A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

Living Well Strategy

Living well IN ARGYLL & BUTE

Supporting Enablement, Prevention, and Self-Management in Argyll & Bute 2019-2024

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NAVIGATING THE DOCUMENT

FOREWORD

People living with long-term conditions live with them 24 hours a day, the input from professionals is a very tiny portion of that time. Coping, surviving and thriving are skills that some people need more support with than others. I see it as a key part of our role as health and social care practitioners that we enable and support self-management.

Hand in hand with self management we need to work towards providing care that is personalised and minimally disruptive. Living with a long-term condition is challenging. As Dr Victor Montori says, in his excellent book championing a patient revolution for careful and kind care "Why We Revolt", "treatments for diabetes, high blood pressure, depression, and other chronic conditions are lifelong, they must be woven into life, interlacing threads with the warps of family, friends, labor, recreation and community. This weaving, like the art of the skilled workers of the Andes, must be planned yet flexible, and must realise the themes that run through the length of the tapestry." Using her "Realistic Medicine" vision, the Chief Medical Officer for Scotland describes how important it is that as health and social care practitioners we "should always consider what matters to the person in front of us and try to better understand how their disease and our treatment fits into the broader context of their lives." An important tenet of personalised plans is self management enabling people to live more independently, confidently and with greater quality in the things that matter to them.

This plan is broad, exciting and fresh. It brings together the work of many individuals and teams and I shall be encouraging everyone I work with to read it! Please do the same! I hope the effect this document has is that many more people have access and encouragement to the support they need to live healthier, happier, more fulfilling lives in Argyll and Bute.

Dr Rebecca Helliwell

GP, Lochgilphead;
Associate Medical Director, Argyll & Bute HSCP;
Clinical Lead, NHSH Realistic Medicine.

INTRODUCTION

What are we doing?

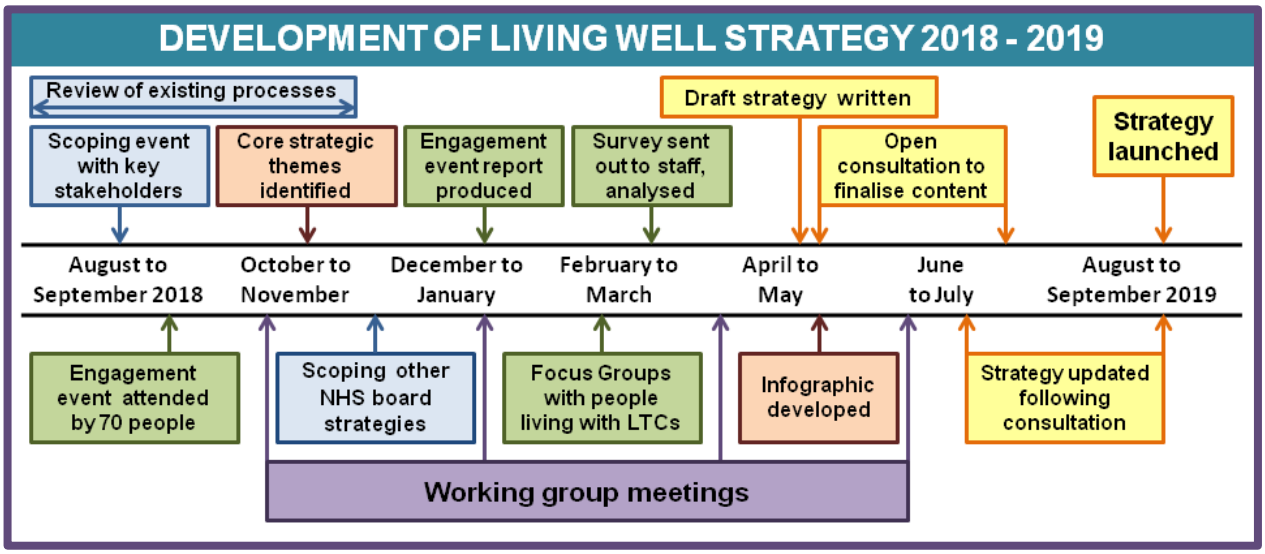
The Living Well Strategy highlights the importance of self management, sets out our intentions to support people to live healthy and well lives in Argyll and Bute.

> **"Long term conditions are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support"**
>
> *Scottish Government definition*

This Strategy has been developed by Argyll and Bute Health and Social Care Partnership (HSCP) and our partners. We intend, through this strategy, to **Empower** people, **Enable** the workforce, and **Improve Access** to support.

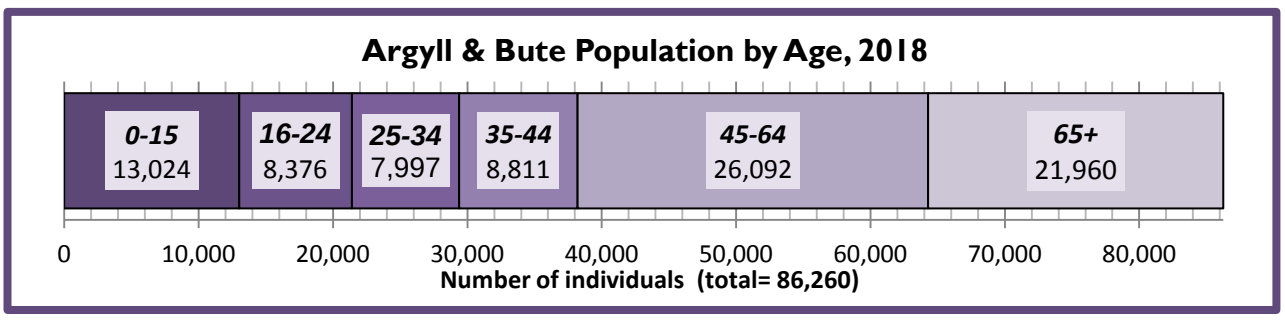
How did we get here?

It was important that this strategy be developed alongside the people affected by it. We consulted with people across Argyll & Bute to determine our actions and outcomes. Our full engagement reports are available at **healthyargyllandbute.co.uk**



Why are we doing this?

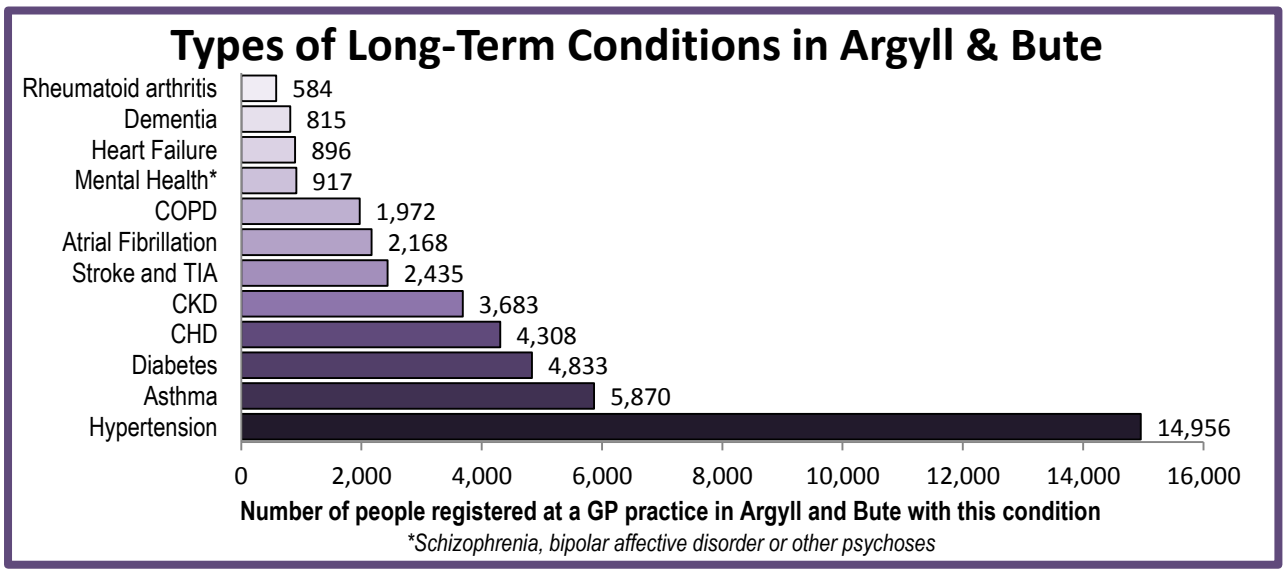
Argyll and Bute has a population of 86,810 with a quarter of the population over 65 and a further 27% within the 45-64 age group.



Source: *National Records of Scotland - Mid-Year Population Estimates*

Data shows that not only are people living longer; they are living longer with long term conditions. It is also reported that an increasing number of people in the middle age group are developing, or at high risk of developing, a long term condition.

Trends show an increasing prevalence of diseases, particularly Type II Diabetes and hypertension, both of which are risk factors for other conditions like heart disease or stroke.

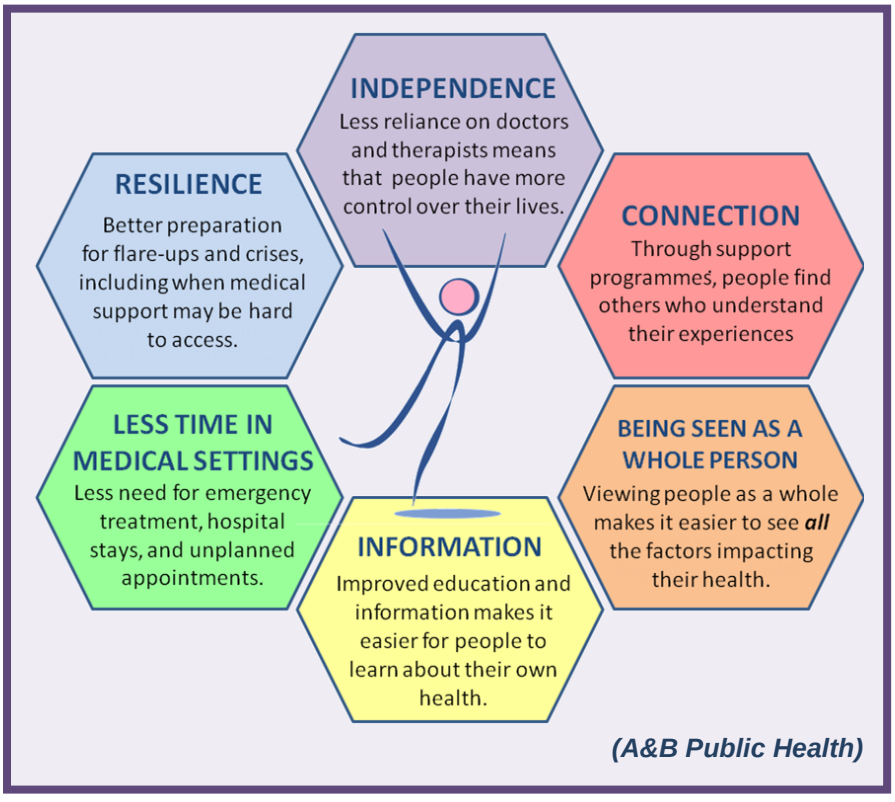


Source: *ISD Scotland Quality and Outcomes data*

People who have risk factors (eg. hypertension, smoking, addiction, pre-diabetes, inactivity, obesity) are at risk of developing one or more long term conditions.

