NHS Shetland

Shetland Public Health Annual Report 2016

Focus on Substance Misuse

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FORWARD

Welcome to my first Public Health Annual Report for NHS Shetland. The main theme of this year's report is alcohol, smoking and drug use and how this affects our health in Shetland. Along with physical activity and diet (the theme of last two annual reports), alcohol and tobacco in particular are major factors which influence our community's wellbeing.

Protecting the population from harms due to the misuse of substances is complex. Some substances such as alcohol and tobacco are perfectly legal for adults to buy and use within some constraints, whilst others are not. There are common factors between substances whether legal or illegal: they can have psychological effects (which is why people use them); they can all be bad for our health; they can be addictive and their use can seriously affect other individuals and communities, either directly or indirectly. There are huge cultural and social influences on why and how people drink, smoke and take drugs; as well as individual ways of thinking and behaving. However, there are also a variety of legal factors which can significantly influence behaviour and consequences.

In Part I of this Report we consider these issues and where possible provide local data on alcohol, smoking and drug use and highlight local action. Whatever the substance there are three key strands to our public health efforts:

Prevention: creating an environment where people choose not to misuse substances

Protection: protecting people for harms of others misuse of substances, for example creating smoke free environments

Cessation: helping people who are using substances to stop: 67% of those who smoke wish to quit.

Whatever your personal views of substance misuse there is a good chance that others will have a different view from you. I hope the information presented in this report stimulates discussion in communities and partnerships around future action to tackle substance misuse in Shetland.

In Part II of the report there is a summary of the work of the Public Health Directorate over the last year. Many of the achievements would not have been possible without the strong collaboration of a range of partners. This demonstrates the huge range of work that the

public health and health improvement colleagues are involved with; highlighting both the successes and the continued challenges in improving the health of the people in Shetland.

Acknowledgments

My thanks for all their hard work in the production of this report go to Elizabeth Robinson, Dr Susan Laidlaw, Elsbeth Clark, Karen Smith, Wendy Hatrick, Kim Govier, Andy Hayes, David Kerr and Emma Fletcher.

Susan Webb

Director of Public Health

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EXECUTIVE SUMMARY

The Public Health Annual Report for 2016 is split into two parts. The first is similar to previous reports where we have focused on a specific theme: this year the theme alcohol, smoking and drug use and how this affects our health in Shetland. The second part summarises the work of the Public Health Directorate over the past year (excluding communicable disease control and emergency planning for which there are separate annual reports).

Part I

We know that too much alcohol is bad for us, but it is completely legal for adults to buy and drink alcohol. Most adults drink alcohol, if not regularly then occasionally, and many people enjoy a drink quite safely. But many others regularly suffer the short term consequences of too much alcohol, and some develop serious illness. The effects of alcohol problems on relationships, families and communities can be devastating; including accidents, violence and other criminal behaviour due to alcohol. Alcohol can directly and indirectly affect mental health, and we know that alcohol has played a significant role in suicides in Shetland. How do we change the cultural norms around alcohol to reduce the harmful effects on individuals, families and communities? 'Drink Better' is our local campaign to try and influence and change people's drinking habits to reduce the risk to their health and other consequences. However, a campaign alone cannot change behaviour and needs to be supported through legislative and environmental changes such as reducing the availability of alcohol. The alcohol chapter focuses particularly on understanding risk, with reference to the new alcohol guidelines, and how we can change attitudes and culture. This includes the local Drink Better campaign and work with the Shetland Area Licensing Board.

We also know that smoking is really bad for our health, being a leading cause of heart disease and cancer, but again tobacco is completely legal for adults to buy and use. 15% of us in Shetland still smoke regularly, despite the cost, increasing social pressure to stop and limitations on where we can smoke. In fact two thirds of smokers say they want to give up: so why is it so hard to quit? We have an excellent smoking cessation service which achieves high quit rates; but is very resource intensive to run, and we are now finding that the people who attend are those who find it the most difficult to quit. And we know that

there are still young people who start smoking, despite seemingly very successful educational approaches in schools. And how do we deal with the new fashion for 'vaping': are electronic cigarettes the safe way to smoke or do they cause more harm than good?

The smoking chapter considers the challenges of prevention given that whilst health improvement work in schools appears to have a significant effect on children, this does not last through to the teenage years and young adulthood and people are still taking up smoking. The success of the local smoking cessation services is highlighted along with the challenges to maintaining this success and having a real impact on smoking prevalence. Finally, the impact of 'e-cigarettes' on both smoking behaviour and smoking cessation is considered.

Often, the general public view drugs as the biggest concern in terms of substance misuse and addiction, but the reality is that smoking and alcohol cause far more health and other problems in our community. Within our society it is really quite acceptable to get drunk and behave in a way we wouldn't normally, making ourselves ill and causing bother to other people. However, most people view 'drugs' in a completely different way; people who take drugs are criminals and second class citizens (whether or not their drug taking affects anyone else) and there is often a perception that people who use drugs will inevitably get ill, and will die from their addiction. However on a population level, alcohol and smoking cause far more ill health and premature deaths that illegal drug taking. And on an individual level, people can reduce the health risks associated with drug taking, such as overdose and infections like HIV and hepatitis. Frequently it is the legal implications of taking illegal drugs that cause more problems for the individual taking them than the effects of the drugs themselves.

Drug taking is now increasing complex to tackle with the wide availability of novel psychoactive substances (NPS). Previously known as 'legal highs', these substances are now illegal but freely available on the internet in particular. The problem with them is that the effects on individuals are extremely unpredictable. One tablet may give a pleasant 'high' or it might kill you.

The other element of drug use that is complex to deal with is the misuse of legal prescription drugs. Although a prescribed drug, such as morphine, may be perfectly safe to use in the right circumstances under medical supervision, it can also be extremely addictive and may end up being used in the same way as its illegal counterpart, heroin.

The chapter on drugs looks at the recovery model to help people stop their drug taking behaviour and addresses the issue of stigma that affects drug users and their families. This is not only the stigma of drug use but also the potential consequences including blood borne viruses and a criminal record. The new challenge of dealing with 'novel psychoactive substances' is also considered.

The three main approaches to tacking substance use and misuse are highlighted in each of the chapters: prevention; protection and cessation. Throughout the report we also consider the complex relationship between substance misuse and inequalities, poverty and social exclusion.

Part II

This describes the work of the Public Health Directorate in the past year, including the Public Health and Health Improvement Teams. We have structured this part of the report to show the diversity of work that we do under a number of key areas:

1. Formulating, implementing and monitoring healthy public policy;
2. Re-orienting public services to become health-promoting;
3. Implementing programmes to improve health for individuals and communities, and across a range of settings, such as workplaces;
4. Encouraging environmental measures to improve health;
5. Incorporating community development approaches, so that communities are empowered;
6. Developing people's personal skills by enabling them to identify their own needs and involving them in planning and evaluation processes;
7. Encouraging appropriate service utilisation, including screening and immunisation services; and
8. Delivering health information and education, including the use of social marketing techniques
9. Tackling inequalities

There is a focus on prevention and inequalities and also the areas where we know we can, and should, do more work including engaging and working with partners. There is a need to continually evaluate, develop and improve services to ensure they are supporting the

most vulnerable people and communities, that they focus on prevention and that they are effective: particularly within the context of diminishing resources.

Within the appendices there are more detailed evaluations for two specific pieces of work ('Beating the Blues' Computerised Cognitive Behavioural Therapy; and the Otago Strength and Balance exercise programme) and also a summary of the results of a survey with primary care teams on the Health Improvement Team's shift into locality working.

PART I

FOCUS ON SUBSTANCE MISUSE

CHAPTER 1 INTERPRETING THE FACTS & FIGURES

There are numerous ways to measure the extent and the impact of substance misuse within communities. But it can be difficult to interpret what the results actually mean and how they can help us to tackle the problems of alcohol, drug taking and smoking.

Why do we need this information? We need to understand the size of the problem so that we know where to target our limited resources. And to see if things are getting better or worse: particularly how successful are the things that we are doing to prevent and reduce substance misuse and the effects of substance misuse.

The information that we can collect can be divided into the following broad categories:

- Prevalence – how many people smoke / drink alcohol / take drugs
- Availability of the substance
- Crime related to substance misuse
- Social effects of substance misuse
- Economic effects of substance misuse
- Health effects of substance misuse
- Treatment services

Prevalence

It is very difficult to find out the exact number of people who smoke, drink alcohol or use drugs: that could only be done by asking every person in a population if they use these substances, and assuming that they answer it truthfully; or by testing every person for evidence of tobacco, alcohol or drug use. Both these options clearly have major logistical, cost and ethical implications. We therefore tend use information that has already been collected, for example in GP medical records, or proactively survey a representative sample of the populations, or use a ‘proxy’ measure.

In Shetland we measure smoking prevalence both using GP data and figures from national surveys that include a sample of the Shetland population. There are pros and cons with both sets of data. The Scottish Health Survey and Scottish Household survey both ask a sample of people in every Health Board area in Scotland a set of questions including about smoking status. The most recent results from the Health Survey (covering 2012-15), which samples about 100 people each year in Shetland, showed that 23% of people smoked.[1] However the Household Survey showed the rate to be 16% in 2013.[2] Because these are small samples, the rates may not be statistically significant. Data from GP practices however could theoretically include the whole population. In practice it does not, as not every patient has their smoking status recorded, although this is improving. Another problem with this data is that they can be out of date: so a patient may be recorded as a smoker who has since stopped and is now a non-smoker but that information has not been updated. Local GP data shows that 15% of adults in Shetland smoke.

With smoking we tend to classify people as smokers or non smokers, and possibly ex-smokers but do not often look at how much tobacco people smoke. However with alcohol consumption we tend to categorise according to how much they drink and how regularly , rather than simply being a drinker or non-drinker. But self reporting of alcohol consumption can be very inaccurate, with people usually underestimating what they drink especially if pouring out 'home' measures. Medical students used to be told that whatever a patient says they drink then the doctor should double it! There has been a lot of work put into raising people's awareness of how much alcohol they drink, and trying to explain how to calculate the amount using units of alcohol. Information from the most recent Scottish Health Survey (2012-15) showed that 51% of men in Shetland were drinking up to 14 units a week, and 35% over 14 units; along with 63% of women up to 14 units and 18% over 14 units.

However, surveys are known to underestimate the prevalence of drinking: a Scottish Public Health Observatory report looked at the differences in estimated prevalences between different surveys and measures of alcohol sales. But sales figures also

[1] Scottish Health Survey results by Board available at: www.gov.scot/Resource/0050/00505568.xlsx

[2] Scottish Household Survey results by Board available at: www.gov.scot/Resource/0048/00486916.pdf

underestimate prevalence because of alcohol obtained from abroad ('duty free'), illegal 'black market' purchases and home-brewed drink.[3]

Assessing the prevalence of drug use is even harder, because drug users may be unwilling to tell anyone about their drug use, and so it has to be estimated from other data sources. These can include from surveys (e.g. in the general adult population, older school pupils, prisoners), from drug offences and drug seizures recorded by the police, from drug testing in prisons, from drug users coming into contact with health care providers because of their drug use or coming forward for treatment. It is estimated that 2.2% of the population in Shetland use drugs: although this proportion does fluctuate from year to year because of the small numbers involved.[4]

There is a survey of alcohol and tobacco use in school pupils: the Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS) which is done in school with pupils aged 13 and 15. Some of the results are shown below on page 27. This survey covers all teenagers in Shetland in these age groups rather than just a sample. Although the survey is done anonymously, there is potential for pupils to either exaggerate or play down substance misuse in front of their peers.

Availability of the substance

There are a number of ways to assess availability. At a local level, the number of shops selling tobacco and the number of licensed premises in an area can indicate availability, and can be compared with other similar areas. Research has shown that there is a link between the number of licensed premises in an area and the level of alcohol consumption: with increased availability leading to increased levels of drinking.[5]

Figure 2.1 on page 26 shows how much alcohol is sold in the UK, which gives a good indication of how much is being consumed on a national level. In the UK, during 1995, an average of nine litres of pure alcohol was sold per head of population aged 15 and over,

[3] Catto S.(Scottish Public Health Observatory) *How much are people in Scotland really drinking?* Edinburgh: ScotPHO, 2008. Available at: www.scotpho.org.uk/downloads/scotphoreports/scotpho080526_alcoholsurveys_rep.pdf

[4] Information Services Division (ISD) of National Services Scotland.

[5] Babor T, Caetano R, Casswell S, et al. *Alcohol: No Ordinary Commodity*. Oxford: Oxford University Press, 2010.

the equivalent of 18 units per week. By 2005, this had increased to 11 litres per head of population: the equivalent of 22 units per week.[6]

On a national level, the income generated by tobacco and alcohol sales and the resultant tax raised gives an indication of availability (see Page 14).

However, for illegal drugs, and illegally produced or imported alcohol and cigarettes, then police intelligence would be the main way to assess availability. In Shetland, the availability of illegal drugs tends to vary, which leads to drug users often using a number of different drugs, or changing their drug of choice. Novel psychoactive substances in particular have a range of physical and psychological effects which vary from drug to drug. Knowing which drugs are available helps to predict what effects we might see in drug users, and helps services to better respond to the needs of drug users.

Crime

There is a wide range of crimes associated with substance use including:

- Drug crimes
- Underage alcohol and tobacco sales
- Drink driving
- Alcohol related incidents including violent crime
- Smoking ban incidents

Crimes can be measured in a number of ways including reported crime; arrests; detections; convictions and number of fines. There are local alcohol related crime figures reported on page 29-30 below.

Crime figures need to be interpreted with care, especially if making comparisons with other areas or over time. An increase in reported crime may be due to a genuine increase in crime or due to increased awareness and reporting. If police resources are increased, then an increase in detection of crime would be expected and vice versa. Furthermore, laws

[6] Catto S.(Scottish Public Health Observatory) *How much are people in Scotland really drinking?* Edinburgh: ScotPHO, 2008. Available at: www.scotpho.org.uk/downloads/scotphoreports/scotpho080526_alcoholsurveys_rep.pdf

and the interpretation of the law change over time and between different areas, so it can be difficult to make international comparisons for example.

Social effects of substance misuse

These include the effects on relationships, families and communities. Alcohol and drugs can have devastating consequences for families in particular. In Scotland, parental substance misuse is identified in 36% of child protection cases on the Child Protection register. In Shetland, in 2015-16, there were 25 children who had specific issues identified at the initial case conference; parental alcohol misuse was identified in six cases, and drug misuse in five cases.[7] Alcohol and drugs are also often factors in domestic abuse and other violence.

Economic measures of substance misuse

Alcohol and tobacco are huge industries worth billions across the world. Scotland exports around £4 billion worth of whisky each year.[8] Governments can raise significant sums of money through taxation of alcohol and cigarettes; although the argument for high taxes is that they fund the healthcare and other costs of cigarette and alcohol use. The UK Government was forecast to have received £9.9 billion in tobacco duty and around £10.4 billion in alcohol duty in 2014-15.[9] So trying to reduce the quantity of alcohol consumed or tobacco smoked could have a detrimental effect on this revenue. We would argue that this would be offset by the decrease in Government expenditure needed for services such as healthcare, police, social care etc.

Substance use has a wide range of economic effects. At an individual level, the cost of alcohol, cigarettes and drugs can be a significant percentage of an individual or household expenditure. A potential (and unwelcome) consequence of increasing the tax and therefore

[7] Shetland Child Protection Annual Report 2015-16 available at www.safershetland.com/assets/files/CPC%202015-16%20Annual%20Report.pdf

[8] DEFRA. UK Food and drink International Action Plan. London: UK Trade and Investment, 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329486/UKTI_Food_and_Drink_strategy_brochure_June_2014_spreads.pdf

[9] Institute for Fiscal Studies. A Survey of the UK Tax System.IFS Briefing Note BN09. London: IFS, 2013. Available at: www.ifs.org.uk/bns/bn09.pdf

the price of alcohol and cigarettes, in order to reduce the quantities people consume can cause people to seek illegally imported cigarettes and alcohol that are not subjected to tax.

The use of illegal drugs in particular is associated with people turning to crime to 'fund their addiction'; whether this is through illegal activity to make money to pay for drugs or to obtain essential commodities that they cannot afford, for example through shoplifting. The effects of drug and alcohol use can cause problems with work and employability, further exacerbating the financial burden. Problems with employment do not only affect the individual but also businesses and employers in terms of low productivity, sick leave and potentially the costs of having to replace staff. But some people who abuse alcohol or drugs can afford to buy them, can still function at work and do not overtly exhibit the behaviour associated with drug and alcohol misuse.

The cost to society of the effects of drugs and alcohol, and also tobacco, is huge when taking into account health services, crime and social consequences. It is estimated that in Shetland the total cost of alcohol use to our community is between £6.8 and £10.8 million a year.

Assessing the scale of the drug market in Scotland is even more difficult given its illicit nature, although a study published in 2009 provides initial estimates of the size and value of the illicit drugs market and estimates of the social and economic cost of illicit drug use in Scotland for the year 2006.[10] The total value of the illicit drugs market was estimated at around £1.4bn. Heroin held the largest share of the market with 39% of the market, with cannabis holding a 19% share, the second largest. Problem drug users held the largest percentage share of the total market (63%).

Health effects of substance misuse

The health effects of substance misuse are wide ranging, costly for the health service and can exacerbate financial and social problems. There are a number of ways to measure health effects including the prevalence of specific conditions directly or indirectly related to substance use; health service usage and treatment and deaths due to alcohol, drugs or tobacco.

[10] Casey J, Hay, G, Godfrey C, Parrot S. *Assessing the Scale and Impact of Illicit Drug Markets in Scotland*. Scottish Government. 2009. Web only available at: www.gov.scot/Publications/2009/10/06103906/0

There are certain conditions that are specifically related to substance use including for example alcoholic liver disease; lung cancer (86% is caused by smoking[11]); alcohol and drug withdrawal; or drug induced psychosis. Others are indirectly related, for example people who are infected with blood borne viruses such as HIV and hepatitis C because of their drug taking behaviour, rather than the effects of the drugs themselves, or injuries caused by violence or accidents due to alcohol.

The number of people who are admitted to hospital is a measure of how many people are drinking so much that it is harming their health. This includes people with liver disease and other medical problems due to alcohol and also those who have accidents and injuries due to excess alcohol. This indicator is in fact based on diagnosis on discharge, because the diagnosis may not be clear on admission**;** and it is presented as a rate per 100,000 population so that we can compare ourselves with other areas and from year to year. In Shetland hospital admissions is one of our key indicators for measuring the burden of alcohol misuse. In 2009-10 there were 770.3 /100,000 population alcohol related admissions to the Gilbert Bain hospital. This has dropped to 677.1 /100, 000 by 2013-14 and then to 588.7 by 2014-15. This drop in the number of people being admitted could be due to a number of factors: a genuine decrease in alcohol related illnesses and injuries; a change in the way conditions are recorded; fewer people being admitted to hospital, but potentially being cared for in the community. There is further information on alcohol related admissions, and also deaths due to alcohol on page 28.

Treatment services

The number of people requiring healthcare services because of smoking or drug or alcohol use is another way of measuring the impact of substance misuse**.** This can include generic services such as A&E and hospital admission, along with dedicated services including the Substance Misuse Recovery Service (SMRS), the needle exchange (community pharmacy) and the smoking cessation service delivered by the Health Improvement Team.

