



Whitelaw, S., Topping, C., McCoy, M. and Turpie, L. (2017) Promoting integration within the public health domain of physical activity promotion: insights from a UK case study. *Journal of Integrated Care*, 25(3), pp. 174-185.

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Deposited on: 28 July 2017

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Promoting integration within the public health domain of physical activity promotion:  
Insights from a UK case study

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Journal of Integrated Care

Vol. 25 No. 3, 2017

pp. 174-185

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1476-9018

DOI 10.1108/JICA-01-2017-0002

## **Abstract**

### Purpose

This purpose of this paper is to report and critically reflect on the methodological processes involved in a formal attempt to promote health and social integration in the rarely reported public health domain of physical activity promotion.

### Design/methodology/approach

A quality improvement (QI) methodology was deployed, comprising three elements: a diagnostic tool that assessed strategic and practice positions; a half day workshop that brought senior leaders together for to reflect this evidence; and a structured process that sought to generate proposals for future integrated action. A mixed-method evaluative approach was used, capturing insights of the integration processes via quantitative and qualitative data collection pre-event, in-event, immediate post event and at 6 month follow up.

### Findings

Insights suggested that despite some critical concerns, this QI process can be considered robust, offering pointers to elements required to successfully promote integration in this domain, including the significance of leadership, the preparatory contribution of a diagnostic tool and position paper, the opportunities for active exchange and planning within a workshop situation and the initiation of a process of integrated work via tangible 'pledges'.

### Originality/value

The paper offers originality in two respects. Generally, it describes and reflects on the relationship between theoretical and empirical dimensions of a model of integration promotion. Specifically, in offering an account of integrative public health work across health service, local authority and third sector partners, it addressed an area that has received relatively limited prior attention.

## Introduction

The theoretical desirability of increased levels of health and social care integration (HSCI) is well established historically (Sun *et al*, 2014), highly prominent in contemporary policy across Europe, North America, Scandinavia and various Commonwealth countries (Rummery, 2009) and evident within the specific context of Scotland (Hutchinson, 2015), where this paper is located. This trend has been accompanied by what Dickenson (2014; 190; *italics added*) sees as two investigative trends - “a proliferation...of *academic literature*” and “a whole industry....aimed at supporting the *practice of integration*”.

The former has been particularly prominent, seeking to variously: define ‘types’ of integration (Cameron and Lart, 2003); map the practice domains in which integration is pertinent (Taylor, 2015); and understand the various organisational, economic, professional and cultural dynamics of integration – particularly the notion of ‘enablers’ or ‘barriers’ (Cameron *et al*, 2015). The latter has tended to translate these theoretical insights into more pragmatic resources, for example: Edgren and Barnard (2015) consider the practical use of ‘complex adaptive systems thinking; Cameron and Lart (2003) set out the structural models through which integrated practice can be expressed (e.g. ‘placement schemes’, ‘multi-agency teams and projects’, ‘case or care management’ and ‘strategic level working’); Cook *et al* (2015) explore optimal pedagogical means of fostering integration (types of academic degrees, optimal educational approaches and forms of leadership development ); and Dickenson (2014) notes the existence of many practical toolkits and audits.

Two forms of critique have however emerged around these trends. First, there is a view that broad exhortations and generalised theoretical development have tended to eclipse practical efforts to promote integration and more realistic empirical assessment, resulting in a relatively poor evidence base (Stein and Rieder, 2009). Furthermore, some feel that the empirical evaluation of efforts at integration undertaken to date have tended to be of a relatively superficial and ‘mechanical’ nature, focussing on *structures* and *outcomes* and failing to capture the holistic and multiple subtleties of the integration *processes* (Dickenson, 2014). As such, Dickenson’s (2014) feels that “the primary debate...has shifted to how we might *make a reality* of this concept” (Dickenson, 2014; 189, *italics added*) and Williams (2012; 550-551) calls for more formalised and explicit “learning and knowledge management strategies”.

Second, in relation to the scope of the exploration of integrative efforts, some suggest that such work has tended to be directed towards acute clinical and care domains (e.g. Taylor, 2015) with relatively little attention being paid to increasingly significant areas where integration is important -

such as, for example, primary and community health services (Rummery and Colement, 2003) and of particular relevance to this paper, 'public health' type initiatives (Rummery, 2009).

