REAL ACTION FOR PREVENTION:

a vision of population health in the Scottish Borders

Report of the Director of Public Health 2023
NHS Borders

FOREWORD

I am delighted to share with you the Director of Public Health Report for 2023, which is my first report for the Scottish Borders. A number of logistic challenges meant that we are slightly later than intended, but we aim to catch up this year! As you might expect, this is a team effort taking the skills and knowledge of many people within the department.

The report is in two sections:

- The first section that focuses on prevention bringing to the attention of our partners the variety of primary, secondary and tertiary prevention interventions available. I want to help address some of the lack of clarity I have found, with terminology often presented as prevention/early intervention but meaning different things entirely.

- The second section shares some of the work of the department of Public Health carried out in 2023. We are an outward facing organisation that seeks to lead, encourage, co-ordinate and improve the efforts of local organisations, groups and allies to improve the health and wellbeing of everyone that lives, works or is educated in the Scottish Borders.

  These reports specifically are:

  * Joint Health Improvement Team Annual Report
  * Alcohol and Drugs Partnership Highlight Annual Report
  * Joint Health Protection Plan
  * Screening Programmes Report
  * A report on Oral Health

This is an important time for public health in Borders and in Scotland. Public Health Priorities are not just for public health departments to deliver. We need to be tackling the fundamental causes of health inequalities, including prevention. This means working through our partnerships with others and thinking about how we work with local communities to shape our efforts. We will be bringing our strategy, tackling Health Inequalities in the Scottish Borders (THIS Borders) to public attention in the next few months but we have already begun by bringing together stakeholders and partners in a series of workshops to share our emerging findings and to help shape the way the evidence is presented and prioritised. This report is therefore a prelude for that work, but is nonetheless important as it also firmly establishes what prevention means to the public health profession and thus used as a point of common understanding with partners.

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The Case for Prevention in Acute Times

What is prevention?

The concept of prevention is one of the fundamental pillars of Public Health and government policy. In broad terms, the three most discussed types of prevention are primary, secondary and tertiary which were concepts introduced in the late 1940s.

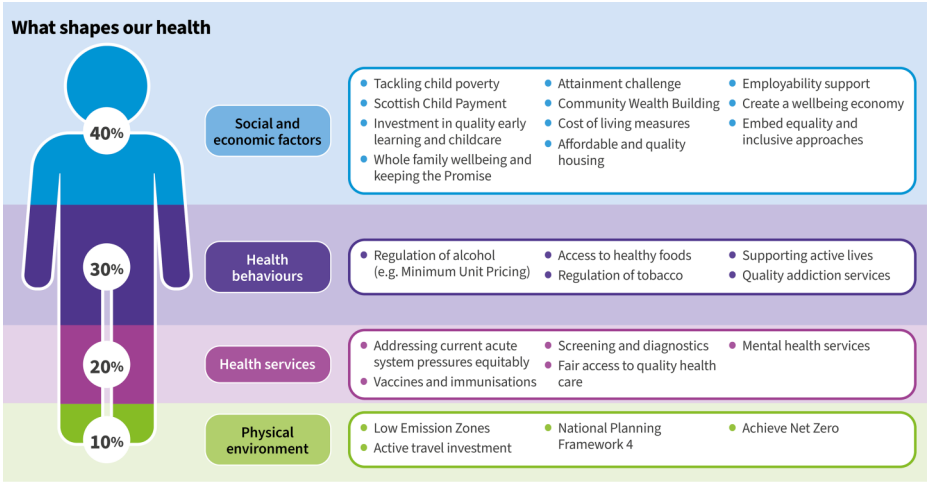
Primary prevention is where action is being taken to stop a condition, disease or illness ever occurring within an individual who is at risk. The target group is usually healthy people who are free of the issue in question but who have associated risk factors. Examples of primary prevention include immunising older adult care home residents against COVID, influenza and shingles (older people). Other examples include seatbelt legislation (drivers and passengers), stopping smoking in public spaces (workers) or violence, as a societal issue.

Secondary prevention is where action is being taken to detect the early signs of a specific disease or issue and intervene before symptoms can develop. The target group are those who have a disease (or precursor to the disease) but are apparently healthy with no visible symptoms. Examples of secondary prevention include screening programmes, redesigning streets to reduce traffic speeds, controlling blood pressure and managing high cholesterol to prevent vascular disease.

Tertiary prevention is where action is being taken to reduce the impact of a disease that has already manifested in an individual, prevent any further deterioration, maintain quality of life, improve function and minimise suffering. The target group are those with an established disease or condition. Examples of tertiary prevention include regular reviews (blood sugar, feet, eyes) for people with type 2 diabetes, providing domestic violence refuges, addressing homelessness and cardiac rehabilitation programmes.

Primordial prevention is a newer concept that was introduced in 1978 which focuses on preventing the development of risk factors for diseases and health problems before they even arise. Unlike primary prevention, which aims to prevent the onset of a specific disease or condition in individuals who already have risk factors, primordial prevention targets the root causes and underlying conditions that create those risk factors in the first place. Examples of primordial prevention strategies include:

- **Health education and promotion**: Providing individuals with accurate information about healthy behaviours, such as proper nutrition, regular physical activity, and avoiding addictive substances, can help prevent the development of chronic diseases such as heart disease, stroke, and cancer.
- **Environmental interventions**: Addressing environmental factors that can contribute to disease, such as air and water pollution, hazardous chemicals, and unsafe housing conditions, can help reduce the risk of developing certain health problems.
- **Policy changes**: Implementing policies that support healthy choices, such as taxes on unhealthy foods and beverages, restrictions on tobacco advertising, and increased access to parks and recreational facilities, can create a healthier environment for everyone.
- **Early childhood interventions**: Providing support and resources to families during pregnancy and early childhood can help ensure that children have a healthy start in life and are less likely to develop chronic diseases.



Adapted from The Kings Fund (**https://www.kingsfund.org.uk/publications/vision-population-health**)

Source: Public Health Scotland

If we take the example of drug use and of addiction to opioid drugs, education for children and young people about the harms of drugs to avoid even trying them is primary prevention. Legislation to limit harmful supply or access would be primordial prevention. Limiting the supply of drugs through criminal justice work are secondary preventive activities. Ill-health and death are prevented by the distribution of naloxone (the antidote to opiate overdose) as well as effective treatment and can be considered tertiary prevention.