Measuring waiting times for services is done frequently for performance management, however it also helps with the overall picture of substance misuse. Generally 100% of patients are seen within three months by the Substance Misuse Recovery Services.

[11] www.cancerresearchuk.org/about-cancer/type/lung-cancer/about/lung-cancer-risks-and-causes

Alcohol Brief interventions (ABIs) is another key indicator which is measured against a target set by the Government for the purposes of performance management. However, the number of ABIs does also give us another estimate of the number of people in the population who drink enough alcohol for it to be potentially harmful to their health.

Other useful data that we can collect includes the number of needles being given out in the Needle exchange: i.e. monitoring the number of needles being given out. Changes in the numbers of people using the needle exchange, or big increases or decreases in the numbers of needles being used or returned gives an indication of changes in drug taking behaviour, and potentially different drugs being used or in different ways.

In summary, there is a wide range of information and data that can be used to describe a picture of alcohol and drug use and smoking, and to monitor progress over time. However care must be taken to avoid misinterpreting data, particularly because of the small numbers involved, which can make it hard to detect trends and make comparisons with other areas.

CHAPTER 2 ALCOHOL

Understanding the risk

The UK Independent Scientific Committee on drugs, reporting in 2010, showed that while heroin, crack cocaine, and metamfetamine were the most harmful drugs to individuals, alcohol, heroin, and crack cocaine were the most harmful to others. Overall, ***alcohol was the most harmful drug***, with heroin and crack cocaine in second and third places.

However, they noted, the findings correlate poorly with present UK drug classification, which is not based simply on considerations of harm. [12]

The UK Chief Medical Officers have recently published updated alcohol consumption guidelines, following a two- year, expert review of the scientific evidence[13]. Their guidance makes it clear for the first time that there is no "safe" level of alcohol consumption. Any level of drinking raises the risk of developing a range of cancers including breast, bowel and mouth cancer. Although we have known that alcohol is a carcinogen (cancer causing substance) since the 1980s, the full extent of the link was not recognised in the previous recommended limits which were set out in 1995. There is also now no justification for recommending drinking on health grounds as previous evidence is likely to have over-estimated the protective effects of alcohol for the heart.

Organisations that are concerned about alcohol and public health have welcomed the new guidelines and in particular that attention has been drawn to alcohol-related cancer. Alcohol is responsible for around 12,500 cancer cases a year in the UK, yet only around half of us are aware of the link.

It is well recognised that excessive consumption of alcohol can result in a wide range of health problems, not just cancer. Some may occur after drinking over a relatively short period, such as acute intoxication (drunkenness) or poisoning (toxic effect). Others can

[12] Nutt, David J et al.Drug harms in the UK: a multicriteria decision analysis, *The Lancet* 2010; **376:** 1558 - 1565

[13] www.gov.uk/government/uploads/system/uploads/attachment_data/file/489795/summary.pdf

develop more gradually, only becoming evident after long-term drinking, such as damage to the liver and brain. In addition to causing physical health problems, excessive alcohol consumption can lead to mental health problems, including dependency.

Why is NHS Shetland interested in this?

The new Government Guidelines are that neither men nor women should drink more than 14 units per week. If people do drink up to this limit it is best that they spread it evenly across the week. It is the longer term affects of moderate alcohol consumption of alcohol that impact on the work of NHS Shetland as well as potential damage from drunken assaults or falls.

- Around 11% of attendances at A&E are estimated to be alcohol related
- Around 190 out of every 1000 primary care (GP surgery) presentations have alcohol related problems
- 15% of psychiatric admissions are due to alcohol misuse and alcohol is considered to be one of the three main risk factors in suicide.[14]

Many people are unaware that they routinely drink above these limits and are at increased risk of long term damage to themselves: mentally, physically and socially. The more often that daily limits are exceeded, and the greater the amount exceeded by, the greater the risk of harm.

The UK Chief Medical Officers alcohol consumption guidelines are based on the following premises:

- People have a right to accurate information and clear advice about alcohol and its health risks.
- Government has a responsibility to ensure this information is provided for the public in a clear and open way, so they can make informed choices.

Consequently the guidelines have been developed so that the known health risks of different levels and patterns of drinking, particularly for people who want to know how to keep long term health risks from regular drinking of alcohol low, are both accurate and expressed in an understandable way.

[14] *Cost of Alcohol Use & Misuse*. Scottish Government, 2008.Web only publication. Available at: www.gov.scot/resource/doc/222103/0059736.pdf

The Governments felt that it is for individuals to make their own judgements as to the risks they are willing to accept when they drink alcohol, including whether to drink alcohol at all, and how much and how often to drink. They believe that these guidelines should help people to make those choices.

The low risk drinking guidelines are based on average risks. Individuals can also take account of other individual factors that could potentially increase their personal risks from drinking or from drinking at particular times. This could include taking account of any previous negative effects experienced from alcohol, the possible interaction of alcohol with any medications they are currently taking, whether they have any other relevant physical or mental health problems that could be made worse by drinking, or other factors that could be relevant such as low body weight or worries about falling.

There will also be situations when individuals will want to avoid the short term performance limiting effects of alcohol, for example, when they are planning to drive, operate machinery, or take part in risky activities.

Weekly Drinking Guidance

This applies to adults who drink regularly or frequently i.e. most weeks

The Chief Medical Officers' guideline for both men and women is that:

- To keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis.
- If you regularly drink as much as 14 units per week, it is best to spread your drinking evenly over 3 or more days. If you have one or two heavy drinking episodes a week, you increase your risks of death from long term illness and from accidents and injuries.
- The risk of developing a range of health problems (including cancers of the mouth, throat and breast) increases the more you drink on a regular basis.
- If you wish to cut down the amount you drink, a good way to help achieve this is to have several drink-free days each week.

Single Occasion Drinking Episodes

This applies to drinking on any single occasion (not regular drinking: use the weekly guideline)

The Chief Medical Officers' advice for men and women who wish to keep their short term health risks from single occasion drinking episodes to a low level, is to reduce them by:

- limiting the total amount of alcohol you drink on any single occasion
- drinking more slowly, drinking with food, and alternating with water
- planning ahead to avoid problems e.g. by making sure you can get home safely or that you have people you trust with you.

The sorts of things that are more likely to happen if you do not understand and judge correctly the risks of drinking too much on a single occasion can include:

- accidents resulting in injury, causing death in some cases
- misjudging risky situations, and
- losing self-control (e.g. engaging in unprotected sex).

Some groups of people are more likely to be affected by alcohol and should be more careful of their level of drinking on any one occasion. For example those at risk of falls; those on medication that may interact with alcohol; or where it may worsen existing physical or mental health problems.

If you are a regular weekly drinker and you wish to keep both your short- and long term health risks from drinking low, this single episode drinking advice is also relevant for you.

Pregnancy and drinking

The Chief Medical Officers' guideline is that:

- If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.
- Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

The risk of harm to the baby is likely to be low if you have drunk only small amounts of alcohol before you knew you were pregnant or during pregnancy.

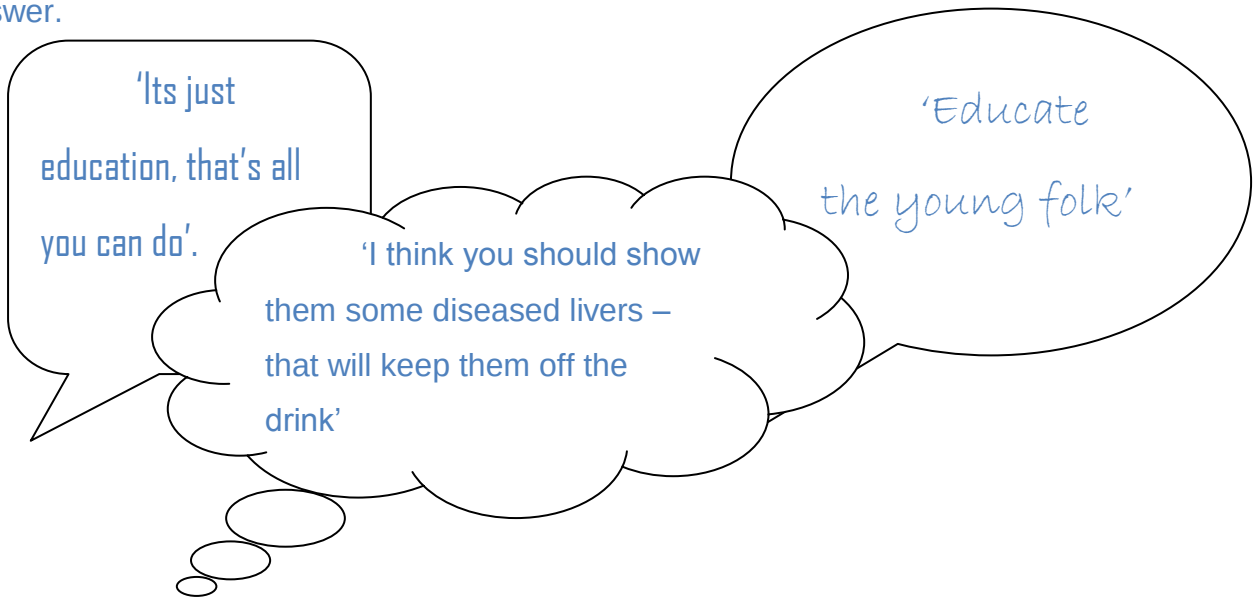
If you find out you are pregnant after you have drunk alcohol during early pregnancy, you should avoid further drinking. Be aware that it is unlikely, in most cases, that your baby has been affected. But if you are worried about alcohol use during pregnancy do talk to your doctor or midwife.

The UK Governments and Chief Medical Officers have tried to makes these guidelines as clear as possible, but they are not simple messages; and they rely on people having the knowledge, skills, ability and understanding to put them into practice.

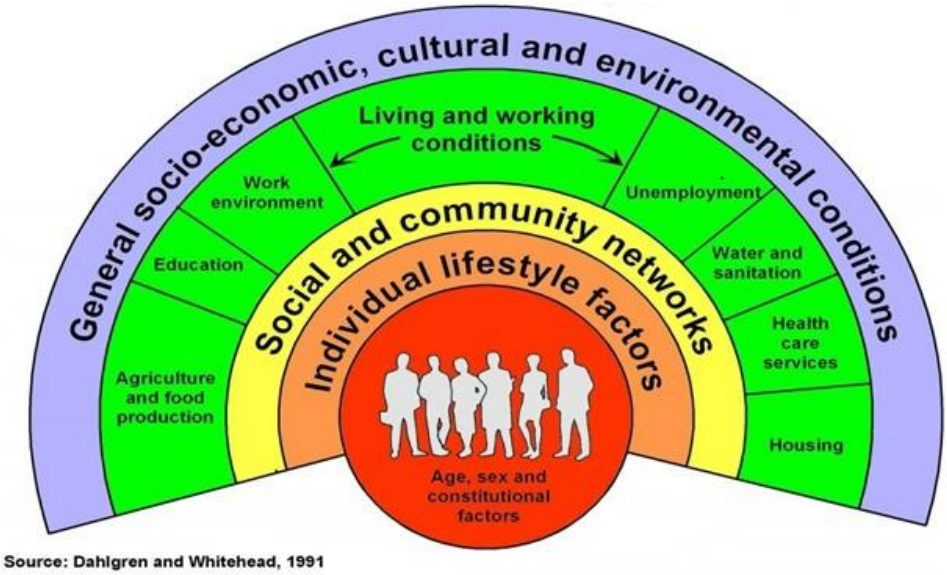
At a recent Shetland Area Licensing Forum, there was debate about the relative responsibilities of education and Licensing Boards in tackling alcohol misuse. The next section looks at the strengths and weaknesses of each approach.

Education, culture change or the law?

Often, when we talk about alcohol misuse in society, we are told that education is the answer.



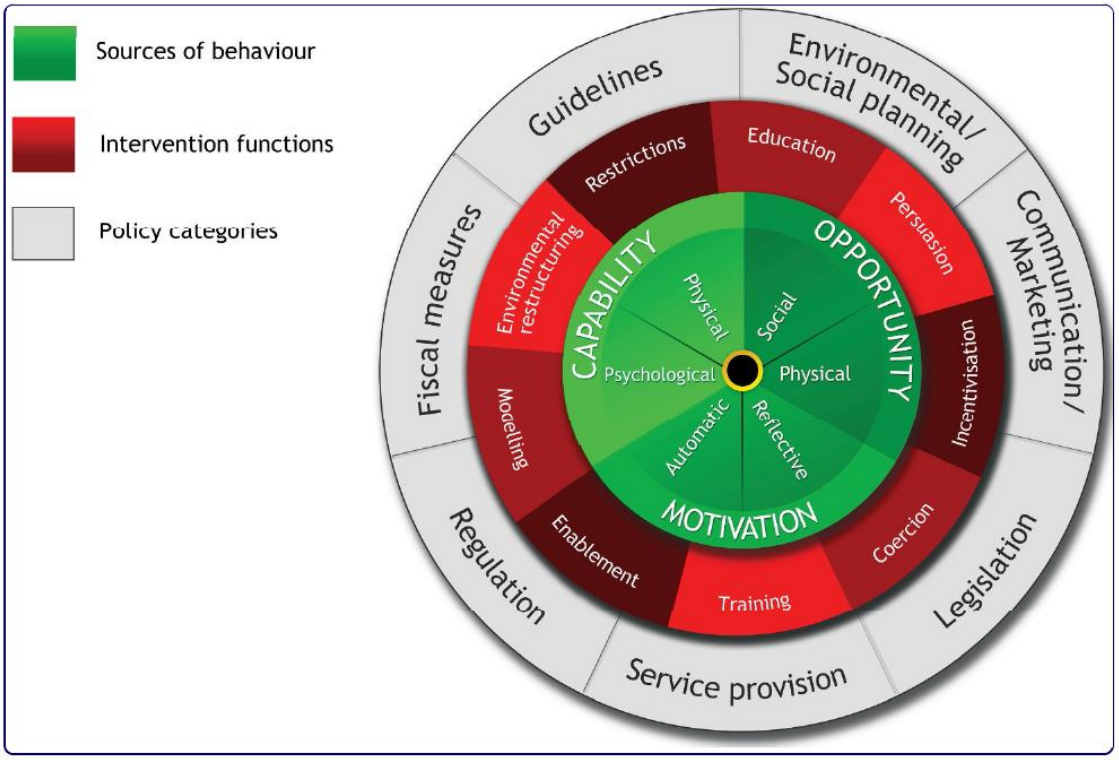
During the 1970s and 80s Health Education became all the rage. It was at this time that the Health Education Board for Scotland was established, and the focus was very much on education in order to help people increase control over their health and their environment. Since then, more and more evidence has emerged about health and the influences on health, illustrated by the diagram below.[15]



Source: Dahlgren and Whitehead, 1991

[15] Dahlgren G., Whitehead M., *Tackling Inequalities in Health: What Can We Learn from What Has Been Tried? Working Paper Prepared for the King's Fund International Seminar on Tackling Inequalities in Health.* London: The King's Fund, 1993.

This Behaviour Change Wheel below represents an attempt to describe all the components that go into effective behaviour change, and shows what a very complex process this is:[16]



Drink Better is a local initiative aimed at changing the alcohol culture from one of drinking for intoxication, to drinking responsibly, and for enjoyment. It is an example of 'communication and marketing' in the behaviour change model.

Many social occasions and events in Shetland (as elsewhere) revolve around entertaining, having a good time, and often, having a few drams. Up Helly Aa, the Simmer Dim Bikers' Rally and the Folk Festival are Shetland traditions that are enjoyed immensely by Shetland residents and visitors alike, that can involve alcohol as an integral part of the festivities.

Rather than focussing on negative aspects of alcohol consumption, Drink Better aims to embrace the positive culture of drinking; we want a culture where people '*drink better*', where the 'good stuff', the 'nectar of the gods', is celebrated and not demonised.

[16] Michie et al.: The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science.* 2011; **6**:42.

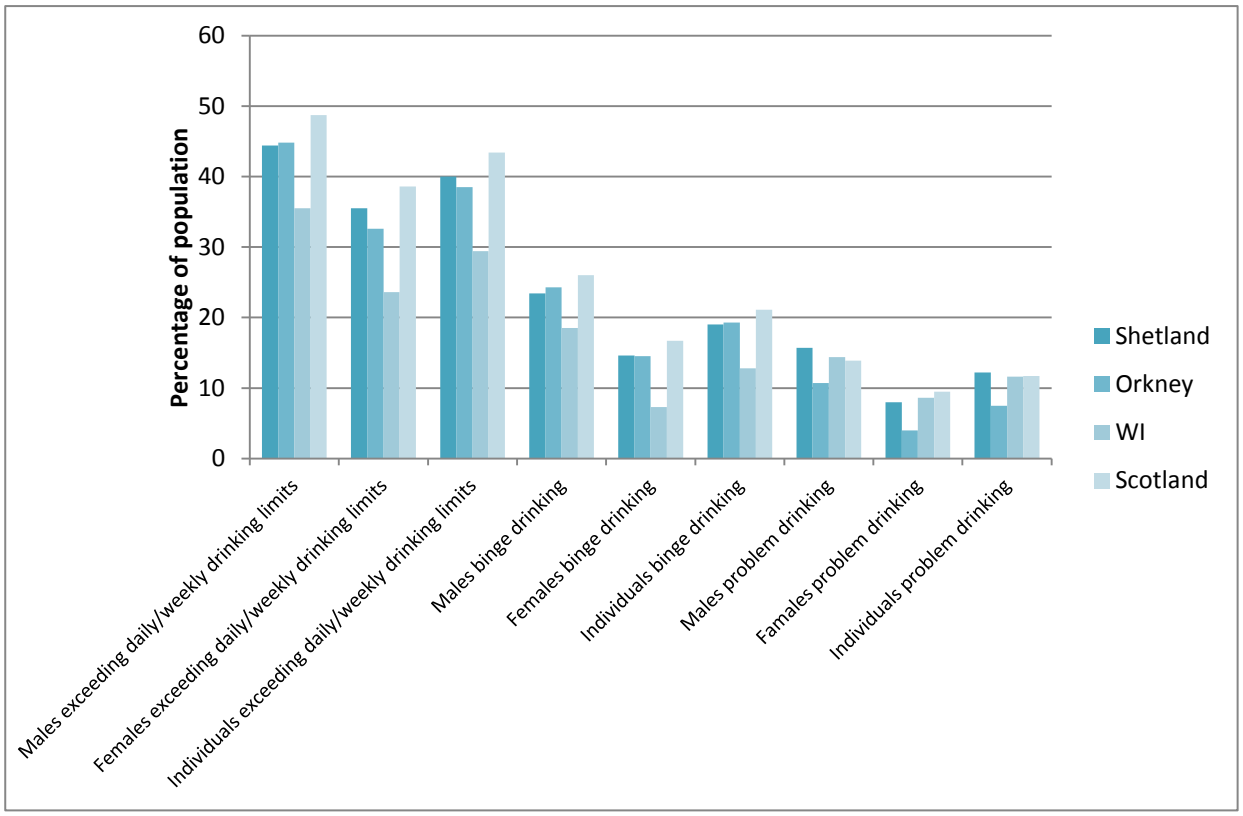
Drink Better's objectives include work to:

- Educate the public, including adults and young people, about drinking, challenging unhealthy relationships with alcohol
- Prevent and speak out against the damage caused by alcohol misuse
- Promote the enjoyment that comes from drinking moderately and reasonably: the culture of taste versus the culture of drunkenness

Why do we need the campaign?

