

## Response to consultation on health and social care strategy for older people

### Introduction

This response to the consultation on a health and social care strategy for older people was led by the Advanced Care Research Centre (ACRC), with the input of a wider group of academics and researchers.

The ACRC<sup>1</sup> is a research centre focused on care in later life. We are undertaking an ongoing multi-disciplinary research programme combining research across fields including medicine and other care professions, engineering, informatics, data and social sciences. Our vision is high-quality data-driven, personalised and affordable care that supports the independence, dignity and quality-of-life of people in later life living in their own homes and in supported care environments.

### Key themes in this response include:

1. Issues relating to care homes are raised in a number of our responses to questions; and we believe they could be an exemplar of opportunities for integration. Care homes are a key site of care for some of our most vulnerable citizens, but the nature of those resident in care homes has rapidly changed with relatively little change in how they are organised or funded. We welcome the concept of the National Care Service (NCS), but there is a need to rethink how both health and social care is delivered in this context.
2. Palliative care and anticipatory care planning, or as we might call it 'care in later life', is often focused at end of life rather than earlier on. Not every older person wishes to have such a discussion, but enabling and empowering older people to have discussions about 'what matters to you?' will be critical in ensuring that clear anticipatory care plans (ACP) and eKIS (Key Information Summary) exist to inform appropriate escalation (or not) of care when unexpected events happen. For older people (and frail people at any age), planning should therefore be offered sooner and not just focused on death/dying, dementia or care home admission but rather on how to be better prepared for a wide range of changes in health.
3. Exercise and physical fitness have an important impact on physical and mental health, and must be a key part of the preventative strategy.
4. Mental health services have been undersold and need particular attention to reach even pre-COVID levels of treatment.
5. Technology provides opportunities for intervention but only where they are designed for context, with the user in mind. They will not be the answer for everyone. This was shown with video calls during COVID – they can work for young people, but less reliably for older, frailer and/or cognitive impaired people.
6. Poorly connected IT systems and clinical/care records are a significant problem, but cultural differences and barriers are likely to be as important as structural ones (or put another way, structure won't solve culture).
7. There is inevitably a tension between national and local; centralisation and decentralisation. There isn't a perfect answer to this, so in some ways it's probably a 'final point' which is that this will need working out over time no matter what the initial choice is, i.e. an 'implementation phase' with some leeway and evaluation.

The consultation document does not explore how the aspirations laid out within it are to be funded. This is a fundamental question, which requires difficult decisions to be made about resource allocation. Many health and social care workers are tired and some are 'burnt out' after having worked so hard throughout the pandemic, often at significant personal cost to themselves. This can lead to experienced health and social care workers, who are needed to take forward the aspirations in this document, taking earlier retirement or moving to other sectors. Additionally, new staff need to be trained and recruited. How to ensure that there are

sufficient health and social care staff to deliver the aspirations laid out in this document is a complex question but one that needs addressing.

### **Our responses to specific questions**

**Question: When thinking about health and social care services for older people in Scotland, what do you feel has worked well in the past? What is currently working well? How do you think services could be improved?**

No service will work well if underfunded, and some of the costs and delays in the system flow from a lack of resources elsewhere. ‘Delayed discharges’ due to delays in organising packages of social care, and admissions that result from capacity blocks in the community are common. Prolonged hospital stays are known to be highly problematic in older people due to physical deconditioning and delirium, and it is notable that in the last decade there has been more financial pressure on: social care, resulting in the threshold of need to receive social care rising; and also primary/community medical care, where GP funding and workforce capacity has been static despite steadily rising need. There are no quick financial wins, but continued under-investment in primary care and social care will lead to unnecessary, expensive and sometimes harmful use of hospital services.

Better use of digital and other technologies offers opportunities for more flexible and effective primary and community care, but these technologies are not always designed for use by older people. Video consulting during COVID-19 restrictions is an example, where many trips to hospital or the GP for short consultations can be avoided, but many older people do not have the right technology or find it difficult to use it because of physical, sensory or cognitive limitations, or because of unfamiliarity. Digital and technology innovation is therefore not a panacea in care for older people, and needs to be carefully designed, implemented and evaluated.

There is the potential for digital and technologically focused interventions but the user and context is key, with the example of video calls during COVID a key example, in that they worked for some younger people, but less well or not at all for older and frailer people. There is an opportunity to look at all the wonderful digital health that is out there and think about how it can be integrated into the NHS and other services. It is not the answer for everything, and it should be an enabler, but there are opportunities where it could be scaled up.

