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/

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[3].
- 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[3].
- 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[3].

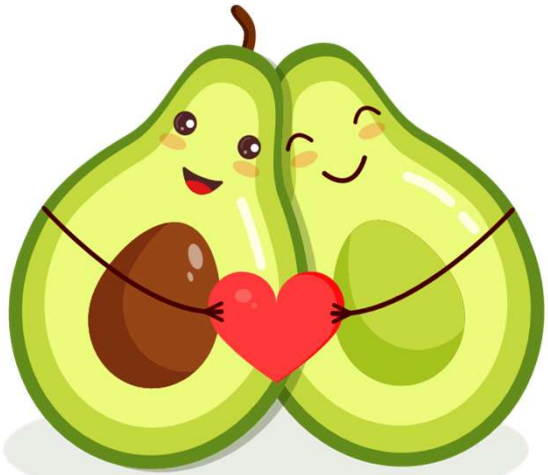
For acceptance for assisted fertility in NHS Scotland, patients are required to have a BMI between 18.5 – 30 kg/m^2

https://www.obesityactionscotland.org/media/jadblmn4/obesity-prevalence-factsheet-2022-23-data.pdf

DIETITIAN NOW AVAILABLE AT EDINBURGH FERTILITY CENTRE

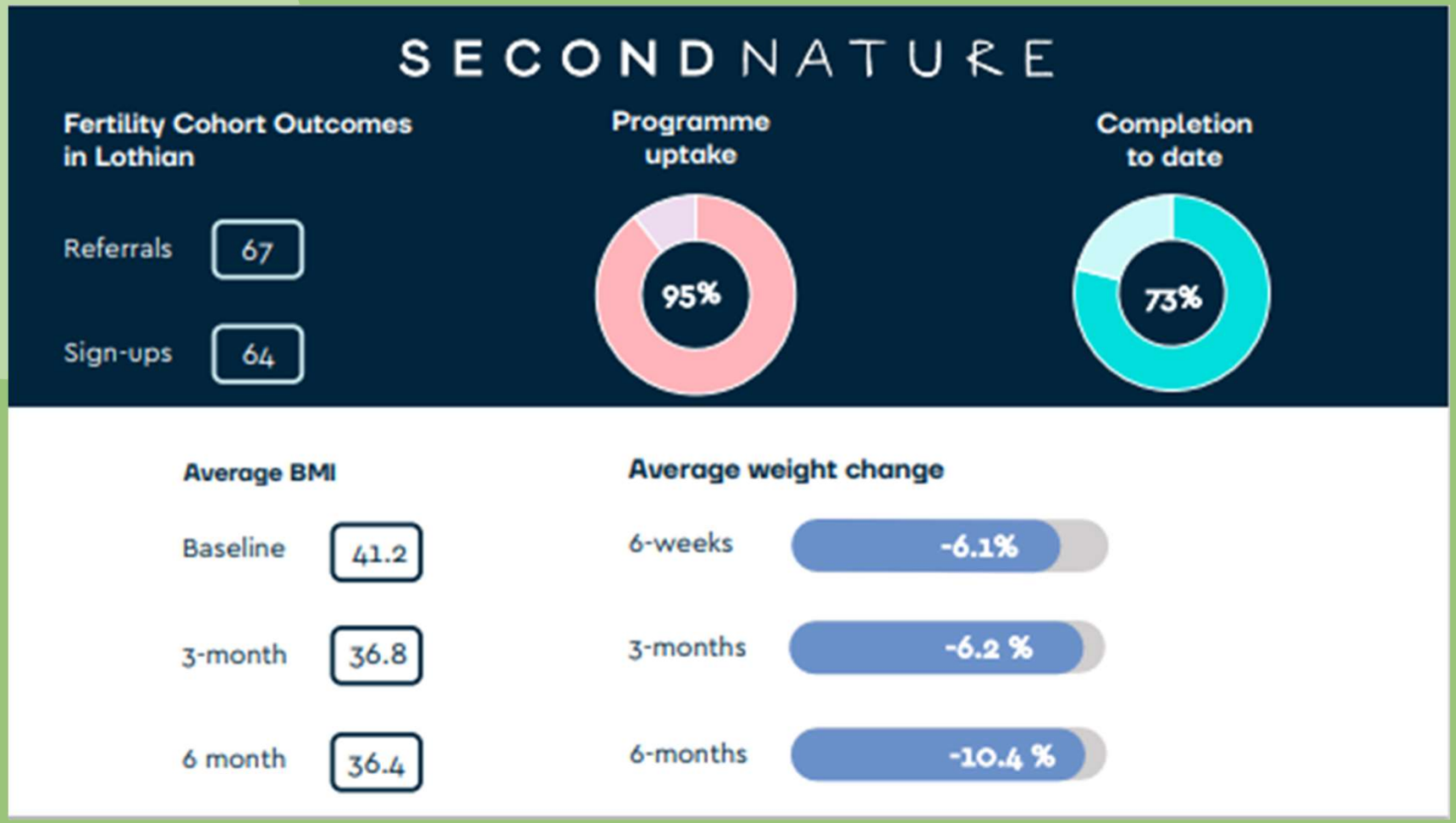
What is offered?

- 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


SECONDNATURE
Fertility Cohort Outcomes in Lothian
Referrals
67
Sign-ups
64
Programme uptake
95%
Completion to date
73%
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”.