In the previous chapter we talked about costs to the health service of alcohol misuse. The following charts show further detail on this, but also the costs to police and other public services in Shetland.

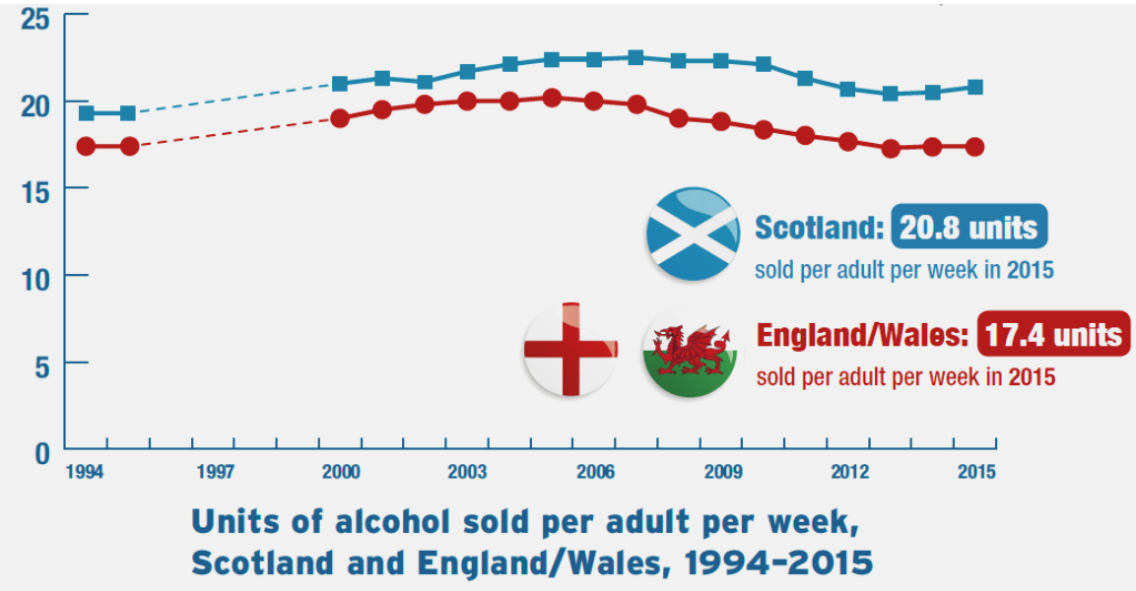
Figure 1.1: The percentages of adults drinking at harmful levels in Shetland, Orkney, Western Isles and Scotland. The figures are taken from the ScotPHO Alcohol Profiles[17]



[17] ScotPHO Alcohol Profiles available at: https://scotpho.nhsnss.scot.nhs.uk/scotpho/profileSelectAction.do

Shetland appears to be the worst of the island boards on a number of measures, although not as bad as Scotland as a whole. (It should be noted that the UK is amongst the worst in the world for dangerous drinking patterns)[18]. Alcohol sales in Scotland were 20% higher than in England and Wales in 2015. This was mainly due to higher sales of lower priced alcohol through supermarkets and off-licences, particularly spirits. More than twice as much vodka was sold off-sales per adult in Scotland than in England and Wales.[19]

Figure 1.2: Units of alcohol sold per adult per week, Scotland and England/Wales, 1994-2015



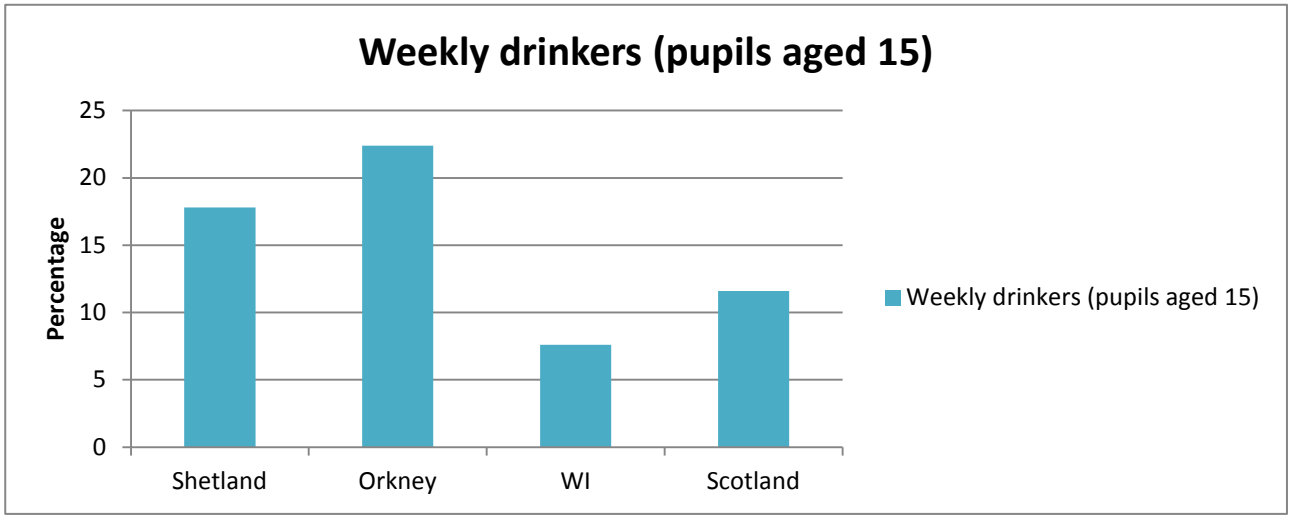
Children & Young People

National surveys are conducted every three to four years to understand the drinking patterns of school children in Scotland. We are able to break these figures down into island areas.

[18] WHO. *Global Status Report on Alcohol and Health 2014*. Geneva: WHO; 2014. Available at: www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_1.pdf?ua=1

[19] www.healthscotland.com/news-articles/news-article.aspx?ID=96

Figure 1.3: Number of pupils aged 15 in Shetland who report drinking alcohol weekly: The Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS)



In terms of Scotland wide data, SALSUS 2013 reports the following[20]:

The majority of 13 and 15 year old pupils who had ever had an alcoholic drink[21] reported that they are more likely to obtain alcohol from a relative or a friend;

- Thirteen year olds who had drunk alcohol were most likely to say that they usually obtained alcohol from a relative (38%) whilst 15 year olds were most likely to get their alcohol from a friend (46%).
- Almost four out of ten 13 year olds (39%) and almost six out of ten 15 year olds (58%) who had ever drunk alcohol said they had got someone else to buy alcohol for them in the last four weeks.
- Thirteen year olds most commonly asked their mother, father or carer (33%) to buy them alcohol, followed by an older friend (18%).
- Among 15 year olds, the most popular response was an older friend (28%), followed by their mother, father or carer (24%).

SALSUS data on the alcohol consumption of teenagers is often interpreted as increasing the need to prevent children from entering pubs or buying alcohol. It is far more likely that the figures are a sign of the availability and affordability of alcohol, given that most of the

[20] SALSUS 2013 reports available at: www.isdscotland.org/Health-Topics/Public-Health/SALSUS/Latest-Report/

[21] Pupils were asked whether they had 'ever had a proper alcohol drink – a whole drink, not just a sip'.

alcohol that young people are drinking comes from the off-sales trade (via a legal purchase by an adult).

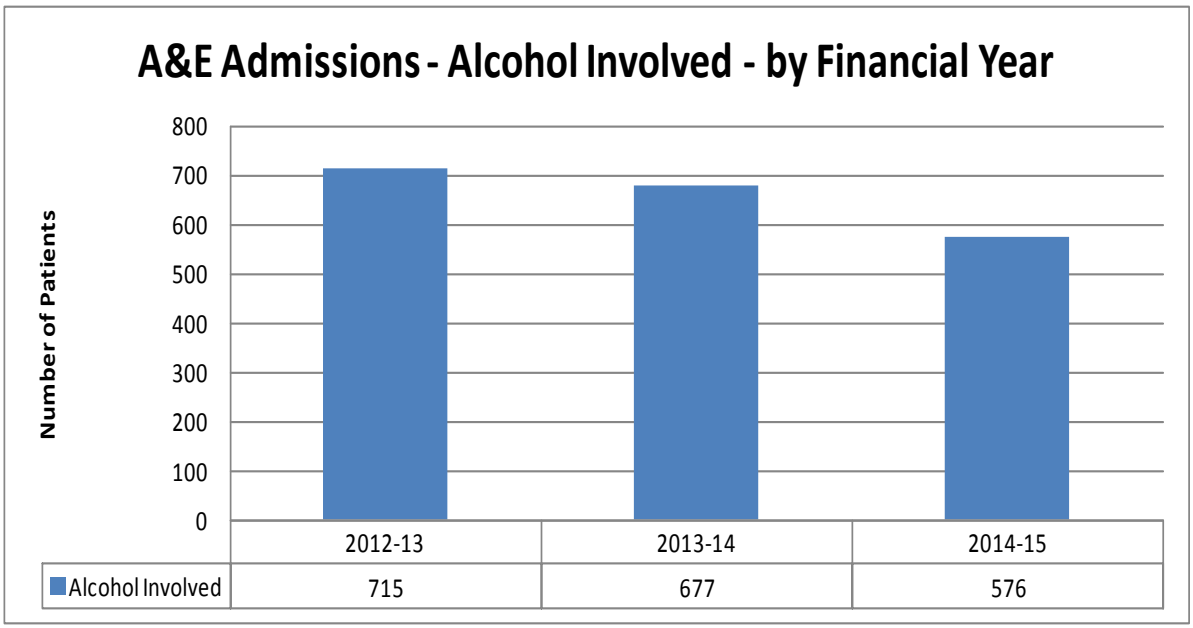
Alcohol related deaths and alcohol related hospital admissions

Alcohol related deaths and hospital admissions are a useful way of understanding the impact of alcohol on the population. The deaths figure will include deaths from diseases known to be related to alcohol consumption, such as cirrhosis of the liver. The hospital admissions figure includes admissions for conditions such as alcoholic liver disease, but also for some where alcohol was known to be a factor, for example injuries arising from alcohol related assault. Between 2004 and 2014 a total of 48 people died of alcohol related conditions during this time, averaging more than four per year.

Table 4: Alcohol Related Deaths in Shetland 2004-14 (NHS Shetland)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Deaths	6	6	6	6	4	3	9	4	0	1	3

Figure 1.4: The number of A&E Admissions to the Gilbert Bain Hospital where Alcohol was involved, over a three year period 2012-15 (NHS Shetland)



In summary, between 2012 and 2015, there were:

- Almost 2,000 admissions where alcohol was involved
- 4 fatalities
- 556 discharged to an NHS service or hospital ward
- 28 discharged to the Police Station

An audit of suicides and sudden deaths in Shetland over the last 12 years shows that alcohol is almost always a contributing, if not a causal, factor. This conclusion is based on a complex auditing process, developed from the UK National Confidential Inquiry into Suicide and Homicide; the data is then used by the National Suicide Register for Scotland. The audit uses information from GP, Psychiatric, and Social Work records, alongside toxicology and post mortem reports, and is conducted by a multi-agency group comprising the Medical Director of NHS Shetland, the Consultant Psychiatrist, and Social Work and Police representatives. We know that the chemical composition of alcohol means that it has a depressant effect on human beings and is also a disinhibitor, making risky behaviour more likely.

Police data

Table 5: Drunkenness and other disorderly conduct recorded by the police, Shetland Islands, 2010-11 to 2014-15 (Police Scotland)

Crime	2010-11	2011-12	2012-13	2013-14	2014-15
Drunk & incapable and habitual drunkenness	18	22	28	15	7
Drunk & attempting to enter licensed premises	0	1	0	0	1
Disorderly on licensed premises	2	0	1	2	3
Refusing to quit licensed premises	0	4	5	9	5
Consumption of alcohol in designated places, byelaws prohibited	7	12	0	7	5

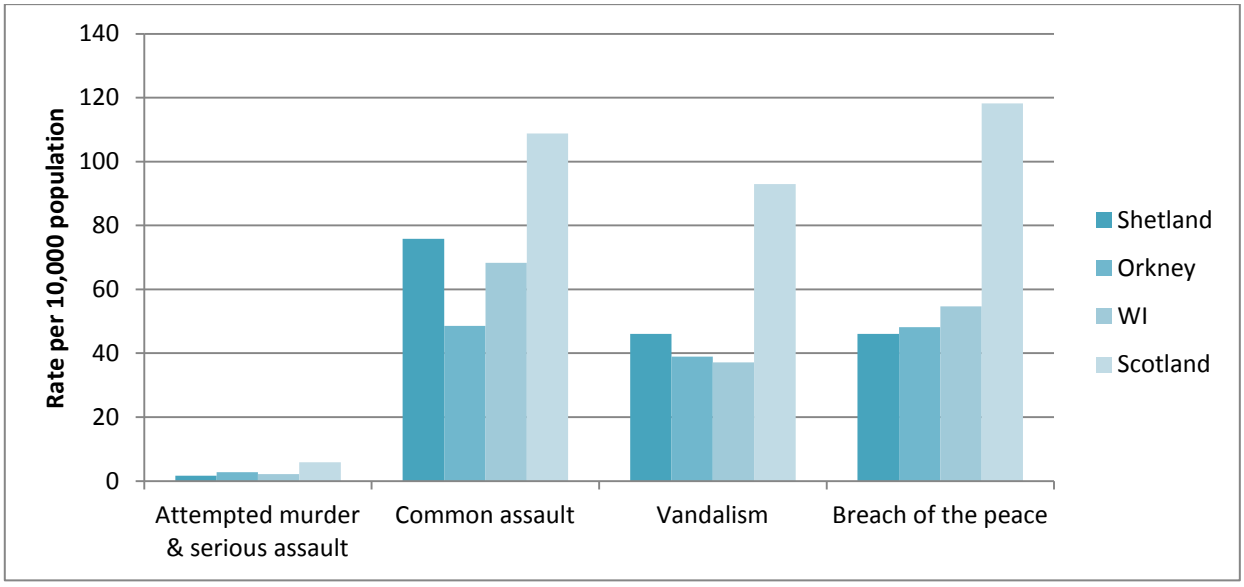
Over these five years, there were 154 offences. Of these:

- 90 were drunk and incapable and habitual drunkenness offences (58.4%)
- 31 were consumption of alcohol in designated places, byelaws prohibited offences (20.1%)

- 23 were refusing to quit licensed premises offence (14.9%)
- 8 were disorderly on licensed premises offence (5.2%)
- 2 were drunk and attempting to enter licensed premises (1.3%)

There were 203 alcohol and/or drug related driving offences within Shetland over the last 5 years, an average of 40 per year. We do not have comparative data for the islands or other areas of Scotland, but we do know that driving while under the influence of alcohol or drugs presents a danger to both self and others.

Figure 1.5: a comparison between Shetland, Orkney, the Western Isles and Scotland in terms of types of alcohol related offences. (ScotPHO)



Alcohol Focus Scotland reports that around three-quarters of all alcohol drunk in Scotland is now bought from off-licences – mainly supermarkets. Rather than alcohol being kept for special occasions, it's become normal to include it as part of the weekly shop and to keep the fridge stocked up. Alcohol has become so embedded in our society that there's a perception that regular drinking is normal, risk-free, and a good way to de-stress, without the recognition that regularly drinking too much increases the risk of cancer, heart disease and mental health problems. This shift to people drinking at home rather than in the pub has been driven by supermarkets selling alcohol at such low prices that pubs simply can't

compete.[22] The Faculty of Public Health suggests that off-licence sales can potentially increase health related harm due to the fact that home measures are often larger than pub measures and as prices in licensed premises increase, and off-licence prices decrease, more people are drinking at home and therefore potentially drinking a lot more than they think. [23]

Studies described and reported by Babor et al consistently show that restrictions on availability are associated with reductions in both alcohol use and alcohol-related problems. [24]

What are the views of dependent users of alcohol?

Research has been undertaken recently with people recovering from alcohol dependency in Aberdeen. These people recognised arguments about free choice and free-will, but also described the struggles faced daily in trying to overcome alcohol misuse and dependency. They suggested the following actions as being supportive to people in recovery (and potentially people worrying about their alcohol use):

- Restricting licensing hours would be a big help, if off sales were not permitted until late afternoon or evening rather than from 10 am
- Most buy alcohol from supermarkets, it is difficult to be in recovery and go about normal daily living tasks if they have to pass the alcohol display. Making it a condition of licences that alcohol is sold in a separate area where people can use the rest of the shop and not enter would be helpful (e.g. the use of aisles at the back of the store away from the tills rather than in the middle of the store)
- In smaller shops, stopping alcohol from being on display behind the counter

So Drink Better is designed to work at several levels. It involves 'educating' young people and 'educating' the public about the new guidance, for example. But at the same time it involves working with Licensing Boards to increase their understanding of the potential

[22] www.alcohol-focus-scotland.org.uk/news/every-child-has-the-right-to-grow-up-safe-from-alcohol-harm/

[23] Faculty of Public health. *Alcohol and Public Health Position Statement*. London: FPH; 2008. Available at: www.fph.org.uk/uploads/ps_alcohol.pdf

[24] Babor T, Caetano R, Casswell S, et al. *Alcohol: No Ordinary Commodity*. Oxford; Oxford University Press: 2010.

power of the Licensing Board in tackling availability of alcohol and therefore accessibility to alcohol.

Social marketing

Social marketing is a method of applying the science of marketing to social policy and behaviour change in the context of health improvement. In a book on social marketing, subtitled 'Why should the devil have all the best tunes?', Gerard Hastings, a lecturer in Social Marketing at the University of Stirling, argues that the techniques used by big companies to get us to eat big brand beef burgers and smoke particular types of cigarettes can also be used to encourage people to eat healthily, preserve their lungs and walk to work.[25]

A key element of the *Drink Better* campaign is the use of social marketing techniques. But to do this we need to be cleverer about understanding our target audiences. Social marketing uses techniques such as branding and 'segmentation'. Understanding the very different reasons that people have for drinking alcohol, and the very different ways that different groups of people use alcohol, will help us to design interventions which are far more likely to have an impact on them, because they are far more likely to be relevant.

Social marketing isn't just aimed at the public though. It also aims to influence people with decision making powers to think about how they can make alcohol use safer, or those who are involved in selling alcohol to think about other sources of income.

[25] Hastings, G *Social Marketing: Why should the devil have all the best tunes* London: Butterworth-Heinemann; 2013

CHAPTER 3 SMOKING

The three strands of tobacco control are prevention, protection and smoking cessation. Schools in Shetland are very good at building tobacco and smoking into their curricula, but we recognise more work is required to stop young people taking up smoking habits. Tobacco protection laws in Scotland are very strong, and there is proposed legislation to ban smoking in cars where there are children present. Shetland Islands Council Trading Standards department have a role in enforcing this legislation.

Smoking remains a public health issue; it has substantial negative health and economic effects on individuals and the economy, and the Scottish Government described it as the greatest single cause of preventable ill health, disability and premature death in Scotland, accounting for a quarter of all deaths per year.[26]

Figures from general practices indicate there are 2950 smokers (over the age of 15) in Shetland. This is around 15% of the population; below the national average of 22%.[27]

Two thirds (67%) of smokers say they would like to quit smoking, and research from Health Scotland (2010) tells us that use of NHS smoking cessation services combined with pharmacotherapy increases a person's chances of quitting smoking by up to four times compared to using willpower alone.[28]

Prevention

There is also a strong relationship between smoking and disadvantage, along with evidence that smoking, (including second hand smoking) has a negative impact on cognition and learning – which is why smoking in young people should be of interest to those interested in education attainment and closing the gap between young people who achieve, educationally, and those who don't.