The comments received in the Scottish Government’s consultation meetings about how social care could be improved very much reflect what older people have told us, and what contributors to this response have seen in clinical practice. Delays in obtaining packages of care for people who need to be supported at home after a hospital admission are one of the key reasons for ‘delayed discharges’. This means that the older person remains at risk of hospital-acquired infection, delirium and physical deconditioning, for examples. Also, ‘delayed discharges’ are one of the key reasons for delays in being able to admit people with acute illness to hospital. The availability of, and access to, social care needs to be increased to address these problems.

Older people are resources in their own right and many are carers, for partners/family members e.g. grandchildren - reciprocal thing – not just users, providers of resources. We need services and more support in the community e.g. surgery and post-surgery care, otherwise people are discharged from hospital but then have to return. Broader issues around ageism, and bias, such as around ethnicity also need to be taken into account. The cost of living crisis is going to impact on older people – huge economic inequality in old age, pensions have kept up with inflation, up to a point poverty wasn’t as extreme as it had been in the past, returning to that, pensions not keeping up with inflation. There is also a huge gender inequality in access to pensions, most older

people are women, most very old are women and most carers are women. Poverty is greater due to less access to occupational pensions etc., ethnicity inequalities equally less likely to have access to pensions (occupational or private or capital), and are run through old age, not specific to a particular cohort.

**Question: What could be done to improve joint working between health and social care services?**

There are major problems due to the lack of connectivity between health and social care. This includes both lack of data connectivity and limited multidisciplinary working.

Poor data connectivity exists within the NHS, but there is a stark divide between health and social care, where electronic records are less common and not always interoperable with each other never mind the NHS. There could, and should, be better communication between services, and more joined up systems. Most NHS systems don't 'talk' to each other currently and this means that information can be lost or not be transferred from one setting to the next, and the gap between NHS and social care systems is even larger. This means that older people and their families are often left having to try and explain discussions that occurred in other settings, which is time-consuming, and important information can get lost. Rather than think about big changes or improvements, a key first step is to start looking at where existing systems could work better together and complement each other. Once that is understood, then we can start looking at where there are gaps and consider how we could address these. It would be really useful to involve NHS and social care staff in these discussions, because they will already know the various communication streams that they use on a regular basis, but the lived experience of older people and their families is also critical to consider.

Beyond individual care, our understanding of primary care and social care is limited by the lack of key data for planning, evaluation and research. COVID-19 brutally revealed that we do not reliably know who is resident in care homes (including people with short/temporary stays) and we do not reliably know who is in receipt of publicly funded care at home. Hopefully, central datasets like SOURCE will improve this, but there is need for board, integration joint board (IJB), and health and social care partnership (HSCP) level intelligence and insight in order to properly understand who this group of vulnerable older citizens are, and what their needs and patterns of care are.

Poorly connected IT systems and clinical/care records are a significant problem, but cultural differences and barriers are likely to be as important as structural ones; or to put another way, structure won't solve culture. There are also often important differences in culture between different staff. This includes between health and social care in general, but also within each, such as primary care and hospitals; social workers and social care staff. An NCS could have the potential to improve some of this, but there are also a number of other changes taking place, such as around mental health legislation, and there is a need to ensure the different changes are coordinated and speaking to each other, such as the focus on human rights. We need a systematic or systemic approach. There is also work needed between services to address cultural differences, coming together more often to see the other's point of view and move beyond that. Part of this would also involve bringing together training.

From the evidence from the users of social care and older people, there are a lot of a lot of things happening in silos and people seeing things as not their responsibility, from the perception of patients and their families/carers. Things can slip through and there can be a sense of lots of different people involved e.g. social worker, GPs, health and hospitals but lots of other things there that are part of health and social care service – 'that's not me, that's someone else'. People on the ground don't know how the system works, don't know what a role is, find they are repeating themselves to multiple healthcare professionals and others, and this has been

the case for a long time. There is a need for clarity on who is responsible and who to go back to if you have a problem.

An NCS could have the potential to improve some of this, but there are also a number of other changes taking place, such as around mental health legislation, and there is a need to ensure the different changes are coordinated and speaking to each other, such as the focus on human rights. We need a systematic or systemic approach. The system should be holistic, so that if, metaphorically speaking, you open one door you get to whole system. There is a tendency for statutory central government funded services to imagine the third sector will pick up problems. The danger is policy change to support health and social care integration has happened but is in fact for person on the ground hasn't.