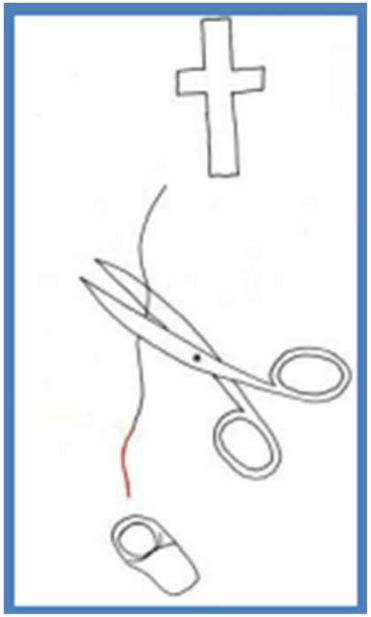
Kirstin Unger
Paediatric respiratory physiotherapist
Interests: Quality Improvement and Health Inequalities

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

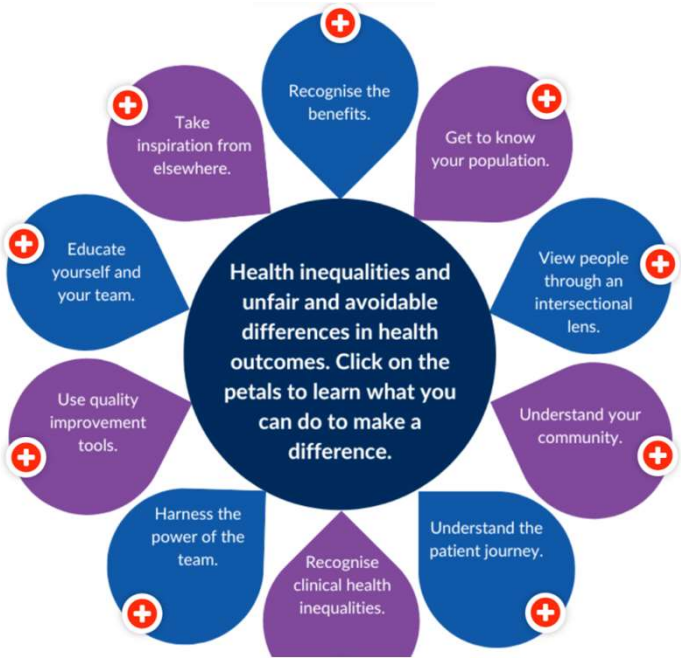
Use understanding of wider determinants to