As noted above, schools in particular undertake some excellent work around tobacco use and smoking: it is very hard to find a primary school aged child in Shetland who thinks

[26] Health Scotland. *Health Scotland's position on e-cigarette use in NHS Scotland November 2014*. Edinburgh: health Scotland; 2015. Available at; www.healthscotland.com/uploads/documents/24383-1.%20NHS%20Health%20Scotland%20Position%20Statement%20on%20e-cigarettes%202015.pdf

[27] Information Services Division (ISD) National Services Scotland

[28] http://www.healthscotland.com/documents/4661.aspx

there is anything good about smoking. But still people take up the habit. Have we run out of ideas for smoking prevention? Or are we placing too much emphasis on education when actually we should be focusing much more on tackling inequalities, disadvantage, vulnerability and poor self esteem that means that young people look for coping mechanisms in tobacco?

There is an additional driver for us, as our funding reduces; we would be able to put fewer resources into adult smoking cessation if people didn't start smoking in the first place, or didn't move from being occasional smokers to regular dependent smokers.

Prevalence of Smoking among young people

The proportion of 13 and 15 year olds who smoke regularly has fallen steadily to its lowest nationally recorded level. In 2013, 2 per cent of 13 year olds smoked regularly, down from a peak of 8 per cent in 1998, and 9 per cent of 15 year olds smoked regularly, down from a peak of 29 per cent in 1996. The proportion of occasional smokers has also fallen to 1 per cent (13 year olds) and 4 per cent (15 year olds)[29].

Family, Friends, Society and Health

Societal factors which appear to increase the risk of a young person smoking include:

- Having friends, parents or siblings who smoke
- Living in a non-traditional family, e.g. lone parents, or with step-parents
- Parents having less knowledge of how the young person spends their time
- Regular social activities such as hanging out on the street, going to concerts or gigs or being out most evenings, whereas pupils who play sport at least weekly are unlikely to be regular smokers
- Not enjoying school
- Difficulty engaging with school, e.g. truanting or a history of school exclusions
- Having physical or mental health wellbeing issues

[29] SALSUS 2013 available at: www.isdscotland.org/Health-Topics/Public-Health/SALSUS/Latest-Report/

- Having non-academic ambitions after leaving school, such as entering work or a further education college, as opposed to university

Attitudes to Smoking

Families of regular smokers are likely to be aware that the young person smokes, but this is not the case with young people who smoke occasionally: most families of all young people would try to convince the young person to stop smoking.

There has been some good progress with respect to young people's attitudes towards smoking, for example:

- The proportion of pupils who think it is ok to try a cigarette to see what it is like has declined steadily over time
- More than 90 per cent of smokers and non-smokers agree that smoking can cause lung cancer and heart disease
- A low proportion of both smokers and non-smokers feel that it is easy to give up

However, there is still some progress to be made on how young people perceive smoking: regular and occasional smokers are more likely than non-smokers to agree with statements about "positive" aspects of smoking, e.g. around issues of relaxing, coping with life and confidence.

Stopping smoking

If two thirds of people who smoke want to stop, why don't they just do it? Some people need that 'last straw' incentive such as a heart attack or birth of a baby to motivate them to quit. (Can we raise awareness about the benefits of stopping smoking **before** getting pregnant, to avoid the damage caused by smoking during pregnancy?) Others people who smoke may have tried many times to stop, but always eventually returned to smoking. The average number of failed (perhaps 'practice' is a better description) attempts before a smoker finally gives up for good is seven to eight. Some people may have smoked for many years and may have no intention of ever giving up and there is really very little that we can do through public health and health promotion initiatives to change that. However, some apparently intractable smokers do unexpectedly find a reason to give up smoking and we must ensure that information, advice and support is available for these smokers when they want it.

A national review of smoking cessation services in 2014 recommended some actions to reduce the variation in quit rates across the country and to improve the consistency of services, under the following headings:[30]

Reducing variation in quit outcomes and consistency between NHS Boards

1. Improving access to varenicline and combination NRT.
2. Offering a variety of behavioural support options, tailored to client needs.
3. Validating quit rates and using feedback from smokers, which ought to be used to inform service development.
4. Improving referral systems and maximising links between a smoke-free NHS and smoking cessation services.

[30] Smoking Cessation Services Review Advisory Group. *Review of NHS smoking cessation services: advisory group report.* Edinburgh: NHS Health Scotland; 2014. Available at: www.healthscotland.com/documents/23527.aspx

Increasing reach and success, particularly with priority groups

1. Identifying clients and maintaining motivation
2. Community development and third sector approaches to client engagement
3. Increasing options for smokers
4. Young people
5. Specific settings
6. Pregnant women

Improving processes within smoking cessation services and training:

1. Follow-up
2. Carbon monoxide (CO) monitoring
3. Training

Around 420 people have stopped smoking (measured at three months post quit) through the NHS Shetland smoking cessation services since consistent recording began in 2003. The original targets from government were that clients should stop smoking for four weeks, and so this was where we concentrated our efforts. Along with the rest of Scotland, we attempted to follow people up at three months, in order to check on progress, but we had a very poor follow-up rate.

Two years ago, the target was changed, so that we are now required to measure at three months rather than four weeks. We feel that this gives us a better measure of success, even though it might be more challenging, as someone who has managed to stop smoking for three months is far more likely to maintain their quit. We also have significantly improved our recording and monitoring data, and our follow-ups are much more effective.

The success of our tobacco control work means the challenge now is that the relatively small number of people who continue to smoke tend to be in the hardest to reach and more vulnerable groups, and find it the hardest to quit.

Current targets

NHS Shetland had a Government target during 2015-1016 to achieve 33 'quits'. That is 33 smokers who live in the more socio-economically disadvantaged areas of Shetland to stop smoking for three months. In fact we helped 51 people out of the 144 who signed up from these areas to stop smoking for at least three months, so not only met the target but

exceeded it by 55%. Four people were helped by pharmacy services and the others were supported by health improvement team in various settings (mainly primary care). The total number of three month quits for the year was 73 (38 men and 35 women).

Our quit rate at three months was 35%, compared to a Scotland-wide quit rate of 20%, so clearly the ways that we deliver our services are accessible and successful. However they require intensive staff input, and the *cost* effectiveness has not yet been evaluated.

The new target we have for 2016/17 is 43 quits at three months within the most deprived areas. This is going to be challenging for the team as in some areas there are very few people signing up to the smoking cessation service despite efforts to engage them. Those that do attend often need more intense support and may have several serious attempts before they quit; they may also need support for much longer than the 12 week programme we offer. We will continue to work alongside colleagues in general practice, community pharmacies and secondary care to encourage referrals and build capacity for others to offer smoking cessation support.

What's next?

- Continue to work one to one with individuals and will run groups if appropriate e.g. in workplaces
- Work with surgeries on an individual basis to engage with smokers e.g. inviting in those recorded as smokers for a Keep Well health check
- Supporting individuals to reduce harm from tobacco and encourage attendance from e-cigarette users
- Work to increase referrals through secondary care routes
- Continue supporting prevention work in primary and secondary schools
- Support the campaign around the ban on smoking in cars while children are passengers

How do we deal with e-cigs?

E-cigarettes are consumer products that help some smokers to quit smoking tobacco. They are freely available over the counter from many shops, often ones that do not sell tobacco products. E-cigarettes have not been tested and licensed in the same way as NRT products. However, two brands have recently received marketing authorisation for medicinal licences from the MHRA (Medicines and Healthcare Products Regulatory Agency). This means that these can become available on prescription, although they are not available as yet.

The evidence base on e-cigarettes is still developing. There is general agreement that they are significantly less harmful than smoking tobacco, but are not risk free:

- Most e-cigarettes contain nicotine, which is addictive;
- The delivery device mechanisms vary widely and users need to know how to operate their device safely;
- The other constituents of e-cigarettes vary - currently little is known about the impact on an individual's health of inhaling heated chemicals using an e-cigarette.

Nationally and internationally, we will need to wait until we see the long term impact of e-cigarette use to understand fully the safety of these products. While smokers will benefit from switching to e-cigarettes, the safest option for non-smokers (either former smokers or never-smokers) is to use neither cigarettes nor e-cigarettes.

Analyses of e-cigarette vapour contents indicate that they contain considerably lower concentrations of many of the major toxins in cigarette smoke. The balance of evidence currently suggests that e-cigarettes present much lower risks than traditional cigarettes, but there are major knowledge gaps. The risks and inhalational toxicity of chemicals once heated are not well characterised, and further research is required in order to assess the risks more accurately.

Are there any benefits to e-cigarettes?

E-cigarettes are increasingly available and popular. There are likely to be benefits to their use but there are also some uncertainties.

The main benefit is likely to be their use in harm reduction, either in established smokers or recent quitters. E-Cigarettes can be effective in supporting reduced tobacco use or as a replacement (replacing tobacco addiction with an alternative that is likely less harmful). The end goal should always be complete abstinence from both tobacco and nicotine.

What are the uncertainties?

There is incomplete evidence about quality, safety and effectiveness of use, particularly in the longer term. Although almost certainly less harmful than tobacco much is still not known and they cannot be recommended as 'safer' based on this. Because e-cigarettes have appeared and developed so quickly, public policy has had to develop fairly quickly as well. NHS Health Scotland issued two position statements, in 2014 and 2015:
The 2014 statement was fairly guarded about the use of e-cigarettes, based on the lack of evidence about their safety and their effectiveness in supporting people to stop smoking:

> 'the NHS only endorses use of licensed products which have proven evidence of effectiveness, safety and quality. These should be concentrated on helping people ultimately to quit tobacco use, and with a view to quitting tobacco and ENDS use entirely. Use of non-prescription items is a matter of personal choice. '[31]

[31] NHS Health Scotland. *NHS Health Scotland's position statement on Electronic Nicotine Delivery Systems – ENDS - e-cigarettes and other smoking simulator products statement.* Edinburgh: NHS Health Scotland; 2014. Available at: www.healthscotland.com/uploads/documents/24383-HS%20ENDS%20postn%20statmt%20311014.pdf

The 2015 statement was slightly more accommodating of the role that e-cigarettes might play, in that it encouraged smoking cessation staff to discuss the range of medicinal and non-medicinal options available to service users, including evidence of effectiveness of each. It stated that should service users want to stop smoking with the support of e-cigarettes, as long as they had considered all the options, they should be supported to do so.[32]

The guidance from Health Scotland is now that:

- Smoking cessation staff should discuss the range of medicinal and non-medicinal options available to service users[33], including evidence of effectiveness of each; [34] [35]
- Once service-users have considered all the options, and if they want to quit using e-cigarettes, they should be supported to do so;[36]
- Services should advise that dual use (e-cigarettes and tobacco) is recommended only as a route towards quitting smoking tobacco. To reduce harm, smokers should aim to give up tobacco completely.

NHS Shetland smoking cessation staff welcome individuals who are using e-Cigarettes (either in place of tobacco or dual use to reduce tobacco) to attend services for support to reduce use further and stop.

[32] Health Scotland. *Health Scotland's position on e-cigarette use in NHS Scotland November 2014*. Edinburgh: health Scotland; 2015. Available at; www.healthscotland.com/uploads/documents/24383-1.%20NHS%20Health%20Scotland%20Position%20Statement%20on%20e-cigarettes%202015.pdf

[33] *Guide to smoking cessation in Scotland 2010,* including its Harm Reduction addendum 2014, the Brief Intervention Practitioners Flowchart and its accompanying E-cigarettes/Harm Reduction for Brief Intervention notes 2015 . Available at: www.healthscotland.com/documents/4661.aspx.

[34] Smoking Cessation Services Review Advisory Group. *Review of NHS smoking cessation services: advisory group report.* Edinburgh: NHS Health Scotland; 2014. Available at: www.healthscotland.com/documents/23527.aspx

[35] Health Scotland Effectiveness Evidence briefings available at www.healthscotland.com/scotlands-health/evidence/effectivenessevidencebriefings.aspx.

[36] "'How to' guide on *cut down to quit* and *e-cigarettes*" is available via smoking cessation co-ordinators.

CHAPTER 4 DRUGS

The recovery model

In 2008, a new Drug Treatment Action Plan 'The Road to Recovery: A new approach to Tackling Scotland's Drug problems' was published by the then Scottish Government. It opened with the following words:

> 'For too long, debate in Scotland has centred on whether the primary aim of treatment for people who use drugs should be harm reduction, or abstinence. We fundamentally disagree with the terms of this debate. We do agree with the United Nations Office on Drugs and Crime, which said in a recent report that *"harm reduction is often made an unnecessarily controversial issue, as if there were a contradiction between treatment and prevention on the one hand, and reducing the adverse health and social consequences of drug use on the other. This is a false dichotomy. They are complementary"'.*[37]

In the Government's view, 'recovery' should be made the explicit aim of services for problem drug users in Scotland. Their view of recovery was **a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society**. Furthermore, it incorporates the principle that **recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment**. In short, an aspirational, person-centred process.

Recovery means different things at different times to each individual person with problem drug use. For an individual, 'the road to recovery' might mean developing the skills to prevent relapse into further illegal drug taking, rebuilding broken relationships or forging new ones, actively engaging in meaningful activities and taking steps to build a home and provide for themselves and their families. Milestones could be as simple as gaining weight, re-establishing relationships with friends, or building self-esteem, but need to be sustained.

[37] UN Office on Drugs And Crime.*Reducing the adverse health and social consequences of drug abuse: A comprehensive approach.* UNODC.; 2008.

Recovery as a principle has been used in the field of mental health for many years and is now being applied to alcohol too.The concept of recovery was key when we re-designed our alcohol and drugs services in Shetland recently. Along with substance misuse nursing staff and a Psychiatrist, the Shetland Substance Misuse Recovery Service employs community substance misuse workers who are able to offer one to one support, moving on skills, housing, debt and family support. The service works closely with a substance misuse social worker. Support for clients includes relapse prevention, trauma, anger management, peer support, and the setting up of a mutual aid partnership where people in recovery can support each other in achieving their aims and goals.

Flying the flag for substance misuse recovery services

Local users of NHS Shetland's Substance Misuse Recovery Services (SMRS) have created a colourful flag to represent Shetland at the Recovery Walk Scotland in September. The walk is taking place in Falkirk and is the fifth annual event aimed at bringing together recovery activists from across Scotland and beyond to celebrate recovery from addiction. The Shetland flag was created during newly established SMRS art classes that run weekly on Monday afternoons. Art therapy is recognised as a valuable tool in the treatment of addiction and substance misuse and it is hoped that the regular classes allow the attendees to access peer support and also offer an alternate, non-verbal means of communication. SMRS staff are available after each session should someone feel the need to speak further.

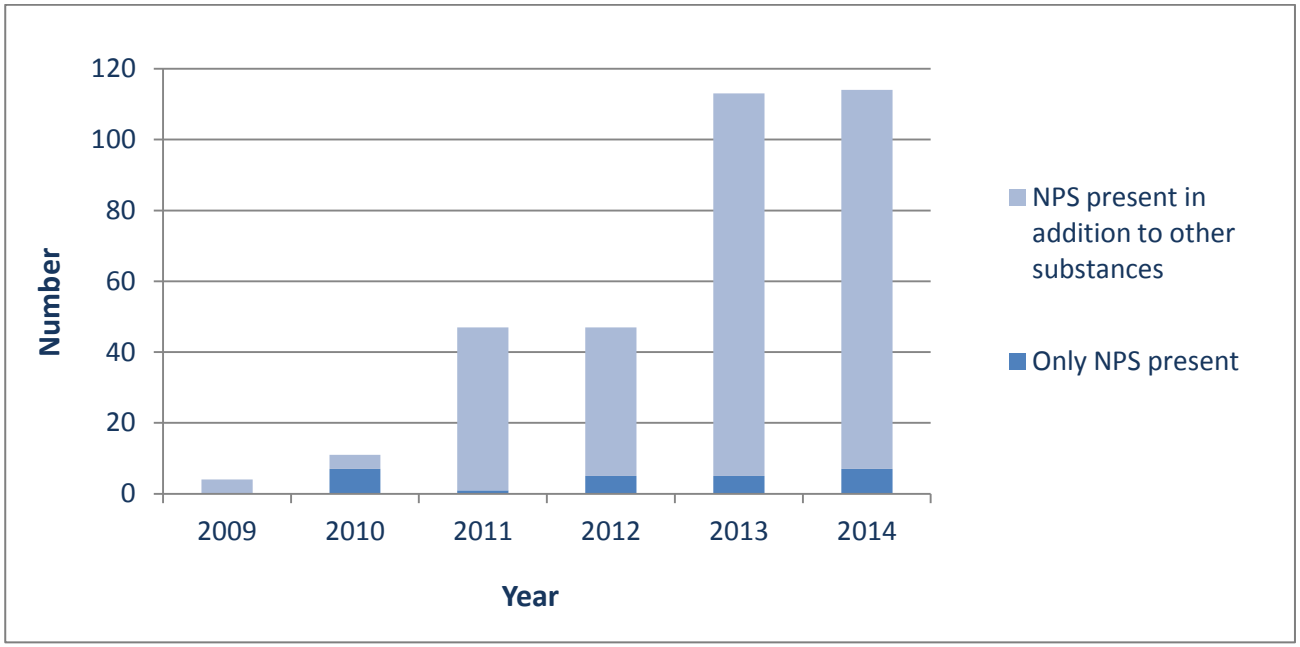
Karen Smith, Alcohol and Drugs Development Officer, and Annie McKee, SMRS worker, displaying the Shetland Recovery Flag.

Novel psychoactive substances

Current situation

In 2014 across Scotland there were 743 deaths, 114 where NPS was present in addition to other substances and seven where NPS was the sole substance present.

Figure 1.6. Number of drug deaths in Scotland where NPS present (data taken from National Records of Scotland Annual Report 2015)



In Europe there are currently more than 450 NPS being monitored by the European Monitoring Centre for Drugs and Drug Addiction. In 2014, 16 public health alerts concerning circulating NPS were issued.

Psychoactive Substances Bill

Legislating to restrict the availability of harmful NPS is difficult. For a substance to be classified under the Misuse of Drugs Act there has to be evidence of harm suffered by the person taking the substance. This can be time-consuming to collect and evoke the required legislative change. Furthermore, once a substance had been banned manufacturers can be adept at making a slight tweak to the content or molecular structure of the new psychoactive substance, to allow the new (albeit nearly identical) substance to avoid falling under the same classification as the original, newly banned substance.

In order to break this cycle and legislate more proactively to restrict the availability of NPS, the Psychoactive Substances Bill came into force on the 26th of May 2016. The bill essentially bans any substance that is mood altering and that is not exempted. Substances which are exempted in the Act are those that are already controlled through existing legislation (for example alcohol, tobacco or medicines) or where psychoactive effects are negligible (caffeine and certain foodstuffs).

Possession of NPS for own personal use is not an offence under the Psychoactive Substances Bill but it is an offence to produce, supply, offer to supply, possess with intent to supply or import or export a psychoactive substance. The purpose of the Bill is very much to disrupt supply and availability of NPS, rather than penalise the end-consumer. This is very important as often the person taking NPS needs support and we want them to feel able to engage with services without fear of repercussions.