There is evidence from COVID-19 that unpaid carers were the people who picked up the problems, and there is a real need to look at what carers are saying, the reality of family care is that they will pick up the pieces, and have been hard hit by services that were closed in March 2020 and have not yet opened up again. Day services, such as lunch clubs, are sporadic.

**Question: When is a good time to have discussions about Anticipatory Care Planning with older people?**

**Question: What would assist you in having discussions with family or medical professionals about how you would like to be cared for, as you approached the end of life?**

Anticipatory care planning is beginning to be utilised more widely, but is often focused at the end of life rather than earlier. Not every older person wishes to have such a discussion, but enabling and empowering older person to have discussions about 'what matters to you?' will be critical in ensuring that clear anticipatory care plans (ACP) and eKIS (Key Information Summary) exist to inform appropriate escalation (or not) of care when unexpected events happen. For older people (and frail people at any age), planning should therefore be offered sooner and not just focused on death/dying, dementia or care home admission but rather on how to be better prepared for a wide range of changes in health.

There are examples of developing good practice in this space. For example, contributors to this response have just completed a training package for staff on Realistic Conversations with NHS Education Scotland (NES) which covers both shared decision-making more widely and anticipatory care planning based around the REDMAP model and including guidance on effective and potentially harmful communication approaches in handouts for trainers (community ACP example)<sup>2</sup>. They have also updated an ACP public information video (aimed at people of all ages) on the NHS Inform page<sup>3</sup>. The approach is described in a published editorial (also from last year).<sup>4</sup> It would be useful to better understand best practice and innovation in anticipatory care planning across Scotland to facilitate further embedding of anticipatory care planning. The itself can be off-putting to older people and families, and other names for it such as 'Realistic Conversations' may be more appropriate and work better.

We suggest that this could also be expanded, mentioning the term 'shared decision making', where the views of the older person are of central importance to decision making, and where the role of health care professionals is to talk honestly about treatment options, and support the older person to make difficult decisions. However, for people with dementia or stroke or delirium, where people's ability to communicate their views has been lost, this can be particularly difficult, and clinicians needs engage with the family, to explore what the person's views would be if they could express those views themselves. This has to be done sensitivity to avoid family

feeling overly responsible for such decisions, because sometimes difficult choices between survival with severe disability, or death, need to be made.

**Question: What is currently working well to support older people who require urgent or emergency care? What could be improved? Is there anything else you would like to add?**

The distinction between planned and urgent care is a blurred one, with much urgent care being dealt with by daytime general practice for example. Similarly, the distinction between primary care and hospital care is also sometimes unhelpful, because many older people would benefit from services which cross the divide.

As identified above, improving anticipatory care planning and making it more widespread is important, but there are also specific types of planned generalist reviews which would also benefit from being more routine. The key example is medication review, particularly for those with very complex medication regimens (polypharmacy or high-risk prescribing) or near the end of life (when 'indicated' drugs will sometimes be futile or harmful). Complex medication review requires a team based approach involving older people, their families, generalist doctors (usually GPs, sometimes geriatricians) and pharmacists. Scotland has many examples of good practice including national polypharmacy guidance and much improved medicines reconciliation at transitions between community and hospital, but implementation remains variable by area. Given that drug adverse events are a common cause of harm and hospital admission, better medicines management has the potential to deliver considerable benefit but will need adequate resource to deliver consistently.

Intermediate care services, such as hospital at home, rapid response teams and falls services are an important way to support the acutely unwell older person to safely remain at home. However, how they are organised and accessed varies by area, with variable eligibility. Fuller integration with primary and hospital care would be beneficial. Other kinds of intermediate care are less well developed in many areas, including community hospitals (or equivalent NHS capacity in care homes), and access to generalist-led multidisciplinary team assessment and intervention in the community (often called 'comprehensive geriatric assessment' although it is an intervention not an assessment). This approach is a highly effective intervention in people admitted to, or recently discharged from hospital<sup>5 6</sup>, and is likely to be effective in older people at high-risk in the community. Implementation of this approach in community settings is recommended, with careful evaluation of costs and impact.

