

THE NORTH OF SCOTLAND PUBLIC HEALTH NETWORK (NoSPHN)

Well North

Anticipatory Care Activity in the
North of Scotland

Introduction

- NoSPHN?
- Anticipatory Care?
- Why we wanted to examine remote and rural anticipatory care
- Aim of the proposal
- Brief description of projects
- Evaluation
- Your thoughts and comments welcome

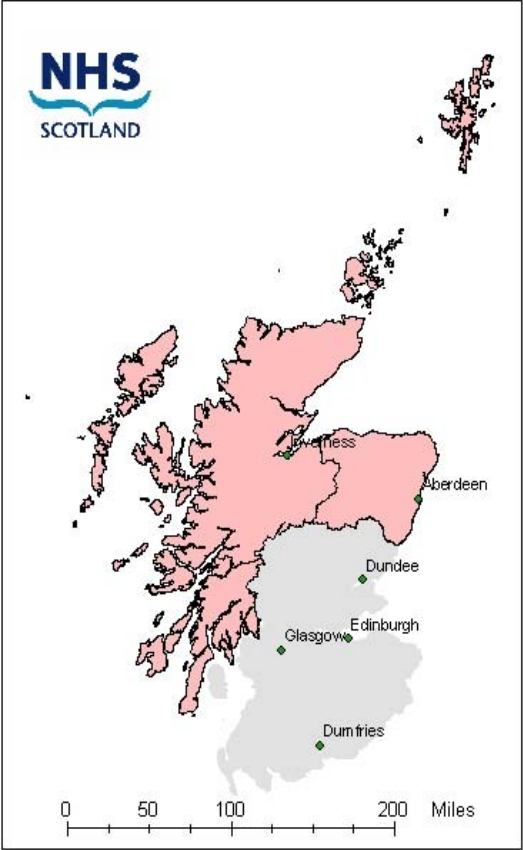
NoSPHN

The North of Scotland Public Health Network (NoSPHN) is a collaboration between NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland and NHS Western Isles.

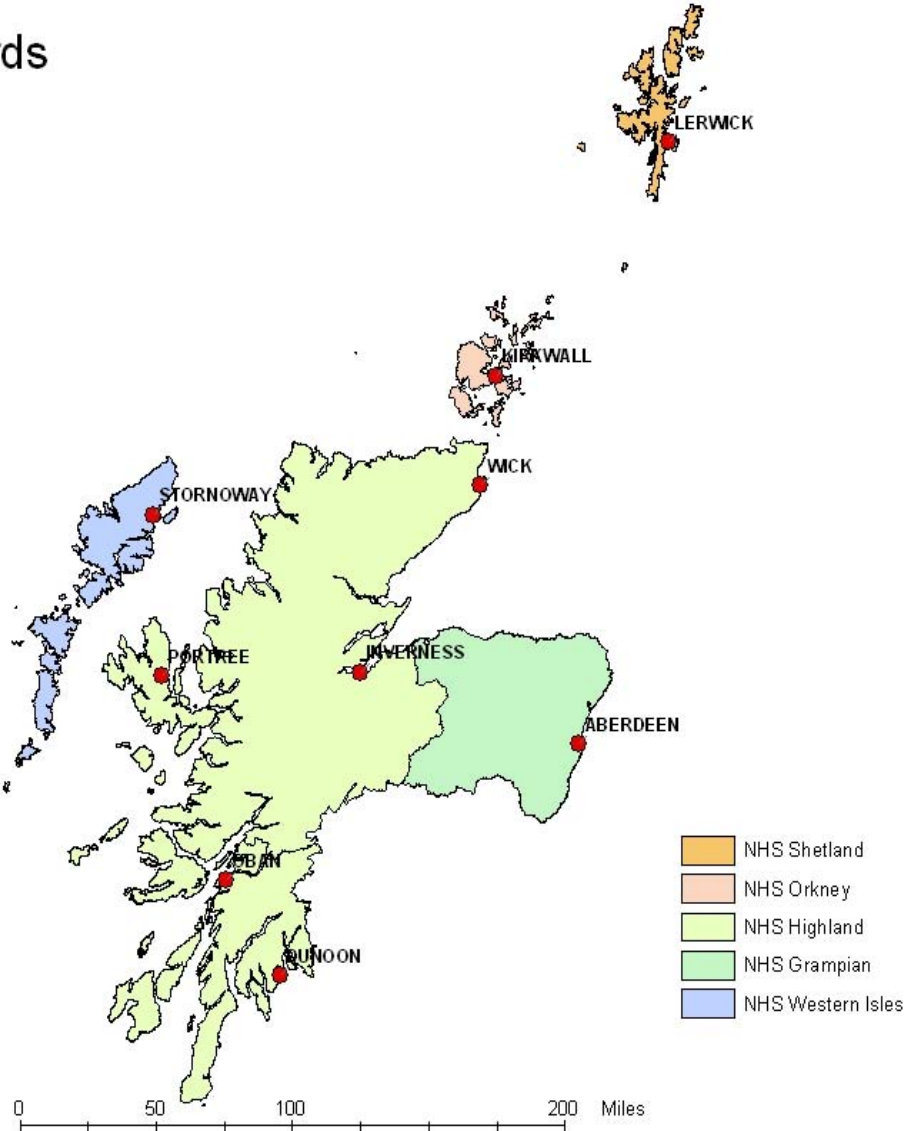
The Network aims to:

- link groups of public health/ health improvement professionals,
- to work in a coordinated manner where this adds value,
- to contribute to improving health and reducing inequalities, thus maximising shared resources.

North of Scotland Health Boards



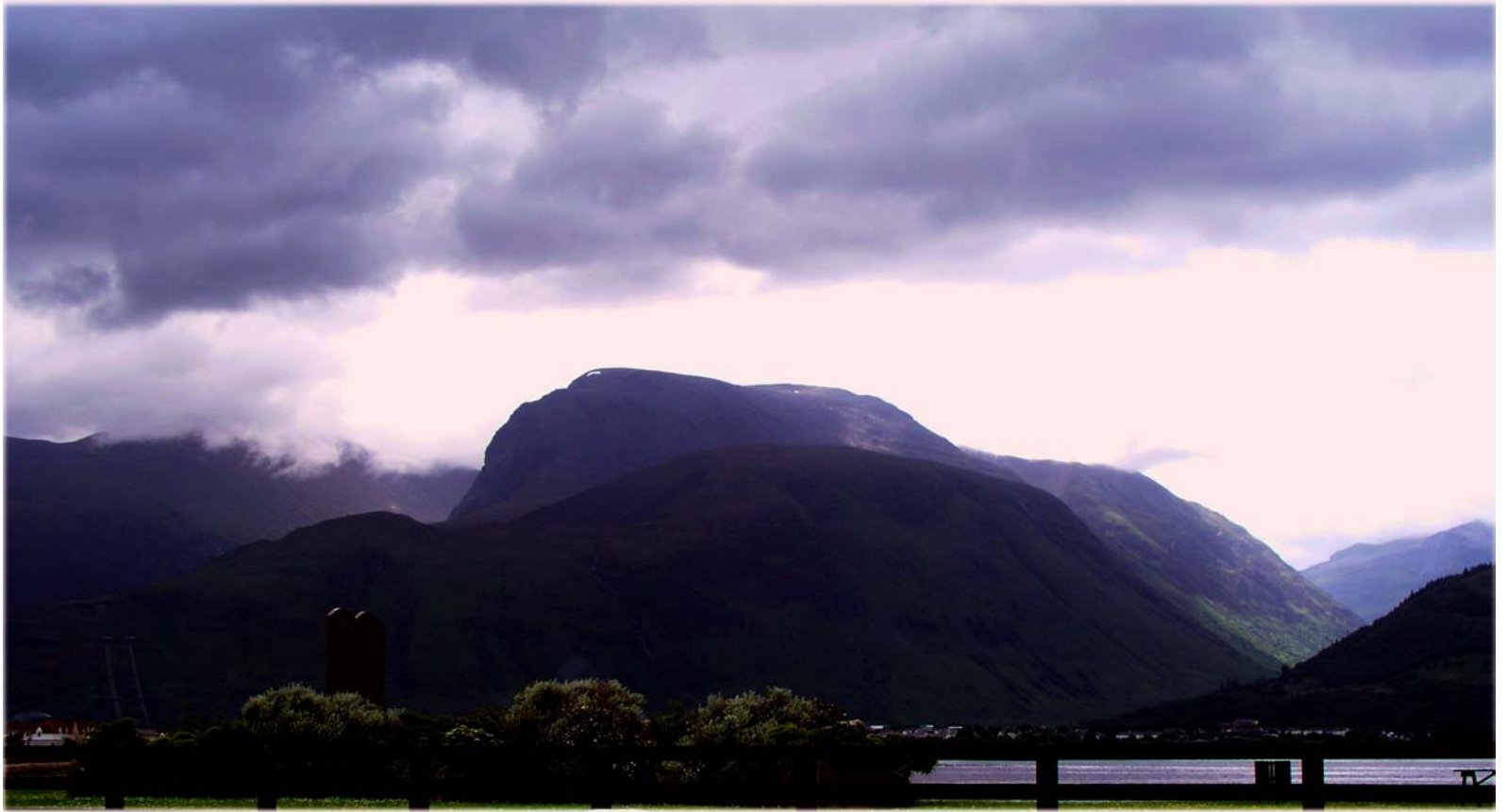
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Pretty?