Images of Novel Psychoactive Substances

Stigma

'Stigma' is when a person possesses an attribute or status which makes him/her different, less desirable or acceptable to others.[38] Stigmatisation as the overt (explicit) exclusion of individuals because they participate in a perceived undesirable phenomenon is a fundamental issue not only around injecting drugs, but also to having an infectious disease diagnosis.[39] [40] So people who have become infected with a Blood Borne Virus (BBV) such as HIV or Hepatitis C Virus (HCV) through their injecting behaviour can be 'doubly' stigmatised. Added to this can be a further stigma of a criminal record for those who have been caught using illegal drugs.

Often stigma, or other people's perceptions, is not about the users' drug-taking behaviour, as this may be 'hidden'. There are often subtle clues which people pick up on and lead to a drug user being stigmatised: e.g. physical appearance, clothing and employment/housing status. However, these same clues may lead to assumptions being made about an individual which are misguided. [41] And the stigma may be self-perceived with the individual feeling more stigmatised that they actually are by those around them.

Negative labels such as 'junkie' and 'druggie' and the embarrassment and reported shame of being associated with a lifestyle of this nature, appears to be relevant to the choices an individual makes, and the injecting practice they deem acceptable. [42] [43] The avoidance of stigma and negative connotations is cited as one the reasons many individuals make an informed decision to choose controlled use of heroin over addiction. The lifestyle of individuals who choose to inject drugs may appear no different from the general public

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[38] Goffman, E.*Stigma: Notes on the Management of Spoiled Identity*. New Jersey: Englewood Cliffs, Prentice-Hall; 1963.

[39] Gilbert, P. Shame, stigma and the family: "Skeletons in the cupboard" and the role of shame. In: Crisp, A.H. (ed.), *Every Family in the Land*; London: Royal Society of Medicine Press; 2004.

[40] Furst R.T, Johnson B D, Dunlap E. and Curtis R. The stigmatized image of the "crack head": A socio-cultural exploration of a barrier to cocaine smoking among a cohort of youth in New York City, *Deviant Behaviour* 1999: 20 (2), 153–81.

[41] Lloyd, C. *Sinning and sinned against: the stigmatisation of problem drug users.* London: UK Drug Policy Commission; 2010.

[42] Clark T. The science of stigma – to help addicts, look beyond the fiction of free will. *The Scientist:* 1998 **12** (16): 9.

[43] Warburton H, Turnbull PJ & Hough M. *Occasional and controlled heroin use: Not a problem?* London: King's College; 2008.

around them. One of the factors injecting drug users report as influencing their choice to inject in a controlled manner is to avoid the stigma of being perceived to be a 'junkie'. [44] [45]

Choosing to use heroin and inject in a controlled way, means a user probably remains hidden from society. Issues around prohibition, the covert (hidden) nature of the act of injecting, and society's fear of drug use and users are often subtle and unspoken. Heroin use and the myths surrounding it fuel the stigmatising attitudes of others. This can have a profound effect on users. Long-term, sustained and apparent controlled use of intravenous substances is still important in terms of risk but still may have the attachment of social phenomena such as stigmatisation. It is certainly the case that linked to stigma is the illegality of the act of injecting and use of an illicit drug.

In the study described below, which focuses on ethical issues, injecting drug use and HCV, stigma was identified as a key theme for drug users. Injecting is portrayed negatively, and it is injecting which leads to transmission of Hepatitis C Virus for so many. Bound up in the stigma of injecting is the morality of right versus wrong and the ethical stance of the negatively portrayed 'junkie'.

Apart from the obvious effect of stigma on psychological wellbeing, whether it is real or perceived, feeling stigmatised also often means that people are very reluctant to seek help and support. That might be support from family and friends, needing occupational input at work or seeking medical help.

Contrary to the portrayal of an 'evil' deviant individual; injecting drug users who participated in the local research displayed acts of integrity, wisdom, friendship, care, support and protectiveness of others. Acknowledgement of these morally good characteristics, and other ethical beliefs together with the strong Shetland community minded spirit described by participants, offer opportunities for services and the wider population to foster an environment where stigmatising behaviour can be challenged and individuals can be better supported and empowered in tackling addictive and risky behaviours.

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[44] Burris S. Stigma and the law, *The Lancet.* 2006: 367: 529–31.

[45] Biernat, M. and Dovidio, J. Stigma and Stereotypes, In: Heatherton, T., Kleck, R., Hebl, M., and Hull, J., (eds), *The Social Psychology of Stigma*, New York: Guilford Press; 2000

'AN EXPLORATION OF THE ETHICAL PARADIGM AND EFFECT OF KNOWLEDGE OF HEPATITIS C VIRUS STATUS ON RISK TAKING BEHAVIOUR IN INJECTING DRUG USERS IN SHETLAND, UK: A QUALITATIVE STUDY'

This is an abstract of a piece of local research undertaken as a PhD thesis. Some background will first be given to set the scene.

Background

Hepatitis C Virus (HCV) is a Blood Borne Virus (BBV) which is treatable and often curable. Transmission of the virus is via the blood, such as through contaminated blood products prior to screening being introduced, and injecting drug use. HCV is often a silent disease with little or no symptoms, meaning many infected individuals may have been unaware of risks taken decades before. At the outset of this piece of research in 2005, it was estimated that there were 50,000 individuals infected with the virus in Scotland, 38,500 un-knowingly[46]. The public health challenge prompted a change in national policy on how to tackle the issue, resulting in the national action plan: *Hepatitis C Action Plan* with government funding to allow localities to progress testing, prevention, treatment and care. Shetland's stoic population and culture where issues such as anonymity and confidentiality can challenge service delivery around sensitive issues was relevant. Shining a light on issues which may further challenge individuals in difficult situations sowed the seed of a research proposal.

Research Aims

The overall aim of the research was to explore the ethical dimension and effect of knowledge of HCV status on risk taking behaviour in Injecting (heroin) Drug Users (IDUs), in the Shetland Islands.[47]

Background to the thesis

Illegal drug use and in particular injecting heroin has a reputation as the most addictive, destructive illicit drug, with users portrayed as evil, untrustworthy and morally corrupt. This

[46] Scottish Executive. *Hepatitis C Action Plan for Scotland Phase 1: September 2006 - August 2008*. Scottish Executive. 2006.

[47] Research on injecting drug use in the past often focused on the medical model of physiological addiction. At the outset of the study, there was less evidence in the literature of exploration of the impact of ethical issues on individuals with HCV.

presents a significant global public health problem and creates ethical dilemmas. The Hepatitis C Virus (HCV) has relatively low prevalence in Shetland compared to Scotland and Europe, but this may not reflect a hidden, more controlled user group.

Methods:

An iterative qualitative methodology was used in a three step process: i) In-depth interviews were conducted with 19 Intravenous Drug Users, using an interview guide developed to address the study objectives. Interviews were recorded and transcribed and supplemented by observational field notes, ii) emerging themes were explored with service providers in two focus groups and service developments proposed, iii) IDUs reviewed and amended/endorsed the proposed developments in a focus group and telephone interviews. Analysis used a thematic-approach based on grounded theory.[48]

Findings:

Powerful cross-cutting themes emerged of: compounding ethical dilemmas, particularly evident around family and younger injectors; and the Shetland community spirit, which is protective but also stigmatising. Injecting criminal offenders face a double stigma, and this, along with the stigma faced by hidden, more controlled users, may discourage testing and treatment. A novel output was the bringing together of user and provider views in the service blueprint.

Results:

This study found that knowledge of Hepatitis C Virus status did affect the behaviour of IDUs in Shetland. IDUs did have ethical concerns around their own behaviour and its effect on others, in particular on their family and the ethics of initiating other users. Although professional stakeholders reported limited understanding of the injecting drug users ethical concerns, this iterative process developed their understanding further. The knowledge and insight gained enabled new public health approaches to be considered,

[48] Descriptor of research methodology terms (iterative, qualitative, thematic, and grounded theory): This piece of local research used a qualitative design - this type of data gathering approach uses the 'quality' of what people say, rather than statistical numbers gathered in quantitative research. The research used a 3-step phased approach which is described as iterative as one phase informs the next. Analysis of the data was themed according to the repeatedly emerging pieces of information, which participants spoke about. Grounded theory is an approach used to analyse data where the emergent findings are rooted firmly in what the participants have said.

that would fit with national policy and a blueprint for different approaches for service delivery was scoped. This was with the endorsement of both service providers and service users. Local issues were considered particularly around anonymity and confidentiality in a remote island community. Specific recommendations for service delivery were made including:

- raising awareness of availability of anonymous testing for BBVs.
- access to, availability and provision of injecting equipment as part of wider harm minimisation in injecting behaviour.
- focus on history, lifestyle and underlying causes of addiction in assessment process
- continuity of treatment and care for users if in prison and once released.

The emergent themes representing the journey into drug taking were summarised under the following headings:

- Challenging early life/fraught lifestyle: *Black sheep*
- *Fun to despair*: Injecting scene, incarceration and death
- *The 'Hep!'*: Hepatitis C Virus status
- Powerful Shetland community-minded spirit
- Stigma

> *"**Stigma** in Shetland to injecting more than Hepatitis C Virus, maybe partly due to ignorance, **if you're a junkie** **[people think]** **you're the lowest of the low**...."*
>
> *"**There's definitely stigma** [against the Hepatitis C Virus] – '**dirty junkie'. I was that dirty junkie**."*

Conclusions:

The research extends the knowledge base concerning injecting drug users and Hepatitis C Virus, and offers unique insights into previously unreported ethical concerns held by users. The ethical paradigm (issues), stigma and community-minded spirit are important dimensions which, if acknowledged by service providers could encourage greater

awareness of the nature of addiction, HCV testing and the treatment journey in positive injectors.

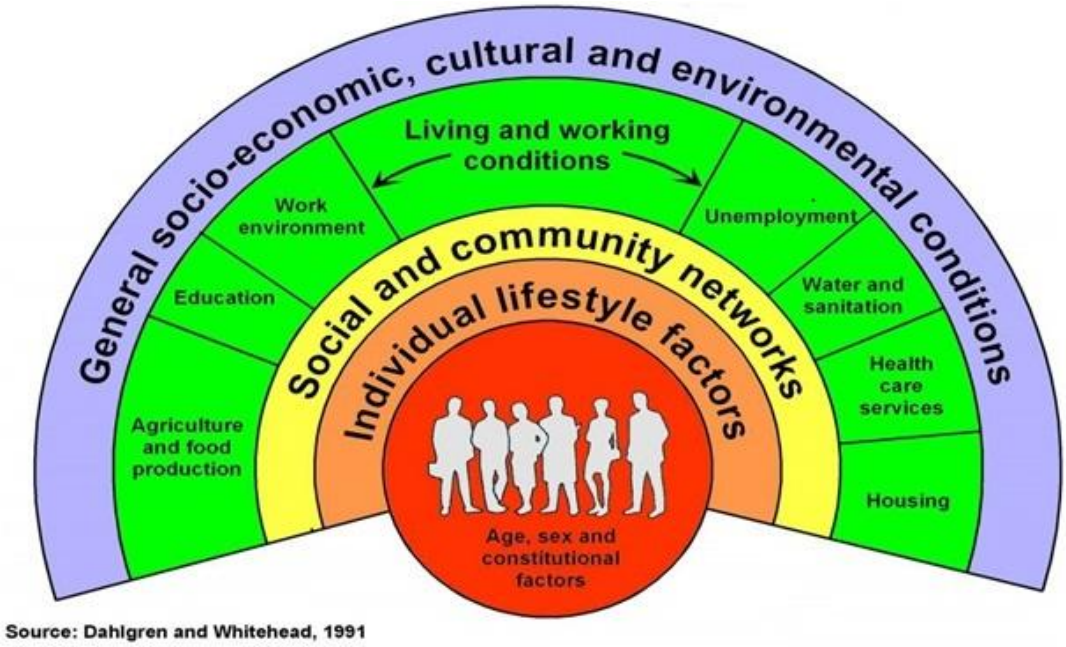
> "*I never injected until I was in my 30s, I was very dismissive of heroin, had no time for it, then it became more socially acceptable, and one thing let to another,* ***you don't think you'll get hooked, it's just a laugh...*** *before I knew it,* ***much to my shame, I was injecting everyday*** *for a couple of years...* ***It's done now and I can't change it****, I was the* ***baddy of the family.*****"**

PART II

PUBLIC HEALTH AND HEALTH IMPROVEMENT ACTIVITY REPORT

More than targets……but targeted more.

Dahlgren and Whitehead created the model below to describe the determinants of health.[49] This model highlights that health care services themselves are only a small part of health improvement. The model shows that the person and their genetic make-up is central to health improvement but then goes on to show how their lifestyle, their community and social networks, their living and working conditions and their general socio-economic, cultural and environmental conditions all impact on health. This is a well recognised model which is widely used nationally and internationally. By using it as a focus for this report we can start to evaluate where we are locally in relation to each of the health determinants and identify and address any gaps.



Source: Dahlgren and Whitehead, 1991

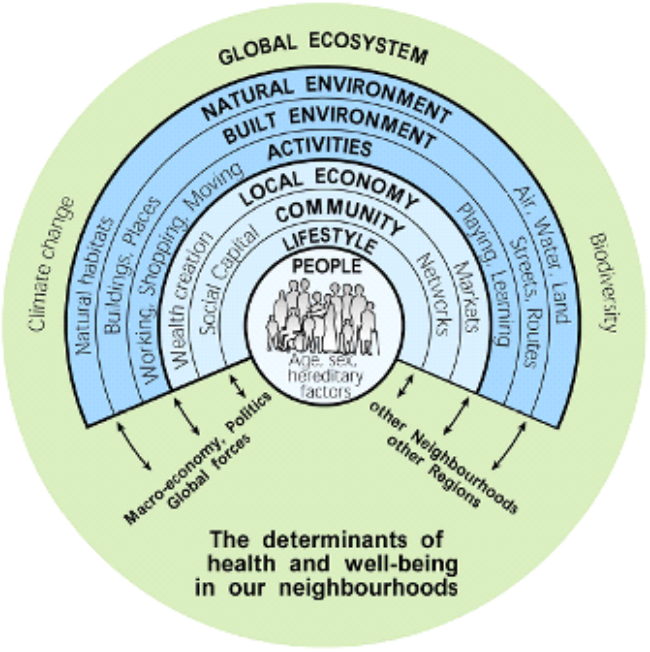
[49] Dahlgren G., Whitehead M., *Tackling Inequalities in Health: What Can We Learn from What Has Been Tried? Working Paper Prepared for the King's Fund International Seminar on Tackling Inequalities in Health.* London: The King's Fund, 1993.

We also need to consider the overarching theme of health inequalities. It has been well documented and is now widely known that there is a large gap in health between the most affluent and the least affluent in society, and in Shetland, these inequalities manifest themselves in ways that are different to mainland Scotland and the UK; we tend to have individuals and families who do not have the financial or personal resources to be able to enjoy a decent life, rather than geographical areas of deprivation.[50]

Barton and Grant and the UKPHA strategic interest group developed the health map (below) based on Dahlgren and Whitehead's earlier model.[51] This map continues to place people at the centre, but sets them within the global ecosystem which includes:

- natural environment
- built environment
- activities - such as working, shopping, playing and learning
- local economy - includes wealth creation and markets
- community - social capital and networks
- lifestyle

These are the social, economic and environmental determinants of health.



[50] Shetland's Commission on Tackling Inequalities. *On Da Level – Report and Recommendations from Shetland Commission on Tackling Inequalities*. Shetland Islands Council: Lerwick, 2016.
[51] Barton H, and Grant M. A health map for the local human habitat. *The Journal for the Royal Society for the Promotion of Health* 2006: **126** (6): 252-253.

In practice, this means that health improvement and public health must deliver a broad spread of activity, and use a wide range of approaches in order to be effective. These can be described under the following headings:

1. Formulating, implementing and monitoring healthy public policy;
2. Re-orienting public services to become health-promoting;
3. Implementing programmes to improve health for individuals and communities, and across a range of settings, such as workplaces;
4. Encouraging environmental measures to improve health;
5. Incorporating community development approaches, so that communities are empowered;
6. Developing people's personal skills by enabling them to identify their own needs and involving them in planning and evaluation processes;
7. Encouraging appropriate service utilisation, including screening and immunisation services; and
8. Delivering health information and education, including the use of social marketing techniques
9. Tackling inequalities

This report is presented under those headings. This helps to show the spread of activity and identifying the areas that we have targeted and those which require to be targeted more.

This report covers most of the public health and health improvement work we do in Shetland, including elements of health protection (immunisation and screening). It does not include other health protection areas such as communicable disease control and emergency planning, which are covered in the Control of Infection Committee Annual report and the Emergency Planning Annual Report respectively.

All the data in this part of the report have been collected locally unless otherwise stated.

1 Formulating, implementing and monitoring healthy public policy

As noted above, society, the environment, the economy and culture all have a major impact on health. Changing these for the better will improve the health of whole communities or populations – which, if successful, will have more impact than working with people individually.

Trying to influence public policy is an important part of the Health Improvement Team's job. By 'lobbying', educating and encouraging decision makers we can try to make sure that they consider health improvement when making any decisions.

Sometimes this can involve changes in the law, usually to try and protect groups of people, e.g. minimum age for buying alcohol and tobacco or drink driving laws. It also involves more local changes, for example, the introduction of parking restrictions to encourage walking.

Healthy public policy doesn't have to be about introducing new laws: it can be about making small changes and thinking about health when making decisions, like considering transport links and paths when building new housing schemes. Public Health and Health Improvement staff lead or are members of a number of multi-agency groups. This allows us to influence decisions across a number of sectors. However, there are number of sectors that we have limited involvement with and others that we are involved in but need to influence more as a matter of priority.

Alcohol Licensing

The Shetland Area Licensing Board's **Statement on Licensing Policy** is currently being reviewed. Licensing is seen as a useful tool for influencing accessibility and availability of alcohol. Work has been undertaken with the Licensing Forum to demonstrate the extent of alcohol misuse in Shetland and its impact on families, communities, and public services, and we will continue this engagement over the coming year.

Physical activity special interest group

We lead the **Physical Activity Special Interest Group** for Shetland. This multi-agency group was established in April 2014 to bring together partners who all had a particular

remit or interest in increasing physical activity for the least active members of our community.

A key part of the work the group has done has been identifying gaps in the provision of and access to physical activity opportunities in Shetland. Sub groups have then been formed to drive forward particular issues. Recently the decision has been made broaden the focus of Shetland Sport strategy group so that it encompasses the wider physical activity agenda. The Physical Activity Special interest group is supportive of this move as they see sport as one of a range of ways to be active and want to firm up the pathways between participation and sport as this will help to improve activity levels.

Some key achievements of the physical activity special interest group over the last year:

- There has been further expansion of localities based activities such as health walks, aiming in particular to support the least active and roll out of the **Laterlife chair-based exercise** programme.
- **Physical activity brief advice** and referral / participation pathways are in primary care and being introduced into secondary care. These are brief sessions which help patients to identify goals to increase their physical activity levels and work through some of the barriers to achieving these.
- Assisting 'NB Communications' in the development of an interactive online map which displays various physical activity opportunities throughout Shetland.
- Increasing hours of access to the Lerwick Flower Park Tennis court by key and equipment hire being administered by Islesburgh reception.
- One of main outcomes of the establishment and maintenance of this group has been the sharing of information across agencies. One example of this is that links were made between the local Active Schools team and the Disability Shetland group. As a result of this Active Schools are now funding transport in and around the area of Lerwick once a fortnight to take members of the Disability Shetland group to the Clickimin to take part in their recreational club.

