

**AHPpreciate and Progress 2024**

**Public Health Chat Show**  
with your host...



**Heather Cameron!**



**AHPpreciate and Progress 2024**

# **Public Health Chat Show**



**Introducing...**

Vicky Laidlaw  
Head of Orthoptics  
See4School Screening



Orthoptists are specialists based in hospital eye service & diagnose and provide non-surgical management of squint, lazy eye, eye movement & binocular vision disorders. Experts in testing and treating eye sight problems in children

Delivery of a the national child surveillance pre-school orthoptic vision screening programme in Lothian to meet Health for All Children 4 Scottish Government policy

**Benefits:** 1) Early detection of treatable visual defects at optimal age for detecting target conditions amblyopia(lazy eye), squint & glasses(William 2009)

Vision defects usually asymptomatic- parents/child unaware of vision problem

Reduced vision can have detrimental impact on a child's education(Bruce et al,2018)

People with amblyopia have x3 increased risk of VI later in life(Chua 2004)

Binocular vision anomalies can have detrimental impact on education (Northway 2013)

# See for school programme and role of Orthoptists in Public Health



Health Protection- protect population health & reduce inequalities

Early intervention-detect and treat at optimal time for improved visual outcomes

Child development-undiagnosed reduced vision-lower literacy achievement

Eyesight vital part in child's development of language, social, cognitive skills. 80% of Learning is through vision

Future educational attainment, employment, driving

Offered to all pre-school children each year  
Nursery settings for equitable access for all  
SIMD quintiles

Health Improvement- maximise value, equity & good outcomes  
for population

ISD data national/local audit-50% increase in incidence of vision defects of children from most deprived backgrounds

Quality control of programme with review of data & key performance/quality indicators locally & nationally

Adjustment of referral pathways with increased shared care with community optometry.

Promote programme for parent engagement with use of posters in nursery ,parent questionnaires(opt out to address inequity)

[www.nhsinform.scotsee4school/](http://www.nhsinform.scotsee4school/)



## Dietitians and public health: Demonstrating impact in maternal health and obesity

Laurie Eyles, Dietetic Service Lead, NHS Lothian  
Professional Adviser, Diet and Healthy Weight team, Scottish Government



## MATERNAL OBESITY

- » In the year ending 31st March 2023, 56.5% of pregnant women had overweight and obesity. This is down slightly from the previous year (56.9%), however it is higher than at any point pre-pandemic<sup>3</sup>.
- » When looking at just obesity, this has continued to rise year on year and is now at the highest level recorded – 27.9%, compared to 27.2% the previous year<sup>3</sup>.
- » Women from more deprived backgrounds are much more likely than their less deprived counterparts to be living with overweight and obesity during pregnancy. More than 60% (60.8%) of pregnant women in the most deprived SIMD quintile were recorded as having overweight and obesity, compared 49.3% in the least deprived SIMD quintile<sup>3</sup>.

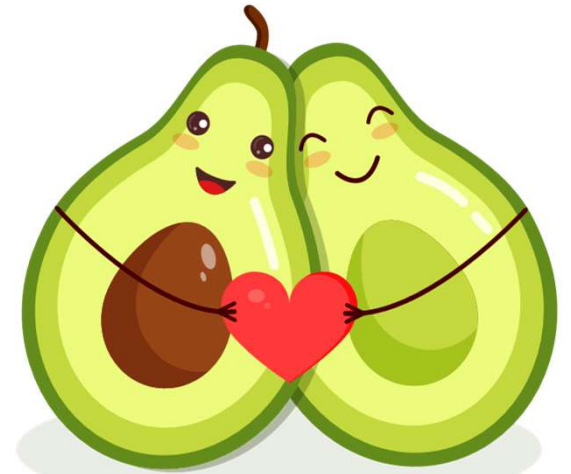
For acceptance for assisted fertility in NHS Scotland, patients are required to have a BMI between 18.5 – 30 kg/m<sup>2</sup>

# DIETITIAN NOW AVAILABLE AT EDINBURGH FERTILITY CENTRE

## What is offered?

- 6 weekly sessions in a group setting, or
- 6 fortnightly 1-2-1 sessions if extra support is needed, or
- Referral to a remote digital programme
- Patient resources about healthy eating and fertility
- Further support up to a year

ASK YOUR DOCTOR IF YOU NEED SUPPORT WITH WEIGHT MANAGEMENT AND PRECONCEPTION NUTRITION



# OUTCOMES

## SECOND NATURE

### Fertility Cohort Outcomes in Lothian

Referrals

67

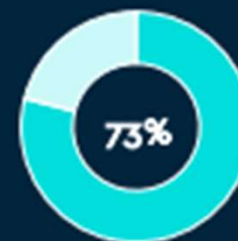
Sign-ups

64

### Programme uptake



### Completion to date



### Average BMI

Baseline

41.2

3-month

36.8

6 month

36.4

### Average weight change

6-weeks

-6.1%

3-months

-6.2%

6-months

-10.4%



# OUTCOMES

Dietetic group programme	Number of patients completing	Average weight loss
101 patients enrolled	63% completed the programme	3kg/4% in 3 months 5kg/5.3% in 6 months

Dietetic 1:1 programme	Number of patients completing	Average weight loss
68 patients enrolled	12 fully complete, programme is 18 months in total so majority of 1:1 patients remain in programme	4.1kg/4.5% in 3 months

- 22 spontaneous pregnancies reported
- 3 pregnancies following fertility treatment
- 16 patients added to fertility treatment list or progressed to treatment as BMI now met eligibility criteria

# OUTCOMES – patient feedback

*'It worked for me, I am currently almost 7 months pregnant, spontaneously!'*

*'The NHS professional who ran the calls was fantastic, very understanding that not the same advice works for everyone. I would say the health service would benefit from understanding that everybody is different and BMI is a very outdated way of determining health.'*

*"The sessions were very helpful, and Eugenia is lovely, I think the service is incredibly valuable and I have felt less on my own with my health. I have greatly improved my motivation to lose weight and become healthier".*

*"I think Eugenia has done an amazing job so far, her words of encouragement and understanding our positions really made the space feel safe and found her advice amazing. She was very knowledgeable and I'm really glad to have been offered a space on this course".*





Kirstin Unger

Paediatric respiratory physiotherapist

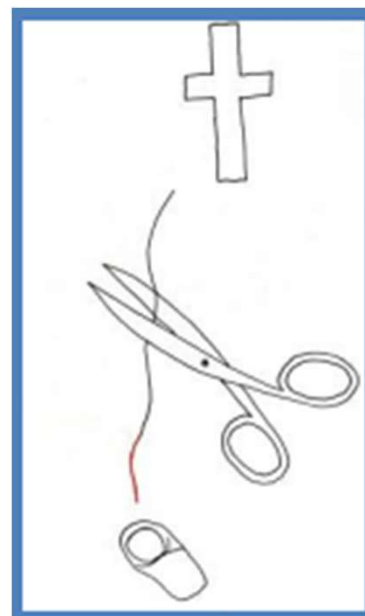
Interests: Quality Improvement and Health Inequalities