The latter has tended to focus variously on 'up-stream' interventions (Hung *et al*, 2007), promoting positive 'well-being' (Friedli *et al*, 2009) and encouraging 'self-management' (Scottish Government, 2013) and in the context of 2014's *Scotland's Public Bodies (Joint Working) (Scotland Act)*, Bruce and Parry (2015) suggest that this is ground on which the need for effective integration is particularly significant.

Whilst some reporting of integrative public health work across health service, local authority and third sector partners has indeed occurred [for example, in relation to 'social prescribing' (Brandling and House, 2009), Men's Sheds (Morgan *et al*, 2007) and, again with specific relevance to this paper, on physical activity (PA) promotion partnerships and integration (Lucidarme *et al*, 2014; Parent and Harvey, 2009)] this has tended to be of project-specific nature with relatively little detailed reporting of the particular integrative dynamics.

In this context and using an evaluative approach that specifically sought to capture the complex nature of the integration process in a relatively holistic way, this paper reports on a formal intervention, *Creating an Active Infrastructure for Health and Social Care (CAISHC)*, that sought to explore and promote the possible nature of integration within the public health domain of PA. It starts by describing the origins and nature of the initiative and goes on to set out an eight stage evaluation process developed by a specially convened working group including local and national working partners and undertaken before, during and after the event. It lays out the various findings of this work and concludes with a broader reflection on the nature of efforts to actively promote integration.

### **The initiative**

In the context of a national level effort to promote health and social integration and as a sub group of the Scottish Government led National Strategic Group for Sport and Physical Activity, the *Health and Social Care Physical Activity Delivery Group (HSCPA)* established a series of five strands of work (see figure 1 below) and the associated HSCPA Strategic Outcomes framework identified an aspirational outcome: '*improvement mechanisms are embedded into health and care service physical activity planning, delivery and review processes*'.

<insert figure 1>

A 'test of change' case study was then sought to explore this domain. On the basis of the high level of priority given to PA generally and specifically the existence of an active local PA Strategy Group (Dumfries and Galloway Physical Activity Alliance) and associated regional alliance vision, outcomes and key principles, the administrative region of Dumfries and Galloway (D&G) was identified as a suitable 'test' site. This region established a *CAISHC* project steering group in July 2015, comprised of national and local level colleagues from the NHS, Scottish and Local Government and two associated universities.

Based on evidence that such processes can be effective in nurturing integration and ultimately supporting a transition from organisational activity to organisational culture (Inkelas and McPherson, 2015), an established quality improvement (QI) methodology (NHS Scotland, 2015) was chosen as an appropriate evidence based vehicle for seeking to develop integrated and ultimately embedded and sustainable action to increase population levels of PA. This QI methodology had two elements.

Firstly a diagnostic tool was used to assess the current strategic and practice position in the locale. This tool set out four development areas ('leadership', 'education and workforce development', 'workplace physical activity for employees' and 'partnerships'). Each area set out a list of sub-criteria against which local evidence of current provision would be mapped. Intelligence on these themes was then gathered from purposely sampled key stakeholders within the local PA strategy group and the *CAISHC* working group and using an adapted matrix from the 'Public Sector Improvement Framework', a 'score' was assigned to each domain -ranging from there being 'little or no evidence' through to being 'national or international leaders'.

A second phase then brought together 27 senior leaders for a half day workshop event in December 2015. These delegates were drawn from NHS D&G, D&G Council and Third Sector organisations; for example, Chief Executives of NHS D&G and D&G Council, Director and Consultants in Public Health, Chief Operating Officer for Acute Services and HSCI, Directors of Finance and Strategic Planning, General Practitioner Performance and Reward manager, Head of Resource Planning and Community Planning and an elected council member. The event was made up of a number of elements associated with the QI appreciative inquiry approach: the prior circulation of the diagnostic assessment (as a briefing paper); a series of inputs/presentations from expert witnesses/critical friends on various evidence-based insights on ways to increase PA levels; small group work, tasked to reflect on the evidence presented; and a structured process that sought to generate proposals for future integrated action in the four development areas listed above; and ultimately, the identification of tangible 'corporate commitments' from each delegate to increase opportunities for

PA. Delegates were also invited to make personal commitments to support the necessary culture change for the promotion of regular PA as part of everyday lifestyle habits. The whole process is summarised below:

<insert figure 2>

### **Evaluation methods**

In an attempt to attain relatively comprehensive and sensitive insights into the whole process, a four-part, mixed methods evaluation plan was conceived from the outset of the initiative, using quantitative and qualitative data to access each aspect of the process:

- *pre-event*: comprising, intelligence gathering; completion of the diagnostic tool; drafting of a generalised 'position paper' highlighting a series of focal points/critical themes (both 'assets' and 'pinch points')
- *in-event*: comprising non-participant observation of critical friend inputs and subsequent small-group workshops by two rapporteurs;
- *immediate post event*: (i) participant questionnaire; (ii) a moderated focus group was held at the conclusion of the event with members of the working group plus critical friends to capture immediate thoughts/reflections on the event process and potential outcomes; (iii) collation of pledges;
- *6 month follow up* to review progress against commitments.

### **Findings**

#### **Diagnostic tool**

Throughout the second half of 2015, a sub group of the D&G PA Alliance gathered local PA related policy and practice intelligence within the set elements of 'leadership', 'education and workforce development', 'workplace physical activity for employees' and 'partnerships' and through a collective decision making process, each was scored (ranging from '1' equating to 'little or no evidence' through to '10' equating to being 'national or international leaders'). The intelligence gathered showed a variety of positions: for example, on the basis of an absence of a member of the Health and Social Care Integrated Joint Board with responsibility and leadership for action to increase population PA levels, the 'Leadership responsibility' elements was scored '1'; whilst on the existence of local higher and further education institutions having PA embedded in their nursing and health and social care curricula, this variable was scored '6' (the highest award).

<insert figure 3>

These insights formed the basis of a public pre-circulated 'briefing paper', providing variously: a broad context for the workshop: setting out specific strengths and weaknesses: and establishing an overall vision of the process.

### **'In event' observation**

Perhaps the most prominent features of this particular model of integration development are the roles of the briefing paper and the 'subject PA experts'/'critical friends' and the impact of these features was the most striking aspect of the 'in event' observation. These inputs were very well received and participant attention and engagement at the time was very high. This was confirmed by subsequent observation within small group work. Two features of the framing of these inputs were welcomed as providing a constructive context: first, the notion that successfully promoting increased PA levels as part of HSCI is not wholly dependent on additional resource and that existing capacity can be better utilised (indeed, the CAISHC working group was clear this event was not to be a pitch for additional funding); and second, the centrality of a 'person centred ethic' within the context of HSCI was welcomed and seen as particularly significant in shaping needs led, tailored opportunities for increasing PA levels of individuals and communities. On the basis of the inputs, the small group work also alluded to a notion that integrated PA work could offer a useful symbolic vehicle for wider HSCI in that it provided a tangible example of what HSCI actually might look like and conformed to many of the principles associated with the HSCI, specifically being needs led, asset-oriented and working upstream.

Some concerns were however also expressed within the workshop, focussing mainly on relatively practical and local difficulties to both integration and the promotion of PA as part of improving health and wellbeing as well as increasing independent living. The challenge of creating 'upstream' work in difficult pressured circumstances was often expressed and various local barriers were suggested, including: limits to public health funding; the general erosion of a PA culture and in particular a series of restrictions to PA expression within workplaces, such as general pressure on staff and time restrictions.

### **Immediate post event: participant questionnaire**

Data from the post event questionnaire were received from 15 delegates (56%). All rated the event as either 'good' (50%) or 'excellent' (50%). The 'subject PA experts'/'critical friends' inputs were rated as 'very useful' by 96% respondents. The results suggest that the majority of delegates had been exposed to new content as shown in figure 3. This may reinforce the notion that the evidence-based content of the presentations also contributed to respectively challenging commonly held

assumptions, developing individual knowledge and fostering the wider collective 'shared' understanding that is required to support the embedding of PA opportunities within organisational cultures.