More information on these diseases and the risk factors for them, including smoking, is available in Appendix 1.

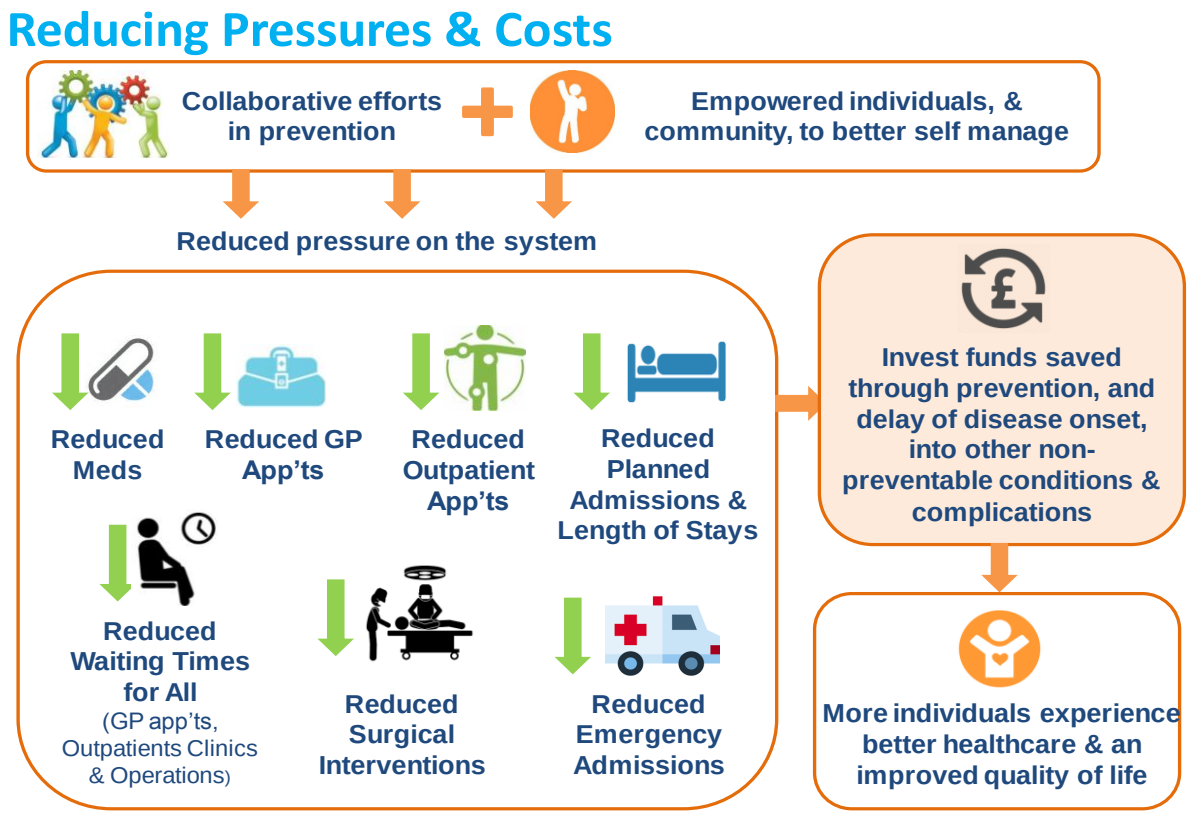
There are many benefits for people who have the tools and support to enable them to live well. Increased self esteem, enabled to take control, feeling connected, less isolated, reduced anxiety, improvement in mood, feeling empowered to challenge and question health professionals, recognised as experts in their condition, able to provide peer support, are just some examples of benefits.



NHS services generally treat people when they are ill. This medical model of healthcare is old fashioned and needs to change if we are going to fully support people to live well. More and more services can be delivered in communities. An increase in peer support models and third sector support is required. A change in culture is needed to build trust between NHS and third sector partners, allowing more people to be signposted to these community services.

Self management does not have to be complicated; there are many quick wins, for example, giving people the right information at the right time, treating people as individuals, recognising the impact of their condition on their day to day life, and ensuring they can access support all allow people to take control.
Local opportunities to support increasing physical activity and weight management carried out as part of a behaviour change model can also be effective.

Supporting people to manage their conditions and live well has the potential to impact on demand for HSCP services. People who are managing their health better are less likely to use these services.



Self-management fits well into the HSCP's strategic objectives, as laid out in our Strategic Plan 2019-2021.

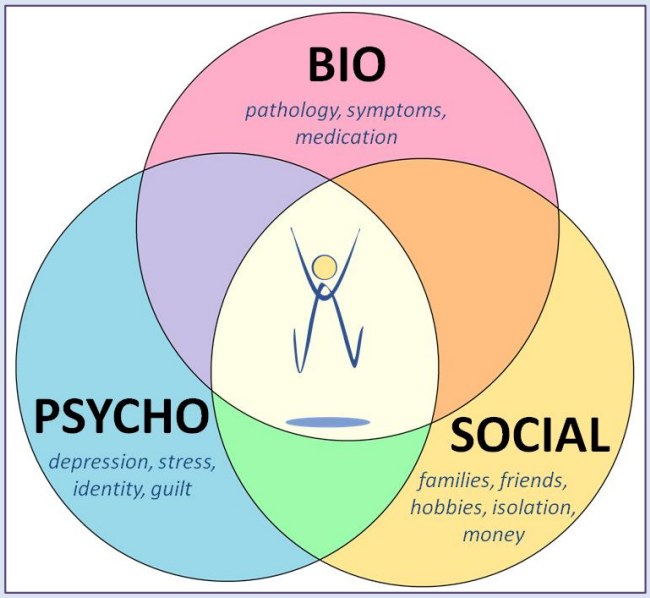
WHAT IS SELF-MANAGEMENT?

In Scotland, the term **self-management** is used in relation to people who already have a long term conditions In Argyll and Bute we are using the term in a wider context - encompassing not just people with long term conditions but also those who may be at risk of developing long term conditions.

Gaun Yersel *defines self-management as:*

"...the successful outcome of the person and the appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more Long Term Condition."

The Health and Social Care Alliance (often referred to as the Alliance)) developed the Self Management Strategy for Scotland - "***Gaun Yersel***" - on behalf of the Scottish Government in 2008. The strategy remains very relevant. *Gaun Yersel* states that "self-management is not a replacement for services. Rather, it's about developing the tools to support people alongside services. By managing conditions effectively, people can take control and live fuller, more independent lives". It's important to remember that people are not always accessing services, most of the time they are living in the community and therefore they have become experts in how their condition affects them. It's important to remember that many of the most effective services that support people are community based, probably third sector and often peer led.

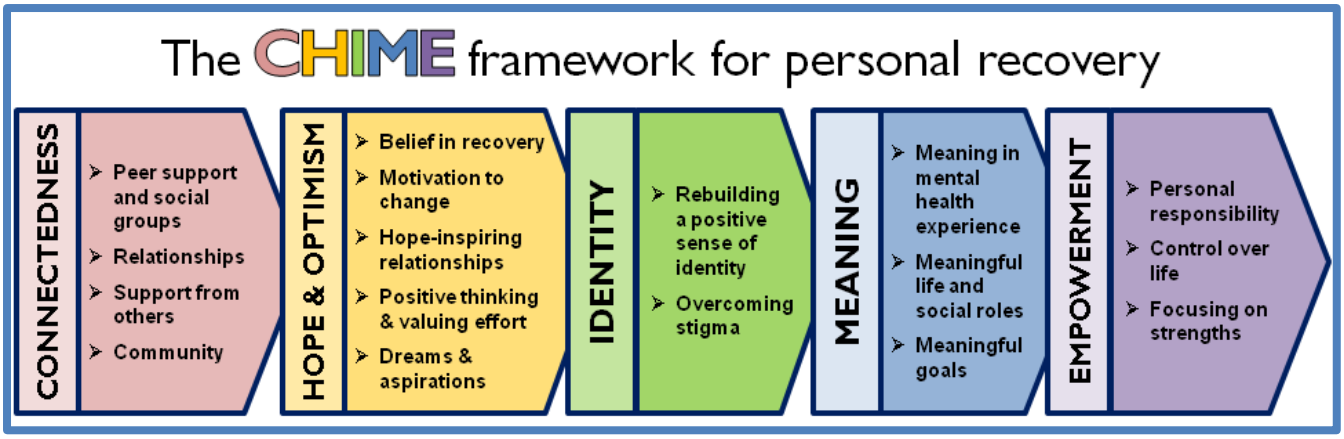


Adapted by Argyll & Bute HSCP from the Health Foundation resource centre

Health and well-being are a combination of biological factors (physical symptoms), psychological factors (such as stress and depression) and social factors (like isolation, money, and work). These factors impact on each other.