One of the key things is that prevention is not restricted to disease or clinical issues, though that is where these concepts originated. Prevention approaches and concepts can be applied to a broad range of activities, and often require engagement across the whole of society as a result. Heart disease, for example, is still the biggest cause of death in the Scottish Borders. A preventative approach would tackle the issue using all domains of prevention.

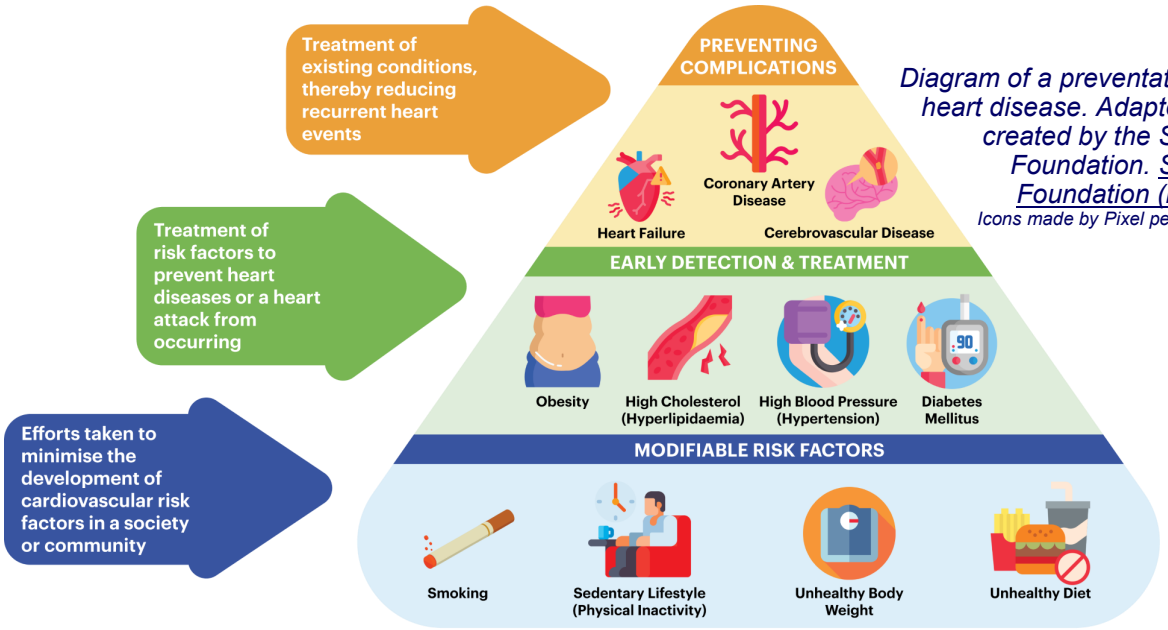


Diagram of a preventative approach to heart disease. Adapted from a figure created by the Singapore Heart Foundation. Singapore Heart Foundation (myheart.org.sg)
Icons made by Pixel perfect and Freepik from www.flaticon.com

Evidence for a preventive approach

Prevention activities have a reduction impact on mortality (death rates) and also on morbidity (rates of illness). Mortality rates are a useful measure of population health; they are unequivocal and easy to measure through death registration data. In 2020 in Scotland, 27% (21.6% in Borders) [1] of all deaths were considered “avoidable”, that is, they could have been avoided by preventative interventions [2]. People who lived in the most deprived areas in Scotland that year were four times more likely to die of a preventable disease than those who lived in the least

deprived areas. In this context, calls for greater focus on preventive care are coming from across the system: from the Christie Commission on the future delivery of public services in 2011 [3] the Health Inequalities Policy Review in 2013 [4], the Scottish Chief Medical Officer's report 2023 [5], and the NHS Long Term Plan [6] in England. Ten years after the publication of landmark work "Fair Society, Healthy Lives" [7] Professor Michael Marmot reiterated his recommendation that preventative strategies are a vital tool to reduce and prevent health inequalities. When acute services (such as hospital wards and package of care provision) are under extreme pressure, as they have been during the COVID pandemic and the recovery phase, there is a drive towards providing and funding immediate care services in response to immediate population demands. Unfortunately, this creates an endless cycle of crises with little prospect for prevention. Prioritising prevention within health and social care is beneficial for organisations and for individuals and it could be argued, for the health of our NHS overall. When we intervene early in chronic diseases to manage and limit complications, we reduce pressure on emergency, acute and frontline services by stabilising patients before they reach a crisis point. Hospital stay is inherently risky, for example, due to the presence of hospital acquired infections, and the potential for errors and mistakes. When we support people to maintain their health and live independently at home, we reduce the number of admissions and decrease the length of stay in hospital. By helping to build up social networks for people in the community, using community development approaches, we encourage care in the community, and avoid admission to hospital. Prevention leads to a better quality of life for more of the population, by increasing the years spent in good health [8] and also sustain & support independent living.

There are clear economic benefits to a prevention approach. Reduced service pressures and a healthier population will lead to significant financial savings, societal benefits, and allows resources to be redistributed to other areas of need. A study by the University of York [9] aimed to try to quantify the difference in cost per Quality Adjusted Life Year (QALY) for public health interventions versus general NHS treatments. A QALY is a way of measuring one year lived in perfect health. They found that for preventative work, the cost per QALY was £3,800, compared to £13,500 for treatments. This supports the position of Public Health Scotland, the King's Fund and UKHSA; that investing in preventative work is of economic benefit [10].

What is a QALY?

A QALY, or Quality-Adjusted Life Year, is a unit of measurement used in health economics and healthcare decision-making to assess the value and impact of medical treatments, interventions, or healthcare programs. It combines both the quantity and quality of life gained as a result of a particular healthcare intervention. QALYs are used to compare the effectiveness and cost-effectiveness of different healthcare interventions.

The concept of a QALY is based on the idea that not all years of life are equal in terms of health and well-being. A year of perfect health is considered to be equivalent to 1 QALY, while a year of less than perfect health is valued at less than 1 QALY, typically on a scale from 0 (equivalent to death) to 1 (perfect health). For example, if a person's health-related quality of life is reduced to 0.5 due to a medical condition or disability, that year would be equivalent to 0.5 QALY. A value in £s can be attributed to 1 QALY.

Here's how the calculation works:

Determine the health state or quality of life associated with a particular medical condition or intervention, often on a scale from 0 to 1, where 0 represents death and 1 represents perfect health

Estimate the number of years a person is expected to live in that health state or condition.

Multiply the quality of life score by the number of years to calculate the total QALYs gained.