All respondents reported that they planned to use the information from the event, for example

*“to ensure physical activity in all work”; “to change my personal and professional priorities”; “feed into Boards and strategic partnership agencies”*

Most importantly, 78% delegates said they intended to do something differently as a result of the event, for example:

*“increase my own physical activity and encourage a change of work culture”; “at a personal and corporate level, attempt to include in local policy and personal fitness”; “looking at our resource allocation and staff skills and particularly looking at work with the care sector-especially those working with older adults”.*

#### **Immediate post event: moderated focus group**

In line with the above intelligence, the general view from the focus group was that the event had been broadly successful, offering a pragmatic context for integration processes and the start of a process intended to heighten the importance of integrated PA actions within HSCI senior leaders. The event appeared to engage the delegates, with its design and flow of sequencing speakers taking them on a journey – from global perspectives to how these are expressed in the UK and Scotland to ultimately consideration of their manifestation locally in D&G. It appeared that delegates were happy to identify and commit to organisational/corporate 'pledges'. At this point, these pledges were seen as potentially feasible as delegates had the authority to influence the changes required and the D&G Physical Activity Alliance was considered an appropriate vehicle to take forward corporate commitments.

This focus group highlighted some critical insights. It was felt that additional attention was required to the formulation of a more balanced and comprehensive delegate list. The broad intent was to attract senior leaders with the potential to effect strategic change and as such, the tendency was to target those within mainstream agencies (such as the NHS and local government). Some however expressed regret that this meant that some stakeholders from a wider range of organisations and services potentially involved in HSCI and the promotion of PA were excluded from the event (for example, the police and fire services). In the context of the pledges, it was felt that follow-on discussions with a wider range of agencies and stakeholders were required.

Some difficult issues were also identified in relation to the group work. Most practically, the allocated 45 minutes was deemed too short for the in-depth discussion and reflection that was required. Furthermore, it was felt that participants wanted to freely discuss the themes raised by the formal inputs/presentations and the limiting of groups to single themes was considered overly restrictive. As such, flexibility to move between groups may have been beneficial in providing wider opportunities for developing action to increase PA levels. Finally, whilst the background papers and diagnostic tool served a number of useful purposes (for example, gave shape to the priorities of the day, highlighted areas of good practice and enhanced the understanding of senior leaders on how they could assist PA within HSCI), the majority of discussion appeared to emanate from the presentations delivered on the day. As such, concerns were expressed over the extent to which delegates were familiar with these details and the resultant quality of the discussion. Those organising the event however recognised the potential existence of different learning styles and offered a mix of pre-reading and ‘in event’ intelligence with the hope that all of the delegates would gain the required insights from one of the sources.

#### **Immediate post event: collation of corporate pledges**

At the conclusion of the workshop, delegates were asked to commit to a personal ‘pledge’ in their role as a senior leader with the ability to change the environment and culture to one that promoted being physically active as a routine part of everyday life. These were themed into four categories with specific, measurable, agreed upon, realistic and time-based (SMART) actions/outputs. These categories were then aligned to the national outcomes for PA (Scottish Government, 2015) demonstrating both progress towards implementation and highlighting the connection between local and national strategy. The pledges related to a series of proposed developments within the following themes:

- *broad policy* (for example, “to work with Integrated Joint Board to develop our commitment to physical activity and consider what this means for allocation of our resources”);
- *funding* (for example, “to establish grants programme to encourage physical activity and focus on 20% of the population who are not active”);
- *environments* (for example, “percentage of developer contributions allocated to raising levels of physical activity”);
- *workforce development* (for example, “I will allow my team twenty minutes break to be active....we will develop a walking route that is suitable for all...and develop a team challenge”).

<insert table 1>

## **6 month event follow-up: review of the extent to which pledges has been fulfilled**

Given the potential complexity of the tasks, progress towards initial implementation has been challenging and the results mixed. Some pledge successes were detectable in areas that could be categorised as lower cost and/or those within the organisation's immediate gift to affect change. For example, a PA break within work hours has been tested, while walking meetings are now more common. Agreement has also been reached to incorporate a health and wellbeing/PA dimension into the local public sector impact assessments and local delivery plans for Health and Social Care has been achieved in a locality delivery plan (Dumfries and Galloway Partnership, 2016). Likewise, some of the governance issues highlighted by the diagnostic tool have been addressed; for example, the absence of PA related leadership at senior levels has been remedied by the DPH now attending the Health and Social Care Integrated Joint Board.