## My project

Aim:

Achieve **'levelling up'** in paediatric respiratory care, where every child can achieve the health outcomes of those at the top of the social hierarchy



Interrupters

## Context

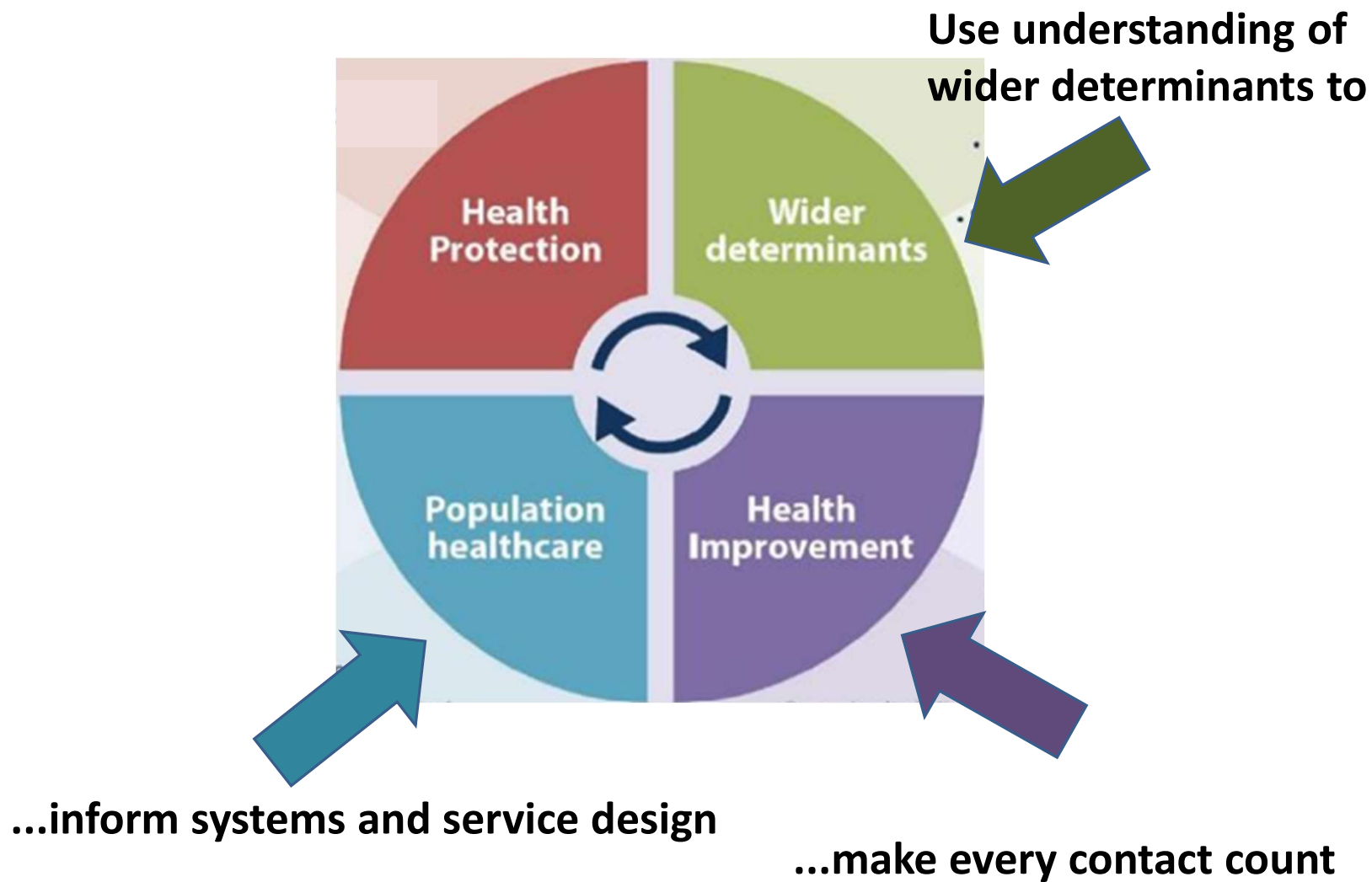
### Modernising patient pathway project

- Extended scope/QI role
  - Test of change, 12 months
- Complex respiratory infection clinic
  - (not asthma, cystic fibrosis, long term ventilation)
- Paediatric respiratory medicine n=700
  - Drs, physiologists, physiotherapists, nursing

