HEALTH AND SOCIAL CARE SCOTLAND

Embedded and emerging good practice in health and social care

Aligned to the *Framework for Community Health and Social Care Integrated Services*

Health and Social Care Partnership: Argyll and Bute				
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Name of good practice: Physical activity and frailty during COVID				
Select (x) all areas that apply to your good practice (select more than one if applicable)				
CLIENT GROUP	Children and young people		Older adults	x
	Younger adults			
SETTING	City		Remote & rural (incl islands)	x
	Corporate		Urban	
SERVICE AREA	Addictions		Management team	
	Admission avoidance	x	Mental health	
	Community care services incl care at home/care homes		Physical disabilities	
	Day services		Physical health	x
	Housing incl Homelessness		Primary care	
	Intermediate Care incl Hospital at Home		Rehabilitation	x
	Justice services		Social care services	
	Learning disabilities		Supported discharge	
	Other – please specify			
ELEMENTS of FRAMEWORK	Anticipatory care planning		Live independently at home or in a homely setting	x
	Assets based approach		Manage own care	x
	Connect with communities	x	Reablement	
	First point of contact		Seamless working with acute	
	Enhanced care in care homes / supported accom		Short term targeted interv to meet more complex needs	
	Fully integrated community teams		Teams aligned with general practice	
	Other – please specify			
ENABLERS	Agile working		Information sharing	x
	Aligned plans	x	Infrastructure	
	Clarity of vision		Management information	
	Clinical and care governance		Shared accountability	
	Collaborative leadership		Strong team ethos	
	Culture and values		Technology	
	Fit for purpose premises		Well-developed lead professional roles	x
	Improvement capacity		Well-developed relationships	x
	Other – please specify			

Argyll and Bute HSCP

Physical activity and frailty during COVID-19 pandemic

Summary of situation	One survey reports that a third of the population believe they have lost strength during the last 15 months. Particular focus needs to be paid to people who are at risk of experiencing loss of mobility or function due to reduction in physical activity/movement. This includes older adults who can no longer access physical activity support, and those who asked to shield. Argyll and Bute had around 3000 people asked to shield. Physical inactivity due to social distancing measures and action to mitigate COVID-19 is one of the factors listed as being indirectly attributable to morbidity and mortality (Douglas et al, 2020). This will result in future and immediate impact on services through increases in frailty and falls, increased pressure on health and social care services, and poorer health and wellbeing for those affected.

Actions taken	• Multi-partner physical activity group has been set up, reporting to Living Well Steering Group and Community Assets Project Board. The group will work towards developing a strategic approach to support more adults to engage in physical activity for health and wellbeing benefits in Argyll and Bute.
	• Group recognises that most communities have a range of services available to support people of all ages to recover or maintain strength and fitness levels, to allow them to stay active and independent. Group focuses on:
	  ○ Communication with staff and public
	  ○ Education and training
	  ○ Maximising use of resources across sectors
	• Funding provided via Argyll and Bute Council to mitigate against impact of COVID-19 on vulnerable population. This is being used, along with Carers Act funding, to ensure carers and those they care for have access to appropriate physical activity support. Local physio teams and carers centres are leading this work in each locality.
	• Additional work to focus on frailty, e.g. PhD research project looking at linking GP system frailty data with health and social care data. This will help establish what precedes use of social care, and potentially the impact of services/interventions on social care use.
	• Additional work to focus on use of efrailty Index in GP practices, and linking to the most appropriate person-centred referral pathways.

Outcomes / impact	• 'Keep On Moving' pathway developed to support HSCP and third sector/leisure services to identify and signpost people who are at risk or have lost confidence or strength and supporting them through programmes to increase activity. • Online 'Argyll Active' programme funded through HSCP grants, with links made to GP, dietetics and physiotherapy teams. • Links made with HSCP TEC teams to support delivery of online classes in conjunction with community hall groups. This will increase equality of service across Argyll and Bute, specifically most remote and rural areas.

	• Health behaviour change training delivered in conjunction with Public Health, to exercise professionals and HSCP staff. • Local physical activity offering to carers and those they care for, via physio teams and carers centres.
Measures / indicators of success	• Increased partnership working across sectors, resulting in maximising resources across sectors. • Person-centred referral pathways developed • Increase participation/referrals Further potential measures of success, not yet evaluated. • Increased independence of attendees • Reduction in frailty, or no further increases in frailty in those attending

Even better if …
(enablers to further the principles of integration and result in 'even better outcomes if …')

- National drivers to link frailty, falls and health/social care outcomes
- Resources available within boards/HSCPs to evaluate interventions
- Resources available within boards/HSCPs to enable good data collection around impact of interventions and linking to social and health care, and use of services.

NATIONAL HEALTH AND WELLBEING OUTCOMES	
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	x
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	x
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	x
5. Health and social care services contribute to reducing health inequalities.	
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	x
7. People who use health and social care services are safe from harm.	
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	
9. Resources are used effectively and efficiently in the provision of health and social care services.	

Health and Social Care Scotland's 5 Essential Elements (click link to listen to statement of intent)	
1. Transforming the approach to improving health, wellbeing and independence	x
2. Building stronger community care systems and primary care services	
3. Establishing a new focus on mental health	
4. Securing a sustainable acute hospital service and specialist care service	
5. Strengthening future partnerships to ensure a modern sustainable workforce	

Links to any published reviews/evaluations	

Before submitting this example of good practice please ensure approval and sign-off by your head of service / chief officer.	
Approved for online publication *(signature and position)*	Fiona Davies, Interim chief officer
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