In contrast, more profound pledges that require systemic policy changes or significant resource allocation have not progressed so easily or quickly. For example, the establishment of a discretionary budget targeted towards the 20% least active has not to date been achieved. Whilst there may be a number of reasons for this, the situation can perhaps be attributed to two related factors. First, there is insufficient staff capacity to develop pledges into more detailed proposals, subsequently delaying immediate feedback to senior leaders. Second, the limited availability of high quality local evaluation data demonstrating the effectiveness of local PA related policy and action on health behaviour/cost effectiveness outcomes can be considered problematic. Consequently, compared with competing services/sectors that are in a position to provide stronger evidence of improved outcome, it is often difficult to advocate for additional PA investment. These barriers are certainly not unique to our local circumstances; Sallis *et al* (2016; 1334) for example identify a "substantial implementation gap" between national PA policy and action based on an insufficient workforce to implement policy and a lack of clarity on the actions that are both feasible and effective in nurturing change. In this context, new local research has been commissioned to determine current resource and impact of local PA programmes covering the key settings within the national physical activity implementation plan (Trost *et al*, 2014) to produce a 'best investments paper' based on the global paper completed in 2014 (Scottish Government, 2014). Once completed, this piece of work will form the basis of discussion with senior leaders to agree further action.

Whilst the focus of the event was explicitly on PA, many of these policy, community, workforce and environment oriented pledges clearly have the potential to have resonance within wider ecologically based integration processes that support wider culture change as well as being applicable to other

public health topic areas in relation to fostering generic processes such as, impact assessment, pricing policy, grants programmes and targeting.

## Discussion

The growing theoretical literature exploring the optimal nature of the active processes involved in nurturing health and social care integration has perhaps tended to adopt a rather dichotomous orientation; for example, Dickenson (2014) sees it as 'science' or 'craft' and Williams (2012) sets up a "structural" and "interpretative" differentiation. Furthermore, in the context of contemporary 'new managerialist' tendencies, many feel that it has been the 'scientific' and 'structural' orientations that have tended to be predominant in this domain (e.g. Rummery, 2009).

In many ways, this case study sought to avoid such a dichotomy. Whilst its predominant ethos drew upon 'craft-based', 'interpretative' orientations, the completion of it was to an extent dependent on both relatively conducive structural circumstances (particularly the existence and functioning of the Dumfries and Galloway Physical Activity Alliance) as well as the deployment of a relatively formalised 'scientific' QI process that contained the required elements of 'learning capacity' – Williams (2012) sees these as respectively: clarity of purpose; background intelligence; clarity of type of learning mechanisms; 'context' (structural and cultural factors); appropriate and effective 'leadership'; and 'resources') and believes that they are often absent in many efforts to nurture integration and rarely executed together. As such, these elements can be considered 'necessary conditions' that provided a conducive context for the *possibility* of integrated PA policy and practice.

In of themselves, these foundations are not however considered sufficient to "realise sustained transformational change" (Hutchison, 2015; 135) and as such, the literature tends to emphasise the need for variously, a general 'sociomaterial' interest in "enactments of work activity, politics and knowledge" (Fenwick, 2010: 104), a localised micro-focus on "the actual practice of integration" (Dickenson, 2014; 193) where networks or communities of interest can explore forms of 'tacit' knowledge (Nicolini *et al*, 2008). Essentially, this reflects the considerable significance of "connectedness" (Nelson *et al*, 2001; 128) and "personal contact" (Lucidarme *et al*, 2014; 58) in processes of integration. In this context, the ethos of the workshop successfully encouraged open communication between delegates, whilst the structure and pledges offered the opportunity for such discussion to be based on tangible work possibilities. In summary, this accommodation of both formal structure *and* simple humanistic expression reflects what Williams (2012) calls 'externalisation' - a process where tacit knowledge is capturing and translated into an explicit form through the workshop mechanisms.

## **Conclusion**

At the onset, this paper highlighted a series of critiques in this area: formal learning processes tend not to be used; there is relatively little empirical assessment of efforts to formally explore processes of integration; what has been done tends to be relatively superficial; and the focus of this work has been on clinical and care integration rather than emergent integrated public health work. This case study has sought to address all of these.

It has successfully used a formal QI structure that has offered pointers to a series of elements required to successfully promote integration - particularly, the successful leadership offered by the Dumfries and Galloway Physical Activity Alliance, the preparatory contribution of the diagnostic tool and position paper and the opportunities for exchange and planning within the workshop. The multiple evaluative strands, synthesising both quantitative and qualitative insights, provided comprehensive and searching insights into the process and outcomes. In particular, it has raised awareness and understanding of senior leaders to the contribution that PA can make to population health and wellbeing and via the pledges, supporting the outcomes of HSCI in the short, medium and long term. Finally, it has successfully initiated a process of integrated work in a public health context that shows potential to benefit the specific PA topic. Furthermore, via the deployment of generic analytical processes and the geographical roll-out of the test QI process across Scotland, we believe there is relatively high potential for transferability into wider integrative efforts.