...inform systems and service design

...make every contact count

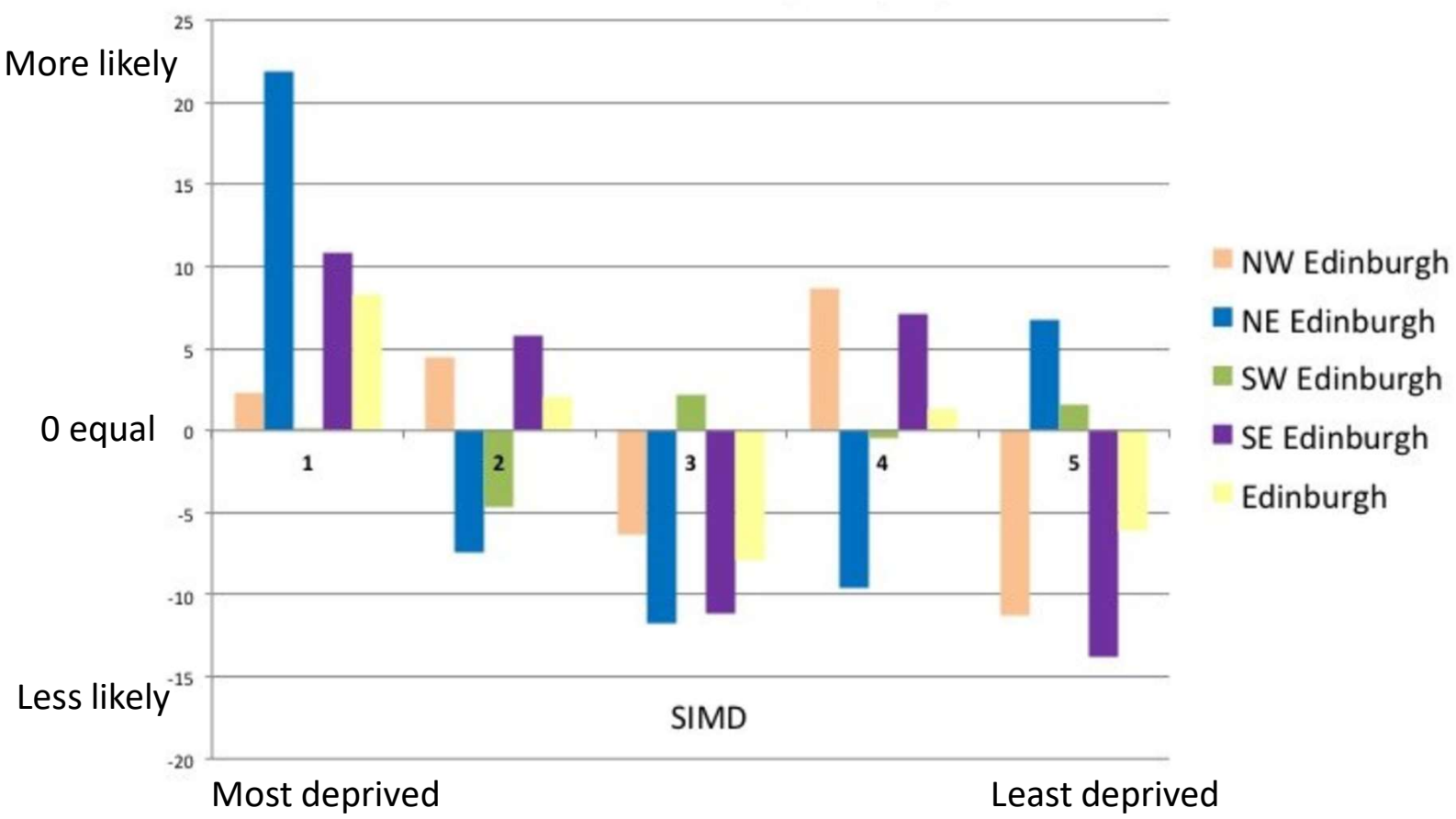
Method

- 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

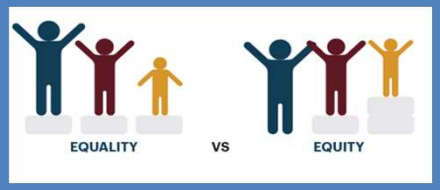


RCGP Learning Tools, Health Inequalities

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

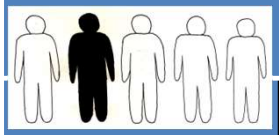


Key insights: Paediatric respiratory health inequalities



Proportionate Universalism

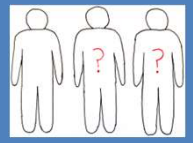
is resourcing and delivering paediatric respiratory care for all, **but varying the type and intensity of input** depending on need to achieve greater equity of outcome



10+ year gap

in life expectancy between most-disadvantaged and advantaged adults
Lung disease = major factor

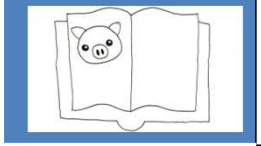
Only find 1 in 3



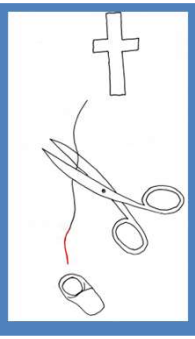
people who are income deprived by looking at where they live
Enter postcode in the Scottish Index of Multiple Deprivation area finder.
Look out for risk factors:
Single parent, 3+ children, disabled household member, ethnic minority, child <1, mother <25

Being ACE

Adverse childhood experiences can impact health **but can be interrupted**
Hopeless => don't adopt prevention
Poor coping strategies => smoking



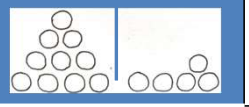
Under 5's early education breaks the poverty educational attainment gap
They need good health to engage



Early life exposures can cut adult healthy lives short - Flags:

- ✧ Recurrent lower respiratory tract infections (age < 2years)
- ✧ Asthma
- ✧ Lower weight (nutrition)
- ✧ Poor housing
- ✧ Exposure to smoking
- ✧ Low maternal educational level

SIMD 1 vs SIMD 5



Under -16's from the poorest areas are twice as likely not to be brought to a respiratory appointment (WNB/DNA)

- ☑ Be curious
- ☑ Build trusted relationships
- ☑ Build health literacy
- ☑ Build hope & healthy coping strategies
- ☑ Refer for benefits advice
- ☑ Reimburse travel expenses
- ☑ Link with health visitors and schools to interrupt ACE trajectories
- ☑ Problem solve WNB/ DNA's
- ☑ Early smoking & vaping prevention
- ☑ Enable early years & school attendance