Scottish burden of disease

In many ways this report is a response to the data published in the most recent Scottish Burden of Disease (SBOD) Study November 2022 [11]. The SBOD study was set up to monitor Scotland's population health, by measuring differences in harm from causes of disease, injury, and death across the entire life course.

The report suggests that, despite an overall projected decline in the population in Scotland by 2043, disease burden could increase by over 20% with subsequent impact on the need for, and provision of, health and social care. This assumes no substantial change to current dietary, exercise and other lifestyle habits of the population. Leading causes are expected to continue to be cardiovascular diseases, cancers, and neurological diseases. A King's Fund publication has noted "huge sums will be wasted if high levels of preventable illness hit over the next two decades" [12].

Primary prevention first

Among the different methods of prevention, primary prevention appears to have the best outcomes and the better return on investment. Primary prevention can be described using the analogy of a river:

There is an oft quoted parable (a version of which was originally credited to the sociologist, Irving Zola [13] that tells of a man and woman fishing downstream. Suddenly a person comes down the river struggling for life. The fisherfolk pull her out. Then another comes and again must be rescued. This happens all afternoon and the fisherfolk are getting very tired from constantly pulling people from the river. Eventually they think, "We need to go upstream and find out why so many people are falling in the water". When they go upstream, they find that people are drawn to the edge to look at the river, but there is no safe way to do this. Many of them fall. The fisherfolk go to the community leaders and report the number of people who have fallen into the river. They also report that this is due to the lack of a protective barrier on the cliff. Community leaders build a wall behind which people may safely view the water. Some still fall, but there are many fewer victims to rescue. This is the "moving upstream" analogy for prevention. Instead of expending all resources and energy on rescuing people, why not stop the problem from even happening? This is not to say that the problem can be eliminated, but there may be fewer people to rescue downstream. The upstream analogy describes primary prevention - this key concept in our public health approach.

Preventive efforts are very cost-effective. Public Health Scotland have recently published on the public health approach to prevention [14], which highlights the benefits of primary prevention. In 2016/17, a typical one day stay in a hospital bed (in England) cost an average £586 [15]. Systematic review evidence has shown better return for investment for primary preventative measures (£34 for health protection such as immunisation programmes, and £46 for legislative interventions such as smoking ban, for every £1 invested). For secondary and tertiary prevention, the return is estimated at £5 for every £1 invested.

Given that primary and primordial preventative strategies are concerned with stopping people developing illness, they require input from across all elements of society: healthcare, local government, third sector, industry, the community, and individuals themselves. Collaborative working is the best way to address the social, cultural, economic, structural, environmental and commercial determinants (upstream factors) that lead to illness for those living in the Borders. [16].

Mobilising a preventative system across Scottish Borders

Our NHS and its support system is a dedicated and systematic approach to health care, based in evidence and leadership. We need to have a preventive system which operates in the same way that is just as strong: co-ordinated, evidence-driven and able to offer sustainable improvement to the health of the whole Scottish Borders population. We need to work together as individuals and as an organisation to effect change. A preventive system has been defined as the "people, processes, activities, settings and structures that can protect and promote and health of individuals and communities." [17]

Prevention in healthcare

As already acknowledged, while the NHS carries out much established preventive work, in times of extremis, the acute pressures of the day can demand time and focus. Public Health wants to enhance and expand prevention activities in the NHS. We know our population's health is in decline, as we grow older as a group. We need to step back, plan, and act now to prevent worsening of the NHS's current situation. The best way to take the pressure off the hospitals is to ensure fewer people need to attend at all!

We can start with developing the role of NHS Borders as an Anchor Institution; establishing our role as a force for good through our actions in relation to our workforce, procurement, land and assets. NHS Borders currently employs 3496 staff (a whole time equivalent of 2783); when we focus on getting it right for our employees we are operating in a way that generates health for the people working in the NHS beyond the diagnostic and treatment services we provide. Each employee is part of a family unit, so the benefits and support we provide them has the potential to spread much more widely throughout our population.

Supporting clinicians to focus on prevention and population health can provide professional satisfaction and reduce frustration, and potentially burnout [18]. There can be a strong frustration when clinicians feel unable to address the underlying cause of many of the health problems they encounter among their patients; when they must "send them back to the conditions which made them sick" [19].

There are opportunities we can take to truly embed prevention in routine health delivery. We can identify chronic conditions early and maximise and support self-management through the inherent skills in prevention of our primary care colleagues. We can make sure our health service delivery does not further exacerbate the health inequalities that already exist (indeed, a national Public Health Action Team is focussed on actions to prevent this).

We can expand our social prescribing offer in the Borders to support people to self-manage and co-produce their own health. Social prescribing connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. As defined by Public Health Scotland, social prescribing is "*commonly used in primary care settings and provides non-medical options for primary care staff to draw on to support their patients' health and wellbeing, including their mental health. Social prescribing - is an approach used to support self-management.*"

It is primarily used for connecting people to non medical sources of support or resources within their community. It can also be used by professionals working in other services and enhances the holistic approaches to addressing health, wellbeing and mental health problems [20].

What is Social Prescribing?

According to the King's Fund: social prescribing, also sometimes known as community referral, is a means of enabling health professionals to refer people to a range of local, non-clinical services. The referrals generally, but not exclusively, come from professionals working in primary care settings, for example, GPs or practice nurses.

Recognising that people's health and wellbeing are determined mostly by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health [21].

Another way to think of this is that it represents primary prevention. If done in a systematic, evidence-based and connected way it has the potential to take out much demand for health and social care. Approximately 3,000 consultation per week in general practice are primarily for social reasons in the Scottish Borders.

Embedding prevention in the work that they do, often in difficult circumstances, is the only rational way to reduce future work pressures. These should be underpinned by ensuring staff understand the impact of health inequalities and stigma experienced by people and groups which lead to barriers to accessing services. As the Director of Public Health, I am happy to work with colleagues to discuss and develop these ideas further. Behaviour change is difficult, so the liberal use of dashboards and ranking tables will help keep the focus, but only on areas where objectives are SMART (Specific, Measurable, Achievable, Realistic and Time bound). Here are some of the measures I would recommend that our colleagues in NHS Borders undertake:

In settings such as the community (in people's own homes), for primary care and attendances at the Emergency Department:

- All activities should be designed to minimise health inequalities.
- Continue to identify people who will benefit from support of the NHS Borders Wellbeing Service.
- Encourage, promote and measure attendance at health promoting events, and collect information on the impact of those events on future behaviour & health.
- Implement ways of measuring social connectedness and encourage more connectivity as a way of building community networks that reduce isolation and improve skills/knowledge.
- Smoking cessation should be particularly targeted at those with most to gain (e.g. people with existing respiratory conditions such as bronchitis or asthma). We must support smokers to substitute less harmful activities at the very least and support them to quit where possible.
- Alcohol screening to identify people drinking outwith guidelines and support them to only drink alcohol within the low-risk guidance and consider trying low or no alcohol alternatives. We should promote zero-alcohol events.
- Promote drug avoidance and effective rapid treatment/resolution through collaboration with partners as well as improve messaging at target groups through social media.
- Implement a deprivation measurement/dashboard to see the impact on our population of our interventions.