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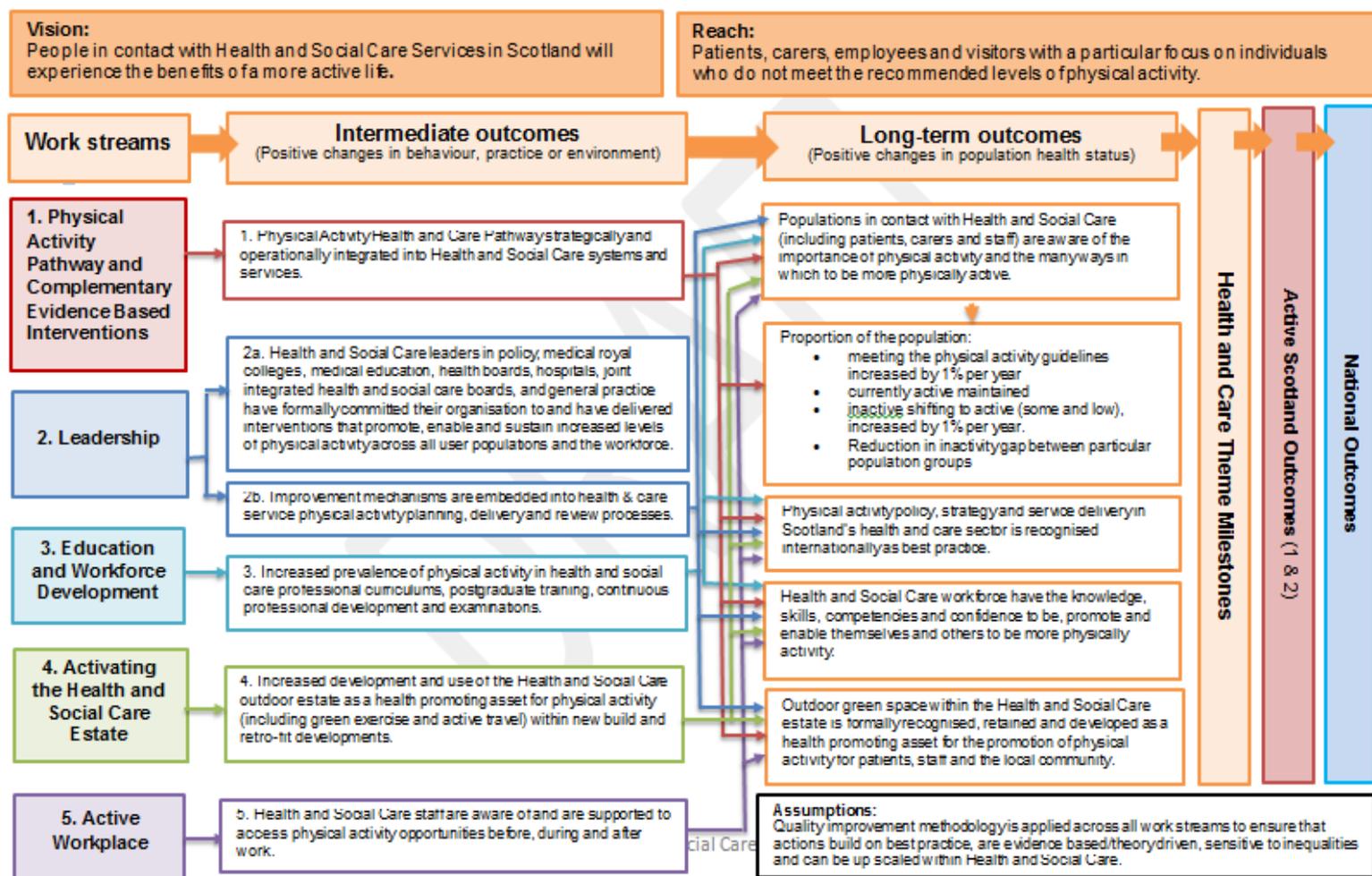
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Figure 1: Strategic context

Appendix 1: Health and Social Care Physical Activity Delivery Group Strategic Outcomes Framework