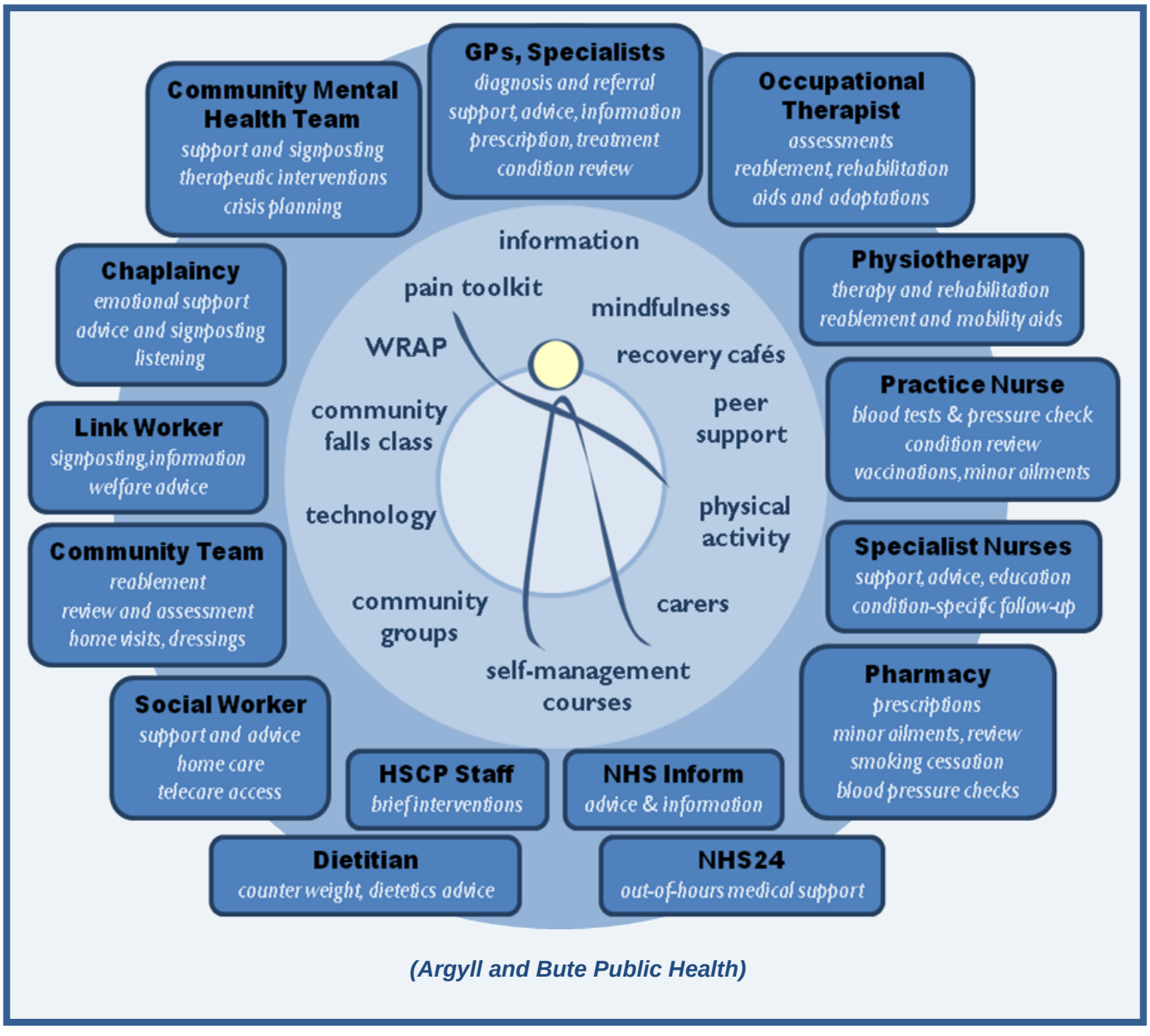
Enabling people to better manage their health does not always include health and social care services; other appropriate services may be financial, housing, socialisation or support.

Recovery is defined by the Scottish Recovery Network as: "being able to live a good life, as defined by the person, with or without symptoms. Recovery can be very personal and mean different things to different people". The CHIME framework is a recovery based framework that groups the common themes that support recovery (www.therecoveryplace.co.uk/chime-framework/)



Adapted from Scottish Recovery Network

There are a wide range of services and support available in Argyll & Bute that can help people to live well. NHS services are complimented, by community based third sector services many of them peer led/supported. Several examples are summarised below.



(Argyll and Bute Public Health)

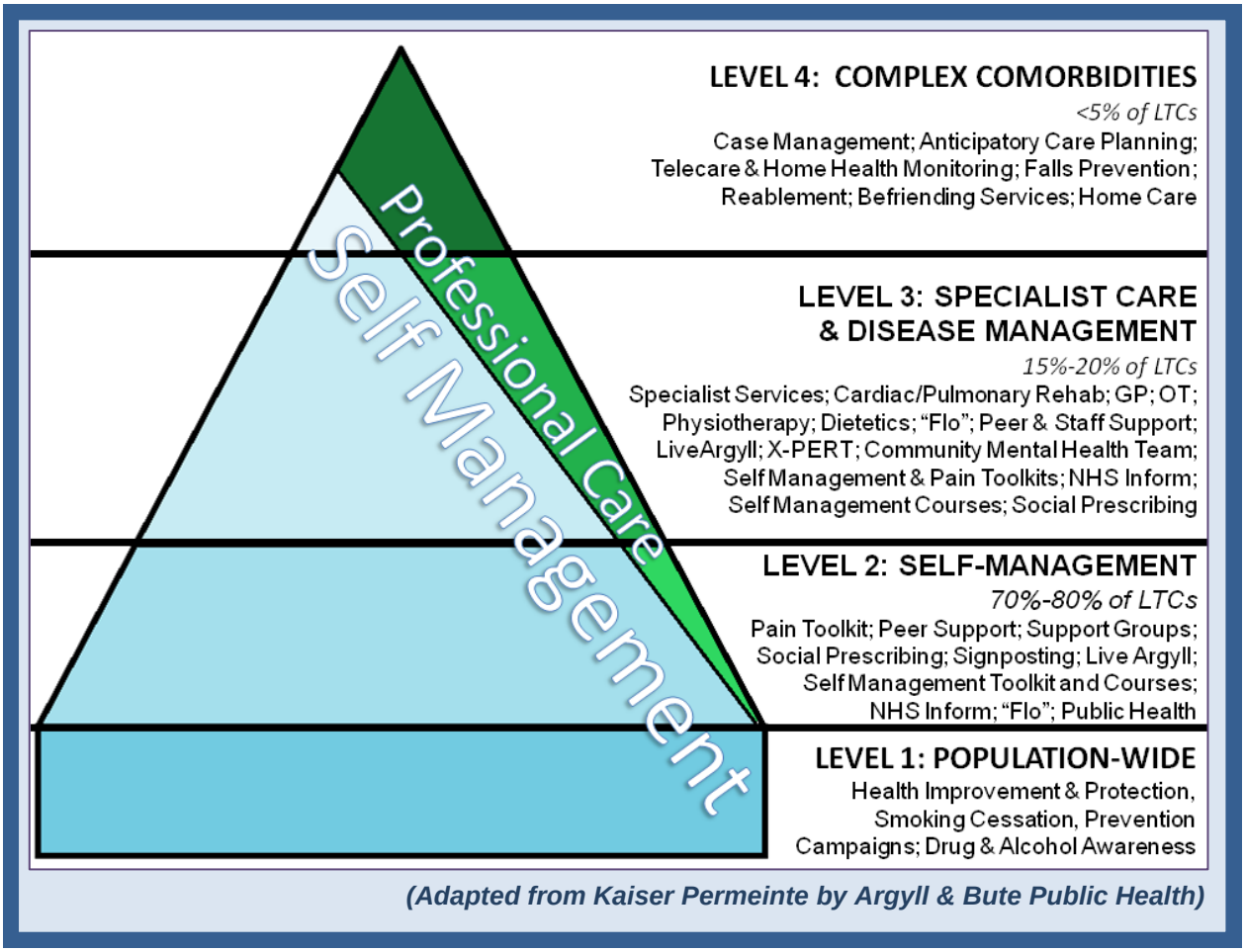
Levels of Self Management

There is no one size fits all with self management. It should be designed around the person (**Person-Centred**) and not around the service. Self management is everyone's responsibility and should be a collaborative approach.

Self management support/interventions/tools should not be seen as something only HSCP professionals are involved in, but rather something we can all do more of in our communities (as noted in our example case studies later in this document).

There are different levels where self-management is required, and the approaches used will vary based on the severity of the condition and level of need. Self management can't be viewed on just one level but crosses all four levels of need from prevention to people requiring more complex care (visualised below)

Providing support and information at the right time and in an appropriate way is important. The table on the next page explains how self management input can be provided at different stages.



(Adapted from Kaiser Permeinte by Argyll & Bute Public Health)

Key stages where people need support (adapted Alliance Diagram)		
Key Stage	**Issues**	**Impact of Self-Management**
Prediagnosis	High risk of developing a long term condition May not wish to change behaviour	Reduced risk of developing a Long Term Condition More able to make healthy choices
Diagnosis	Life and ability to manage may already have been seriously impacted by symptoms People feel challenged about their place in the world and the reality of the situation	Can help people come to terms with diagnosis Key to helping people reconnect with themselves and others Helps people make better decisions about their treatment options
Living for today	People need information and skills to maintain optimum well being Serious risk of social exclusion Risk of depression and anxiety	Supports people to navigate an often difficult journey Challenges social exclusion by helping people build bridges back into society and social roles
Progression	Cycle of illness and wellbeing arises from fluctuations in condition Increasing severity of symptoms Struggle to get additional support during flare ups Possible loss of capacity Increased risk of depression, anxiety	Helps to avoid (or reduce) flare-ups/crisis by enabling people to recognise early warning signs and react effectively Tackles psychological impact of flare ups/crisis or progression Supports changing needs
Transitions	Moving between services sometimes to different levels/ types of support/change in lead professional Dealing with multiple needs/conditions and therefore a range of services Often a stressful time and this can have serious impact, including on persons condition	Supports people to manage transition processes Maintains focus on the person's needs ensuring services are organised around these Provides people with control at a time when this can be undermined Helps to avoid (or reduce) flare ups/crisis
End of Life	Difficult time, complex challenges Death may be premature Person may have to cope with symptoms of condition alongside end-of-life challenges	Supports people to maintain control Addresses broader needs e.g. emotional, financial family and lifestyle Enables people to use advanced/anticipatory care plans to plan the end stages

What helps people to self-manage?

There are many factors that help people self-manage. Some examples are listed below.

The more access people have to these examples, the better enabled they will be to live well in Argyll and Bute.