### AHP Fellowship added value

- QI work considered health inequalities
- 2 physiotherapy students contributed



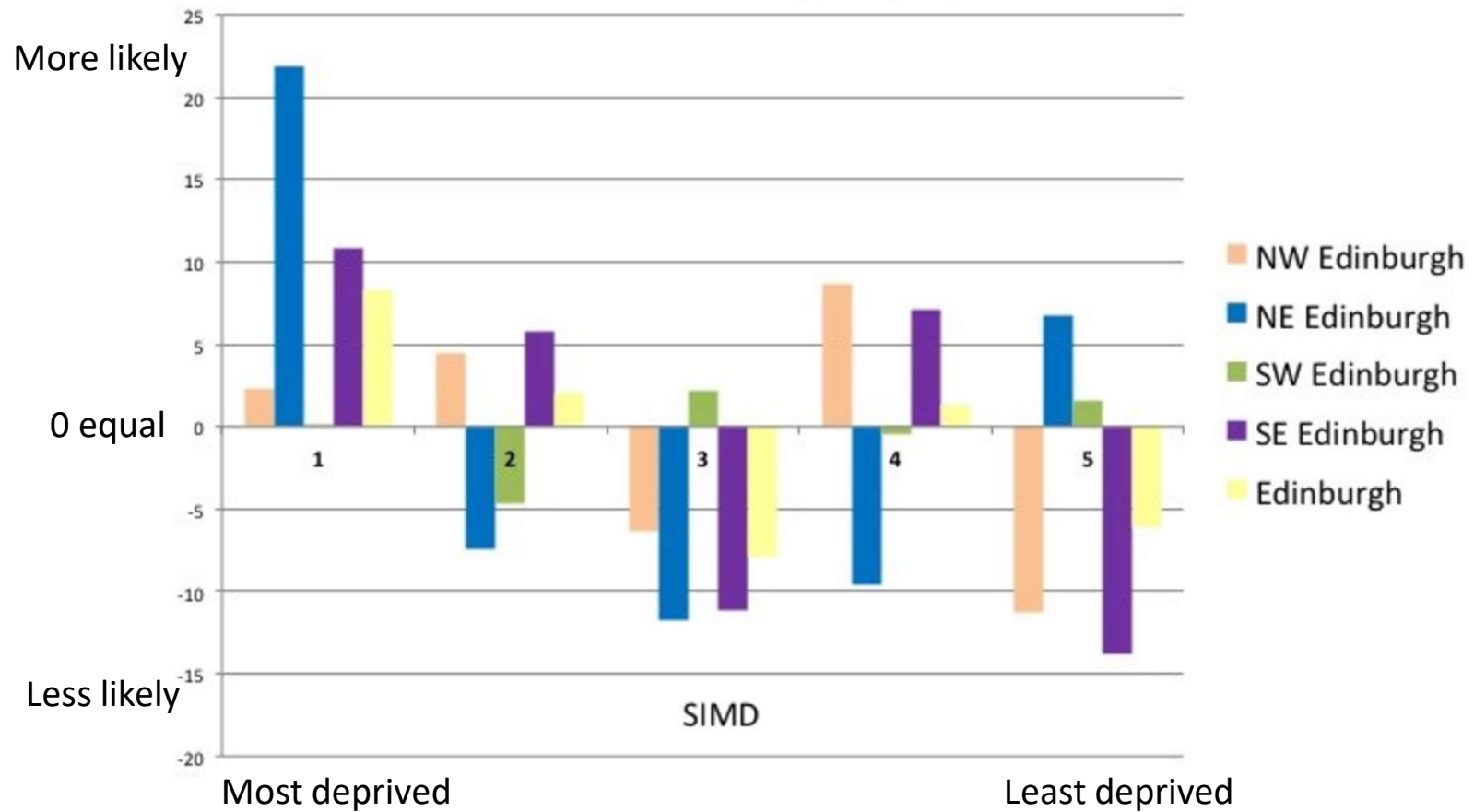


## Method

- Learning
  - Take inspiration from elsewhere
  - Understand the patient journey
- Get to know our caseload socio-demographics  $n=700$ 
  - Who is referred (or not)
  - Who attends (or doesn't)
- Develop resources


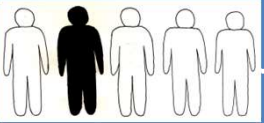
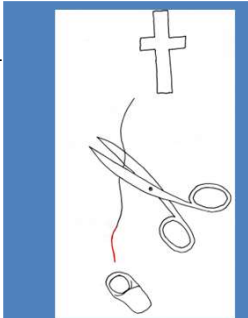
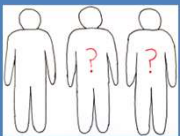
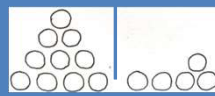

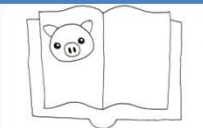



“0” is where there are equal proportions of an SIMD quintile in an Edinburgh locality compared to the proportion represented in the respiratory caseload





## Key insights: Paediatric respiratory health inequalities

 <p><b>Proportionate Universalism</b></p>	<p>is resourcing and delivering paediatric respiratory care for all, <b>but varying the type and intensity of input</b> depending on need to achieve greater equity of outcome</p>
	 <p>Early life exposures can cut adult healthy lives short - Flags:</p> <ul style="list-style-type: none"> <li>✦ Recurrent lower respiratory tract infections (age &lt; 2years)</li> <li>✦ Asthma</li> <li>✦ Lower weight (nutrition)</li> <li>✦ Poor housing</li> <li>✦ Exposure to smoking</li> <li>✦ Low maternal educational level</li> </ul>
<p><b>10+ year gap</b></p>	<p>in life expectancy between most-disadvantaged and advantaged adults Lung disease = major factor</p>
<p><b>Only find 1 in 3</b></p> 	<p>people who are income deprived by looking at where they live Enter postcode in the Scottish Index of Multiple Deprivation area finder. <b>Look out for risk factors:</b> Single parent, 3+ children, disabled household member, ethnic minority, child &lt;1, mother &lt;25</p> <p>SIMD 1 vs SIMD 5</p>  <p>Under -16's from the poorest areas are twice as likely not to be brought to a respiratory appointment (WNB/DNA)</p>
<p><b>Being ACE</b></p>	 <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Be curious</li> <li><input checked="" type="checkbox"/> Build trusted relationships</li> <li><input checked="" type="checkbox"/> Build health literacy</li> <li><input checked="" type="checkbox"/> Build hope &amp; healthy coping strategies</li> <li><input checked="" type="checkbox"/> Refer for benefits advice</li> <li><input checked="" type="checkbox"/> Reimburse travel expenses</li> <li><input checked="" type="checkbox"/> Link with health visitors and schools to interrupt ACE trajectories</li> </ul>
	<p>Under 5's early education breaks the poverty educational attainment gap They need good health to engage</p>  <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Problem solve WNB/ DNA's</li> <li><input checked="" type="checkbox"/> Early smoking &amp; vaping prevention</li> <li><input checked="" type="checkbox"/> Enable early years &amp; school attendance</li> </ul>