Plans for 2016-17

- Work with the Shetland Islands Council, Shetland Integrated Joint Board and other key decision makers (through the Community Planning process) to understand their roles in improving public health. To then decide where more involvement/representation from the team is required in terms of influencing decision making and the order of priority.
- Development of a local Physical Activity, Sport and Health Strategy.

2 Re-orienting health services to become health-promoting

Primary Care Strategy

Individual and family lifestyle change programmes are primarily delivered through health improvement practitioners based in Health Centres. This move to localities took place over two years ago and has been hugely successful in increasing referrals to all programmes. The aim of the move to direct delivery of programmes in localities is to build up belief and confidence in the primary care work force so that through time they will deliver programmes themselves, with the health improvement team being there to provide training and updates in relation to the programmes and behaviour change. However, the current demand on primary care and the knock on effect prevent this from happening. A recent survey undertaken with the Primary Care staff by health improvement unequivocally reveals that the health improvement programmes would not take place if health improvement staff were not there to deliver them. A summary of the results of the survey are contained in Appendix C. This overwhelming response by primary care staff has forced the team to reconsider the plan for direct delivery of health improvement by primary care staff, at least in the short term**.**

Van Den Broucke argues that by working on an individual level on behaviour change acts as an assessment of community needs and assets allowing the wider determinants of health to be identified and tackled as well.[52] The health improvement practitioners often find that within a defined community, the same barriers to change are presented repeatedly by different people, which provides a good basis for developing community work. An example of this was in Yell where many **Counterweight** clients felt that there was a lack of fruit and vegetables locally. The health improvement practitioner contacted all the shops in Yell and has now produced an information sheet which is used in Counterweight appointments to show patients how the shops will support them to access fruit and vegetables more readily.

Nevertheless in primary care, we still need to develop the capacity to do prevention, early intervention, supported self-management and anticipatory care effectively and as a core part of the service we deliver. We know that this will pay dividends in terms of better health

[52] Van Den Broucke S. Needs, norms and nudges: the place of behaviour change in health promotion. *Health Promotion International* 2014; **29** (4): 597-600.

and quality of life, and reduce the demands on services in the longer term. To get ahead of the demands which will be placed on services through an aging population and increasing long term conditions, and in order to shift care closer to home and into local communities, the majority of people need to be more independent and resilient and self-manage, so that support can be focussed on those with the greatest needs.

One of the 15 key improvement projects that the Health Board is committed to is the implementation of an asset based approach to health care and prevention. This programme will include self care and self-management, realistic medicine and looking at different ways of supporting frequent attenders of services who might benefit from a level of social rather than medical support.

In her report *Realistic Medicine* the Chief Medical Officer for Scotland explains how the current primarily authoritative model used in healthcare needs to change to one where the practitioner and the patient can combine their expertise and are more comfortable in sharing the power and responsibility of decision-making.[53] This is an approach which is similar to how the health improvement practitioners work through their use of behavioural change approaches. The report describes how the model needs system and organisational change in order to be implemented as illustrated in the house of care model (below).

[53] Chief Medical Officer. Chief Medical Officer's Annual Report 2016; Realistic Medicine. Edinburgh: Scottish Government, 2016.Available at: www.gov.scot/Resource/0049/00492520.pdf

We have demonstrated through our achievements that working like this can improve patients' outcomes. As previously highlighted, though, primary care staff are currently limited in working in this way due to the demands on the service. A robust plan needs to be part of the self-care/self management project, in order to support this shift. Health Improvement staff are key to this piece of work as they can provide the expertise and insight to help staff change to this way of working.

In order to re-orientate health improvement delivery in primary care the implementation of the House of Care model will involve three phases:

1. Phase 1: Health Improvement deliver behaviour change and specific health improvement programmes directly with patients; at the same time plans are developed and delivered to change organisational processes required to support other practitioners to work in this way, including primary care staff best suited to delivery of programmes.
2. Health Improvement staff train and support staff to deliver behaviour change techniques applying this to wider areas of work such as self-management. Health Improvement would also support primary care staff to deliver specific health improvement programmes (e.g. counterweight) themselves which may involve health improvement staff delivering the initial three sessions then primary care staff delivering the remainder.
3. Primary care staff deliver behaviour change and specific health improvement programmes with patients directly. Health Improvement staff withdraw and deliver specialist only services for more complex cases and provide training updates on programmes to staff and evaluations services for assessing programme impacts with a focus on meeting inequalities.

In addition the health improvement team have been working alongside the **Shetland Mental Health Forum** to implement the **Triangle of Care** and are currently looking at how this can be integrated into their practice. This represents another key feature of the **House of Care** model.

Plans for 2016-17

The following actions are described in Shetland's **Primary Care Strategy**. Health improvement and Public Health will provide support for their implementation.

- Develop a comprehensive anticipatory care programme with better case management to reduce the burden of disease, reduce the out of hours workload, prevent hospital admissions and reduce hospital bed usage with shorter lengths of stay and quicker discharges.
- Increase understanding within communities, the workforce and in management of the importance of this approach and the payoff.
- Develop a Primary Care Workforce Plan that includes an understanding of core skills required to deliver prevention and anticipatory care effectively and the amount of time required to do this well - who needs to do it, how do they do it in the team and how do they all need to be supported?
- Provide skills development and training as well as a structure which provides guidance on roles and responsibilities, including specifically 'end of life' conversations and the use of advanced directives, primary/ secondary prevention, more holistic social care and reducing poly-pharmacy.
- Focus in the short term on the areas where there will be the biggest payoff e.g. using SPARRA[54] data to focus on poly-pharmacy and anticipatory care.
- Develop and implement a framework and programme for self management and self-care, which should include a comprehensive website with links to self-care advice for common conditions, and support for staff in helping patients develop their own capacity for self-care.

Secondary Care: Health Promoting Health Service

We take a lead on the **Health Promoting Health Service** (HPHS). The aim of HPHS is to support the development of a health promoting culture and embed effective health improvement practice as part of healthcare delivery. This is not without challenges – if easy, it would already be done, and there are lots of competing demands on staff time –

[54] SPARRA: Scottish Patients at Risk of Readmission and Admission

but time for all of us to recognise that we're part of solution and that staff in hospitals have a significant contribution to make to prevention / secondary prevention. The HPHS programme also includes a focus on staff health and wellbeing and on income and financial wellbeing in recognition of the impact these have on health.

Community based health services also have a significant contribution to make in prevention and some people believe that prevention should be done in the community setting. However there is great scope for supporting the good work carried out in the community when the public access hospital services. For many, it may be too late by the time people get to hospital, but making the most through opportunistic face-face contact with the large numbers of patients, carers, visitors and staff in hospitals are key reasons for taking this approach.

As a service provider and employer, the NHS affects the health of its patients, staff and the wider community. The NHS also has the potential to be an organisation that actively promotes health and tackles inequalities, and it has a unique contribution to make in the broader picture of changes required to improve health outcomes for all.

One particular highlight from the last year was the roll out of the physical activity pathway into secondary care.

Managed Clinical Networks (MCNs)

A managed clinical network (MCN) is a linked group of health professionals and organisations across different sections of the health service (including community, hospital and specialist) working together in partnership with social services, voluntary organisations and, most importantly, patients and carers. Members of the Health Improvement Team take an active role in a number of MCNs. As described above, there is still a role for prevention even once somebody is in hospital or in care services. For example, if someone has respiratory disease, it is just as important that they stop smoking as if they didn't have the disease.

- **Respiratory MCN** – The main focus for health improvement is smoking cessation provision in secondary care.

- **Cardiac MCN** – We contribute to the Heart Improvement Plan focusing on overweight and obesity management; physical activity brief advice and intervention; and healthy eating awareness.
- **Diabetes MCN** – here health improvement contributes to obesity and overweight management; physical activity brief advice and intervention, and the link between health improvement and dietetics.
- **Falls MCN** – Falls prevention is included within holistic health improvement and also promoted through specific physical activity interventions.

The Health Workforce

'Working for health equity: the role of health professionals' sets out the role that health professionals have to play in tackling the wider determinants of health.[55] The report illustrates that there are many things that the health system can do to influence the wider social and economic factors beyond access to health care services rather than tackling the symptoms and behaviours that people present with. Much of this action is taking place on a national level through incorporating this into the training of the workforce. Locally, however, the health improvement team need to further understand the gaps in knowledge of staff in order to help them influence the wider determinants more effectively.

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[55] Allen M, Allen J, Hogarth S, Marmot M. *Working for Health Equity: the role of health professionals* London: UCL Institute of Health Equity, 2013.

3 Implementing programmes to improve health for individuals and communities, and across a range of settings

Workplaces

We have a high level of employment in Shetland, but in-work poverty appears to be increasing and one in five households in Shetland have an income of £13,500 or less; this is less than half the median household income of £28,068.[56] The number of people in work, however, means that workplaces are a very useful setting for health improvement work. More and more employers understand the need to promote the health and wellbeing of their staff, in terms of efficiency and productivity. This links to issues identified in Shetland, such as the number of men lost to suicide over the last few years.

We have developed a unique approach to **Keep Well Health Checks**. We deliver these by targeting small businesses, or lone workers identified through health centres; as far as we know, we are the only area of Scotland that uses this approach. A total of 252 checks took place during 2015/2016, with 136 to date in the current financial year. The aim is to target people who would not otherwise be accessing health services. Although primarily we wish to detect risk factors for heart disease and cancer early and support lifestyle change, we also look out for wider wellbeing issues which impact on health, such as poor mental health, low income, housing and relationship issues. (We now talk about 'wellbeing checks' rather than 'health checks'.)

As checks have been delivered over the past three years we are now being contacted by businesses who have already had the health checks but have now taken on new employees, an indication that the checks are valued. All data from the checks is fed into EMIS so it is possible to track action that individuals have taken as a result of the checks.

Plans for 2016-17

We plan to undertake a piece of work to look specifically at the impact of having health checks on workplaces and organisations. This will be based on a sample survey of participants and managers.

[56] Shetland's Commission on Tackling Inequalities. *On Da Level – Report and Recommendations from Shetland Commission on Tackling Inequalities.* Lerwick: Shetland Islands Council,2016.

Healthy Start

The **Healthy Start** scheme gives eligible families free vouchers to spend on milk, fresh or frozen fruit and vegetables and infant formula milk. The vouchers are for anyone who gets income support, income-based job seekers allowance, child tax credit, is on a low income, or is a teenager.

The Child Health Team had identified that one of the barriers to discussing entitlement to Healthy Start was staff confidence in talking about money matters. Joint training was organised between the local **Citizen's Advice Bureau** (CAB) and Health Improvement to deliver training on debt advice and awareness of benefits along with Healthy Start. The training was attended by midwifery, health visiting, and occupational therapy and trainee nurses. The Health Improvement team also spoke to local shops to promote the scheme and encourage them to sign up to the Healthy Start Scheme.

Counterweight

Adult Weight Management services continue to be delivered using the **Counterweight Programme**. The demand on the service has continued to increase with 290 patients recorded as beginning the programme in 2015/16. We know this number to be higher as not all individuals give permission for their data to be included. The programme is delivered in both group and one-one settings, allowing the most cost and time effective means to be sought. We keep patients preferences at the forefront to ensure they receive the best service for them in a location that is convenient. This has included workplace and community groups being run alongside one to one GP practice based interventions.

The following data is based on all patients who commenced the programme between March 2015 and September 2016. The team have seen 430 patients in this 18 month period; 108 patients so far have reached their 5% weight loss target; and a further 33 reached their 10% target. Research on the Counterweight programme overall shows that 31% of the participants had lost over 5% of their weight at 12 month: and our figures match with this. Further data analysis is required in order to look weight loss maintenance beyond 18 months. During this 18 month period, there were 2542 appointments which an average of six appointments per patient.

The table below shows the number of patients attending each session of the programme.

	Screening	Session number					Follow up at 3, 6, 9 & 12 months			
	(From March 2016)	1	2	3	4	5	3 months	6 months	9 months	12 months
No of patients	88	401	363	303	246	214	205	107	72	46

We are currently working with the dietitian to further develop the referral pathway for adult weight management in Shetland. As well as dietetic led weight management support on an individual level, the dietitian is looking to set up a **Dietetic-led Counterweight** group. Dietetics will also be offering **Counterweight Plus**, a low calorie liquid diet programme from early 2017.

Child Healthy Weight

The results of the 2014 Health Behaviour in School Aged Children in Scotland (HBSC) survey were published in October 2015. NHS Shetland had paid for a larger than normal sample to be surveyed, in order to give us a useful level of data. In relation to child healthy weight there were a number of areas highlighted including low levels of daily fruit and vegetable intake, relatively low levels of individuals eating crisps and chips daily, but 25% of young people eating sweets on a daily basis.

There were low levels of individuals meeting daily physical activity guidance and high levels of sedentary behaviour both during the week and at weekends. It is worth noting that 80% of pupils reported that they travelled to school by bus or car. Even allowing for distance this suggests that, where appropriate, we need to support and encourage a change in attitude towards active travel.

Primary 1 data from 2015-16 showed that 27.1% of the children were described as being ‘at risk of overweight or obesity’, because they had a high BMI. This is higher than the average for Scotland, and is the highest percentage in Shetland for the past few years: since 2009 the figure has fluctuated between 19% and 24%. No children were assessed as being at risk of underweight in this year group.

We know that ‘statistically speaking’ the increase in the number of children with a high BMI in one year may not be very significant because of our small population. However, the

figures still show that over a quarter of the children in P1 last year had a problem with their weight at the point at which they were measured.

There is still a need for all teams working with families and children to become more confident and adapt their way of thinking when raising the issue of weight. This can be a difficult conversation; however it does not *need* to be difficult. We know that it is much easier to change habits and routines when they are not so engrained. Early intervention is key to tackling any behaviour change, particularly eating and activity. Further work and development is needed with all key agencies and sectors to ensure that children and parents are getting the help and support needed to provide healthy, sustainable life habits for themselves and their families. It would be incredibly helpful to have political backing for reducing the availability and attractiveness of sugar laden soft drinks and promotions of high calorie/low nutrition foodstuffs.

We have continued to deliver **SCOTT (children's weight management programme) and Counterweight Families.** Both programmes aim to help the whole family make healthy lifestyle changes and for BMI maintenance of the children concerned (**not** weight loss). Since March 2015 eighteen children have been engaged in the child healthy weight programmes, nine of whom have adopted a healthier lifestyle or stabilised their BMI or both. Working through child healthy weight programmes with families and seeing the complexity of many inter-relating issues has reinforced to health improvement staff the need for a programme which incorporates the adoption of a healthy lifestyle as part of wider more holistic programme such as the Life programme - a holistic, family centred approach which supports the needs of a whole family and aims to break the 'intergenerational' poor health and poor outcomes faced by the most vulnerable in Shetland (see page 101 for more on this approach).

Continued work alongside key departments such as child health and schools service is ongoing to ensure that families are given the opportunity for support either through the programme or through less structured support. We continue to see children who are severely obese, whereas, ideally we would like to see all children and families before they reach that point before habits are far entrenched.

Reducing mental health problems and suicides

Our rate of suicides or deaths of undetermined intent (measured over five years because of the small numbers involved) continues to fall, although the rate of male suicide is still above the national average. We use rates because this allows us to compare ourselves more easily to other areas, but this was actually 23 people who have completed suicide over the last five years – enough people for two football teams. We continue to work with partners such as **Mind Your Head** and **Samaritans** to increase community awareness and confidence in talking about mental health, and deliver training in workplaces to increase knowledge of mental health issues and help people develop skills in supporting people with mental health issues. We have also continued to audit every sudden death that may be due to suicide or drugs, identify common themes and trends and take appropriate action if possible.

The Health Improvement Team and the Mental Health Team worked together to implement the **Computerised Cognitive Behavioural Therapy (CCBT)** programme **'Beating the Blues'** as part of a European Funded Project pilot. It consists of eight, one hour sessions done at weekly intervals and is designed for mild to moderate depression or anxiety. Health Improvement's role was to support people to start the programme and keep going with it. NHS Shetland was the only board that delivered support alongside the programme in this way. A pathway and information sheet was developed to outline how the support should be delivered. The end of year evaluation has shown than Shetland performed well within Scotland in terms of completion rates: this has led to funding being extended by a further 12 months and includes an upgrade and update of the CCBT programme. A summary of the evaluation for the 1st year of the pilot can be found in Appendix A.

Access to services to support people with low level mental health issues has been recognised as an area of need both through Shetland's Primary Care Strategy and recent research undertaken by Mind Your Head. The workload associated with dealing with mental health problems remains a significant issue for primary care staff and members of the community. GP colleagues recognised that with additional training, the Health Improvement Practitioners already based within Primary Care could deliver **Behavioural Activation interventions** - a low level high intensity programme which is evidence-based and is recommended as a first tier intervention for mild to moderate depression. It can

also be helpful for 'sub-syndromal' low mood. It is an approach that is potentially extremely helpful for people who do not want to engage with more cognitive 'psychological' approaches, and will help to manage the volume of mental health issues that exist in the community and present to primary care.

This view was shared by the health improvement team as often behaviour change programmes such as **Counterweight** or stop smoking support can involve tackling underlying low level mental health issues. It was felt that specific training in this could enhance their work in other behaviour change programmes as well as being a stand-alone programme for tackling the low level mental health issues. We know that people in Shetland can access computerised CBT (the **Beating the Blues** programme) and telephone guided self help or CBT via the **NHS 24 Living Life** service. However many people dislike the idea of an approach that involves no face to face contact, and behavioural activation will provide a welcome alternative.

Working alongside members of the Mental Health team including the GP with a special interest in mental health, a successful bid was made to the **Primary Care Mental Health Transformation Fund**. This has allowed us to employ a practitioner on a temporary contract to organise the implementation and evaluation of **Behavioural Activation** in Primary Care in Shetland. The training is scheduled to take place in early October 2016.

Smoking cessation

Smoking cessation services again exceeded their targets (51 people quit at three months against a target of 33) which we see as a significant achievement for all the staff involved locally in helping people to stop smoking. Our smoking rates remain low compared to the rest of Scotland (less than 16% from GP systems data, 17% from Scottish Household Survey data) and the people we are helping now are generally those who find it the hardest to quit. This includes mothers smoking in pregnancy: midwives are now fully trained in delivering smoking cessation support and a range of programmes aimed at reducing the numbers smoking at booking are in place.