- Self-care: improving physical resilience and balance across our population, especially older people e.g. Yoga/Tai Chi, Pilates.
- Self-care: encourage the appropriate use of services including NHS24 by promoting messages and working with groups connected by a common desire to promote health and wellbeing (social movement through a network of networks).
- Self-care: encourage walking and active travel using interventions that target people appropriate for their life stage.

- Ageing Well – anticipatory care planning for old age; promote power of attorney; develop support systems for minor illnesses by empowering self-help groups; and have in place rescue arrangements for collapse/falls before they are needed. These should be targeted to those most likely to need admission in the coming year (50% chance or more), and this should be assessed annually. It is important that we create space for people to plan ahead, and discuss what a good old age looks like, and what a good death might be. By planning for these eventualities, we can share and discuss difficult circumstances more openly. We encourage women to plan for a good birth, so it seems strange that we do not plan for other inevitable health challenges.
- Starting Well – promote breast-feeding, target smoking/drinking in pregnancy, improve uptake of vaccinations especially in areas/groups where uptake is poor, healthy weight should be promoted/supported through homes, nurseries and schools, identify those with delayed development and provide proportionately more services in these.
- Support the wellbeing of residents through mental health promotion activities.
- ALISS should be widely used in primary care.
- A Key Information Summary (KIS) can be created for each patient to extract information to be made available for other people and services looking after the patient and enables the creation of 'anticipatory care plan' which helps people and their carers plan ahead for any changes in their health needs KIS summaries, anticipatory care/ future care planning [22]
- We can medicalise normal wear-and-tear issues too readily. A social prescribing system is needed that connects and supports our citizens to de-medicalise many of the issues related to ageing. This needs to be a systematic arrangement and provide an evidence-based Social Wellness Service. Across the Scottish Borders there are already around 100 people working in the area, but are dispersed and not working to a common purpose or goal. Approximately 3,000 consultations per week in general practice and community care are primarily due to social reasons; some of these also attend the Emergency Department. A Social Wellness Service would give agency to people to manage many of their own problems and should be urgently implemented to help support the scarce resources in the NHS. Modelled on General Practice, it should be accessible to all, when needed, but with the aim of building capability and capacity to support self-care and enhanced problem solving.

What is ALISS?

ALISS, a local information system for Scotland, aims to make information about sources of support for health and wellbeing easy to discover. Its foundations lie in the lived experience of people trying to find local services, clubs, groups, and activities to help them live well [23].

ALISS enables people to work together to make information more widely available and easily findable through a variety of digital channels. ALISS is a coproduced, web- based system for finding and sharing information about community assets across Scotland.

For in-patient and out-patient services

- Stop Smoking – monitor all, and encourage harm minimisation by using alternatives such as nicotine replacement. A critical point of behaviour change is becoming a patient, and we should use Making Every Contact Count - an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing [24]
- Embed routine enquiry about money worries and signpost to welfare and benefits advice (Money Worries App).
- Alcohol screening and brief intervention – record and review on a regular basis as this can be subject to change, and consider working with peer-led support.
- Everyone should be entitled to an annual medication review. Not all medications work as intended nor are taken in an effective manner due to side-effects.
- Support to reach target BMI (Body Mass Index). This might include dietary supplementation for those under or a peer-led programme of managing weight loss.
- Measure & protect ambulatory capacity when under treatment. At each important contact, capacity should be assessed to show where declines have occurred (and displayed graphically to help visualise the trajectory).
- Being in a bed should be a last resort; a dashboard of time spent in bed should be the normal way of surveillance in wards to encourage rapid mobilisation.
- Discharge planning needs to be measured in terms of effectiveness. Hospitals are a risky place for vulnerable people so in-patient time should always be minimised, recorded and reviewed. Lessons should be learnt and good practice disseminated.
- Future care planning for all.
- Strength and balance training – falls avoidance should be part of every routine contact.
- Promote power of attorney so everyone has had at least one recorded discussion at least every three years, and more frequently when needed. Broaching the subject by a healthcare professional is likely to be more acceptable than from a relative.
- Promote Value-Based Health and Care - a values-based conversation about future planning of health would use the acute reason for attendance, when appropriate, to have a wider discussion about self-care and keeping well. Each discharge should include an anticipatory care plan for the next decade. For older attendees, this might also include an opportunity to think about power of attorney and planning for a good old age.
- Patients often spend a long time waiting; can we not utilise this time to educate, inform and engage those people in improving their underlying well-being, when appropriate and safe to do so? Could we expand use of audio visual equipment in this regard?
- We operate a medical model, but often overlook the social functioning aspects of people's illness. We should routinely collect Patient Reported Outcome Measures [25] when providing or beginning treatment so we can assess how well we have done in restoring social functioning for our patients.

For our staff (and their families, when appropriate)

Consider having department/ward dashboards (aggregated/average figures):

- Vaccination coverage.
- Screening access.

Consider having ranking tables across organisational sub-units for:

- Steps/activity.
- Competitions that encourage team building. Have, at least annually, a wellbeing event for the service area/department.

- Routinely offer of referral to smoking cessation, healthy weight and emotional support resources/ Wellbeing Service. Recording of such data will help others coordinate efforts and pick up themes and trends when presented in aggregate.
- Raise awareness of sources of local support for those with concerns about the alcohol use of themselves of those close to them.
- Routinely enquire about money worries and signposting to welfare and benefits advice, as well as the Money Worries App.
- Build a safe space to discuss disability, gender and race and help staff self-identify and thus access support that is available.
- Use of standing desks for those seated most days, and allowing movement every hour, especially those working remotely, will generate the myokines that support muscle, bone and immune functioning. It may be helpful to set targets for steps per day at work, and monitor and report on them through regularly updated dashboards.