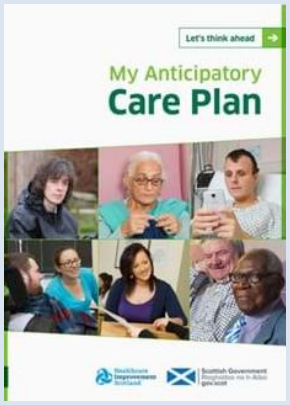
Not all of these are examples of services but some are how as an HSCP we should communicate and support people who are accessing our services. Taking a person centred holistic approach, and ensuring we signpost people to community support will positively impact on their ability to self manage.

Planning for the future

Planning ahead can help people to be more in control, help to manage their condition, and support health and wellbeing changes.

Anticipatory care plans

People with some long term conditions may already have an Anticipatory Care Plan (ACP) in place, but they could be more widely used. These plans should be developed in partnership with the person, their family/carers and their health professionals. They should be person-centred, reflecting the person's wishes on how they currently manage and how they plan to manage in the future. A good ACP records the person's preferred actions and interventions if their physical or mental health deteriorates. It should also cover legal and practical issues that may arise as conditions become more complex.



ihub.scot/media/1982/my-acp.pdf

Effective ACPs shared with relevant professionals, can help reduce hospital admissions.

Legal Planning

There are other practical steps everyone should take whether diagnosed with a long term condition or not, such as: making a will and setting up power of attorney. Many people leave this until it is too late. Age Scotland and Citizens Advice both have information on how to go about doing these.

- Power of attorney
- Will
- Welfare guardianship
- Care and support
- Money matters

Setting up a power of attorney early while there is still capacity can save a lot of heartache, expense and in many cases prevent lengthy unnecessary hospital admission. Power of attorney allows a legally appointed person to make financial, health and care decisions when the person receiving care is deemed incapable.

Dying Well

Good Life, Good Death, Good Grief is an initiative of the Scottish Partnership for Palliative Care. Its vision is "for Scotland to be a place where people are well informed about the practical, legal, medical, emotional and spiritual issues associated with death, dying and bereavement."

www.goodlifedeathgrief.org.uk has a range of resources available to support people to plan for the future. It also offers practical support for families, carers, communities, and guidance for health professionals.

Palliative care is important in the later stages; this can range from practical symptoms, support, practical help and advice to preparing for death. Talking about death and dying is difficult for many people and may be put off to avoid upset - but in fact, early planning for death reduces later stress on the person and their families, by enabling people to plan their death and final stages with their wishes taken into account.

Further palliative care information and support can be found at www.nhsinform.scot/care-support-and-rights/palliative-care

This strategy identifies four top-level outcomes based on our engagement activity. These outcomes are:

Outcome 1 – People *People living in Argyll and Bute have the tools and support they need to support them to live well.*	
1.1	People living with Long Term Conditions will be more informed about how to manage their condition
1.2	Self management courses and toolkits are accessible to people
1.3	People in Argyll and Bute will understand what support is available and know how to access it
1.4	People in our communities will be more physically active
1.5	The skills and expertise of people living with their conditions is recognised and supported
Outcome 2 – Communities *There are a wide range of local services to support people to live well*	
2.1	Our community assets (services) are recognised and promoted
2.2	Links with the third sector and HSCP will be strengthened
2.3	There will be an improved understanding of community led self management and peer support activity, and its availability in our communities
2.4	Joint working opportunities will be increased for community groups/organisations to support them to build on existing activity/resources
2.5	There will be an increase in activities available in communities
Outcome 3 – Our workforce *Staff are able and motivated to support the people they see to live well.*	
3.1	Our staff will feel supported to self manage their own health and wellbeing
3.2	There will be increased understanding of what support and activity is available in our communities and how people can be signposted to it
3.3	The workforce will feel more confident in referring/signposting people to community led activities/support
3.4	Our staff will feel better equipped to support people to self manage
Outcome 4 – Leadership *There will be effective leadership to support delivery of the Living Well Strategy*	
4.1	Living Well in Argyll and Bute has a clear and recognisable brand and identity
4.2	Good practice for Living Well is recognised and promoted
4.2	A strategic group exists to lead and direct Living Well activity in Argyll and Bute
4.3	There are effective connections between Living Well activity in Argyll and Bute
4.4	The Living Well Strategy has a 5 year action plan with achievable and measurable outcomes

Outcome 1 – People

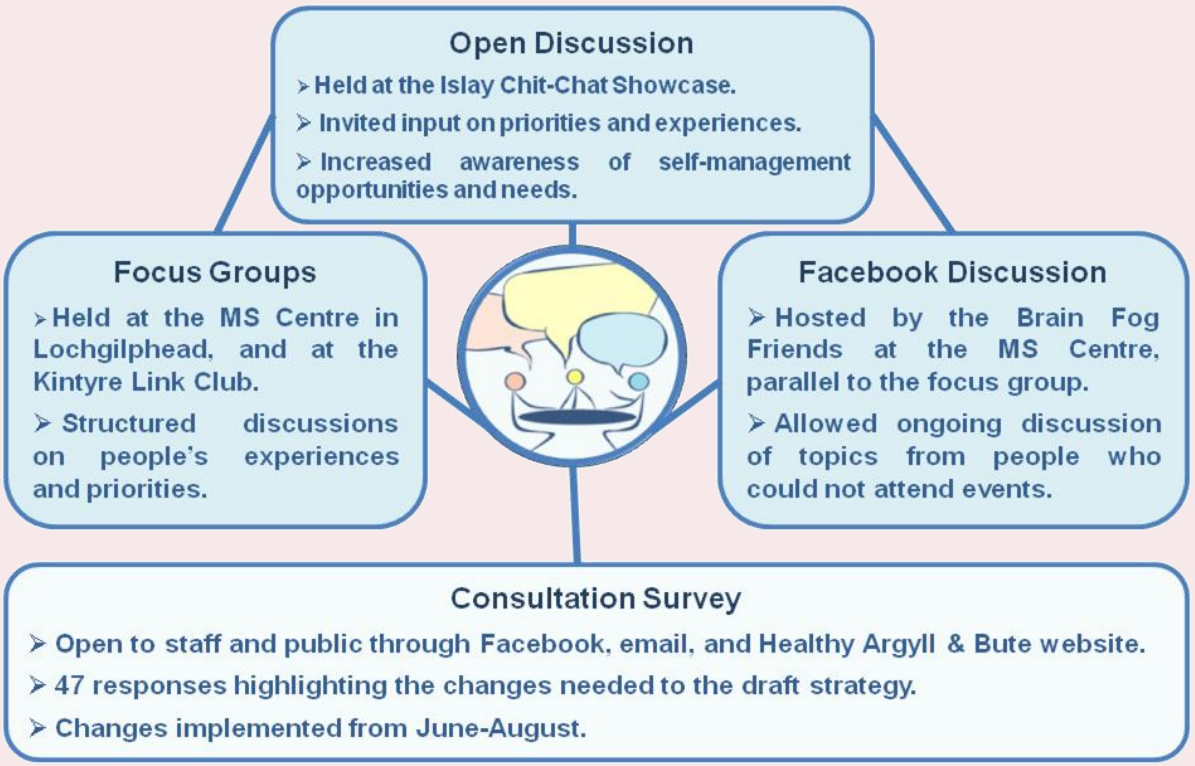
People living in Argyll and Bute have the tools and support they need to support them to live well

What do we know?

- People need access to the right support at key stages.
- Self management support should be in partnership with people
- People are experts. They know more about how their condition impacts on them
- Healthy lifestyles can reduce disease development
- People are living longer with long term conditions; increasing older population
- Significant increase in obesity, diabetes and hypertension, all of which are risk factors for other diseases
- People who have accessed self management support feel more in control of their condition
- People with mental health conditions are at higher risk of developing health conditions and vice versa.

What did we do?

This strategy was developed with input from people with direct experience of self management– staff, carers, and most of all, people with long-term conditions. As such, we went out over several months to consult with these people on their priorities, needs, and experiences.



Summary of the engagement activity informing the strategy (A&B Public Health)

What did people tell us?

Community support
People credited being part of a community or support group with improving their health. Sharing experiences and peer support is a key need. People who had attended self management courses valued them and felt more able to self manage and to access services appropriately. Access to services and to community support can be difficult from rural communities

Professional input and understanding
It was difficult to know who to turn to or how to access professional help. There is a perceived lack of continuity both within and between services. People felt that NHS staff don't routinely signpost to community services. There was a lack of recognition of the expertise of the person with a condition. It was important to be heard, believed, and respected by professionals. There was a perception that GPs were gatekeepers to all services, and uncertainty on where they go for the right support, eg pharmacies. They want their stories and experiences to be heard.

"I thought I was protecting myself from the world, but I was stopping myself from living my life."

Exercise and activity
Exercise may be difficult or intimidating for some people, but was seen as very important. People also said that having available, accessible activities helped them to self-manage.

Catherine Kennedy Think its very important to get a chat and a laugh is the best medicine..

"Be Kind To Yourself"
An important theme was the benefit of holistic approaches. Rest, relaxation, pacing, and comfort are key to self-management, as is self-forgiveness. Mindfulness, meditation, and gentle activities like Tai Chi were highlighted as helpful.

Information and signposting
Access to information and available services locally & nationally alleviates anxiety and helps people to feel more independent. People often struggled to find information about their conditions. Knowing what was trusted, good-quality information was difficult. Most information is online, which may not be easy for everyone to access. People felt there was a gap in signposting to services, support and information.

Only 1 person was aware of NHS Inform.

Those that did find support did so through:

- **Online searches**
- **Word of Mouth**
- **Community Postings**
- **Support Groups**
- **Advocacy Networks**

What do we need to do?

The following key actions have been identified.

Increase promotion of physical activity and community activities by using a range of methods, social media, press releases, and working with our third sector partners and community groups to support us to do this.
Explore ways to improve access to community support
Develop a bank of case studies/personal stories and share widely using different methods of communication
Support staff with skills to empower and enable people
Identify ways to improve signposting for people to make it easier for them to find the right type of support or information
Increase access to self management courses and tools
Explore how we raise awareness of our self management experts

Outcome 2 – Communities

There are a wide range of local services to support people to live well

What do we know?