Care homes are a key site of care for some of our most vulnerable citizens, but the nature of those resident in care homes has rapidly changed with relatively little change in how they are organised or funded. Specifically, the needs of people living in care homes have become increasingly complex, but the amount and type of care provided to residents has not increased to match. As a result, people living in 'residential care without nursing' have very high health care needs and resemble those living in 'residential care with nursing' 10-15 years ago. We welcome the concept of the NCS, but there is a need to rethink how both health and social care is delivered in this context. Social care workers will need better training and support to develop skills in health assessment, and care homes need more consistent health care support than is currently provided by primary medical care. Developments such as the use of specialist liaison services (in older age psychiatry) and attachment of Advanced Nurse Practitioners (ANPs) are promising, but need implementation and evaluation at wider scale. A specific example is the provision of palliative care. Almost one in five deaths now occurs in care homes and this is likely to rise. Care home staff commonly provide excellent, compassionate care at the end of life, but staffing levels, training and health care support is variable and sometimes inadequate (particularly compared to hospices for

example). Involving and supporting social care staff in anticipatory care planning, and providing adequate NHS support social care workers to provide optimal end of life care should be a priority.

A project, led by Dr. Jo Hockley, is looking at developing a teaching/research-based Care Home Centre of Excellence and Community Engagement, called ToRCH.

**Question: Is there anything else you would like to add about preventative and proactive care for older people?**

**Question: Access to leisure facilities or any other type of physical activity – what would make this easier?**

Exercise and physical fitness have an important impact on physical and mental health, and is a key preventative strategy. Our response to this question is largely taken from an ACRC briefing paper on ‘Physical activity: An underrated intervention for people in later life’ published in June 2022.<sup>7</sup>

Physical inactivity is the fourth leading cause of death, with a similar risk to health as smoking and obesity.<sup>8</sup> The World Health Organisation (WHO) Global Action Plan<sup>9</sup> and Scottish National Policy for Active Living<sup>10</sup> were launched in 2018 with the aim to support people to be ‘more active, more often’. However, progress to increase physical activity levels, particularly for older people, has been slow.<sup>11</sup>

The main problem, particularly for people over 65, is that levels of inactivity remain high in the UK and many older people are sedentary for more than 8.5 hours a day.<sup>12</sup> In Scotland, national survey data for 2018 suggests that whilst 67% of those aged 45-54 met the recommended physical activity guidelines, this drops dramatically to 31% among those aged 75 and over. Furthermore, older people living in the most deprived areas are at most risk of inactivity.<sup>13</sup>

There is overwhelming evidence for the health benefits of a physically active lifestyle and exercise. Unlike many pharmacological interventions, physical activity can be beneficial for several physiological systems simultaneously, such as metabolic (Type 2 diabetes) heart disease and musculoskeletal conditions without causing harm or other contraindication.<sup>14</sup> In addition, benefits to mental health, such as depression and anxiety can be alleviated by physical activity. Even light physical activity can reduce depression and the mental health impact associated with isolation in older people.<sup>15</sup> Consequently, physical activity has potential to impact on health across the life course. However, we know that simply advising people to be active isn’t helpful and counselling people in primary care to promote physical activity has a limited effect.<sup>16</sup> Most research focuses on individual level behaviour change interventions,<sup>5</sup> yet behaviour change is complex and a more united effort across policy, academia, communities and health and social care is needed<sup>3</sup>.

The WHO Global Activity Plan on Physical Activity recommends a ‘whole system’ approach that takes into account society, systems of governance, equitable access to opportunities and services (see the image below)<sup>3</sup>.

*Figure: Recommendations for increasing physical activity for older people (adapted from WHO Global Activity Plan on Physical Activity, 2018).*



Exercise and fitness training also prevents frailty and reduces the risk of cardiovascular disease, stroke and cancer (as well as falls and dementia). Furthermore, there is also an increasing body of evidence that too much sitting (sedentary behaviour) is a risk factor for poor health, independent of the time spent doing physical activity-some important research in this area has been led by Scottish researchers. We also know that enabling older people to participate in exercise and fitness training is complex and difficult. Understanding and addressing barriers to participation need to be addressed, including people knowing what is available, and how often to go, and with the cost whether to access activities as well as clothes, equipment and transport.

**Question: Is there anything else you would like to add about mental health services for older people?**

The impact of the pandemic disrupted different services and this was dealt with differently in different areas and even within different hospitals / clinics in different areas. For instance, in some areas, they turned memory clinics to phone only as they didn't have the equipment for video calls. It is difficult to assess people over the phone re dementia. For some cases, it is obvious but for most, it's not good enough. There are huge waiting lists and a backlog.