**Figure 2: Process overview**

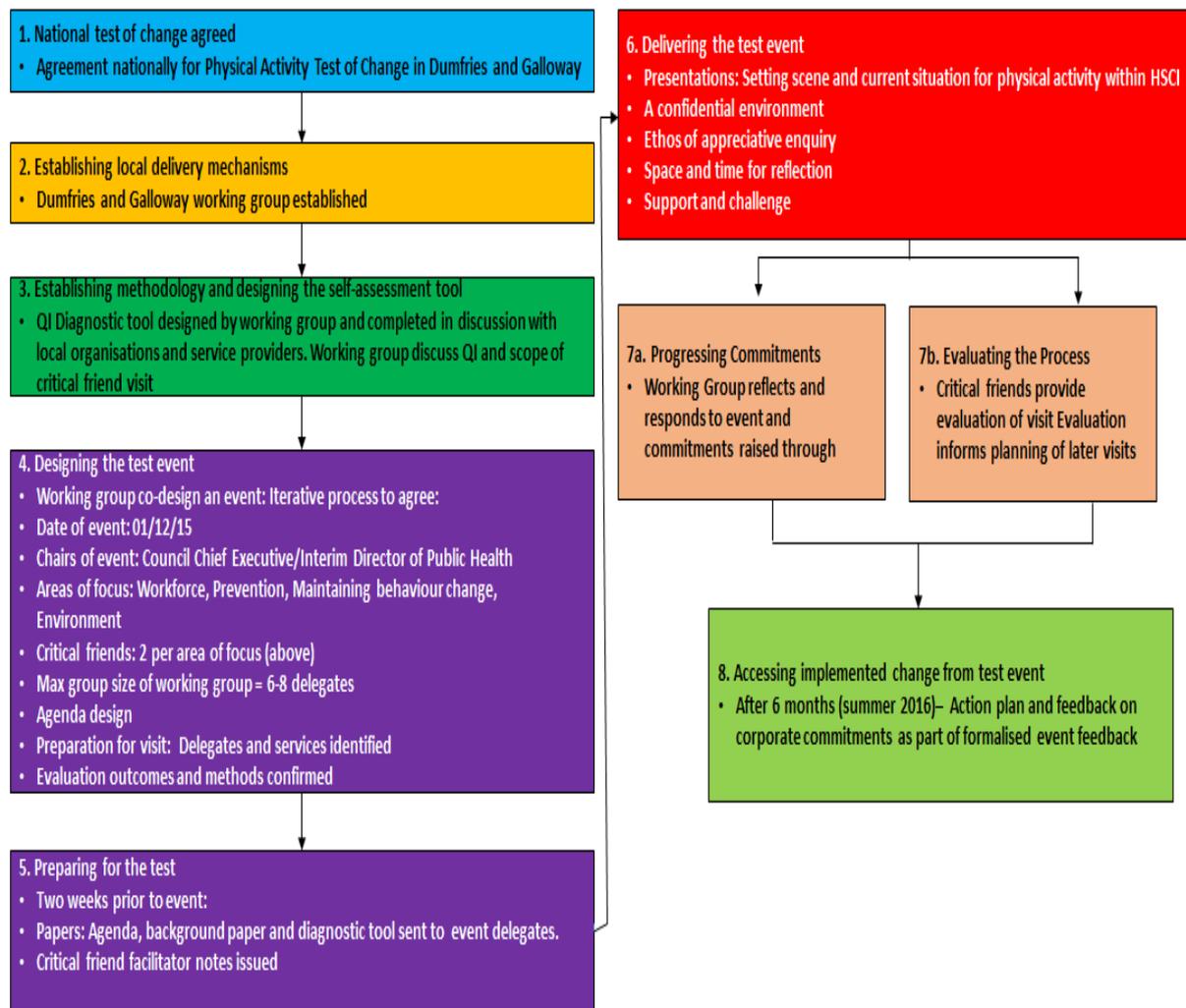
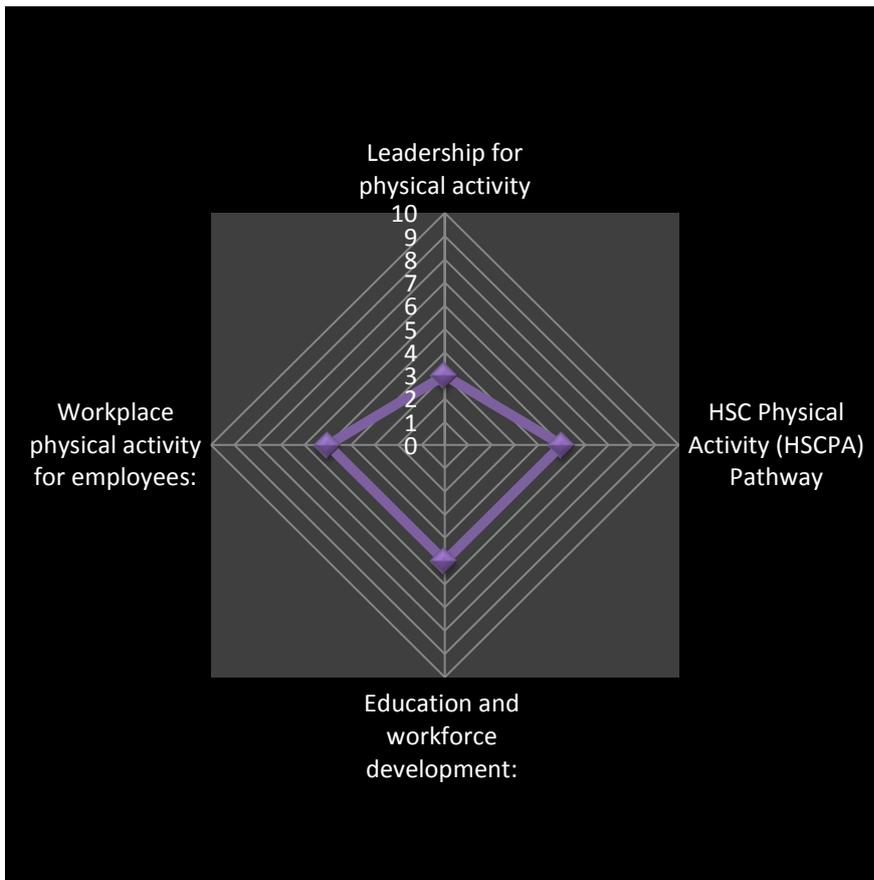