- There are lots of community led activities in place across Argyll & Bute.
- People can live in a community and not be aware of them or signposted to them. Those that do value them
- Staff don't know about them or how they can support people
- It's difficult to keep a register of all community services up to date
- Self management courses and pain workshop are held but uptake is low
- Several groups/organisations are accessing the same bank of volunteers; there is a risk of saturation.

Examples of person-centred community-led approaches

- Strachur Hub
- Lorn and Oban Health Options (LOHO)
- Self management courses
- Self management toolkit and personal plan
- Diabetes self management education
- Branching Out
- MS centre Mid Argyll

Short case studies are available to read later in this strategy

What did we do?

As part of our planning and scoping work we invited some of community partners to come along and tell us what was happening in their communities on self management. We also asked them to identify any gaps.

What did our communities tell us?

These are some of the points identified in our scoping work. The report is available on wwwhealthyargyllandbute.org.uk

- Our community partners were able to highlight a number of examples of self management activity across Argyll and Bute.
- They identified a need to promote these activities with our HSCP staff as they felt there was a lack of knowledge of what these services can offer.
- There is varied support available but it is inequitable and can be patchy meaning not accessible to everyone.
- There was an element of volunteer fatigue and something would need to be done to address this.
- The benefits of these services to people accessing them needed to be more widely promoted

What do we need to do?

The following key actions have been identified.

Devise a resource of community and third sector services to include pharmacy, GP and HSCP services to be promoted and marketed across Argyll and Bute. Thus allowing clarity on what is available and how to access it
Link up with and work alongside LIVE Argyll, Versus Arthritis, LOHO, MS centre etc to build on and coordinate what is already in place to allow us to increase reach/awareness and accessibility
Identify support available in our communities and find ways to ensure people are able to access the right support when they need it
Work with the voluntary sector/community groups to explore how volunteers in relevant groups could further support self management and increase physical activity
Promote the use of NHS Inform and other national websites widely in our communities
Develop stronger relationships and understanding between HSCP workforce and our third sector partners
Increase promotion and recognition of the work of our community organisations and in particular peer led activity
Support community capacity building

Outcome 3 – Our Workforce

Staff are able and motivated to support the people they see to Live Well

What do we know?

- Our HSCP services are working to capacity
- Our workforce is dedicated but continues to work to a traditional medical model
- How services are delivered needs to change
- Staff need support to enable people to self manage

What did we do?

We engaged with staff through an online survey cascaded through management structures across the HSCP, 263 staff responded

What did staff tell us?

The survey provided us with very important information about the general knowledge and understanding our HSCP workforce has about self management. From the data provided this was lower than we would like and provides a good starting point for improvements in our action plan. Some examples include-

Signposting to community led education courses - from our responses (68.64%) were not aware of community led education courses to support self management, and only 21% of those staff regularly referred people to them. 17% of all respondees did not know what the content of these courses were.

Signposting to local resources – such as community support centres or carers' centres was mixed, with the majority of regular signposting being clinical.

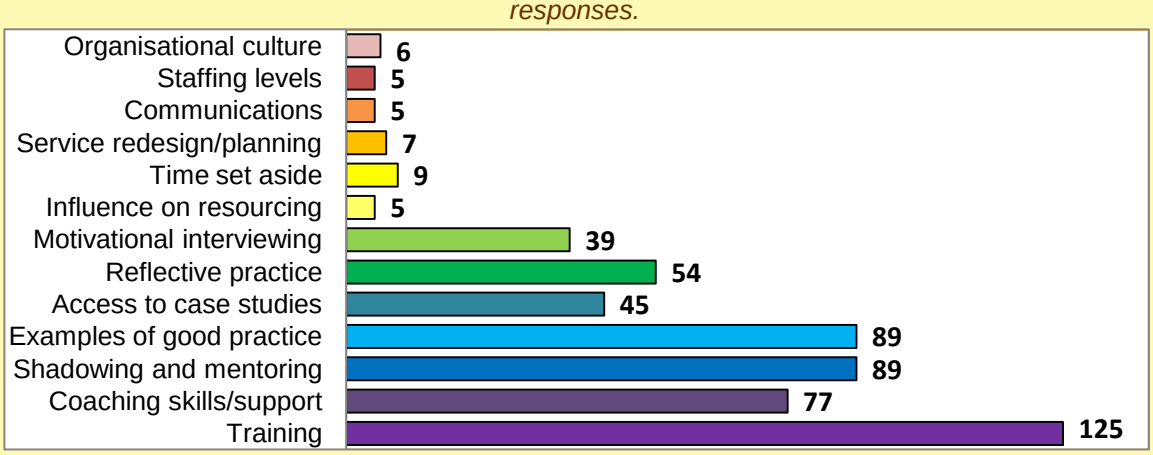
Information resources – 50% of staff in the survey still give out verbal information, only 29% signposted to websites.

It was also felt that the HSCP's culture may not be receptive to self-management in some cases, due to a very medicalised model of care and to increasing workloads for staff making it hard to develop new approaches. However, it is worth noting that increased self-management, if implemented successfully, would reduce this workload and the limits on capacity and time which were highlighted throughout the survey.

Another emerging theme was the need for **improved communication and information availability**, both in terms of informing staff of what they can recommend, and providing service users with prepared documents on self-management resources. Specific suggestions included a database or directory of available services; email bulletins and reminders of self-management courses; and leaflets available to hand out.

Staff development needs- we asked staff to identify what development needs were required to support them

*We asked: "**What development do you think would help you/your staff/your colleagues to improve their delivery of person-centred care?**" These were the responses.*



What do we need to do?

The following key actions have been identified.

Develop and utilise case studies to promote what works well for our citizens to support staff to refer to community services, identify ways to promote and make available widely to our staff
Increased promotion of self management activity to staff
Develop training and development opportunities to support staff to deliver person centred care
Explore development of a new model of HBC/MI training and ongoing support to include coaching support for staff
Increase awareness and availability of resources such as the self management toolkit, WRAP/anticipatory care plans, goal setting and pain toolkit
Identify our self management champions and promote them
Explore development of a resource/directory of trusted community services and make it easily accessible to our staff

Outcome 4 – Leadership

There will be effective leadership to support delivery of Living Well Strategy

What do we know?

Realising the benefits of improved health and wellbeing and taking a more holistic approach in Argyll and Bute will take a significant culture change and this will only be achieved through clear leadership and direction.

The HSCP Strategic Plan sets out clear intentions to transform how health and social care services are currently delivered and the Living Well Strategy provides an opportunity to do this.

What did we do?

We scoped out relevant aligned work streams in Argyll and Bute and discovered they have similar themes and aims. We interviewed service leads and professional leads.

What did people tell us?

In order to support a culture change that enables a more person centred approach, more robust governance and leadership is required. There are several aligned pieces of work currently in place within Argyll and Bute, more could be done to link them up and make better use of resources. Some examples are highlighted below.

Aligned Work in Argyll & Bute

AILP

The **A**ctive and **I**ndependent **L**iving Strategy 2017-20: 'Enabling AHPs to Enable the People of Scotland', promotes enablement, empowering staff and patients to think differently and achieve their full potential. **AILP** is underpinned by an acknowledgement of the importance of prevention and early intervention to people's lives.

Reablement

Reablement helps people learn or re-learn the skills necessary for daily living, which have been lost through deterioration in health and/or increased support needs. A focus on regaining physical ability is central, as is active reassessment. It may also comprise of interventions like exercise programmes and provision of equipment to improve function or regain daily living skills.

Social prescribing/Link Workers

Social prescribing links medical care to (typically) non-clinical, locally delivered support services**.** It enables professionals to refer to a range of activities and services. It empowers citizens and communities, supports independence, reduces reliance on primary health care and ultimately delivers better outcomes for citizens. **Link workers** enhance social prescribing by not just signposting but supports people to enable them to attend social prescribing activities and/ or support within their community.

Aligned Work in Argyll & Bute

Type 2 Diabetes Prevention and Management

Argyll and Bute HSCP have been awarded a sum of money to implement the Scottish Government's "A Healthier Future: type 2 Diabetes prevention, early detection and intervention: framework" 2018. To date a needs assessment has been carried out across the HSCP involving the public, service users and staff and an initial implementation plan for 2019/20 funding has been created

Mental Health

Mental Health services have recently undergone review, with examination of both the NHS Highland Mental Health Needs Assessment and Community Mental Health Services. The Partnership has adopted and supported a recovery approach to mental health care, forming working relationships with the Scottish Recovery Network over the last 8 years. The essential components of CHIME (Connectedness, Hope and Optimism, Identity, Meaning, Empowerment) are integral to the care and treatment within mental health services in Argyll and Bute HSCP.

Transforming Primary Care

This is work currently underway to support the new GP contract. Key to this work is access to a multi disciplinary team through the GP practice including Physiotherapist and CPN. The additional input from Physiotherapy will support further development to the MSK service allowing better and quicker access to services for people suffering with musculoskeletal pain. The additional CPN resource will improve local access to mental health services. Link worker roles will also be developed. All of these roles will be funded through the transforming Primary Care Fund as part of the new GP contract

Realistic Medicine approach

Realistic medicine refers to putting the person receiving health and social care at the centre of decisions about their care and creates a personalised approach. It encourages health and care workers to find out what matters most to patients so that the care of their condition fits their needs and situation. Realistic medicine recognises that a 'one size fits all' approach to health and social care is not the most effective approach for the patient or the NHS.

A&B Self-Management Partnership

The self management partnership is an recently developed partnership. It was formed with partners who were working together to deliver Self Management courses and pain workshops across Argyll and Bute. The partnership is expanding to support further development of community led self management approaches in Argyll and Bute

Falls/Frailty

Falls account for 87% of emergency admissions for unintentional injury in people aged 65 years and over. Falls and frailty are closely linked. Frailty is a clinically recognised state of increased vulnerability in older adults. It is associated with a decline in an individual's physical and psychological reserves. Frailty is related to falls in that an older person living with frailty has an increased risk of falling; conversely, a fall may be a sign of underlying frailty.

Chaplaincy

Chaplains provide support to staff, patients and relatives/carers and in this respect have a wider remit than all other NHS employees. In an average week they talk to managers, a wide range of staff, patients, carers and as well as seeing people in the hospital buildings will see people in their own homes. By listening to people in a non-medical way, chaplains can support people work through their anxieties and concerns.

What do we need to do?

The following key actions have been identified.