Physical Activity

Adults need 150 minutes of moderate activity or 75 minutes of vigorous activity for health (or a combination of both) as a minimum, each week. The main measure used for

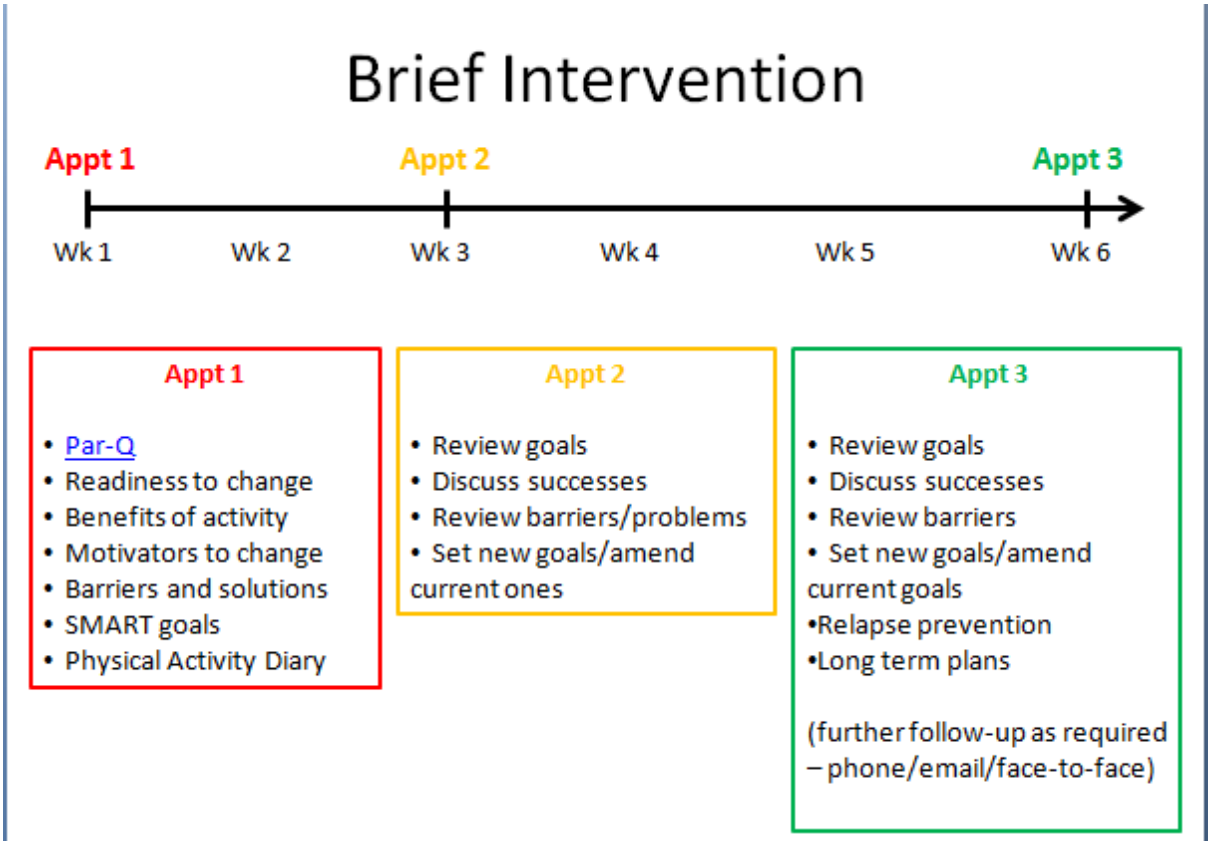
recording adult physical activity levels in Shetland is through the Scottish Health Survey. The latest data was published in March 2016 and is for the period 2012 – 2014, which shows that 64% of adults in Shetland are meeting physical activity guidelines. The data also shows that 36% of adults are not meeting these recommendations, 18% of whom are undertaking very low activity (less than 30 minutes weekly of moderate activity or 15 minutes of vigorous or combination of both). If this is the case there is still a great deal of work required to help these people become more active, as it is widely known that getting the least active more active has the greatest health gains overall. The validity of Scottish Health Survey data could be questioned as it is based on a sample of 300 people over a 3 year period, but can serve as an indication of activity levels.

In recognition of the need for better data on physical activity levels we have been working over the past three years to increase data collection on physical activity levels in primary care by implementing the physical activity brief advice pathway. As far as we are aware, this is the only current method to record individual adult physical activity levels in Shetland. In addition this allows the least active to be targeted and given the appropriate advice in the appropriate way to maximise chances of becoming more active.

Over the past year Health Improvement team have reviewed how we train staff to deliver physical activity brief advice and intervention for physical activity in primary care. The review was instigated through staff working in primary care and gaining hands on experience of how this could work. Four main areas were focussed on.

1. The training for staff had to be shorter – Action taken: training reduced from 3 hours to 15 minutes.
2. The recording had to change from paper based to electronic – Action Taken: EMIS Template developed.
3. There needed to be a defined programme for patients to follow - Action taken: a brief intervention pathway was established to consist of three, one-one appointments with more follow ups where necessary. Simple resources were created to sit alongside the pathway consisting of; an information booklet for practitioners on the main areas to cover and a workbook for patients. (See example pathway below)

4. Sometimes primary care staff did not have time to deliver the interventions – Action taken: primary care staff given the option of delivering themselves or referral to Health Improvement Practitioner in their practice.



The pathway has also been integrated into Shetland's weight management pathway (currently in draft). It is anticipated that this will further increase 'buy-in' from primary care staff.

The EMIS template, with support from the information team, has recently been updated to reflect the national changes to classifications of activity levels.

The training delivered in primary care has been adapted for secondary care. As part of the training, feedback is being sought from individual departments as to the best ways of recording physical activity levels in secondary care. Ideally physical activity levels would be screened in secondary care and then information sent back to primary care to be recorded on the EMIS template. We are currently exploring ways that this could happen.

This work has been recognised at a national level and members of the team delivered a presentation to the **National Physical Activity Special Interest Group** earlier this year,

which enabled us to express an interest, now accepted, in being part of a national pilot for trialling a new clinical champion model for physical activity brief advice. The findings will be shared and learnt from nationally.

Otago Programme – Unst Pilot

The **Otago exercise programme** is a strength and balance programme which is designed to help people reduce their risk of falling by improving strength, balance and confidence.

It is particularly suited to people who:

- Have experienced a fear of falling
- Sometimes feel unstable on their feet
- Can lack confidence when walking
- Have experienced a fall(s)

The NHS Shetland physiotherapy team led the roll out of this programme in Unst with co-ordination support provided by members of the health improvement team. The programme ties in well with health improvement as it is a multifaceted programme which touches on all areas of health from nutrition to foot care. It provides a way of ensuring that holistic health improvement in vulnerable older people takes place, whilst also increasing mobility.

This project involved input from occupational therapists, podiatry, physiotherapy, opticians, health improvement practitioners, the practice nurse, community nurses, pharmacy and social care staff from Bruce Hall Terrace and Nordalea Care Centre. This multi-disciplinary, multi-agency way of working fits exactly with the sort of approaches described in the **Older People's Health and Wellbeing Strategy** for Shetland; and we should be using this approach more often. It involved partners being flexible, using a team approach, being inclusive and breaking down barriers, and clearly demonstrated the value of joint working and sharing of skills. The programme is made up of eight, weekly sessions consisting of one hour of specialised strength and balance exercises followed by a talk. Each talk is based on a topic that ties in with falls prevention, for example, eating a healthy diet, being active and looking after your mental wellbeing. Participants practice the exercises twice weekly between sessions. The programme was designed by

physiotherapy in order to meet all national falls prevention guidance. The evaluation of this programme is included at Appendix B.

Alcohol Brief interventions (ABIs)

Alcohol Brief Interventions continue to be delivered within the key settings of primary care, Accident & Emergency, Sexual Health Clinic and Maternity, again exceeding the nationally set target for 2015-16. However, during the first half of 16-17, the numbers of ABIs in primary care have fallen showing that this is not yet embedded in primary care practice. In addition there has been difficulty in collecting data from maternity and A&E which are moving / have moved to new electronic patient record systems.

Keep Well checks are used to identify people who may be more disadvantaged or vulnerable, and need an ABI.

Employability / Unemployment

It is well documented that being in employment is good for an individual's mental health. More recently Van Der Noort et al undertook a systematic review of prospective studies on the health effects of employment.[57] They concluded that employment is beneficial for health, in particular for depression and general mental health.

In Shetland an Employability pathway has been established to support people into employment. It has 5 stages and is in line with the national model (see below). Both national and local employability agencies operate within the pathway, as well as other support services. Each agency has a clear understanding of their role within the pathway and uses a case management approach where support is delivered in line with an individual's goals.

[57] Van Der Noordt, M et al. Health effects of employment: a systematic review of prospective studies. *Occupational and Environmental Medicine* 2013. Available on line at: http://oem.bmj.com/content/early/2014/02/20/oemed-2013-101891

Employability Pathway Working Group

The **Employability Pathway Working Group** is the local strategic group tasked with overseeing the operation of the pathway and keeping abreast of national and local developments. We are core members of this group and recently Elsbeth Clark was nominated as the Vice-Chair. Although the pathway has been used successfully and is robust in nature, there is still room for a pre-pathway step, involving keeping people in employment so that they never need stage one of the pathway.

Fit for Work

As part of the Employability Pathway we have promoted the Fit for Work service. This service aims to:

- support people to reduce the length of sickness absence
- reduce the chances of people falling out-of-work and on to benefits
- increase awareness of the benefits of working to a person's health
- increase the positive actions taken by employers, employees and GPs in contributing to a change in attitudes towards health and work.

We do need to promote this service further, as uptake hasn't been high, and there would be definite benefits from employers, GPs, and staff members working together to help people to stay in work where possible.

As the website states: 'There's a very strong evidence base for sickness absence that shows that the sooner the causes of absence are identified, and acted upon, the better. Intervention at four weeks, compared to six months, has a greater impact as an employee is more likely to still have an attachment to work. The longer an employee is off work, the lower their chances of ever returning to work.'

Condition Management Programme (CMP)

Early in 2015 we were successful at bidding for funding from the European Structural Fund to set up and deliver a **Condition Management Programme**, in partnership with **Job Centre Plus** and as part of **Shetland's Employability Pathway**.

The purpose of the CMP is to provide intensive support to clients to overcome barriers to work. An Occupational Therapist was employed, to support 15 unemployed people into work experience, paid employment, volunteering and other non paid opportunities.

Robust referral and monitoring and reporting systems were developed in order to be able to measure effective outcomes. 16 individuals were supported through the programme.

In addition to the one to one work the CMP practitioner also delivered a **reading for well being group**. The group was held over 10 weeks from November 2015 as a pilot. It took place at the Old Library and was facilitated by Eleanor Bartlett and Jim Taylor. Referrals for this closed group were received from the Community Mental Health Team (CMHT), Substance Misuse Recovery Service (SMRS) and the employability pathway.

The group was based on the work of the Reader Organisation, with a focus on the shared process of reading. The concept is not a 'book club' or a literacy class. Reading has a surprising number of health benefits and can support in the recovery of mental and physical illness. It is an excellent form of relaxation and research has demonstrated that just six minutes may be enough to reduce stress levels by more than two thirds.

Shared reading and reading aloud may be helpful for people who are socially isolated, lack confidence, have poor communication/interaction skills, limited concentration and poor motivation. Attending a group can add structure and purpose to daily routine (which those experiencing mental problems often lack), and the group itself provides a safe environment to reflect on difficult feelings in a productive manner (using the text theme or character to gain insight into oneself).

The group attendance ranged from three to five consistent attendees, all male. A variety of material was read, mainly short stories, but also a few poems too. The group put forward suggestions of authors, genres and themes, and the facilitators located texts to meet these requests. Members were encouraged to read aloud a segment of the story/poem, although

there was no pressure to do so. An informal discussion was held at the end of each reading to reflect on the text.

Feedbacks forms were completed with positive responses. Participants generally felt that the group improved their mood and that they found the experience relaxing. If another group was to run, all stated that they would be interested in attending again. People felt that the sessions gave them something to 'get up and out of the house for' therefore adding a motivating factor, which is important for those struggling with low mood.

Plans for 2016-17

- Development of a **Weight Management Programme** and pathways for those with BMI of 35 or greater, or BMI of 30 plus other health conditions.
- Staff training in **Behavioural Activation** and **Motivational Interviewing**
- Further develop **Alcohol Brief Intervention** programme as part of Tier 1 and 2 Alcohol support programme, with clear referral routes into the Substance Misuse Recovery Service.
- Development of **Condition Management Programme** to support people currently in employment but vulnerable to job loss due to health or social issues.
- Promote and develop referral pathways into **Fit for Work** service.

4 Encouraging environmental measures to improve health

Healthy Working Lives

The Scottish Centre for Healthy Working Lives is a national organisation that provides information and support to promote health in the workplace. They have a web-site and telephone helpline and offer a range of training. They run the Healthy Working Lives Award programme consisting of a bronze, silver and gold award levels aimed at promoting health in the workplace. Health Improvement has supported organisations to achieve these awards over the last 10 years. The majority of workplaces which hold the award are those with a large number of employees and we are working to create a simpler programme which incorporates Keep Well (or Wellbeing checks), and is more appropriate for smaller organisations, but with the same aims as the national programme. A design is in place and is currently being piloted.

Training with workplaces

Mental health for managers is a one-day training course developed by the Scottish Centre for Health Working Lives (SCHWL) in partnership with the Scottish Development Centre for Mental Health (SDCM). We focus particularly on mental health for managers because the need for good mental health and wellbeing is so universal and linked to so many other aspects of work. The training is designed to encourage good practice in promoting positive mental health and well-being, thereby contributing to a more open culture that puts mental health on the agenda alongside physical health, social inclusion and productivity.

Over the past year 21 supervisors/managers from the Shetland Islands Council have been trained. Participants reported that they felt the course had equipped them with tools to help talk to staff who they were concerned about as well as giving them a better understanding of mental health in general.

The need for Mental Health for Managers training amongst NHS staff has been raised through the **NHS Shetland Health and Safety Committee** and a commitment to this is now in place board-wide. The first session is due to take place at the end of October 2016.

Housing

The Public Health team have been involved in the Housing Joint Strategic Needs Assessment for Older People in Shetland, thinking about how we can join up assessment processes e.g. medical housing points, or use health improvement skills to avoid expensive adaptations to properties: for example in delivery of weight management services before housing adaptations are required.

Active Travel

There is plenty of research to say that Active Travel is one of the most successful ways of improving health, through building physical activity into people's day to day lives. Increasing the number of people who choose to walk or cycle instead of taking the car, where practical, is a key strand of the **Shetland Active Lives Strategy**. Staff highlighted a funding opportunity for a feasibility study for active travel hubs; this resulted in the establishment of a **Shetland Active Travel Group** and an application being submitted, led by Zetrans, which has been successful. As members of this group we are helping to progress the project. This is a useful example of the role that Health Improvement plays in initiating actions which can then be taken on by other relevant bodies.

We have taken a lead in working towards **Cycle Friendly Employer Status** for NHS Shetland Gilbert Bain site, which allows access to a small pot of funding. An assessment was undertaken in May of this year and there is one outstanding action to be achieved before status can be achieved. In addition we actively promote the cycle friendly employer award to businesses we work with.

Plans for 2016-17

- Evaluation of the **Mental Health for Managers** training programme is done through electronic survey and is undertaken by the national Healthy Working Lives team. This is carried out immediately after the training and 6 months post training. The programme evaluates well, but we haven't yet looked at the longer term impact of it. Does it really lead to change in attitudes in the workforce and to sustained changes in how mental health issues are managed? Over the next two years we plan to apply a Return on Investment assessment to the training in order to identify the long-term benefits of the training and decide whether to continue to deliver the training or to look at alternatives.

- Contribute to Active Travel Feasibility study (Low Carbon Travel and Transport Fund, Transport Scotland)
- Continue lobbying to increase opportunities for active travel and reductions in the availability and accessibility of sugar-laden foodstuffs, particularly in public service organisations.

5 Incorporating community development approaches, so that communities are empowered

We are in the early days of developing asset based approaches within communities in Shetland. Often the tradition is to identify needs and then try to find ways to fill these needs in order to tackle health inequalities. Applying an asset based approach, on the other hand, involves identifying what assets there are in a community and building on these. Current cuts in public services make it even more imperative to look at the asset based approach in order to make full use of all resources at our disposal. Asset based approaches are not a replacement for investment in services or for addressing the structural causes of health inequalities, but they can reduce demand on services in the long term and bring about more effective services.

Although every person has health assets to offer they are often not taken advantage of. Asset based approaches uncover the knowledge, skills, connections and potential in a community. This in turn increases capacity, connectedness and social capital.[58] Marmot[59] takes this a stage further by suggesting the use of an asset based approach in order to implement effective strategies for reducing health inequalities focusing on:

- Inequalities in being well and well being rather than mortality as a measure of health inequality
- Disability free life expectancy instead of mortality – i.e. those who suffer health inequalities are more likely to have shorter-lives compounded further by disability.
- Tackling the causes of the causes
- Implementation of proportionate universalism – delivery on health should be universal but to scale in terms of disadvantage levels
- The importance of mental health and stress and personal and community resilience on physical and health and life chances, individual control and social support
- Strengthening the role and impact of ill health prevention

[58] McLean J. *Asset Based Approaches for Health Improvement: Redressing the Balance* Glasgow: Centre for Population Health Glasgow, 2011.

[59] Marmot M., *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*. London: The Marmot Review, 2010.

- Create and develop sustainable communities that foster health and well-being, ensure social justice and mitigate climate change.

Community Health Walks

Two years ago health improvement organised for walk leaders training funded through **Paths for All** to come up to Shetland. As a result of this walks have been held in a six geographical areas across Shetland and in one workplace. Two of these groups meet regularly and are run by a workplace and a community. The remaining four groups were led by us but have been difficult to maintain long term due to capacity.

In recognition of the latter we have recently successfully applied for **Paths for All** funding to increase our capacity to make the health walks more sustainable. The aim is to have trainers within Shetland who can secure the continued roll-out of health walks and related programmes. The project involves the co-ordination and further development of walking projects already in existence in Shetland, with a firm focus on integration across NHS, Local Authority and Third Sector Partners. Core to this will be to recruit more volunteer walk leaders and establish health walks in communities and led by communities where they are not taking place in Shetland on a regular basis. This includes targeting inequalities groups and linking in with **Community Sports Hubs**, whilst also tying in with the physical activity brief advice pathway. Clear outcome measures have been set for the project which will be rolled out over the next two years.

The attempt by a local group of parents to take ownership of the empty Quarff school building and turn it into an active play area is a great example of community empowerment, even though in this case it was ultimately unsuccessful. Public health and health improvement are often not directly involved in this work, but very much support the approach and would be happy to offer support.

Plans for 2016-17

In line with the Board Strategic Plan, to implement an asset based approach to health care and prevention. This will be a multi-dimensional cross cutting project to include: self care and self-management, realistic medicine and frequent attenders.

6 Developing people's personal skills by enabling them to identify their own needs and involving them in planning and evaluation processes

One of the roles of health improvement is to identify those whose voices aren't being heard and help them to be heard, through advocacy, inclusiveness and a bottom up approach, in line with Derek Wanless' 'Fully Engaged Scenario' where 'levels of public engagement in relation to their health are high' and 'the health service is responsive'. [60] The Shetland Mental Health Forum is a great example of this type of approach being taken forward.

Mental Health Forum

We lead the **Mental Health Forum** for Shetland. The Forum has membership from carers, service- users and from a range of mental health related services and agencies. The forum has a varied role ranging from promotion of mental wellbeing and reducing stigma to putting forward ideas for change in current services and in some cases actioning these.

In the past year this group has:

- Developed an engagement and communication framework to help people understand the ways that they can be involved in influencing mental health services.
- Updated the group role, remit and membership in order to strengthen its networking capacity.
- Increased membership to approximately 20 active members
- Successfully applied for funding for **Triangle of Care** training, organised and held the training and are now working through an action to implement this. (Triangle of Care is a set of 6 key standards developed by the Carers Trust for building a therapeutic alliance between carers, service users and professionals, to enhance partnership working within mental health services).