Figure 3: Diagnostic Tool – four areas of development scoring



**Table 1: Six month follow up of workshop commitments**

<b>Commitments</b>	<b>Theme</b>	<b>Progress</b>
Physical activity as a core component of all public sector impact assessments	Policy	Physical activity and wellbeing proposal submitted for consideration.
Establishment a physical activity discretionary budget targeted to 20% least active population	Policy	Proposal drafted for Local Authority Chief Executive. Discretionary budget would provide 50% match funding towards projects aligned to the Active Scotland Outcomes Framework and that were evidenced based.
Percentage of developer contributions allocated to raising levels of physical activity	Policy	Director of Public Health to update from meeting with Director peer led Train the Trainers course for piloting with GP's.
To further physical activity awareness within health education and training of health care professionals	Policy/ Environment	Clinical Champions Model to be developed. SBAR paper completed with support received from GP Sub Committee. Discussions with NHS Health Scotland and Scottish Government to develop and pilot peer led evidence based training programme. Discussions to include Nursing and Managed Clinical Networks on-going.  SBAR paper completed recommending all physical activity screening to SCOT-PASQ  Meeting held with Depute Nursing Director to discuss Clinical Champions model and establish links between UWS physical activity course and continuing promotion within practice.
Development of specific Leisure and Sport Strategy to form part of a wider physical activity plan	Policy	Dumfries and Galloway will progress a new physical activity strategy incorporating Leisure and Sport as key theme of an overarching plan.
Embed physical activity within the Stewartry Health and Social Care Plan	Policy	Physical activity referenced and text provided to other three localities
Enable Physical Activity local partnership to take forward corporate commitments	Policy	Chief Executive agreement for partnership to progress actions regarding commitments.
Provide physical activity opportunities, breaks within workplaces	Workforce	Pilot physical activity break within Nithsdale Health Improvement service.  Pedometer Licence for workplaces challenges across public, private and third sector being explored.
Provide opportunities to increase awareness of physical activity for health and wellbeing across workforces	Workforce	Promotion of Edinburgh University Mooc, CMO infographics. Establish workforce pedometer challenge for HSCI staff