Raise the profile of self management and its impact at senior leadership and Integrated Joint Board (IJB) levels
The self management partnership needs to have a clear purpose and plan in place and be promoted and visible
Further develop the self management partnership to support its development as an ongoing resource to support self management delivery and coordination the community
Formalise a governance structure for the self management partnership to report to, to ensure implementation of the Living Well Strategy.
Develop a Living Well brand and Identity
Identify and forms links between current related workstreams/projects
Develop a communication plan to highlight and promote Living Well activity
Develop an implementation plan for the Living Well Strategy
Develop/formalise a strategic group to drive forward the Living Well implementation plan

LIVING WELL ACTION PLAN

Summary

This is a summary of the Living Well action plan and links to our 4 previously identified outcomes. These actions are based on our findings from our engagement activity with people, community and our workforce. This action plan will be supported by partnership working across Argyll & Bute and will link to other relevant work currently being carried out. The more detailed action plan can be found at www.healthyargyllandbute

Aims		Actions	
OUTCOME 1 - PEOPLE	1.1	Devise a small leaflet to be shared widely in communities, signposting to health and wellbeing support	Short-Term (0-1 year)
	1.2	Make links with the HSCP transforming primary care work stream to ensure that Living Well is linked to any new developments around the new GP contract.	
	1.3	Share our engagement reports with leads for link working and developing access to MSK practitioners in GP practice	
	1.4	Develop social media campaigns to promote • Self management courses • NHS Inform • National service directory • Health and well being campaigns	
	1.5	Work with community organisations to develop a bank of case studies • Self management course participants • Physical and social activities	
	1.6	Engage with local & national organisations and the public to explore ways to recognise expertise	2 - 4 years
	1.7	Work with local organisations to explore the development of Living Well Champions	
	1.8	Explore the potential development of a Living Well incentive scheme	
OUTCOME 2 - COMMUNITY	2.1	Develop or build on an existing resource of community services, HSCP services, GP & pharmacy that highlights what they are and what support is offered	0-1yr
	2.2	Work with local groups to build community capacity through the self management grant and health and well being networks	0-2yr
	2.3	Link up with and work alongside other organisations to build on and coordinate what is already in place	2 - 4 years
	2.4	Scope out what is available in communities and identify gaps, opportunities and Identify local resources to support self management	
	2.5	Maintain development of local resources on the National service directory accessed through NHS inform and promote widely	
	2.6	Work with community groups/voluntary sector to explore potential links with their volunteers and self management and physical activity	5+ Yrs

OUTCOME 3 - WORKFORCE	3.1	A training Public health prospectus will be developed that will promote training opportunities with the HSCP for our workforce this will include health behaviour change and health inequalities.	Short-Term (0-1 year)
	3.2	Identify online materials and courses that can be built into PDPs	
	3.3	Identify areas of good practice and promote as exemplars	
	3.4	Build in examples of good practice from our communities and promote at staff training and awareness events	
	3.5	In partnership with the Alliance develop a round of staff reflective practice development sessions across A&B using real case studies and user stories.	
	3.6	Ensure the HSCP workforce plan has actions embedded that help staff to support the people they work with to Live Well	
	3.7	Identify activities/opportunities that promote engagement between HSCP and third sector organisations at very local levels (such as local showcase events within the local hospitals)	2 – 4 Years
	3.8	Develop a network of local coaches to help staff to continue to develop and practice their skills.	
	3.9	Foster and develop a network of Self-Management Champions/coaches within our workforce	
OUTCOME 4 - LEADERSHIP	4.1	Gain buy-in and support from the IJB and senior leadership teams.	Short-Term (0-1 Year)
	4.2	Launch the Living Well strategy across Argyll and Bute through a series of locality based road shows	
	4.3	Ensure Living Well strategy is actively promoted at every opportunity (inc. LPGs, HWNs, team leads meetings, professional leads meetings). Develop infographic updates on implementation, to be shared on a bimonthly basis with support from our communication department	
	4.4	A Strategic Group will be in place to oversee the implementation of the action plan and ensure it is linked to other related work	
	4.5	The Argyll and Bute Self management partnership will be asked to support elements of the implementation plan	
	4.6	Progress updates on the implementation plan will be reported to the A&B HSCP Professional Leads group on a regular basis	
	4.7	Brand identity for Living Well will be developed and embedded into all relevant work	
	4.8	The Living Well strategic leadership group to identify how to be more involved in the realistic medicine approach	
	4.9	Scoping and review of current self management approaches and potential developments to be carried out to support people with mental health conditions.	
	4.10	The public health role of all professional groups for example AHPs to be considered and embedded into all associated work	

PERSON CENTRED CASE STUDIES

The next section is made up of some example case studies of person centred approaches to self management.

Most of these are co-productive examples led by the third sector and developed from the needs of communities.

Funding for many of them is a challenge and due to the fragility of funding can be at risk.

But the evidence of improved self management from these approaches is strong.

The case studies contained in the next section are summarised below:

- **Strachur Hub:**
  A partnership approach between the GP surgery and volunteers to support people to be more independent, less isolated, and self manage their conditions.
- **Lorn and Oban Healthy Options (LOHO):**
  A charitable organisation that works closely with HSCP services but also delivers a range of healthy options services.
- **Self Management Programme:**
  A partnership approach with third sector organisations coordinated by Versus Arthritis, delivering self management courses and pain workshops across Argyll and Bute
- **Self Management and Pain Toolkit:**
  Personal plans that support people to manage their condition delivered as part of self management courses.
- **Diabetes Education Programmes:**
  2 programmes - X-PERT and ABBBIE - are structured education programmes, run by specialist HSCP staff across Argyll and Bute
- **Branching Out:**
  A 12 week programme outdoor woodland based activity for people referred by mental health teams. Run by Argyll communities trust (ACT). It offers activity, peer support and personal development.
- **MS Centre Mid Argyll:**
  Supports people with long term conditions in Mid Argyll and offers outreach to Kintyre and Islay. It offers a range of therapies, activities, and support.
- **Wellness Recovery Action Plans (WRAP):**
  Peer-led self management plans that support people with their mental health recovery and plan for setbacks.

Strachur Hub

Strachur Hub was developed in 2016 by a local practice nurse and proactive local volunteers. **The objectives were to:**

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

In the past 3 years the hub has worked with local providers such as Cowal Befrienders, Interloch transport, the Strachur medical practice, a local hotel and local tea room, and the village hall to provide a health and well being service to the community.

The service is provided collaboratively by a range of professionals from GP practice, public, third sector and local volunteers.

THE COMPETITION HOTS UP BETWEEN THE BLUES AND THE REDS - BOCCIA

Key measured outcomes (By Dr F McKirdy)

- 80% reported increased confidence
- 87.5% improvement in their overall health
- 91% reduction in falls
- 96% increased socialisation and exercise most enjoyable aspects
- 100% of respondents recorded improved quality of life

What do we do?

- Support older frail people at risk of falls
- Work with people who are lonely and isolated
- Provide exercise for people with weight or mobility issues
- Support people in need of transport
- Offer mindfulness to people with mental health needs
- Offer education/ support to people with diabetes to manage their condition
- Offer reablement on discharge from hospital
- Preventative exercise for younger age groups
- Support for people with dementia
- Respite for carers

What does it cost?

- £12,827 per year
- £251 per week for 51 weeks
- 5 hours a week
- Average attendance 52 per week
- Average hourly rate is £0.96p per person per hour

Lorn and Oban Healthy Options (LOHO)

LOHO is the link between health services in Oban and Lorn (Physiotherapy, Dietetics, and Lorn Medical Centre) and the community. It provides a specialist individually tailored service predominantly activity based to support and educate people to make positive changes to improve their health.

Healthy Options Steps to a Healthier Future

Changing Behaviour
Clients work with qualified professional staff.

Changing Minds
By engaging in activities and envisaging a better future, attitudes change

Changing Lives
Health and wellbeing is created. There is less need for support, and a wider vision on what is possible.

"I feel better able and better equipped to manage my life choices"

8,381 total health intervention sessions projected to be delivered in 2019 (*LOHO Strategic review Feb 2019)*

"If a problem has a solution don't talk about the problem"

95% of new consultations referred from GPs or AHPs

Healthy Options Services

- 1 to 1 consultation and personalised programmes
- Social prescriptions
- Link working
- Education programmes, including self management courses
- Social/physical activity programmes
- Tai Chi, walks
- Tailored 6 to 8 week reablement programme
- Outreach
- Support healthy villages developments, Oban healthy town
- Client progression within Healthy Options and other community organisations in a "Healthy Living Community"

"By developing skills to keep people healthy we empower our clients to better manage current conditions and significantly reduce the risk of new health problems in the future"

"I've felt my strength and mobility improve after just one session which really helps me to deal better with living with MS"

Mini case study

One of our mainstream clients with long standing mental health problems that medical services were struggling to treat was happy for us to share their story.

Healthy Options Intervention: A graded and supported exercise programme was tailored to the client's needs and abilities: the client was offered the opportunity to participate in a health & wellbeing education programme and in group exercise and gym sessions.

Health Outcome: The client experienced a marked improvement in their mental health. A 39Kg weight loss, reversing weight related liver damage. 19 GP consultations in 2016 went down to 5 in 2018. A supervised reduction in medicines was achieved resulting in a saving of £2700 in drug costs.

Self-Management Programme A&B

Versus Arthritis coordinates and supports delivery of the self management programme Living Well. The programme is delivered in partnership with North Argyll Carers, MS centre, and Lorn & Oban Healthy Options and is open to anyone with a long term condition. The programme for delivery includes:

- Self-management sessions (5 weeks modular programme)
- Pain Toolkit sessions
- Tai Chi sessions-taster sessions and courses
- Health walking groups
- Peer support including group activity
- Building community capacity for integrated self-management support.

- ✓ 47% reported increase in quality of life
- ✓ 17% increase in confidence in expressing how their condition affects them
- ✓ 15% increase in confidence on dealing with everyday life

April 2018 to March 2019 Activity

- 13 self management courses
- 9 Pain Toolkit sessions
- 23 Tai Chi classes (5/6 weeks)

Participants

- 361 with 1 or more of the above interventions
- 303 walkers participating in 3 walking groups

Volunteers

- 20 volunteers
- 9 new volunteers just completed training course and due to be inducted.