Prevention interventions in social and community care

- Isolation is particularly problematic and can be aggravated by loss of hearing and sight. Everyone should have these assessed at least annually, and any deterioration addressed proactively.
- Alcohol screening and brief interventions should be widely available and routinely assessed.
- Social functioning is a key driver for wellbeing, both physical and social. Interventions that encourage connecting with others (using communities of common interest) to address isolation will yield improved outcomes. Linking across generations is a valuable adjunct: young children respond well to older people and this is often reciprocated. Initiatives such as “adopt a grandparent” have evaluated well. The more diverse and richer the social environment is for a person, the greater is the resilience against future illness and need for admission.
- Ensuring food and drink available is in line with healthy eating guidance and avoids those with high fat, salt and/or sugar.

For social care

As employer/commissioner

- Proactively raise awareness of modifiable health risk factors and signpost staff providing care to sources of support and advice.
- Encourage increased physical activity whilst in work, and support/encourage such activities outside of work. Use of standing desks for those seated most days, and allowing movement every hour, especially those working remotely, will generate the myokines that support muscle, bone and immune functioning.
- Setup collaborative methods to encourage behaviours that encourage wellness; peer support works best to encourage and support long-term behaviour change.
- Develop an understanding and process for promoting good respiratory hygiene to prevent spreading colds and other infections.
- Develop a strategy for quickly identifying stress at work situations and managing issues such as carer responsibilities e.g. flexible working.

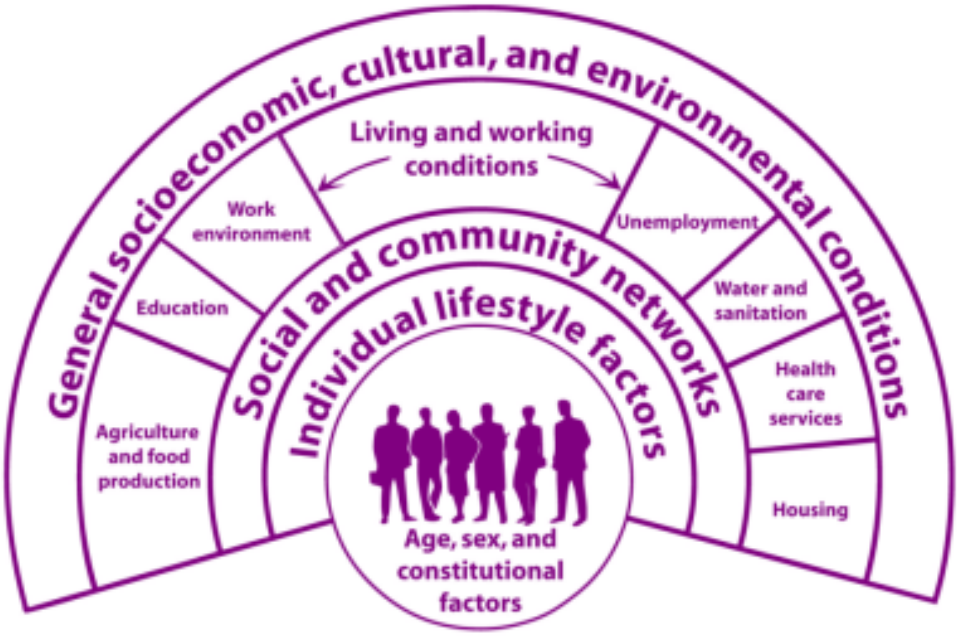
For the client group

- It is important to monitor trends; surveillance showing deterioration and thus opportunities to limit the harm before becoming a crisis, and indeed to reverse the trend are needed and charted. All carers should therefore have knowledge of and access to simple measures they can employ to address common issues; they should feel confident to work across boundaries to deliver patient-centred care.

- The carers and relatives of clients are an important source of support and advice. Have we adequate and routine measures in place to meet their wellbeing needs including their health-related behaviours? Are these collected and measured, and actions taken to pick up trends or gaps?
- Assess everyone with respect to harmful behaviours (smoking, alcohol consumption etc.), record and monitor with annual reviews. Have their biometrics on a dashboard that is shared with all carers will ensure collective ownership.
- Regularly assess balance, frailty, and vision/hearing. These change with time, and proactive assessment (at least annually) will pick up issues before they become disabling.
- Social functioning is a key driver for wellbeing, both physical and social. Interventions that encourage connecting with others (using communities of common interest) to address isolation will yield improved outcomes. Linking across generations is a valuable adjunct: young children respond well to older people, and this is often reciprocated. Initiatives such as “adopt a grandparent” have evaluated well. The more diverse and richer the social environment is for a person, the greater is the resilience against future illness and need for admission. Loneliness is a particular issue for individuals needing social support, and their often-limited mobility means specific interventions are needed for this set of groups.
- Whilst opportunities to encourage more physical activity can be scarce, even those with limited or no mobility can carry out specifically designed activities in a chair.

Partnerships and community development

Given that so many factors outside of the health service influence the health of Borderers, multiagency partnerships are essential to address the wider determinants of health. This was captured in a widely shared and supported model first espoused by Dahlgren & Whitehead in 1991 [26]. Public Health will need to strengthen our work with transport, housing, town planning, social services and food systems. We know how important our work with community third sector and advocacy groups is; these groups understand local need and experience so they can use community assets to make the most of health-benefitting opportunities. There are many excellent examples of community-based preventative work across the Scottish Borders described in this report.



Source: Dahlgren and Whitehead (1991)

We know that social prescribing is a whole population approach that works particularly well for people who:

- Have one or more long term conditions.
- Who need support with low level mental health issues.
- Who are lonely or isolated.
- Who have complex social needs which affect their wellbeing.

Social prescribing link workers also support existing community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners. We are lucky to have a strong sense of community in the Scottish Borders, and a large cohort of our population are active and able older adults. One preventive approach to partnerships and community development will be to tap into the potential of the community in the Scottish Borders, working to develop sustainable new peer support.

Partner institutions

Scottish Borders Council (SBC) is the lead place-maker locally and has a duty to promote wellbeing for residents. There is strong evidence that our health can be affected by both the working environment, our environment where we live as well as our genetics. Workplace interventions to improve health and wellbeing are applicable to all employers although it is recognised that in different industries and settings there may be unequal access to the following opportunities to prevent ill-health and improve the wellbeing of our employees. It is especially our anchor institutions that will drive and set the tone for others. The biggest anchor institutions here are NHS Borders (NHSB) and SBC but not exclusively so. I therefore suggest the following interventions for our anchor institutions as employers, to promote prevention, having previously described more specific interventions for NHSB.