With mental health services, for instance with a cognitive impairment, there is a need for family members to help. If individuals can do a video call by themselves, they, in all likelihood, didn't have dementia. Hearing impairments also made calls difficult.

Mental health services' importance was undersold. Access was closed and there is a risk of digital exclusion. It is better now, but there remains a backlog. In terms of community facilities and the third sector, some clubs and services are still closed. The base level before COVID is still not being met. We need better integration with social care, and more social work input into discharge planning meetings, for instance. This would help people be discharged quicker, into the community and help provide the right services at the right time. We should have no cut off for access to general therapies for depression etc. for instance Health in Mind Midlothian<sup>17</sup> should be available to anyone aged over 16, but is restricted to 16-65 years old.

In addition to improved access to services, different services could "talk" to each other better, e.g. GPs to psychiatry, relevant nurses etc. Communication between different parts of the healthcare system – in some

areas, hospital records are in same system; elsewhere, completely different and suggests stigma related to mental health remains.

More needs to be done to support old age psychiatrists to be trained. According to Alzheimer's Scotland, there are 90,000 people with dementia in Scotland and only 3,000 of those are under 65.<sup>18</sup> By 2031, it is projected that there will be approximately 102,000 to 114,000 people with dementia.<sup>19</sup> Yet, 10% of psychiatry posts in Scotland remain vacant.<sup>20</sup>

## **Preventative and Proactive Care**

### **What is currently working well?**

It is difficult to fully answer this because we are in a period of flux – many older adults have stopped accessing services because of COVID and many have not yet returned to normal life in the same way younger adults have done. There are also more issues with accessibility – travel is a particular barrier given the lack of public transport and reduction in community provision (e.g. dial-a-bus). It is also quite an individualised question – different services have different success rates. The postcode lottery has always been an issue – access to appropriate services can be restricted based on where one lives and what is available locally, both in terms of referrals and accessibility. Access to services in rural areas, even though on the peripheral areas of big cities, have always been difficult to access, including for those living in affluent areas. There is much to be done to improve accessibility, and this is linked to understanding what is needed in areas. There may be informal provision which is sufficient for some contexts, and therefore more formal efforts can be focused elsewhere. So a better understanding of services is needed and a review with those who use / may use them would be useful to understand what needs to be improved from the perspective of those who are service users. However, realistic medicine and time for GPs to rationalise medication in response to increasing frailty is working.

We have also found hospital at home, intensive GP / community nurse / carer input to manage common conditions that previously resulted in hospital admission, such as delirium or problems walking, have helped. This is also the case with rapid response teams / falls teams via single point of access i.e. integrated local multi-disciplinary teams (MDTs), and having more generalist teams who are prepared to see anyone, both in hospital and the community. Also, empowering anticipatory care conversations with older person and their families.

### **How do you think services could be improved?**

Services could be improved in several ways: firstly, by avoiding the Beveridge fallacy, we postpone but rarely prevent inevitable decline, polypharmacy reviews by experienced generalist clinicians who are capable of managing complex holistic decisions, usually a GP, and the enablement / empowerment of the older person to have the 'what matters to you?' question leading to a clear anticipatory care plan (ACP) and eKIS (Key Information Summary) to inform appropriate escalation of care (24/7). Finally, as above, further rapid response and hospital at home, when led by generalists who practice realistic / holistic medicine.

### **Is there anything else you would like to add?**

Prevention is very difficult to implement, given it can be difficult to define what actually needs to be prevented. Older adults can become overwhelmed when considering all the things they need to do in an attempt to prevent the many issues that may occur as a result of aging. If there is a defined need to prevent – then the appropriate

mechanisms should be provided including clear information about why the prevention intervention is being implemented / introduced to the individual. Otherwise, more general efforts such as life-long healthy approaches to live can be more effective.

**What support would you need to assist you in self-managing your general health or any long term health conditions that you have?**

This is an important issue and we suggest the 'House of Care approach'<sup>21</sup> and that all clinicians are trained in CARE approach with focus on the empowerment element as we know that most clinicians score lower on this (and measure patient experience with CARE measure + provide further training for those in need of further input). Volunteer run walking groups etc. rather than the focus on delivered services in expensive to build 'facilities'. Use of third sector (Church halls / village halls / community centres). Here would be the opportunity to look at all the wonderful digital health that is out there and think about how it can be integrated into NHS / services. It is not the answer for everything, and it should be an enabler in many instances, but there are opportunities out there that could be scaled up.