This partnership approach to course delivery has now been formalised into a working Self Management Partnership which also includes membership from A&B HSCP and the Third Sector Interface. The partnership has been successful in being allocated funding from the Health and Social Care Alliance to support the development of a more sustainable community led model for the self management programme.

What do you value most about attending the sessions?

"The understanding of our conditions within the group. The help and support I've received, and I have had a lot of support!
And the friendship."

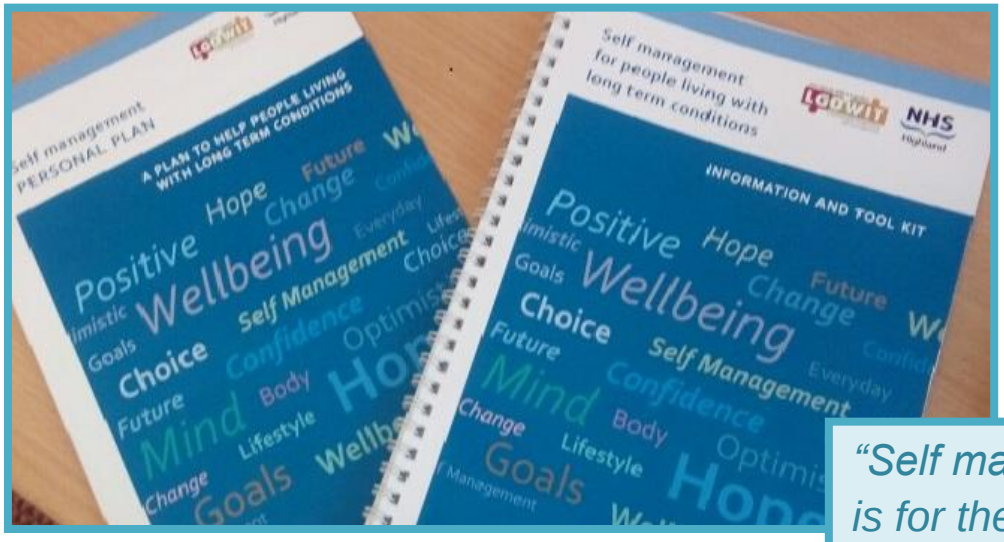
Tai Chi in Gigha

Self-Management Toolkit / Self-Management Personal Plan and Pain Toolkit

The Self Management toolkit and personal plan are person centred approaches supporting people to manage their condition, by understanding their symptoms and how they impact on their daily lives, manage their medication, set personal goals and give tips that will help them to get back into the driving seat.

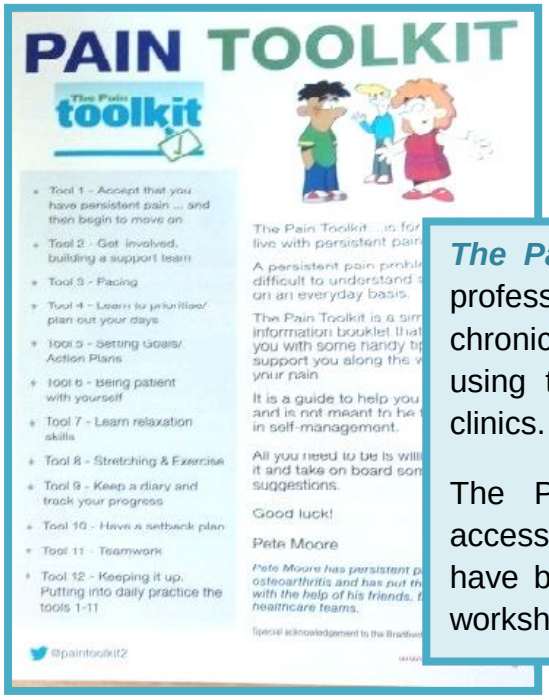
NHS Highland has worked closely with LGOWIT (Let's Get On With It Together) A self management partnership in Highland to develop the Self Management Toolkit and the Personal Plan.

These resources have been designed in partnership with third sector organisations and people living with long term conditions. They are now available to people attending Argyll and Bute self management courses. Further development of these resources will be to identify different ways that the plan and toolkit can be utilised widely across other related services including HSCP services.



"Self management is for the life I live, not the conditions I live with"

www.lgowit.org.uk



The Pain Toolkit has been introduced to health professionals as a tool to support people with chronic pain. Physiotherapists across A&B are using this tool to support people attending their clinics.

The Pain toolkit is also available to people accessing self management courses and there have been some stand alone community led pain workshops held using the pain toolkit as a resource.

Diabetes Education, X-PERT & ABBBIE

X-PERT: The X-PERT Diabetes structured education programme is offered across Argyll and Bute to adults with, or at risk of, type 2 diabetes. X-PERT diabetes is a group programme which is delivered in six 2.5hour sessions over the course of six weeks. The programme promotes self-management and aims to empower people with diabetes, ensuring they are receiving up to date knowledge and education in a relaxed and friendly manner, to enable them to discuss their ongoing treatment with their healthcare professional.

Each week of the programme different topics are discussed and participants are given the opportunity to think about making changes or setting goals.

> "The whole programme was very useful and has improved my knowledge"
>
> "Very good course, I think every diabetic should go on this course"
>
> *Quotes from A&B X-PERT participants*

ABBBIE: ABBBIE (Argyll & Bute Basal Bolus Insulin Education) is an interactive course available throughout Argyll and Bute for adults with type 1 and 2 diabetes taking multiple daily injections of insulin.

ABBBIE is a four day programme and people attend once a week for four weeks. During the sessions participants learn how to match their insulin to their food and their lifestyle. The aim is for people to be able to work their diabetes into their chosen lifestyle, rather than working their life around their diabetes.

The sessions have a curriculum to follow but they are relaxed and there is always lots of discussion, with the opportunity for people to learn from each other.

> "I found the course to be a massive help in understanding the condition I have had for 20+ years. [The educators] have been very helpful and patient during the course, repeating things when necessary and allowing me to feel more confident in controlling my blood glucose levels."
>
> "This was a great opportunity to discuss issues which can't be dealt with at 'practice reviews' or 'annual reviews'. Just having the time raises lots of issues – very helpful!"
>
> "A true self-improvement course, quite inspirational, freshens my approach"
>
> "Being in a group was helpful, listening to other people discussing how they treat and cope with diabetes"
>
> "I now feel more up to date and have developed a genuine interest in understanding how to manage my blood glucose levels better"
>
> *Quotes from A&B ABBBIE participants*

Branching Out

Branching Out is a scheme first developed by *Forestry Scotland* in 2007 and in 2015 *Argyll & the Isles Coast & Countryside Trust* (ACT) launched a project to bring Branching Out to Argyll.

It aims to improve the quality of life of adults with moderate to severe mental health problems. Participants are referred by NHS community mental health teams. Branching Out supports people through a 12 week programme of outdoor, woodland based activities. These activities support members to overcome local issues such as isolation, lack of access to appropriate services and stigma. Taking part and making contact with other members of the group gives participants strategies to maintain positive mental health.

"When everyone started there'd be no eye contact. Now it's a vibrant group with lots of chat & a network of peer support"

"I've been an occupational therapist for 21 yrs. Branching Out has given us the best set of outcomes of any group work we have ever run"

Many participants in the programme need continued support and a follow on scheme ***Moving On*** picks up after the 12 week programme. It gives a different approach giving people the chance to volunteer for different activities shaped by the participants themselves. Projects such as producing books of poetry and recipes are examples of the therapeutic benefits of the programme.

Branching Out: 2 years on

- 16 programmes completed across Argyll & Bute
- 5 teams able to deliver programmes
- 226 people referred
- 120 have completed a John Muir award
- 12 Moving on pilots trialled

Branching Out in Argyll costs on average £43/person per 5-hr session. It achieves all of the outcomes outdoors in a group setting that an OT would hope to achieve in a clinical, 1-to-1 setting.

14% of the average cost of running a session has been spent on participant travel. Lack of access to activities contributes to social isolation; enabling travel is key to combating it.

"We are talking about ordinary people doing ordinary things like making themselves a seat and a table to sit and eat from... people working together and getting on. People like me who seldom sees anyone, cannot even approach being angry in that situation."

BEES

Walking slowly
through the trees
I somehow hit a hive
of bees
Upset they were
And they attacked
I ran behind Carlyn and threw her back
Stung she was
And set for a fight
I took to my heels and I took flight!

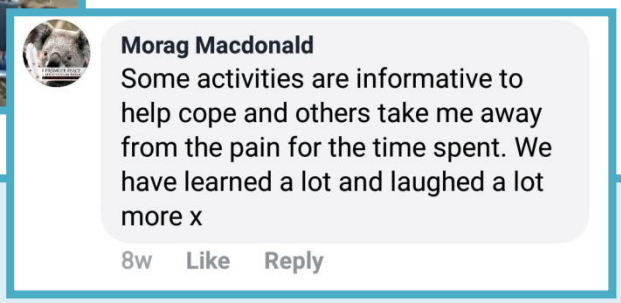
-Gus

MS Centre, Mid Argyll

The Multiple Sclerosis(MS) Centre, Mid Argyll supports people living with various long term conditions across Mid Argyll, Kintyre, Islay and Jura to effectively self manage their own conditions enabling them to live happier, more fulfilling lives. The service offered is highly personalised, with support often given to the whole family, not just the person with the condition(s).

Over the years the work and reach of the organisations has grown and developed to include an outreach service for people previously hard to reach.

Recipients of the service have described the crucial difference the work of the MS Centre, Mid Argyll have made, not only for their self management but their overall wellbeing and it has become a fundamental part of their life.



Support is offered in a variety of ways with access:

- to a range of therapies
- to a range of exercise classes all adapted for people with poor mobility, balance or for those who have not exercised for a while.
- to self management workshops and Pain Toolkits
- to Peer support
- to education on own condition, educating family and friends through our Try on A Long Term Condition workshops.
- to one to one supportive listening and preparation for appointments
- to scribes for benefit forms, and companion as assessments.
- to community activities and groups
- to Group and individual outings.
- to up skilling for centre Members to enable and empower them to become volunteers, run classes -
- to Home visits
- to networking and signposting to other organisations
- to online support through private facebook groups
- to connecting people in their own homes to group members participating in our self management workshops.