Bleak?



Vulnerable?



Anticipatory Care?

Sanjeev Sridharan, Wendy Gnich, Megan Hume and Ian MacDougall (University of Edinburgh)

- Increased engagement of patient as co-producers of health
- Focus on early detection of problems
- Emphasis on simple (though perhaps diverse) sets of services for a large number of individuals
- Attention to the long term relationship between the patient and the practitioner
- A focus on “rules of halves”
- Emphasis on population health
- These initiatives are informed by a theory of inequalities
- Such initiatives are complex and consist of multiple interacting interventions.

Keep Well (National programme)

- Increase the rate of health improvement in 45-64 year olds in areas of greatest need – focus on those at high risk of CVD and diabetes
- Enhancing primary care services
- Invitation to attend a free health check (risk assessment) for people aged 45-64 living in certain areas of Scotland (by postcode?)
- Appropriate interventions
- Monitoring and follow up.

Why a remote and rural focus?

- Need to explore how to effectively target those experiencing health inequalities in remote and rural areas.
- Such targeting is problematic given the heterogeneity of these populations.
- Access deprivation, income deprivation, fuel poverty.
- Sustainability.

What are we aiming to achieve?

- To increase the reach of health improvement interventions, that deliver anticipatory care for those experiencing health inequalities in remote and rural areas (what are the key issues?).
- With improved knowledge on targeting in remote and rural communities, the project aims to influence policy and disseminate such learning.

Objectives

The objectives are to how best to:

- Identify hard to reach individuals
- Target hard-to-reach individuals and households in remote and rural areas
- Optimise access where sparseness of the population is a key feature
- Enable individuals to agree and meet goals for change
- Make best use of social marketing and community development approaches in a heterogeneous population – both to identify barriers and solutions to access and deliver interventions
- Improve the responsiveness of services
- Deploy resources effectively and efficiently where sparseness of the population makes economy of scale difficult especially where a subset of the population is to be targeted
- Share learning nationally with other remote and rural areas.

The programmes

1. **NHS Grampian** (Dufftown practice - 2,500): A Self Caring Community Initiative comprising e.g. tele care home monitoring systems, community development and social marketing approaches and focussing on specific chronic diseases and conditions where there is a higher prevalence.
2. **NHS Highland** (North West Sutherland - 3,500): Review existing services to identify people at risk and then working to increase access and uptake by social marketing, reviewing provision and timing of services.
3. **NHS Orkney** (population - 22,000): Focusing on long-term conditions eg developing primary and secondary prevention, self-care and education; and enhancing the prevention and self-care aspects of clinical services, protocols and care pathways.

Programmes ctd

4. **NHS Shetland** (Unst and Fair Isle - 776): Holistic approach using a deprivation and social exclusion tool to work with vulnerable and excluded individuals or households to identify needs and develop appropriate local service responses.
5. **NHS Western Isles** (11,074): Use of a risk factor screening tool for CVD that incorporates a screen for diabetes. This will be offered to adults (40-69 years) targeting activities with inequalities groups and within deprivation areas particularly through mobile services.
6. **NHS Grampian and NHS Highland** (maximum population 13,500). Use of Adult Healthy Weight Care Pathways to identify patients who are overweight or obese, with co-morbidities, through general practice in selected rural areas and provide evidence based lifestyle interventions, support to existing staff and local interventions to improve access to a healthy diet and physical activity.

Evaluation

- Whether and to what extent Well North programmes increase the reach of anticipatory care interventions.
- Whether key issues have been identified in targeting anticipatory care working.
- Determine how effective such models have been in delivering anticipatory care in remote and rural settings.
- Generating high levels of learning about targeting remote and rural inequalities in anticipatory care.
- We are exploring other evaluation outcomes and possible funding.

Contacts

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