Hannah Cairns

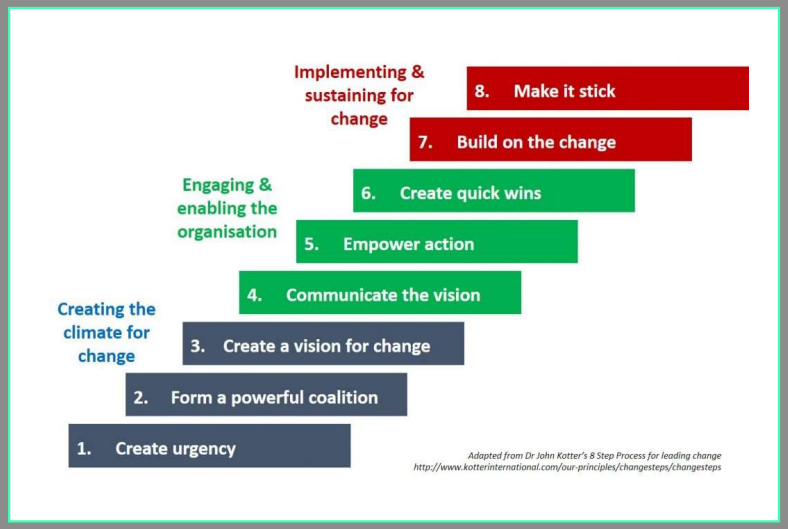
Chief Allied Health Professional

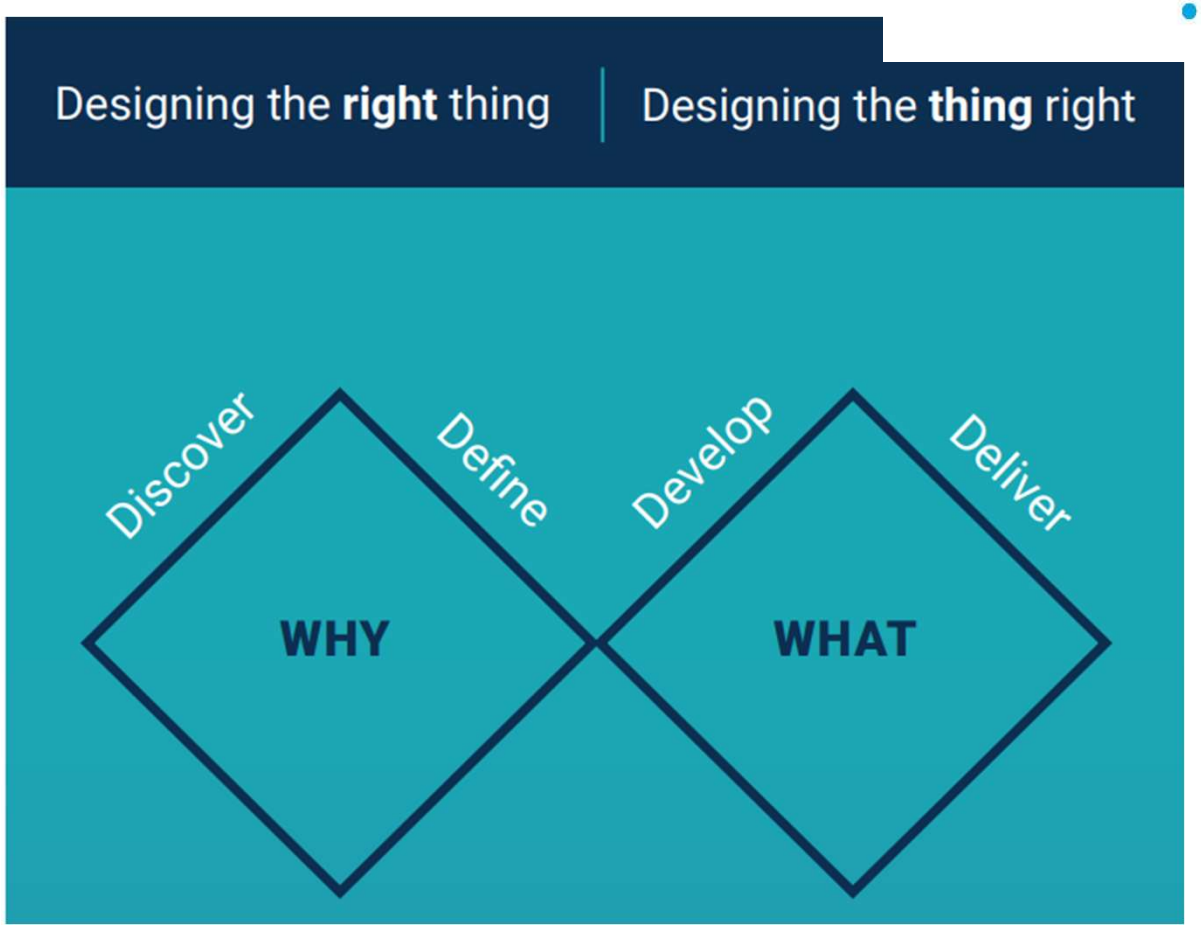
Hannah.Cairns@nhslothian.scot.nhs.uk

Reducing Avoidable Harm through Falls Prevention

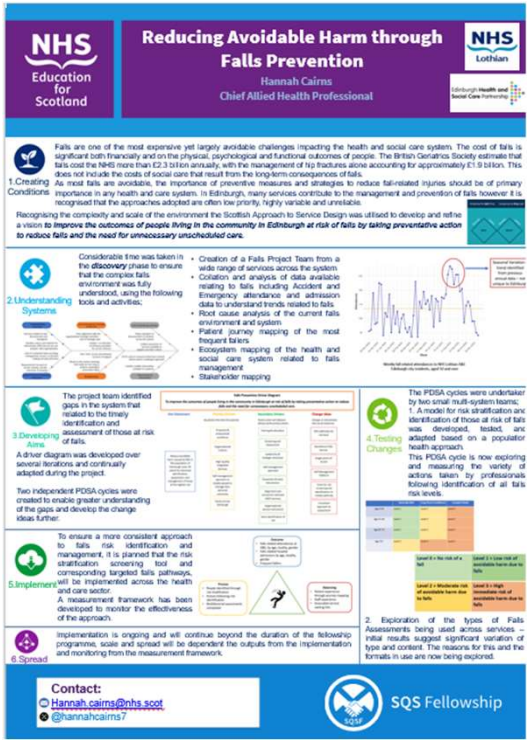
Edinburgh **Health and Social Care** Partnership

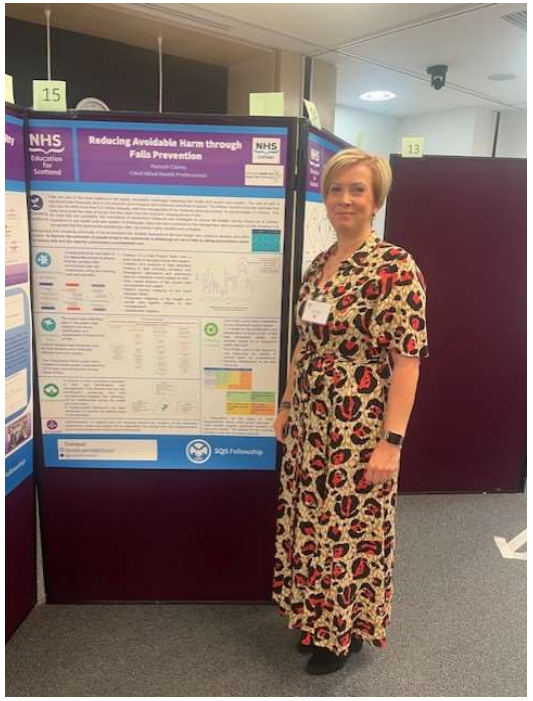
Edinburgh **Health and Social Care** Partnership