Primary Prevention

- Access to well paid jobs.
- Flexible working opportunities.
- Train managers in supporting mental health and wellbeing including suicide prevention.
- Ensure employees are involved in decision making.
- Promote vaccination and screening programmes.
- Follow healthy eating principles for provision of food and drink.
- Encourage in work physical activity (e.g. walking meetings, taking proper breaks).
- Adopting smoke free grounds policies.
- High blood pressure is a stealthy, hidden cause for early death and disability. This is entirely preventable, but needs specific support to identify cases. The use of self-administered mechanisms has greatly improved access to information, and if this is supported by appropriate occupational health access, could generate longer and more fulfilled lives for those who would otherwise succumb unexpectedly from heart attacks or strokes.

Secondary Prevention

- Monitor sickness absence to understand causes and take action to reduce variation and the underlying causes.
- Implement supportive absence policies.
- Support access to health services such as stop smoking services.

Tertiary Prevention

- Access to occupational health and wellbeing services.
- Flexible working opportunities (including support for carers).

It is important to address the needs of children. They are our future and efforts at prevention and reducing health inequalities begin here. Therefore, any intervention needs to target children and their developmental needs. I am disappointed that I have not been as engaged as I would like to be with those who lead our education department. I look forward to doing so in the coming year. To encapsulate some of the many things I hope to collaborate with them on I make just a few key suggestions:

- Review/update substance use policy for schools to incorporate particularly regards vaping (covers alcohol, drugs and tobacco).
- Increase the uptake of school meals as evidence indicates that this improves educational attainment.
- Measure the Adverse Childhood Experiences (ACEs) of children in the transition from primary school to help tackle health inequalities early and prevent the lifelong harm that can result.
- Ensure compliance with the Nutritional Requirements for Food and Drink in Schools (Scotland) regulations in all education settings and endeavour to locally source as much food as possible. This can prevent oral health problems as well as promote healthy weight.

Borders College and other education institutions also play a role in improving the health of our residents, with most wishing to train to take up better employment opportunities. They may also wish to consider the following, and certainly to open a dialogue with public health to see where we can support and collaborate:

- Ensure staff understand the impact of health inequalities and stigma experienced by people and groups which lead to barriers to accessing services.
- Equip staff to discuss self-referral to Wellbeing Service to support healthy behaviours and emotional wellbeing.
- Ensuring food and drink available is in line with healthy eating guidance and avoids those which are high fat, salt and/or consumables, maximising locally produced foodstuffs.
- Consider alcohol free events and promotion of low/no alternatives.
- Promote physical activity, whether through set piece sports events or other social occasions.
- Promote and support breastfeeding.
- Consider allowing premises to be used as shared community spaces outside of standard operating times. If we want to create a health and promoting culture amongst our residents it would help if local groups can utilise some of the facilities to promote their activities.

The planning department of SBC has a significant role in place-making and controls access to harmful activities through its licensing functions. I would suggest the following interventions, which can be the basis of a future dialogue and collaborative work:

- Restrict advertising of products high in fat, sugar or salt by the local authority via transport networks, or third parties on council-owned assets and events.
- Use the licensing system to improve the local food environment.
- Robustly apply the Alcohol Licensing Objectives including protecting and improving public health and protecting children and young persons from harm.

The cultural and sports life of a community shapes many collective activities in any place. The importance of sport is that it encourages physical activity, but also brings people together, even those who would not otherwise engage in competitive physical activities. Cultural events and dances can help bring entire families together. The prime agent that delivers these for residents is Live Borders. This has faced some challenging times, and its scope to deliver additional work may be significantly reduced. However, I would welcome an opportunity to engage with Live Borders to:

- Help them participate in and contribute to social prescribing through the integrated Social Wellness Service.
- Use community spaces and events to host health promoting activities. For example, in other areas, libraries have hosted immunisation sessions. Community spaces have been utilised for community groups, but I would like to turn these groups into agencies that also promote wellbeing and good health so we can build a social network of networks that become the constituent parts of social movement for health.
- Ensure staff understand the impact of health inequalities and stigma experienced by people and groups which lead to barriers to accessing services.
- Use a data driven approach to prioritise increasing physical activity in those who are least active.
- Ensuring food and drink available is in line with healthy eating guidance and avoids those with high fat, salt and/or sugar.

All of us need a shelter, and for most of us this is the home we live in. These homes are an important component of place-making, and the policy set by SBC is a key driver to encourage provision of safe and health promoting homes. We know that many of our homes are old and are difficult to heat. We know that people can be lonely and isolated in their homes due to disability and illness but also due to the distributed nature of our population and the varying challenges in using public transport. I look forward to continuing our dialogue with the housing policy unit. However, we have over 12,000 households that rent from the registered social landlord (RSL) sector. These agencies expend much effort in ensuring that tenants, especially those in need, are supported. I therefore make the following suggestions by way of commencing a dialogue with this area:

- Ensure staff understand the impact of health inequalities and stigma experienced by people and groups which lead to barriers to accessing services.
- Equip staff to discuss self-referral to Wellbeing Service to support healthy behaviours and emotional wellbeing. We should work together to create smoke-free homes, and work to ensure that houses meet the Scottish Housing Quality standard.
- Ensuring food and drink available is in line with healthy eating guidance and avoids those which are high fat, salt and/or consumables.
- RSLs should take a census of all their residents, not merely their tenants, so we have a more complete understanding of the group that they look after. Sharing this information may help the health and social care system provide more targeted and pre-empt potential admissions with early intervention. Working with GP colleagues may help us develop a system of early warning: some GP colleagues have claimed that they can predict homelessness two or three years in advance of it taking place.

- RSLs should look to collaborate with the potential Social Wellness Service, as social prescribing will help build greater resilience amongst their tenants.
- RSLs should look, in their role as employers, how they can meet the suggestions previously made for their staff and I look forward to supporting them to operate as Anchor Institutions.

Private businesses are a key driver for the economic wellbeing of our communities. We recognise the challenge for private business currently and that smaller businesses have issues of scale when adopting the recommendations for employers. The pandemic, the changes brought about by EU Exit, and then the cost of living crisis have all had an impact on the profitability of this sector. Small businesses, in particular, can feel isolated and unsupported.