Wellness Recovery Action Plans (WRAP)

Wellness Recovery Action Planning (WRAP) grew out of the personal experience of people living with long-term mental health conditions. It helps them take control over their own mental health recovery and wellness. It recognises that they are the expert in their own experience and there are no limits to recovery.

Resources that encourage self-compassion and boost optimism

- ***Wellness Tools***: what you do already to keep yourself well. Activities that you enjoy, that help you through the day.
- ***Daily Maintenance Plan***: the daily routines you need to keep yourself feeling well and in control of your life.

Source: Scottish recovery network

WRAP can be used every day to help people deal with challenges to their mental health.

WRAP Workshops are not classes, but small groups where everyone has an equal voice. Over 9-12 hours of workshop sessions the focus is on wellness and recovery not illness. Facilitators are people who have their own recovery story and journey who are trained to share their experiences of wellness not illness. WRAP workshops have been held regularly in Cowal and Bute. They are likely to be replaced with a new peer led model of support called peer2peer. This model is based on the same principles of supporting people to build inner resilience.

The philosophy of WRAP recognises that everyone is unique, and their path to improved wellbeing will also be unique.

Through this peer-led self-management process people can also be signposted to skills like: changing habits and behaviour; assertiveness; self-talk and affirmations; goal-setting; problem solving; mindfulness; grounding (for anxiety); focusing; breathing and relaxation exercises; journaling.

WRAP supports people with their mental health recovery and to gain resilience.

Recognising that life brings you knocks, and preparing to deal with them:

- **Triggers and Action Plan:** the things or events that make you feel low or stressed and how you can plan to deal with the effects of these triggers.
- **Early Warning Signs and Plan**: the signs that tell you that you are starting to struggle or becoming unwell, and plan to control these early warning signs.
- **Things Are Starting To Break Down Plan:** in spite of your best efforts you begin to feel worse and worse and you need to plan to stop things getting even worse.
- **Crisis Plan and Post Crisis Plan**: during and after very difficult periods, to help you get back in control.

Fundamental to this is belief that people can and do change, learn and grow, including gaining insight into what keeps them well, being curious about their responses to life and trying new ways to keep well and deal with setbacks.

SIGNPOSTING

Useful Links & Organisations

These are just some links that may be useful for people looking for more information relating to health, support, advice. They are also useful for our workforce and partners to help them to sign post people.

We have only identified a very small number of resources here. NHS Inform, Argyll & Bute Advice Network, and Argyll & Bute Council also have links that will direct people to a wide range of services available to them.

Advice & Information

NHS Inform - Health information and links to trusted information sources
www.nhsinform.scot/

NHS 24 – Out of hours advice for urgent health concerns and self help guides to help you manage everyday health concerns. www.nhs24.scot/

NHS Highland –Find NHS services in Argyll & Bute.
www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute

Argyll & Bute Council – Access to Social care, housing, welfare and other Council services in Argyll & Bute. www.argyll-bute.gov.uk/

Argyll & Bute Advice Network – Access to some local services
www.argyllandbuteadvice.net/

ALLIANCE Scotland –A national voice for self management and other resources
www.alliance-scotland.org.uk/

Healthy Argyll & Bute – Website for Health & Wellbeing .
www.healthyargyllandbute.co.uk/

Pain Association – Support in managing chronic pain.
www.painassociation.com

Marie Curie – Cancer and terminal illness support.
www.mariecurie.org.uk/

LAAS – Advocacy service for patients and carers in Lomond and Argyll.
www.laas.org.uk/

SAMH – Scottish Association for Mental Health, can connect you to mental health services and support.
www.samh.org.uk/

Scottish Recovery Network – An initiative to promote recovery from mental illness and trauma.
www.scottishrecovery.net/

Community pharmacy – Your local pharmacy can offer support, advice and treatment for minor ailments and minor illness

Appendix I

Data on Long-Term Conditions in Argyll & Bute

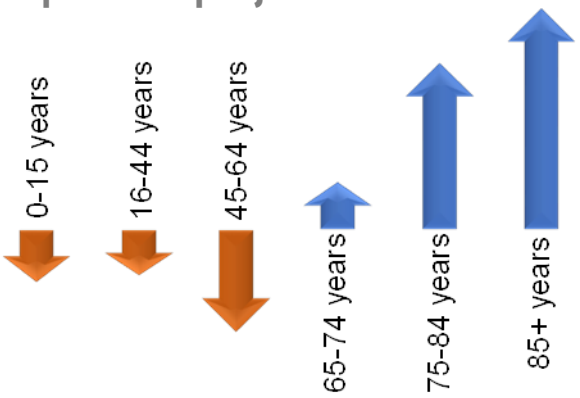
2019 Population size

86, 863 people

Age	Number	%A&B	%Scotland
0-15	13,086	15%	17%
16-44	25,111	29%	37%
45-64	25,834	30%	27%
65-74	12,349	14%	11%
75-84	7,388	9%	6%
85+	2.595	3%	2%

Argyll and Bute has a higher proportion of older people than Scotland as a whole, with **11.6% aged 75+** compared to 8.5% nationally.

Population projections 2019-2029



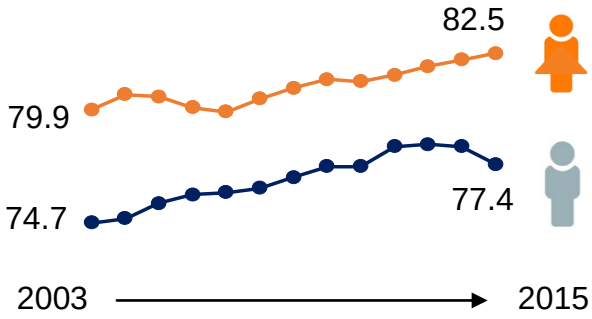
Over 10 years, the population is projected to **decrease overall by 4%** to 83,120 people. The population is projected to **increase by 32% for those 85+** to a total of 3,437 people in 2029, with an increase to 2,715 people by 2021.

The decrease in population overall and increases in numbers of the oldest in society represents a challenge to the model of how care is delivered.

People report that they wish to remain in their own homes if possible.

Source: National Records of Scotland (NRS) 2016-based population projections

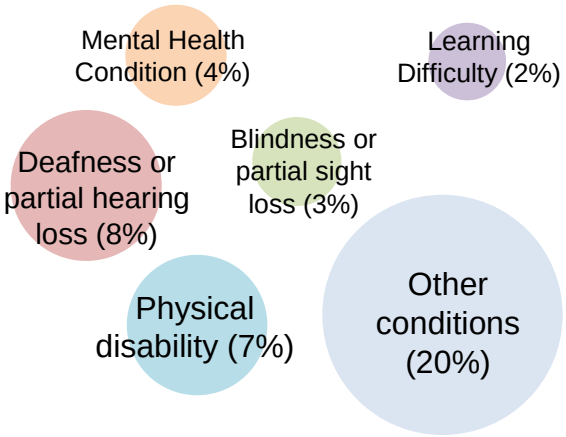
Life expectancy



Source: Scottish Public Health Observatory (3-year mid-point) life expectancy from birth

Life expectancy in Argyll and Bute has increased but remains lower for **males (77.4 years)** than for **females (82.5 years)**. Male life expectancy is close to Scotland as a whole (77.1 years). Female life expectancy is **higher than for Scotland** as a whole (82.1 years).

Health Conditions



Overall, **32%** said they had **one or more health conditions**. This rose from 10% in those aged 0-15 to **86% in those aged 85+**. The most common conditions were **deafness or partial hearing loss** (25% of those aged 65+) and **physical disabilities**.

Source: Census 2011 Note that people could select more than one type of condition

Appendix 2

Associated Documents

All of the below documents can be found at
www.healthyargyllandbute.co.uk

Scoping and Planning Event
A report on the scoping and planning event held with key partners in August 2018

Living Well Engagement Report
This report summarises our 3 community and public enagagement sessions we held while developing this strategy. The reports from the individual sessions in Lochgilphead, Kintyre and Islay are available on our website as above

Staff Survey Report
This report summarises the responses from our staff engagement survey

Consultation Report
This report summarises the responses to our survey on the consultation of the draft strategy.

GLOSSARY OF TERMS

Key words & phrases

AHP	Allied Health Professions, a term which covers all healthcare workers who are not doctors, pharmacists, or nurses. For example: physiotherapists, clinical scientists, or dietitians.
ACP	Anticipatory Care Plan. A plan arranged between a person, their carers/family and their health professionals, to ensure their needs and wishes are taken into account in future care.
Comorbidity	When multiple conditions or illnesses exist in the same patient – common with long-term conditions.
HSCP	The Health and Social Care Partnership, an organisation combining NHS and Council resources in Argyll & Bute to provide health and social care services in the area.
HWN	Health and Wellbeing Network. A network which brings together health and social care staff, volunteers, and service users to help improve and support healthy living. There are 8 local HWNs in Argyll & Bute.
LPG	Locality Planning Group. There are four LPGs in Argyll & Bute, and their function is to bring together key players in health and social care to make decisions on a local level about services.
Long Term Condition	Also “LTC”. Any health condition or illness that lasts longer than 4-6 months, particularly if it has an impact on lifestyle or capacity.
MI	Motivational Interviewing. A technique to effectively help people to change their behaviour.
MSK	Musculoskeletal. MSK practitioners include physiotherapists, rheumatologists, and occupational therapists.
Person-Centred	An approach to services that is built around the individual and recognises the need for people to have a voice in their own care.
Power of Attorney	A written authorisation for someone else to act on your behalf in legal matters if you become incapable.
Polypharmacy	A situation where someone is taking multiple different medications at the same time.
Third Sector	Voluntary services and not-for-profit organisations.
WRAP	Wellness Recovery Action Plan. A plan for managing conditions, designed by the person themselves and with a focus on their strengths and capacity.

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Partners & Sources

NHS Highland
Argyll & Bute Council
Argyll HWNs
Versus Arthritis
MS Centre Argyll
ALLIANCE Scotland
Kaiser Permiente
Health Foundation
LOHO
Argyll & Bute Self-Management Partnership
Strachur Hub
Branching Out
Scottish Recovery Network
Argyll and Bute HSCP Public Health Department

Find our complete action plan and a summary of the strategy at:
www.healthyargyllandbute.co.uk

To keep up with health and wellbeing work in Argyll and Bute:

On Facebook
Search ***HEALTHY ARGYLL AND BUTE***

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