Scottish Quality and Safety Fellowship





Edinburgh Health and Social Care Partnership

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

Edinburgh Health and Social Care Partnership

Falls Related Trends in A&E Edinburgh HSCP

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

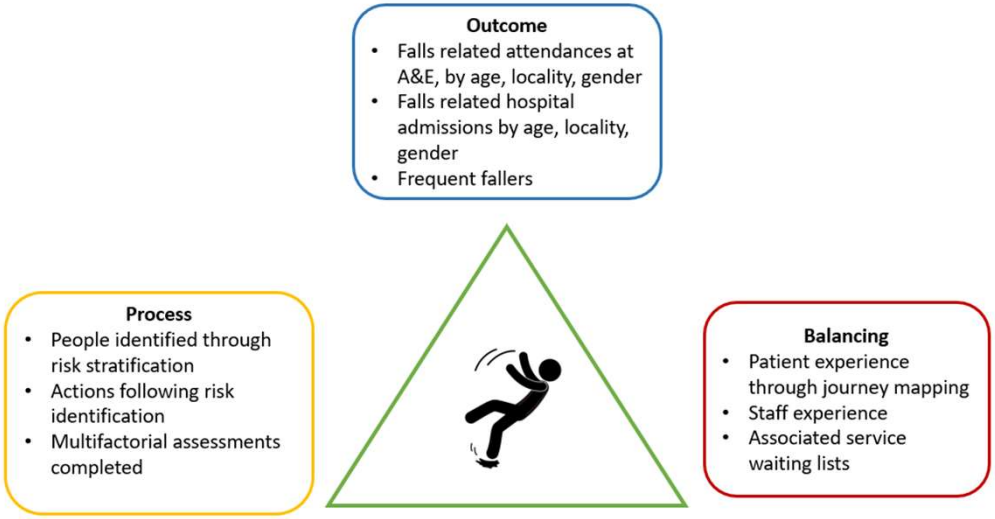
Changes or interventions that can be tested out