- There has been an increase in the proportion of food consumed out of the home in Scotland and in 2021 the average was three out of home trips per week, mostly from fish and chip shops and other takeaways. It is often the case that out of home food comes in larger portions compared within the home. The sector can help by reducing the portion size of unhealthy options and making it easier to choose healthier options through, for example, using lower calorie versions of usual ingredients [27]. This is particularly of importance in supplying food to children.
- Promoting and supporting breastfeeding whenever possible.
- Making lavatories available for our ageing population (Just Can't Wait scheme).
- Participating in wellbeing activities when held locally.
- High nicotine content and single-use vaping products have been shown to be particularly addictive and problematic. The sector should pre-emptively try to reduce their commercial reliance on these types of products – working as a whole system would mean no-one would lose out by not stocking such items.
- Make sure every employee carries out sufficient physical exercise to maintain their health and wellbeing. There is good evidence that 10,000 steps a day is a target to aim for to maintain both physical and mental health, accepting that those who stand all day, are getting their allocation without walking.
- Consider promoting the Money Worries App to help support staff who may be struggling with finance, due to the cost of living crisis.
- There is no wealth without health, as identified by the City of London Corporation. We are happy to work collaboratively with business partners to tackle the commercial determinants of health [28] and therefore also prevention activities that concern our entire population.

Communications and community engagement

Strong effective communication involves a clear dialogue with the public. Our prevention agenda in Public Health is clearly aligned with the recent "Time for Change" community engagement work on-going across the Borders.

Time for Change advises people can take action to support their own health by:

- Getting vaccinated
- Use NHS Inform for advice
- Future care plans for the frail
- Connect with others socially
- Participate in Waiting Well
- Move more

And these actions will be supported by the following initiatives currently being carried out by NHS Borders:

- Value based health & care
- Pharmacy first
- Right place, right care
- Oral health care strategy
- Patient initiated review
- Waiting well
- Social prescribing

We when work together to use evidence-based dissemination strategies we can communicate clear risk-factor based advice to the right people, in a way that is clear and easy to understand. We can have a conversation between the NHS and our service users as equals and partners to discuss what matters most to the individuals in our population and how we can best support people to stay well. We can also work with our partners in the Integrated Joint Board and Community Planning partnership to participate in their initiatives, and help develop the ones that will support our THIS Borders strategy. We want to work more closely with the other anchor institutes to help promote wellbeing and health through better prevention.

ALISS (A Local Information System for Scotland) is a free, national digital programme that enables people and professionals to find and share information on organisations, services, groups, resources and support in their local communities and online. Anyone can use it to find information about activities such as support groups, fitness classes and social clubs. ALISS also includes information about health and social care services. We are working with senior colleagues to ensure that ALISS is our 'go to' resource for people in Borders to know what is available in their area.

Evaluation and monitoring

High-quality evaluation is an essential part of preventive programmes and their implementation. If we can increase our evaluation in Borders of our local initiatives across defined settings then we can inform opportunities for scaling up at a national level. This is going to be most impactful if we can include health economic evaluation of our initiatives, and there is a backdrop of easily accessible and transparent sharing of best practice across Scotland.

We are currently working on developing data indicators for wider social and environmental determinants of health that we can consistently report on across our Health and Social Care Partnership. Using the Scottish Indicators of Multiple Deprivation index has limitations when applied to our rural population in the Borders. When we have reliable data for priority populations locally, we can better measure differences in health and wellbeing outcomes. This is essential for when we come to decide what to invest, and importantly what to disinvest in, in the longer term.

Environment: flooding and climate adaptions

The climate crisis is a health crisis. Work is on-going across NHS Borders to share environmental sustainability between portfolios and work across sectors to develop a Climate Adaptations plan led by Facilities. We are working with national colleagues at Public Health Scotland to share and understand best practice in this area. Of particular concern to Borders are the risks of flooding and the impact on the food system when many of our population are involved in agriculture for their employment. We need to act now to prevent and mitigate the impact on the physical health, mental health and employment opportunities of Borderers.

Local activity

Our Joint Health Improvement Team's (JHIT) Annual Report is presented to reflect each of Scotland's six Public Health Priorities and aims to share highlights or insights into the work of our skilled and experienced team members. The overall aim of JHIT is to reduce inequalities in health by promoting good health throughout the life stages: building capacity and capability within our communities and workforce and creating a healthier future for all.

The Alcohol and Drugs Partnership (ADP) is a partnership of agencies and services responsible for reducing the harms associated with alcohol and drug use. This year's ADP annual report focuses on the key outcomes we want to deliver, and summarises the data from last year's activity.

The Joint Health Protection Plan (JHPP) with Scottish Borders Council describes our health protection community activity and details our action plan. The health protection function across the South East of Scotland has undergone major changes in the last six months, and continues to protect the public from communicable disease and environmental hazards working as one regional team during the day-time and with local cover at night and weekends.

The NHS Public Health Annual Screening Report for 2020-23 details the delivery and uptake for the six screening programmes. It has been a challenging time for screening with the impact of the global pandemic and a high degree of national activity including the development of new standards for the bowel screening programme, and an on-going audit into cervical screening.

As with many other aspects of health, the most important factors for maintaining good oral health sit outwith healthcare or dental services. Recognising that for some people their life circumstances can place them at increased risk of poor oral health, NHS Borders have an active Oral Health Improvement Team who work closely with various partners and agencies to help create environments which support oral health. In response to an oral health needs assessment undertaken in 2018, a Strategic Plan for Oral Health and Dental Services is in advanced stages of development and will be implemented from April 2024.

Conclusions and recommendations

Conclusions

This is an important time for public health in Borders and in Scotland; we are now living post-COVID and well into the 'recovery phase'. Public Health Priorities are not just for public health departments to deliver; we need work closely together to tackle the fundamental causes of health inequalities. Our partnerships with others and developing ideas about how we work with local communities will shape our public health efforts going into 2024 and beyond.