*Hannah Cairns*

*Chief Allied Health Professional*

*Hannah.Cairns@nhslothian.scot.nhs.uk*

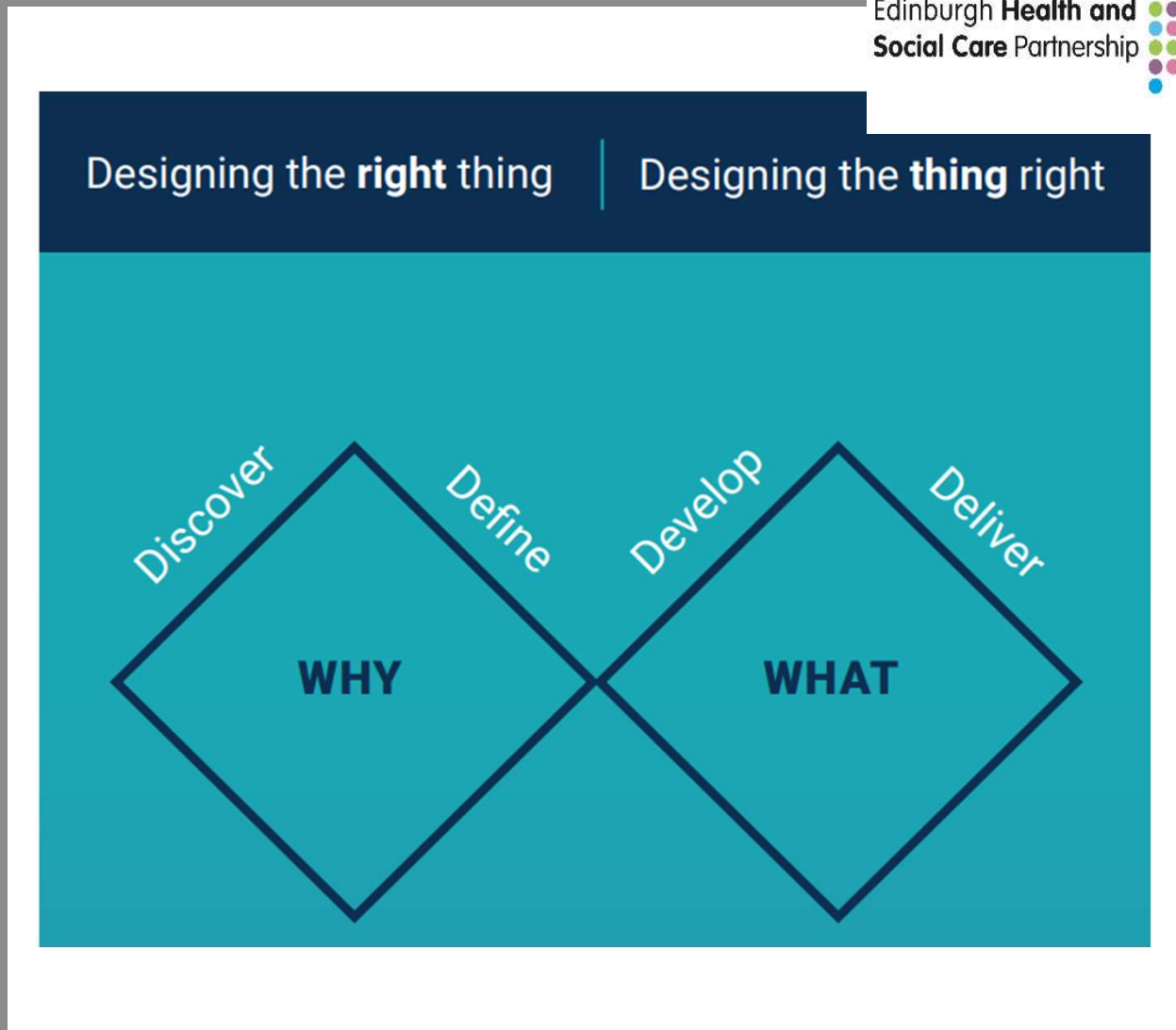
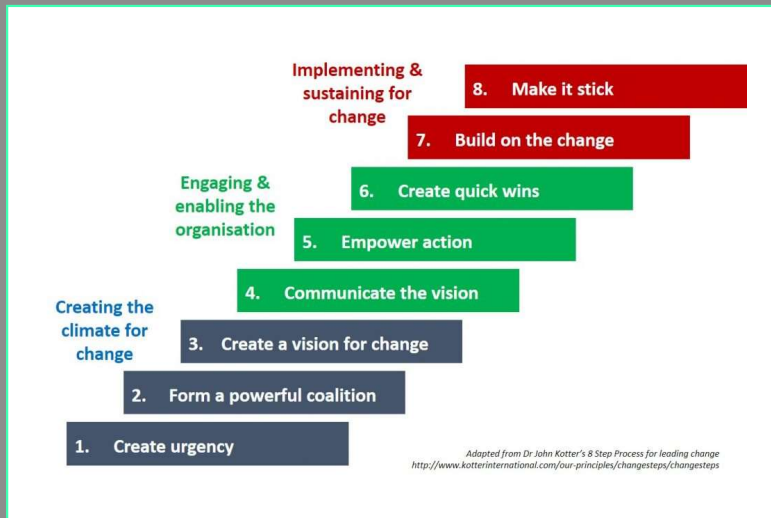


# Reducing Avoidable Harm through Falls Prevention



Edinburgh **Health and  
Social Care** Partnership





# Scottish Quality and Safety Fellowship



## Reducing Avoidable Harm through Falls Prevention

Hannah Cairns  
Chief Allied Health Professional

Falls are one of the most expensive yet largely avoidable challenges impacting the health and social care system. The cost of falls is significant both financially and on the physical, psychological and functional outcomes of people. The British Geriatrics Society estimate that falls cost the NHS more than £2.3 billion annually, with the management of hip fractures alone accounting for approximately £1.9 billion. This does not include the costs of social care that result from the long-term consequences of falls.

1. **Creating Conditions:** As most falls are avoidable, the importance of preventive measures and strategies to reduce fall-related injuries should be of primary importance in any health and care system. In Edinburgh, many services contribute to the management and prevention of falls however it is recognised that the approaches adopted are often low priority, highly variable and unreliable.

Recognising the complexity and scale of the environment the Scottish Approach to Service Design was utilised to develop and refine a vision to improve the outcomes of people living in the community in Edinburgh at risk of falls by taking preventative action to reduce falls and the need for unnecessary unscheduled care.

2. **Understanding Systems:** Considerable time was taken in the discovery phase to ensure that the complex falls environment was fully understood, using the following tools and activities:

- Creation of a Falls Project Team from a wide range of services across the system.
- Collation and analysis of data available relating to falls, including Accident and Emergency attendance and admission data to understand trends related to falls.
- Root cause analysis of the current falls environment and system.
- Patient journey mapping of the most frequent falls.
- Ecosystem mapping of the health and social care system related to falls management.
- Stakeholder mapping.

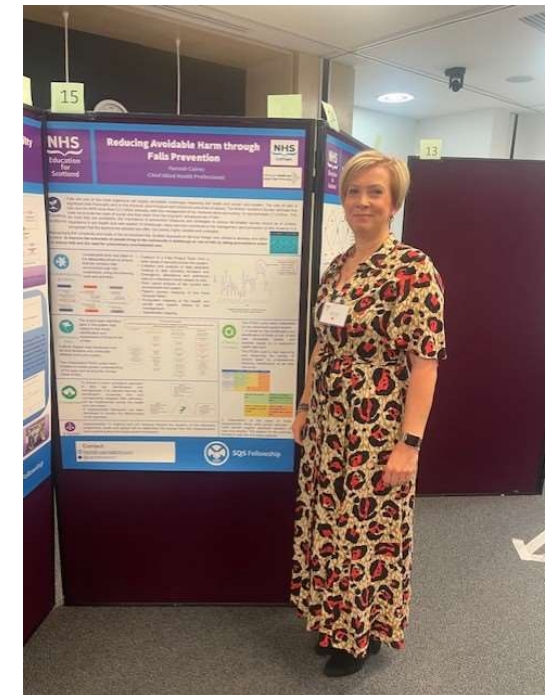
3. **Developing Aims:** The project team identified gaps in the system that related to the timely identification and assessment of those at risk of falls. A driver diagram was developed over several iterations and continually adapted during the project. Two independent PDCA cycles were created to enable greater understanding of the gaps and develop the change ideas further.