- 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

Edinburgh **Health and Social Care** Partnership

Edinburgh Health and Social Care Partnership

Measurement Framework



Edinburgh Health and Social Care Partnership

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

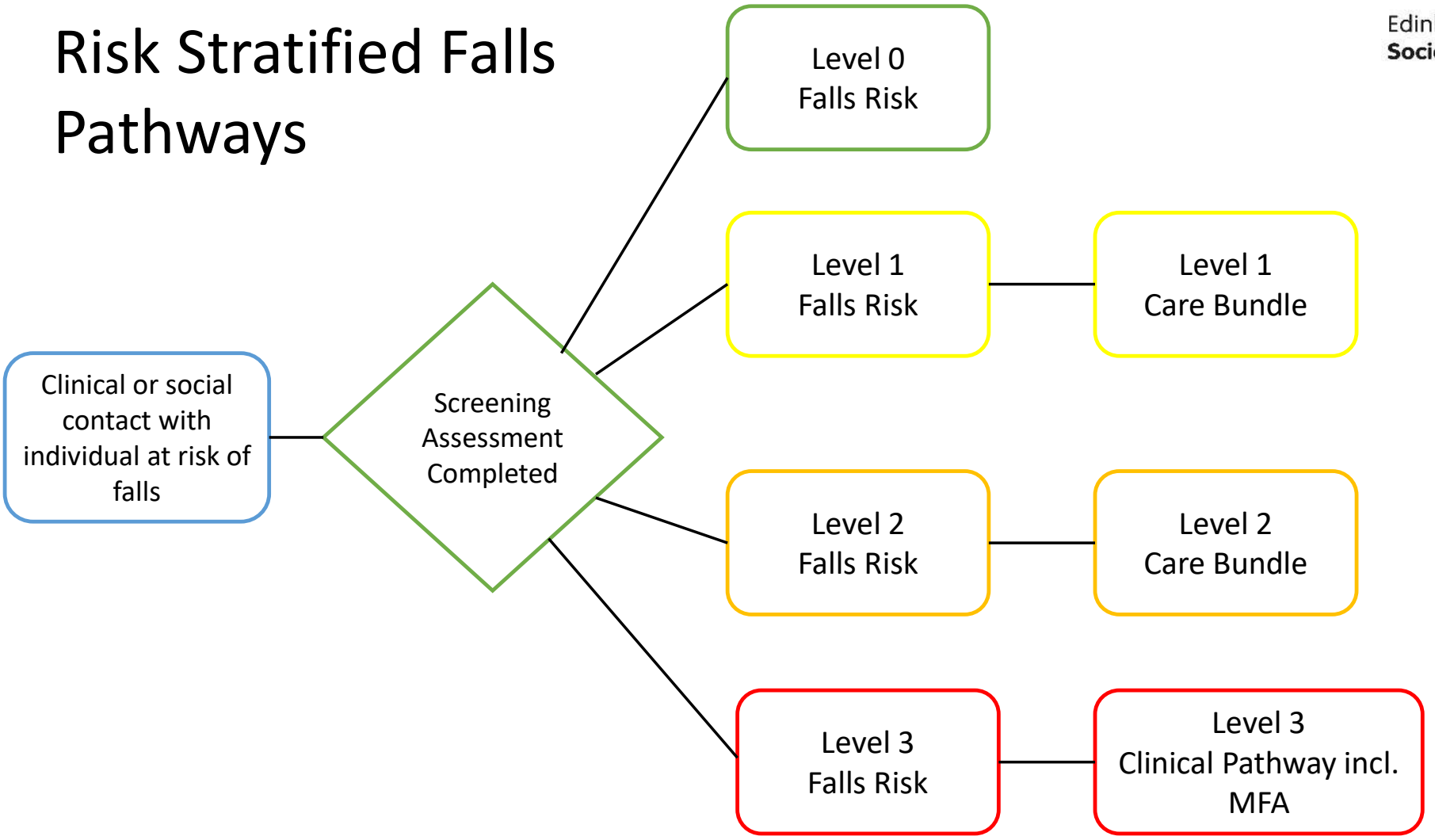
Risk Stratification Levels

Edinburgh Health and Social Care Partnership

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

Edinburgh Health and Social Care Partnership



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

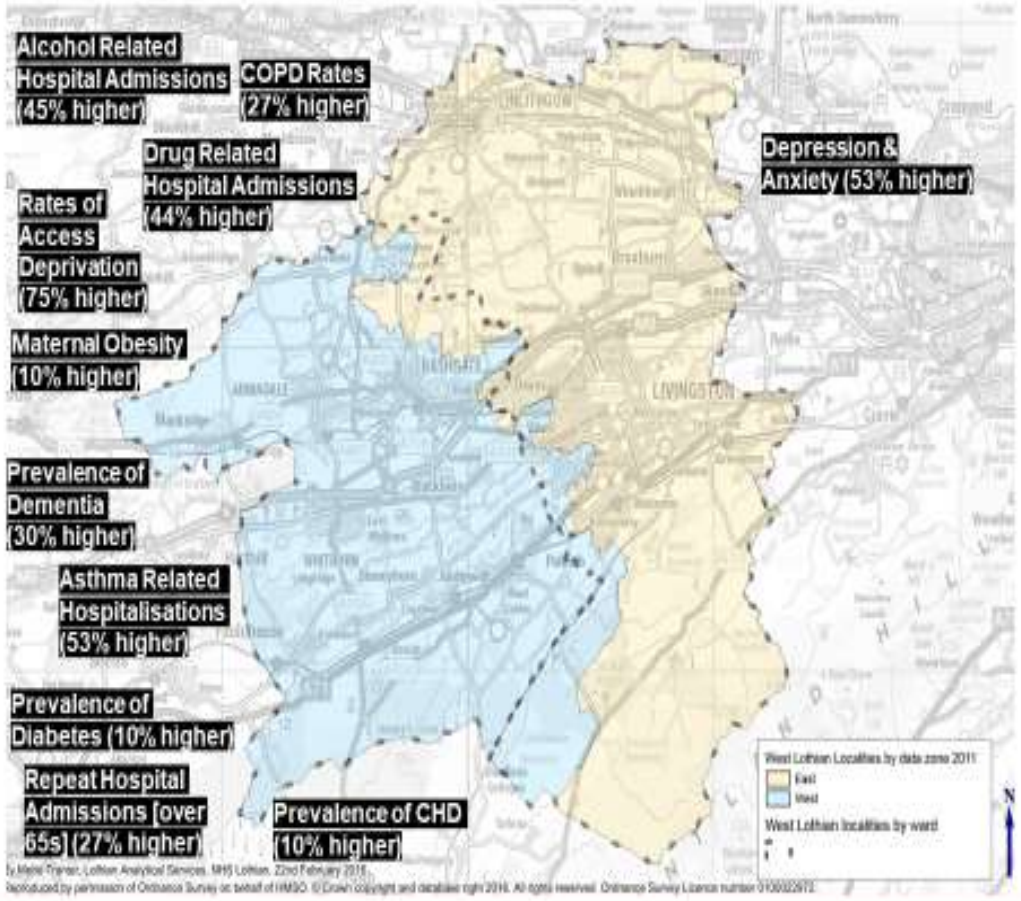
- Investment in early intervention
- A human-rights based approach
- Self- management
- Care and treatment provided as close to home as possible
- Planned care rather than crisis care
- Specialist care in the right place

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

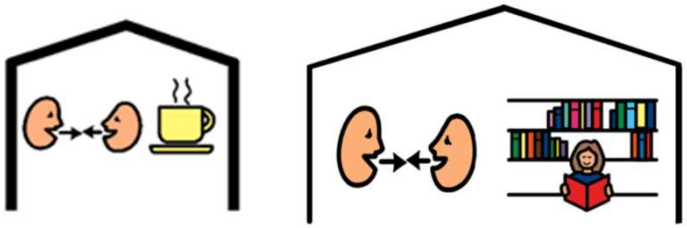
Inequalities: East/West Locality

Indicators where difference is 10% and above



INTEGRATED HEALTH AND SOCIAL CARE

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

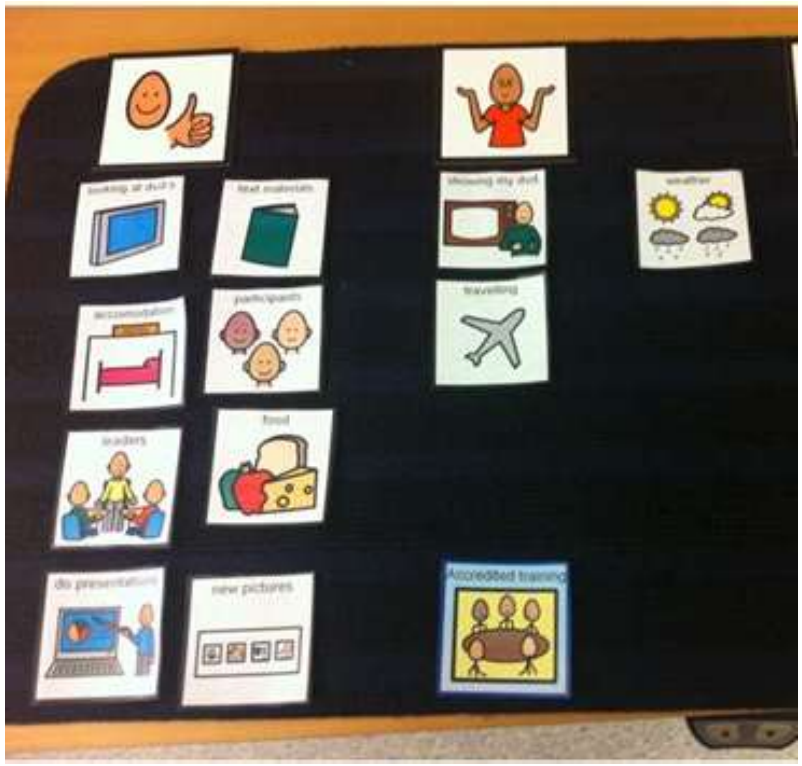
- ❑Raise profile of SLT
- ❑Offer staff and service users a safe space to explore good communication , increase their skills and confidence, reduce likelyhood of distressed behaviours