Recommendations

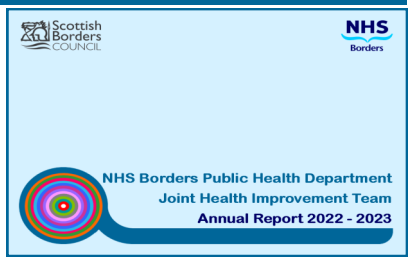
1. We need a **strong leadership focus on prevention**, and this needs to be connected to mainstream work within the NHS Board. An indicative ring-fenced budget, no matter how small in the early years, will galvanise interest and action, and could act as a catalyst for change. Working collaboratively with SBC may open up opportunities for change and improvement for future years. All this could be overseen by a dedicated Board or Committee which we need to consider would give this work the heft and importance it needs and deserves.
2. We need to work collaboratively with our **anchor institutions** and get **Health in All Policies** [29] clearly established. Public health advice on health matters is a necessity for those whose business is not health, but even there, prevention is not something that can be carried out without planning and consideration for consequences. Most of the activities we carry out as service providers have an impact on health and wellbeing. It would be risky, if not dangerous, if we carried out complex interventions such as surgery without appropriate support and oversight by skilled surgeons. It is therefore also true for activities that impact on health and wellbeing of the whole population and groups within them. The Public Health Department is keen to engage and help support change, using evidence-based approaches.
3. We have clearly identified that the health and social care system is under increasing demand. The demographics of our population is that which Scotland will experience in 2054. We are therefore living in Scotland's future. **It is imperative that as people age, they age well**, and are equipped to deal with minor ailments. Social Prescribing and working closer with primary care is the route to more self-management and to decrease demand for healthcare. A more profound conversation about the safety of healthcare is also needed, as small dispersed services provided by a few experts is not sustainable. The size and scale of our healthcare infrastructure needs to change to diminish the harms that people are suffering due to the myriad ways complex healthcare can let people down. Smaller services have less resilience overall and as the quantum of care is less, experts can become deskilled in rarer diseases and interventions.
4. We need to back a solution for **social prescribing at scale**. We need a service that can provide for the needs and demands of around 3,000 consultations per week. Many of these may well be from a smaller cohort of people in need making multiple contacts. Until we have a cohesive way to support these individuals which diverts them away from healthcare, our system will continue to struggle. A Social Wellness service is the obvious solution which links together elements of Live Borders, the NHS Wellbeing Service, What Matters Hubs, Local Area Co-ordinators and also the disparate components within RSLs that support people to manage at home. By working together in a seamless way and across all our towns and communities, working with the faith sector, community groups and third sector colleagues through Borders Community Action, we can begin to tackle the issues of seeking medical solutions for social problems. This will take time, which is why action to make this happen needs to be expedited.

All these actions will be supported by the THIS Borders Strategy which will be coming to the Board shortly. This is a way to embed health inequality reduction in everything that we do. This needs to be sustainable and carried out at scale, which is why it is emerging from cross-agency discussions.

Public Health Activity in Scottish Borders 2023

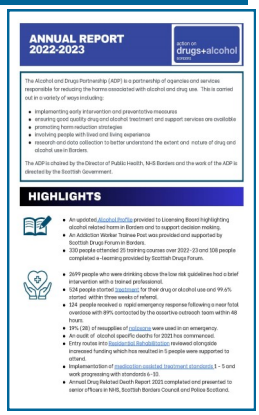
JHIT Annual Report

Attachment 1



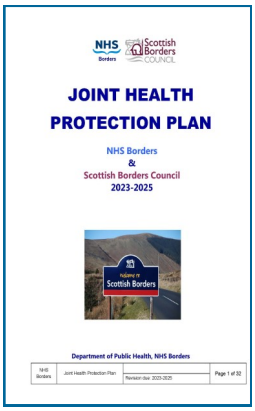
ADP Highlight Annual Report

Attachment 2



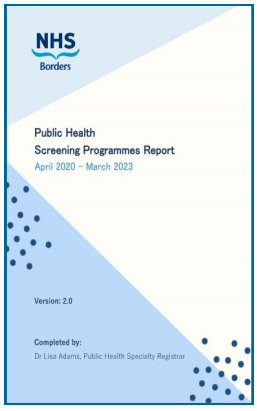
Joint Health Protection Plan

Attachment 3



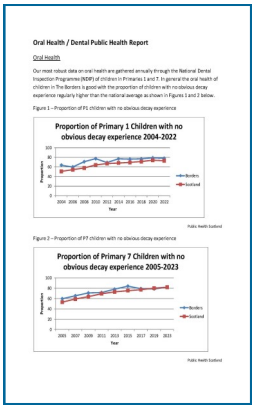
Screening Programmes Report

Attachment 4



Oral Health Report

Attachment 5



REFERENCES

1.	https://publichealthscotland.scot/services/discovery/overview/what-data-is-available-on-discovery/
2.	https://www.nrscotland.gov.uk/files/statistics/avoidable-mortality/2020/avoidable-mortality-20-report.pdf
3.	Christie Commission on the future delivery of public services - gov.scot (www.gov.scot)
4.	https://www.healthscotland.scot/media/1538/health-inequalities-policy-review-march-2014-english.pdf
5.	https://www.gov.scot/publications/realistic-medicine-doing-right-thing-cmo-annual-report-2022-2023/
6.	https://www.longtermplan.nhs.uk/online-version/
7.	https://www.parliament.uk/globalassets/documents/fair-society-healthy-lives-full-report.pdf
8.	https://www.healthscotland.scot/media/1089/economics-of-prevention-mar16.pdf
9.	https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP166_Impact_Public_Health_Mortality_Morbidity.pdf
10.	https://www.healthscotland.scot/media/1089/economics-of-prevention-mar16.pdf
11.	Scottish Burden of Disease Forecasting Briefing (scotpho.org.uk)
12.	Prevention Rather Than Cure | The King's Fund (kingsfund.org.uk)
13.	https://iaphs.org/wp-content/uploads/2019/11/IAPHS-McKinlay-Article.pdf
14.	https://publichealthscotland.scot/media/17437/public-health-approach-to-prevention-and-the-role-of-nhsscotland.pdf
15.	Modelling the annual NHS costs and outcomes attributable to healthcare-associated infections in England | BMJ Open
16.	making-case-public-health-interventions-sep-2014.pptx (live.com)
17.	https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030
18.	A new approach to primary care for Australia | Centre for... (cpd.org.au)
19.	The health gap: the challenge of an unequal world - The Lancet
20.	https://www.healthscotland.scot/publications/social-prescribing-resources
21.	What is social prescribing? | The King's Fund (kingsfund.org.uk)
22.	https://services.nhslothian.scot/anticipatorycareplanning/gp-practice-teams/
23.	https://www.alliance-scotland.org.uk/digital/aliss-a-local-information-system-for-scotland-2/
24.	MECC Implementation guide (publishing.service.gov.uk)
25.	https://doi.org/10.1136/bmj.g7818
26	Göran, Dahlgren, and Margaret Whitehead. "Policies and strategies to promote social equity in health." (1991) - *citation only*
27.	https://www.obesityactionscotland.org/media/1rfhqj35/local_levers_for_diet_and_healthy_weight_final.pdf
28.	https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)00590-1/fulltext
29.	Implementing health in all policies.pdf

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