**What support do older people need after surgery?**

Like other areas, this is individual and depends on if they have someone at home or if they don't – and also the capability of the person / people who are at home. Arguably, the only way to deliver 'good', optimal care is to develop systems that are all for individualisation and support.

Post-surgery can be a lonely time for those who don't have anyone and they can experience a roller-coaster of emotions, which can lead to longer-term issues that related to mental health issues, as well as a reduction in physical capability. In terms of physical – patients need to be encouraged to get up and get moving as soon as it is safe for them to do so. They might need support to do this and that can include someone to help them physically move, but also support to understand why they are being encouraged to move and the benefit this can have for them. Mentally – it can be useful for patients to have someone to talk to about their experience and to support them emotionally in their recovery.

**Integrated Unscheduled Care**

**Is there anything else you would like to add?**

Easy access to expert medical generalist supported by generalist nursing and care teams. More generalists in hospital who have experience of community based care, such as GPs or nurses with community experience, to enable appropriate management. Appropriate community based nursing care with increased GP resource to provide medical cover as required. When a full complement of district nurses with carer support in place then exceptional care to allow someone to die at home possible.

**If you have any queries about this response to the consultation, please contact Layla Robinson, Partnership and Engagement Manager ([Layla.robinson@ed.ac.uk](mailto:Layla.robinson@ed.ac.uk)); or Rob Mackie, Communications Officer ([rob.mackie@ed.ac.uk](mailto:rob.mackie@ed.ac.uk))**

## Contributors

The following people have contributed to different parts of this consultation response:

- Dr. Drummond Begg, General Practitioner (GP), Penicuik
- Dr. Kirsty Boyd, Reader in Palliative Care, Molecular, Genetic and Population Health Sciences, Usher Institute, University of Edinburgh
- Dr. Helen Frost, Research Fellow, Advanced Care Research Centre (ACRC), University of Edinburgh
- Prof. Bruce Guthrie, Professor of General Practice and Director of the Advanced Care Research Centre (ACRC), University of Edinburgh
- Dr. Jackie Gulland, Senior Lecturer in Social Work, School of Social and Political Science, The University of Edinburgh
- Dr. Jo Hockley, Research Fellow, Deanery of Molecular, Genetic and Population Health Sciences, Usher Institute, University of Edinburgh
- Dr. Pearse McCusker, Senior Lecturer in Social Work, School of Social and Political Science, The University of Edinburgh
- Prof. Gillian Mead, Professor of Stroke and Elderly Care Medicine, Ageing and Health, Usher Institute, University of Edinburgh
- Dr. George Palattiyil, Senior Lecturer and Head of Social Work, School of Social and Political Science, The University of Edinburgh
- Dr. Lucy Stirland, Old Age Psychiatry, St John's Hospital & Postdoctoral Clinical Lecturer in Old Age Psychiatry, University of Edinburgh
- Layla Robinson, Partnership and Engagement Manager, Advanced Care Research Centre (ACRC), University of Edinburgh

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<sup>1</sup> [www.edin.care](http://www.edin.care)

<sup>2</sup> [ACP in the Community \(REDMAP\) handout for participants | Turas | Learn \(nhs.scot\)](#)

<sup>3</sup> [Anticipatory Care Planning \(ACP\): Thinking ahead | NHS inform](#)

<sup>4</sup> <https://academic.oup.com/ageing/article/50/6/1894/6329810?login=false>

<sup>5</sup> Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, et al. Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane Database of Systematic Reviews. 2017(9)

<sup>6</sup> National Institute for Health and Care Excellence. NG56 Multimorbidity: clinical assessment and management. London: National Institute for Health and Care Excellence; 2016.

<sup>7</sup> [ACRC Briefing Papers | The University of Edinburgh](#)

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<sup>13</sup> The Scottish Government. The Scottish Health Survey. A National Statistics Publication for Scotland Edinburgh Scotland 2020

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<sup>17</sup> [https://www.health-in-mind.org.uk/services/midlothian\\_access\\_point/d99/](https://www.health-in-mind.org.uk/services/midlothian_access_point/d99/)

<sup>18</sup> [Statistics | Alzheimer Scotland \(alzscot.org\)](#)

<sup>19</sup> [Dementia Epidemic | Alzheimer Scotland \(alzscot.org\)](#)

<sup>20</sup> [Plans to transform mental health services set to fail if psychiatric roles aren't filled, RCPsych survey suggests](#)

<sup>21</sup> [Introducing the 'House of Care' \(health.org.uk\)](#)