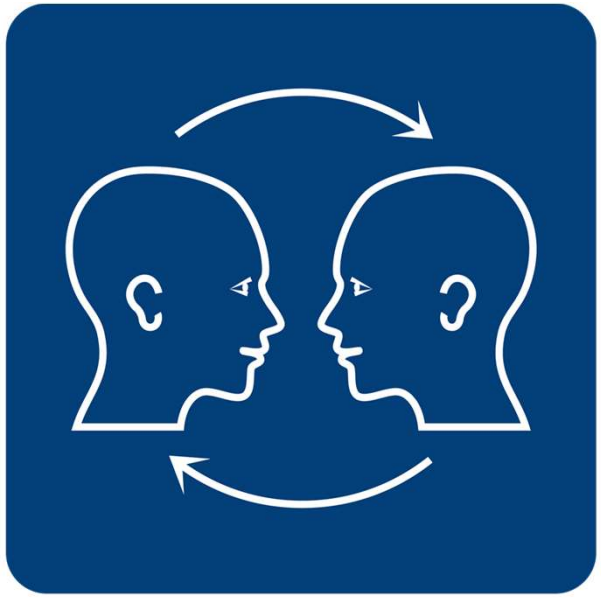
Ultimate aims :

- ❑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

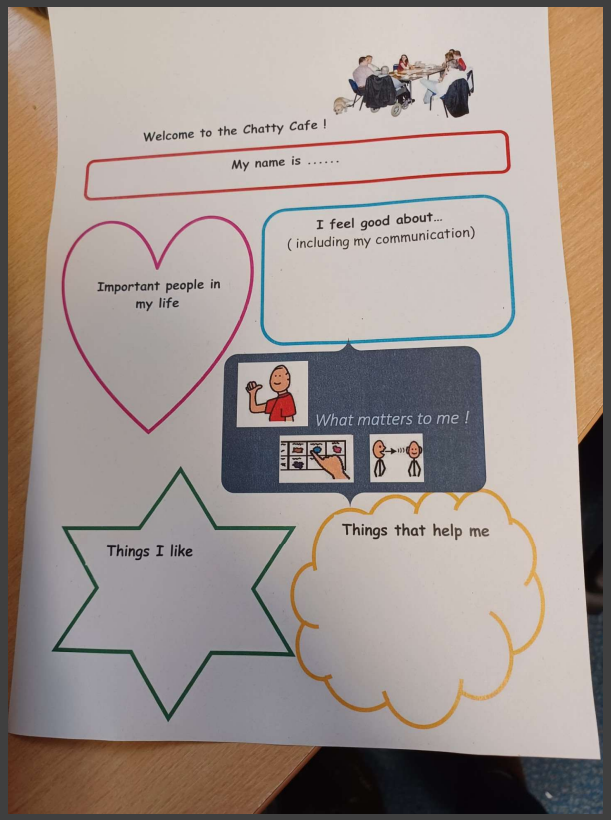
[Communication Access UK – Inclusive communication for all (communication-access.co.uk)]

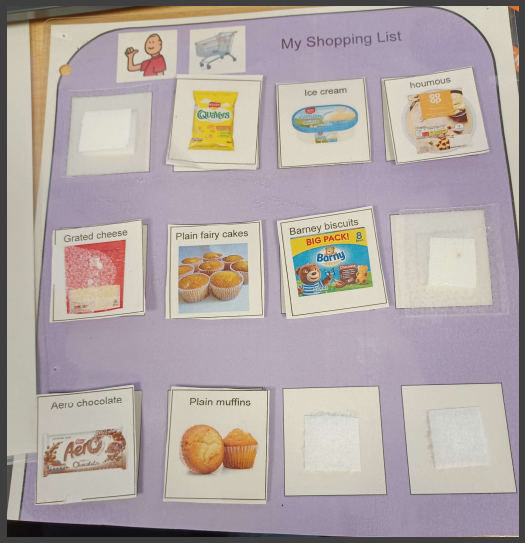




The Communication Access Symbol for the UK

What did we do and who attended ?





What difference did we make ?

We can make a noise about it - it's bee 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

