in Clacks community development and in Stirling employability.

13 Fallin Healthy Village

Healthy Stirling Partnership is testing an asset based approach to improving health improvement – Healthy Village - in the former mining community of Fallin. The focus is on engaging with the community about what they thought a Healthy Village was and whether it was something they would want for Fallin.

Initially, all of the engagement happened on the street, with officers going out on different days and at different times of the day, talking to people as they went about their daily business.

The target was to speak to 100 people and ask them 6 questions: ‘What makes a person healthy?’; ‘What does the phrase Healthy Village mean to you?’; ‘What would you change about your own health?’; ‘What would you change about your family’s health?’; ‘What would you change about your village’s health?’; and ‘For Fallin to become a healthy village, what would need to be done?’

Anti social behaviour issues kept coming up and it was decided to have a focus group to discuss these in more detail. Wellbeing also came up often and a second focus group was organised around this.

A number of individuals from the community attended a Community Council meeting to raise anti social behaviour issues. Some of those individuals said the Healthy Village work might have encouraged them to raise these issues. The Community Council also believes this and has had a boost because people are attending their meetings. At the same time, a gala committee was formed and they have been discussing events to improve community spirit.

A newsletter reporting back from Fallin 100 was distributed to all houses in Fallin. A Community Event was organised to present all of the information to the community and get them to say what they thought was a priority. Some of the comments from the event – ‘Gets local people to think about their community’; and ‘Given great outlook today on the survey done, plenty of information available’.

All of the information generated from Fallin 100 and Community Event has been presented to 4 key community organisations. Two of these, the Community Council and Fallin Community Enterprises to take the lead on progressing the Healthy Village.

The vision for Fallin Healthy Village has been drafted from the Fallin 100 responses to the question ‘What does the phrase Healthy Village mean to you?’ and has been agreed by these two community organisations.
Throughout the period work with community planning partner agencies has been taking place either on a one to one basis or through update meetings, including with the community. The vision has been shared and from this they have started drafting an action plan.

The next steps are to produce an update on the vision and the action plan to be distributed to every house in Fallin.

Forth Valley Health Improvement/Health Inequalities Group