4. **Testing Changes:** The PDCA cycles were undertaken by two small multi-system teams: 1. A model for risk stratification and identification of those at risk of falls was developed, tested, and adapted based on a population health approach. This PDCA cycle is now exploring and measuring the variety of actions taken by professionals following identification of all falls risk levels.

5. **Implementing:** To ensure a more consistent approach to falls risk identification and management, it is planned that the risk stratification screening tool and corresponding targeted falls pathways will be implemented across the health and care sector. A measurement framework has been developed to monitor the effectiveness of the approach.

6. **Spread:** Implementation is ongoing and will continue beyond the duration of the fellowship programme, scale and spread will be dependent on the outputs from the implementation and monitoring from the measurement framework.

Contact:  
Hannah.cairns@nhs.scot  
@hannahcairns7



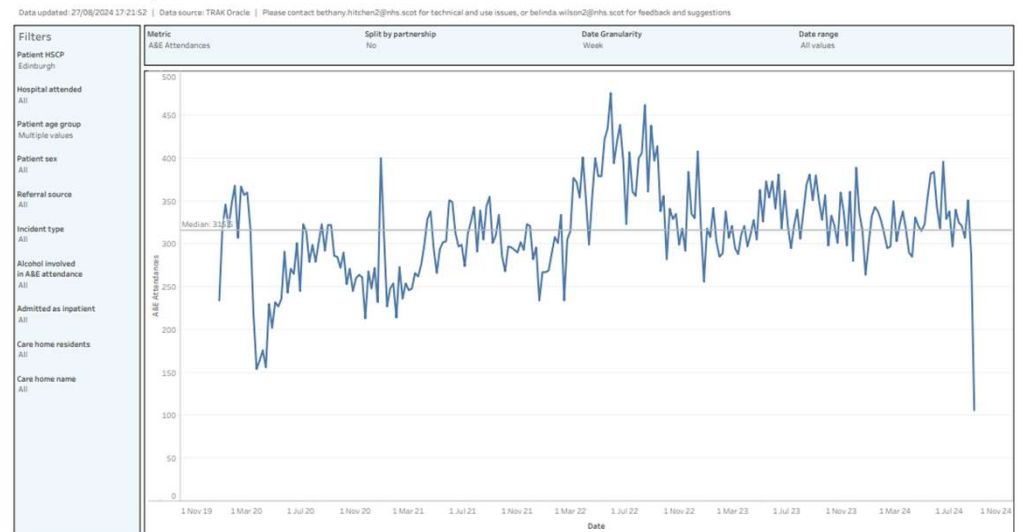
# Population Health Approach

---

- Differs from Public Health
- Not about the whole population
- Targets groups of people with similar characteristics
- Adopts a holistic approach
  - Proactive – via system-wide data collection
  - Personalised - informed by what we know from the data
  - Preventative – using the data to predict risk

# Falls Related Trends in A&E Edinburgh HSCP

Fall-related activity trends in A&E



## Falls Prevention Driver Diagram

*To improve the outcomes of people living in the community in Edinburgh at risk of falls by taking preventative action to reduce falls and the need for unnecessary unscheduled care.*

### Aim Statement

Reduce avoidable harm caused by falls in the population of Edinburgh [over 50 years] reducing the need (%) for unscheduled care (A&E attendance & hospital admission) by (date)

### Primary Drivers

*Key factors that drive the outcome*

Proactive & empowered workforce

Organisational Culture

High Quality Integrated Services

Self-management approach to enable people to manage their personal outcomes

Equity across Edinburgh

### Secondary Drivers

*Factors which will influence delivery of the primary drivers*

Training & education

Screening and Assessment

Leadership & strategic directives

Self-management approach

Prevention & early intervention

Alignment and connection between HSCP services

Organisational service restructure

Early identification of risk

### Change Ideas

*Changes or interventions that can be tested out*

Falls pathways by risk level (Service User)

Falls Service

Single-point-of-access

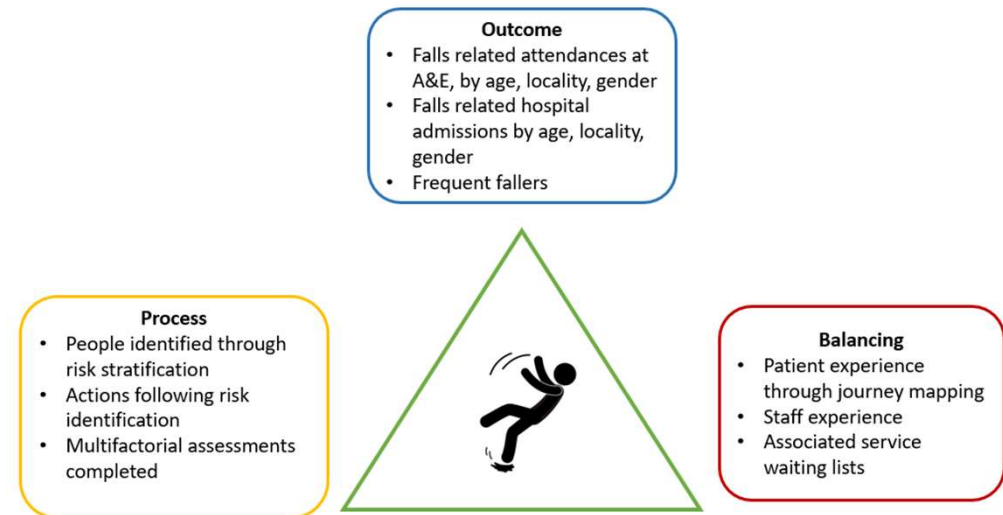
Self-Management Platform

Tools for risk screening and identification to initiate pathway

Consistent approach to assessment



# Measurement Framework





# Falls Risk Stratification

---

	Generally Well	Long Terms Condition/s	Complex Needs
Age 0-50	Level 1	Level 2	Level 3
Age 51-64	Level 1	Level 2	Level 3
Age 65-74	Level 1	Level 2	Level 3
Age 75+	Level 2	Level 3	Level 3

# Risk Stratification Levels

## Level 0 = Very low risk of a fall

They exercise regularly or often which may include walk briskly outdoors and they can get up from the floor independently.  
They may have had a single fall and/or have a temporary mobility aid post injury/surgery.