Public Health: AHP Curricula

Taught vs. embedded

Coaching

Beyond healthy conversations

Population health

Community engagement

Placements – project / HIS / third sector

Ideas and inspiration

Pyjama paralysis, activity monitoring, observations

Sexual health over 50's Pelvic health physio

Project placements

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

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

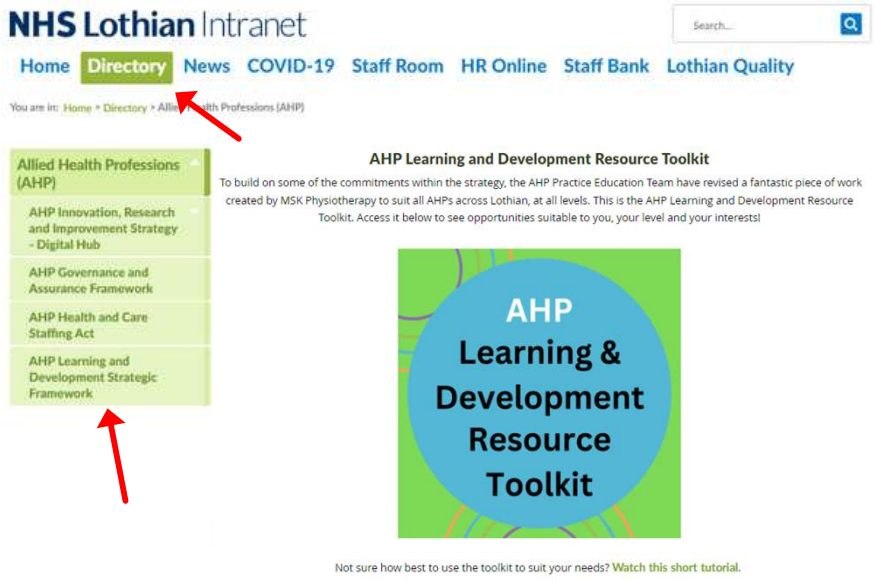
Royal Society for Public Health UK

- Allied Health Professions Hub

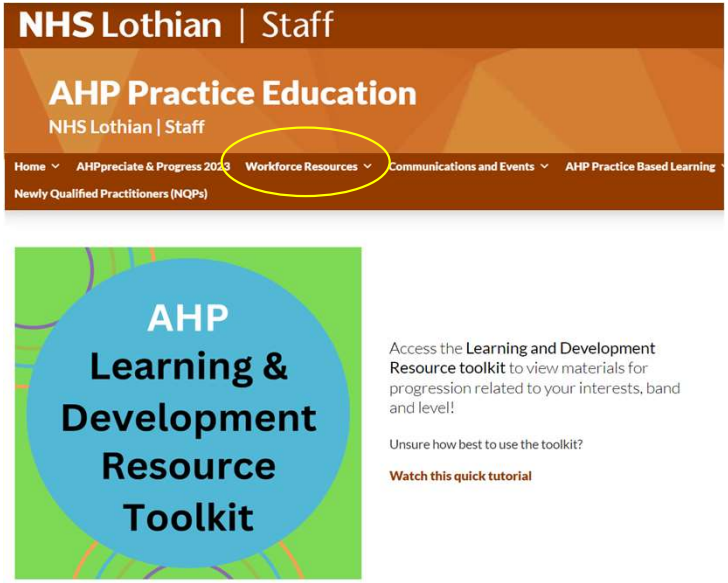
Allied Health Professions Learning and Development:
Strategic Framework 2024- 2027

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

NHS Lothian Intranet:



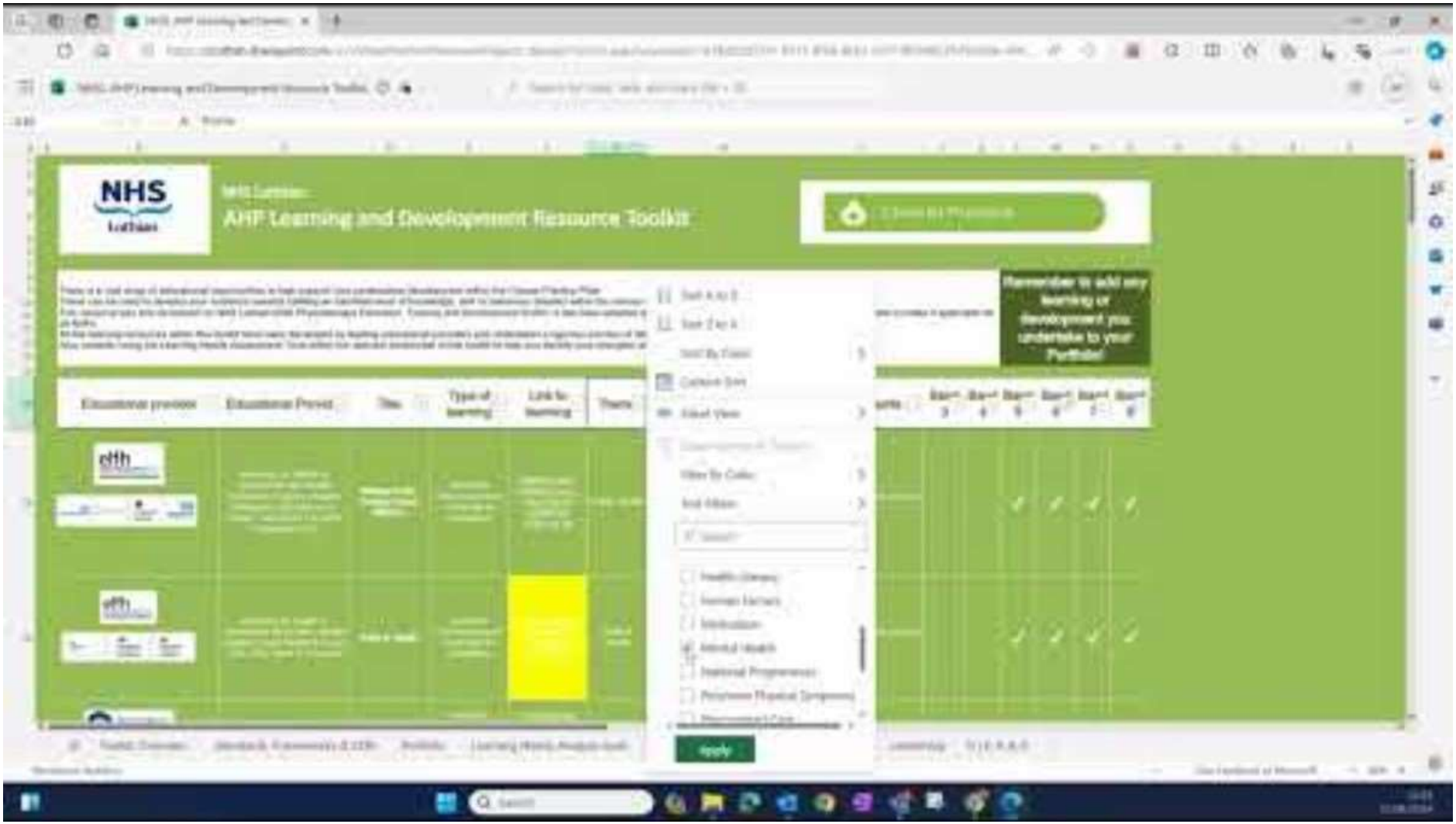
NHS Lothian AHP PE Internet:



Access here directly:

NHSLothian AHP Learning and Development Resource Toolkit.xlsx

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



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