## Level 1 = Low risk of avoidable harm due to falls

They are managing well but are becoming less active "slowing up" and less confident.  
They may have a well-managed long-term condition.  
They may be taking 1 or 2 medications.  
They can walk outdoor, use stairs, and do their own shopping,

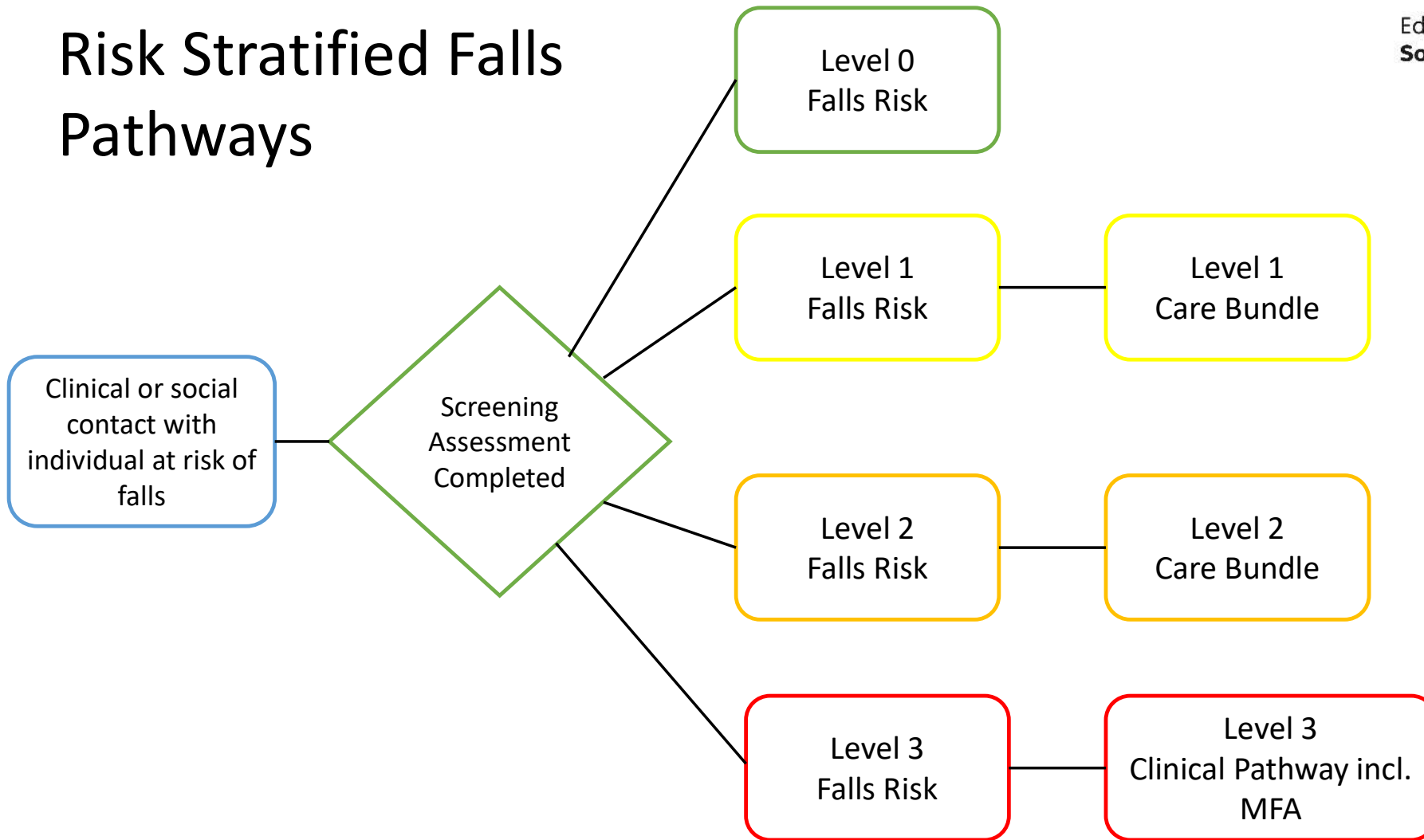
## Level 2 = Moderate risk of avoidable harm due to falls

May have 2 or more long term conditions which are not well managed/controlled.  
May be on 2 -3 medications.  
May have a history of falls or a fear of falling.  
More evidence of slowing and needing help with activities of daily living

## Level 3 = High immediate risk of avoidable harm due to falls

May have several long-term conditions.  
Polypharmacy (4 or more medications).  
History of falls causing harm and/or near misses and reduced mobility because of a fear of falls.  
They may be able to transfer independently, engage in light housework and be in depended in some aspect of their personal care.  
They need help with all outdoor activities, aspects of personal care and house keeping.

# Risk Stratified Falls Pathways



# West Lothian Health & Social Care Partnership Vision

*Working in partnership to improve wellbeing and reduce health inequalities across all communities in West Lothian*

## Strategic Priorities

### Improving Health Inequalities in Partnership

- Focus on prevention and self-management
- Supporting people to make informed choices
- Working with communities in partnership with others to maximise impact
- Alignment with the Local Outcomes Improvement Plan and locality priorities
- Wider determinants

### A 'Home First' Approach

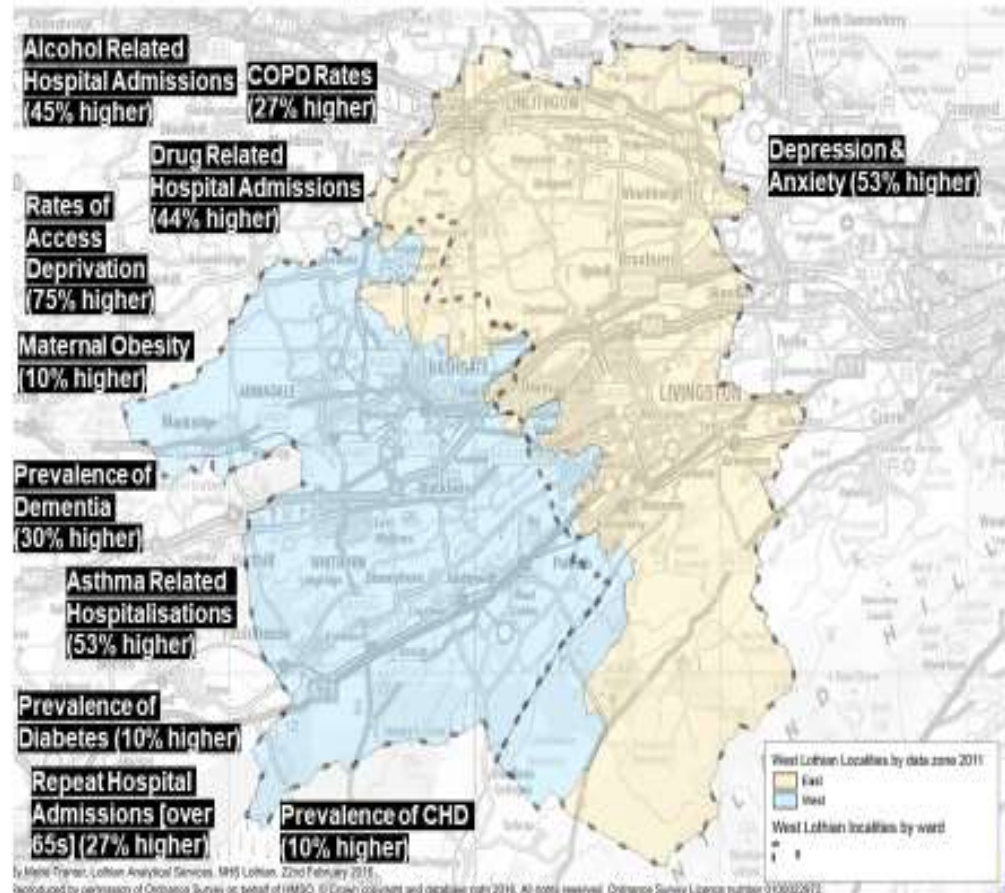
- Investment in early intervention
- A human-rights based approach
- Self- management
- Care and treatment provided as close to home as possible
- Planned care rather than crisis care
- Specialist care in the right place

### Enabling Good Care and Treatment

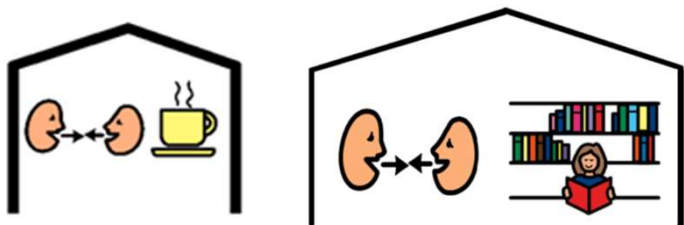
- Supporting our workforce to deliver high quality care
- Improvement through transformation including digital transformation
- Support for unpaid carers
- Managing financial resources effectively through clear investment and disinvestment
- Sustainable service delivery

# Inequalities: East/West Locality

Indicators where difference is 10% and above



Adult Learning Disability SLT Service



## Chatty Cafes/ Libraries

- Free drop in sessions
- Sep – Dec 2023
- 2 x Chatty Libraries/ /SWEd
- 3 x Chatty Cafes /Midlothian
- 2 SLTs , plus 1-3 SLT students
- Layers of public health :  
individual, community,  
population



# Our Aims /Rationale

---

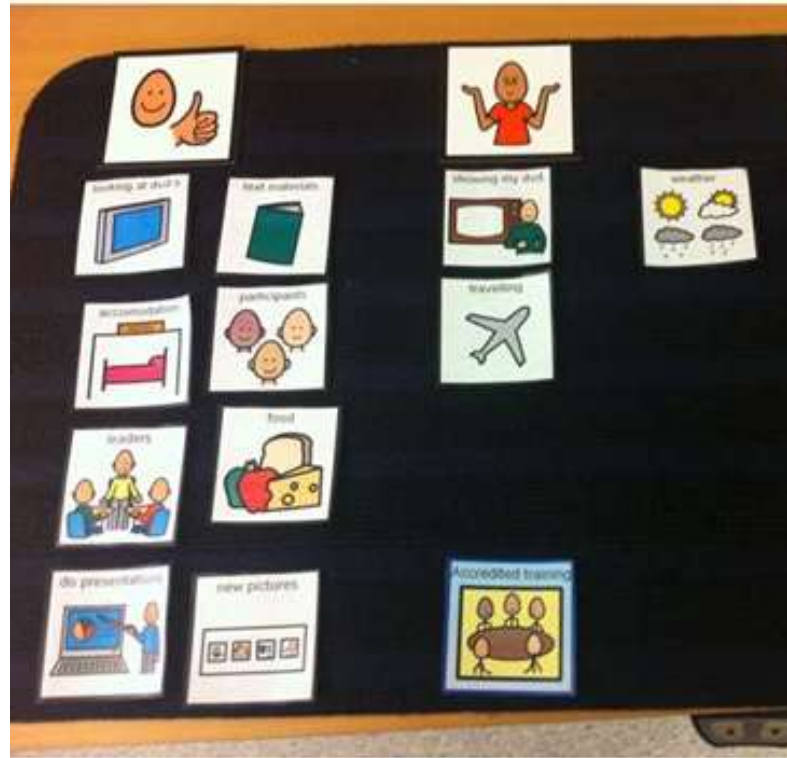
- Raise profile of SLT
- Offer staff and service users a safe space to explore good communication , increase their skills and confidence, reduce likelihood of distressed behaviours

## **Ultimate aims :**


- Reduce SLT waiting lists / help people to self manage communication support needs (CSN's)
- Make the Communication Environment at the Beacon Café more inclusive



# Preparation



[Communication Access UK – Inclusive communication for all \(communication-access.co.uk\)](http://communication-access.co.uk)

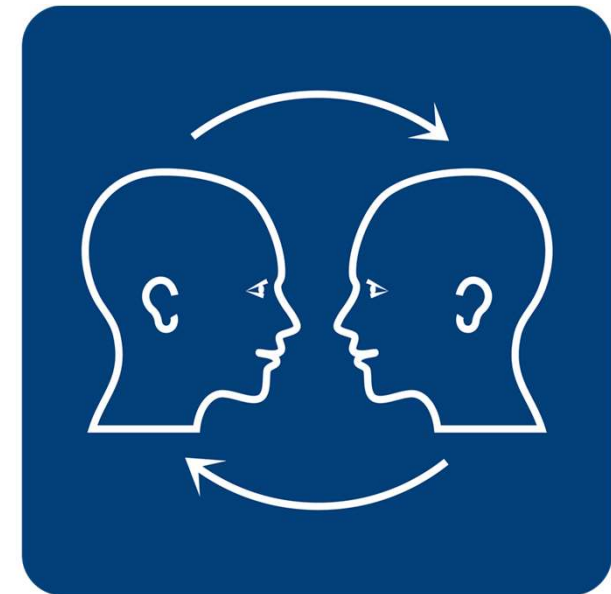


**Drop in to see, try or chat about**

- Talking Mats
- Communication Passports
- Intensive Interaction
- Boardmaker resources like visual timetables
- Signing
- Other tools to help people to have conversations with others

**Everyone welcome!**

For more information contact Andrea or Anna  
Speech and Language Therapists on



The Communication Access Symbol for the UK



# What did we do and who attended ?

Welcome to the Chatty Cafe !

My name is .....

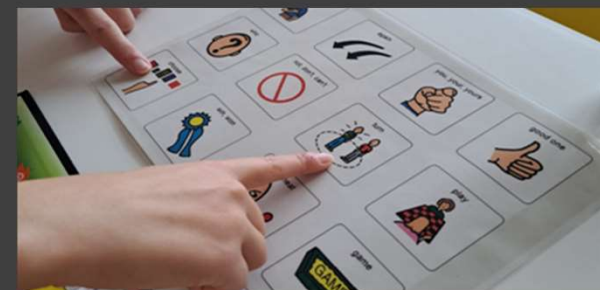
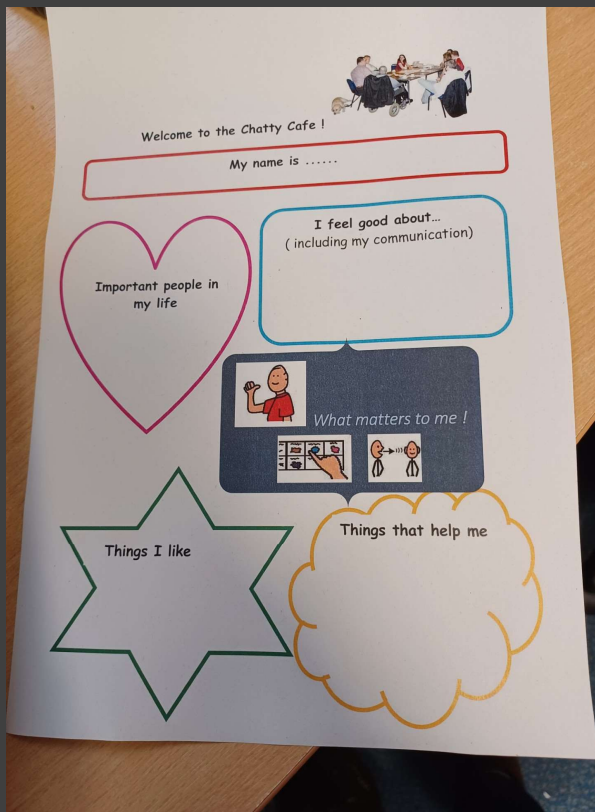
Important people in my life

I feel good about...  
(including my communication)

What matters to me !

Things I like

Things that help me





# What difference did we make ?

We can make a noise about it - it's been a really great partnership and inclusive atmosphere in here. I will start hunting out the lanyards!

Beacon manager

"All questiones answered and we were shown a way forward! "

staff

wonderful to meet you all, very useful and informative conversations for us to think about in our communication style with our clients and families.

Visiting OT students

"Mixing with others in the café and other people trying to communicate with me made me feel included "

Service user

# Thank you for Listening !

---

[Andrea.ruck@nhslothian.scot.nhs.uk](mailto:Andrea.ruck@nhslothian.scot.nhs.uk)



# Public Health: AHP Curricula

Taught vs. embedded

Coaching

Beyond healthy conversations

Population health

Community engagement

Placements – project / HIS / third sector



**Queen Margaret University**  
EDINBURGH

# Ideas and inspiration

Pyjama  
paralysis,  
activity  
monitoring,  
observations

**Project  
placements**



Sexual health  
over 50's  
Pelvic health  
physio

Profiling micro-  
nutrients of canned  
food at food banks.  
Life span targeting



**Queen Margaret University**  
EDINBURGH

# AHPs in Public Health resource links

[UK Allied Health Professions Public Health Strategic Framework 2019 - 2024](#)

- [Scottish allied health professions public health strategic framework implementation plan: 2022 to 2027](#)

[HCPC standards: Promoting public health & preventing ill-health](#)

- [Updated standards of proficiency – gap analysis tool](#)

[Royal Society for Public Health UK](#)

- [Allied Health Professions Hub](#)

# Where do I find the AHP L&D Resource Toolkit?

## NHS Lothian Intranet:

The screenshot shows the NHS Lothian Intranet homepage. The navigation menu includes Home, Directory, News, COVID-19, Staff Room, HR Online, Staff Bank, and Lothian Quality. A breadcrumb trail indicates the path: Home > Directory > Allied Health Professions (AHP). A red arrow points to the 'Allied Health Professions (AHP)' link in the breadcrumb. Below the breadcrumb, a sidebar menu lists various AHP-related topics, with a red arrow pointing to 'AHP Learning and Development Strategic Framework'. The main content area features a search bar and a section titled 'AHP Learning and Development Resource Toolkit' with a brief description and a large blue circular graphic containing the text 'AHP Learning & Development Resource Toolkit'. A small text at the bottom of the page reads: 'Not sure how best to use the toolkit to suit your needs? Watch this short tutorial.'

## NHS Lothian AHP PE Internet:

The screenshot shows the NHS Lothian AHP PE Internet homepage. The navigation menu includes Home, AHP Appreciate & Progress 2023, Workforce Resources, Communications and Events, and AHP Practice Based Learning. A red circle highlights the 'Workforce Resources' link. Below the navigation menu, a large blue circular graphic contains the text 'AHP Learning & Development Resource Toolkit'. To the right of the graphic, there is a text block: 'Access the Learning and Development Resource toolkit to view materials for progression related to your interests, band and level! Unsure how best to use the toolkit? Watch this quick tutorial'.

**Access here directly:**  
[NHSLothian AHP Learning and Development Resource Toolkit.xlsx](#)

# Tutorial – How to use the AHP L&D Resource Toolkit

**NHS Licham**  
AHP Learning and Development Resource Toolkit

Remember to add my learning or development you undertake to your Portfolio!

Educational provider	Educational Provider	Type of learning	Link to Learning	Share
edh				
edh				

Sort By: [Dropdown]  
View: [Dropdown]  
Filter by Category: [List of categories with checkboxes]



# **AHPs in Public Health L&D links in the toolkit**

## **Health Education England: e-learning for healthcare (elfh)**

- Making every contact count, Physical Activity and Health, Obesity, Mental Health & Wellbeing, Healthy Ageing, Health disparities and inequalities, Social Prescribing, Falls & Fractures, Cardiovascular disease, Alcohol, Smoking & Tobacco, Anaphylaxis, Healthier Weight Competency Framework

## **NHS Education for Scotland: Turas Learn**

- The roles of AHPs in Public Health webinar

## **[AHP Careers Fellowship Scheme | Turas | Learn \(nhs.scot\)](#)**

- Open now until 6th November