[60] Wanless D. *Securing our future health: Taking a long-term view* London: Public Enquiry Unit, 2002.

- Developed a multi-agency **Mental Health Awareness Month** campaign due to be held in October 2016.

Carers of people with mental health problems have particularly welcomed the opportunities to be involved in shaping and developing mental health services. The challenge, of course, is to ensure that the service improvements required are seen through. There are huge opportunities to build on this successful model, though some clinicians can find it a challenging approach. Although this particular piece of work isn't solely the responsibility of Health improvement, the value of involving patients and carers in developing care pathways, and patient information, for example, is immense, and also contributes to increases in effective self management and potentially fewer crises.

Plans for 2016/17

- Complete a scoping exercise on all mental health services available to Shetland residents and their carers in order to better inform the public (due to be finished by the end of March 2017).
- Work alongside **Drink Better** to tackle the stigma surrounding mental health and alcohol plans are currently in the early stages.

7 Encouraging appropriate service utilisation, including screening and immunisation services

Detect Cancer Early (DCE)

The aim of the national Detect Cancer Early programme is to diagnose cancers at an earlier stage (Stage 1) so that treatment outcomes are better, compared to when the diagnosis is made at a later stage. The percentage of breast, bowel and lung cancers that were diagnosed as Stage 1 in the two year period January 2014- December 2015 was low at 16.9% (15 patients); compared to 25.1% for the whole of Scotland. This figure has not varied much over the four years of the DCE campaign, ranging from 15.6% to 19.3%. Our target has been 29% (a 25% increase in the baseline, which equates to six more people being diagnosed at Stage 1 rather than a later stage).

The factors that influence this figure include completeness and accuracy of the data; screening rates; presentation at the GP; GP referral rates and waiting times for secondary care appointments and diagnostics. We are reliant on NHS Grampian for much of our data capture, and are working with the teams there to ensure the accuracy and completeness.

There is no screening programme for lung cancer and the current advice for people to visit their GP after three weeks of a cough is difficult to manage given the prevalence of non-specific viral infections, especially in the winter.

The national DCE campaigns do not seem to have made much difference to the figures in Shetland by encouraging people to present earlier with symptoms, although with the very small numbers involved it can be difficult to interpret. However we will continue to promote national awareness raising campaigns for breast, bowel and lung cancer. Publicity materials are widely distributed across Shetland with the aim of reaching all communities, especially the most remote and rural, and ensuring that the materials are available in a variety of settings including local rural shops and post offices, leisure centres and public halls. Other national campaigns to promote early detection of cancer are promoted locally; for example oral cancer week is promoted annually, including free checks at dental surgeries.

There has also been work with community pharmacists and other community based practitioners to identify people with potential cancer trigger symptoms who are using these

services e.g. following medications reviews. Once patients present to their GP, our GP referral rates are amongst the highest in Scotland, so low GP referrals does not seem to be a specific issue.

There are no significant delays for cancer diagnostics and even if there were, one or two weeks is unlikely to make any difference to the stage of the cancer, particularly if the patient has waited two years before going to their GP. At the beginning of the programme we reviewed our capacity for any increase in clinical workload, and used some of the non-recurrent allocations for diagnostic equipment.

Looking at the breakdown of cancers detected at Stage 1 in the two year period 2014-2015:

- 26.9% of breast cancers were stage 1. This is much lower than other areas (40.5% across Scotland) but can be explained by no breast screening during this period.
- 11.8% of bowel cancers (4 people) were Stage 1. This is lower than Scotland (15.4%) but slightly higher than our neighbouring Boards, Grampian and Orkney.
- 13.8 % of lung cancers (4 people) were Stage 1. This is lower than Scotland (17.9%), but again slightly higher than Grampian (12.1%).[61]

The number of cancers where the staging is not known can make a significant difference to the figures, especially where the numbers are so small. For Shetland, the staging was recorded for all lung cancers, and for all but one bowel cancer (compared to 4.8% and 9.8% for Scotland). However for breast cancer, with Shetland residents the staging was not known for 15.4% of cancers (four patients) compared with 3.0% for Scotland.

In order to identify if there is any more than can be done to encourage patients in Shetland to present earlier with symptoms potentially consistent with cancer, we are conducting a retrospective audit of late presenting cancers.

Screening

The national population based screening programmes for adults are for breast cancer; bowel cancer; cervical cancer and abdominal aortic aneurysm. There also a range of

[61] Source: Information Services Division (ISD) National Services Scotland

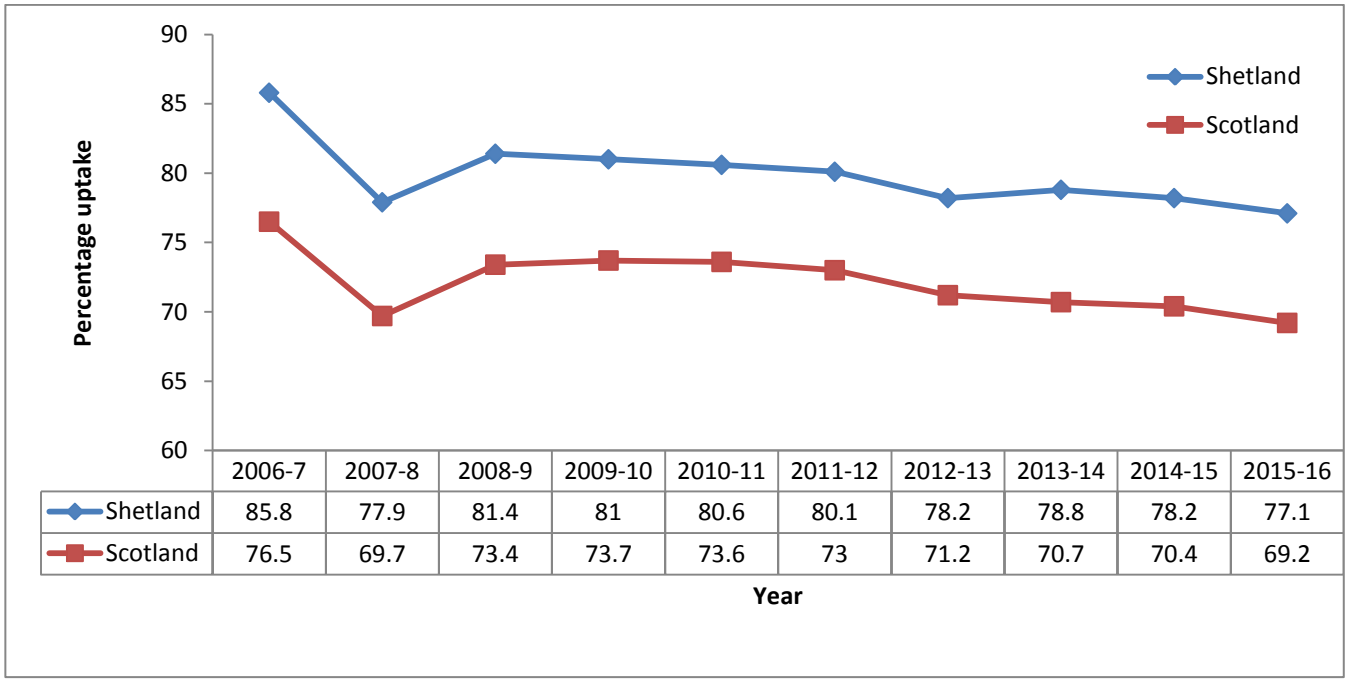
antenatal and neonatal screening programmes which are offered to pregnant women and their babies; and childhood screening programmes including vision testing.

The **cervical screening programme** has been in place nationally since 1988. Cervical screening is designed to detect pre-cancerous changes in the cells sampled from the cervix (the neck of the womb). This is known as 'cervical intraepithelial neoplasia' (CIN) and can be effectively treated to prevent cervical cancer developing. The 'smear test' is the process of sampling the cells and is usually carried out at the woman's own GP practice, by the practice nurse or GP.

Up until June 2016, cervical screening was offered to all women aged between 20 and 60 years in Shetland every three years, as in the rest of Scotland, with over 1,800 women in Shetland screened every year. The only women who are not offered screening are those who have had a total hysterectomy. This applies to about 6% of Shetland women. Following a review of the evidence of effectiveness of the programme, the age range has now changed to 25 to 64 years of age. Women aged 25 to 49 continuing to be screened every three years, and those aged 50 to 64 being screened every five years.

Figure 2.1 Uptake of Cervical Screening

(Percentage of women aged 20-60 who have had a screening test in previous 3.5 years)



	2006-7	2007-8	2008-9	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Shetland	85.8	77.9	81.4	81	80.6	80.1	78.2	78.8	78.2	77.1
Scotland	76.5	69.7	73.4	73.7	73.6	73	71.2	70.7	70.4	69.2

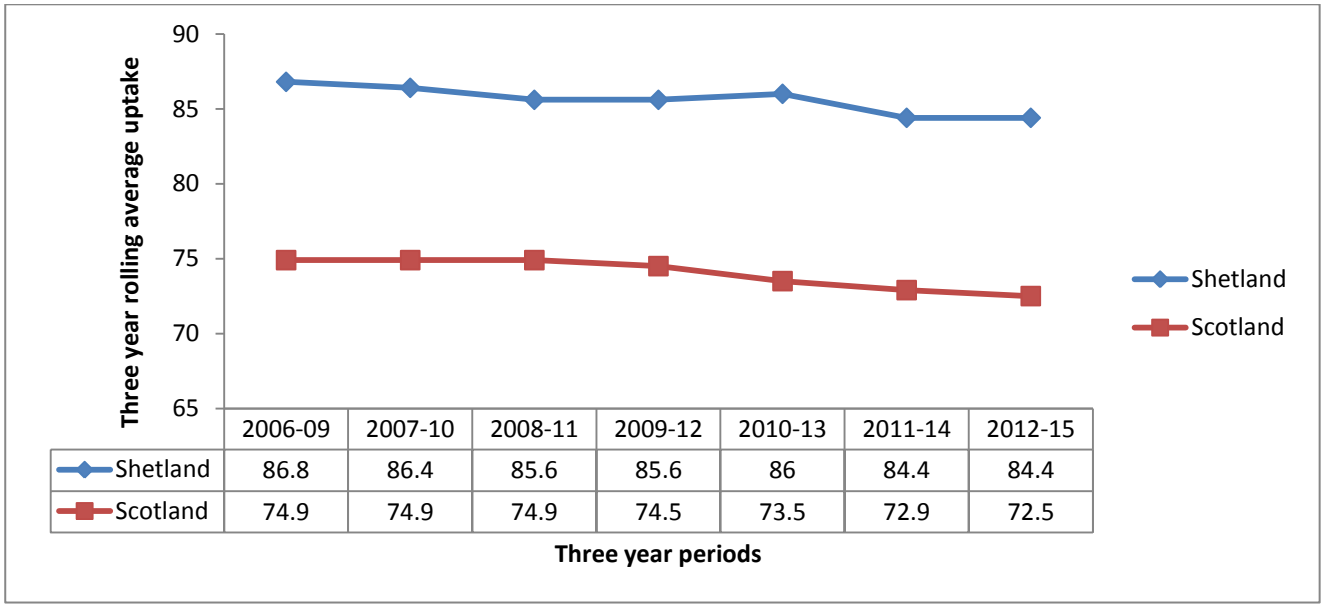
Source: Information Services Division (ISD) National Services Scotland

The chart above shows that Shetland has a consistently higher uptake compared to the rest of Scotland, currently the highest in Scotland. However, the uptake rate has been dropping in Shetland, as in the rest of Scotland over the past 10 years. We are now below the target of 80% uptake. This is despite ongoing campaigns to encourage women to take up their screening invitation. We know that the drop is mostly in the younger age group. This may, at least in part, be due to the introduction of the HPV immunisation campaign which protects women against a virus that causes cervical cancer; young women may think they do not need smears if they have had the vaccine. However it does not protect against all the strains of HPV that cause cancer so women still need to go for smear tests.

The Scottish **Breast Screening programme** invites all women between 50 and 70 years old for breast screening every three years. All women should receive their first invitation by the age of 53. Women aged over 70 are not sent an invitation but are still welcome to make an appointment to attend for screening. The programme in Shetland is delivered in conjunction with NHS Grampian and a mobile breast screening unit comes up to Shetland every three years. The screening consists of having a mammography (like an x-ray) of the breasts. If there is any abnormality seen on the mammogram, the woman is referred for further investigation.

Figure 2.2 Uptake of Breast Screening

(Percentage of women aged 50-70 who have been screened in each three year period)



	2006-09	2007-10	2008-11	2009-12	2010-13	2011-14	2012-15
Shetland	86.8	86.4	85.6	85.6	86	84.4	84.4
Scotland	74.9	74.9	74.9	74.5	73.5	72.9	72.5

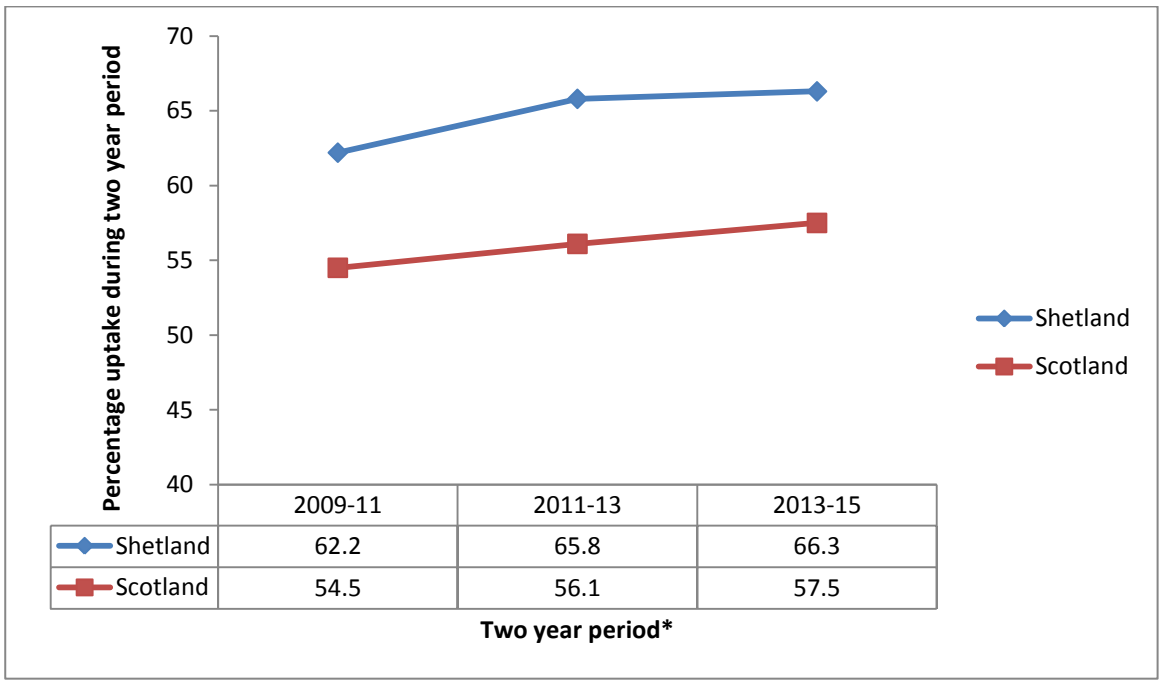
Source: Information Services Division (ISD) National Services Scotland

The chart above shows that, like the other screening programmes, we have a high uptake of breast screening in Scotland, consistently higher than the rest of Scotland, and usually the highest in Scotland. Howe, like cervical screening, there has been a gradual slight reduction in uptake since 2008, more marked in Scotland as a whole than in Shetland. However, uptake rates are still above the target of 70%.

The **National Colorectal (Bowel) Cancer Screening Programme** was introduced in Scotland in 2007 and rolled out by NHS Board, with NHS Shetland starting in October 2009. Men and women aged 50-74 are invited every two years to take part in the screening using a test kit that is posted out, completed at home and returned to the National Screening Centre in Dundee. The test (called the 'FOB' test) looks for evidence of blood in the faeces, which can be a sign of bowel cancer. If blood is found then the patient is invited to attend for a further investigation, a colonoscopy, at the Gilbert Bain Hospital.

Figure 2.3 Uptake of Bowel Screening

(Percentage of adults aged 50-70 invited during each two year period, who have been screened.)



	2009-11	2011-13	2013-15
Shetland	62.2	65.8	66.3
Scotland	54.5	56.1	57.5

Source: Information Services Division (ISD) National Services Scotland

*each two year period runs from November to October.

The chart shows that the uptake of bowel screening in Shetland is higher than the rest of Scotland and is gradually increasing. It has consistently been the highest in Scotland since the programme started, and exceeds the target of 60%. The figures below show the difference in uptake between men and women in Shetland, with women having a higher uptake; a similar pattern to Scotland as a whole.

Table 2.1 Uptake of Bowel Cancer screening in Shetland and Scotland 2009-15 by gender

	2009-11	**2011-13**	**2013-15**
Men	57.3%	62.2%	62.8%
Women	67.4%	69.6%	70.0%
Total	62.2%	65.8%	66.3%

Source: Information Services Division (ISD) National Services Scotland

A screening programme for **Abdominal Aortic Aneurysms (AAA**) for men aged 65 was implemented in Scotland through a phased rollout from June 2012. NHS Shetland started screening in October 2012 and by November 2013 all NHS Boards were participating. An AAA is a swelling of the aorta, the main artery in the body, as it passes through the abdomen. As some people get older, the wall of the aorta in the abdomen can become weak and balloon out to form an aneurysm. The condition is most common in men aged 65 and over and usually there are no symptoms. Large aneurysms are uncommon but can be very serious. As the wall of the aorta stretches, it becomes weaker, and it can rupture (burst). If the aneurysm ruptures, this leads to life-threatening internal bleeding and, in 8 out of 10 cases, death. The Scottish AAA screening programme aims to reduce deaths associated with the risk of aneurysm rupture in men aged 65 and over by identifying aneurysms early so that they can be monitored or treated. The screening test is a simple ultrasound scan of the abdomen. Men aged 65 are invited to attend AAA screening and men aged over 65 can self-refer into the screening programme. Most men have a normal result and are discharged from the screening programme. Men with detected small or medium aneurysms are invited for regular surveillance screening to check the size of the aneurysm. Men with large aneurysms are referred to vascular specialist services.

Because the programme was only fully implemented in 2013, there has only been one set of uptake figures published to date. These show that in Shetland between October 2012 and March 2014, 414 men were eligible to be screened; 414 were invited and 376 were screened, giving an uptake of 90.8%. This was the highest in Scotland, with the Scottish average being 85.8%.[62]

Out of the 376 men screened, six aneurysms were detected; four small and two medium sized, these men are not on annual or quarterly recall for repeat surveillance scans.

Immunisation

Immunisation is one of the key public health measures to prevent infection and illness and death due to infectious disease. In Scotland, as in the rest of the UK, there are a number of national immunisation programmes including the childhood immunisation programme and the annual influenza vaccination programme for over 65s and pneumococcal and shingles vaccinations for older people. There are also a number of selective programmes which are targeted at groups or individuals at increased risk of certain infections such as TB and hepatitis B.

The Board's Vaccination and Immunisation Group meets regularly and reports to the Control of Infection Committee on uptake rates, and on local actions to improve uptake and comply with national policy. 2015-16 was again a busy year with further changes to the childhood programme, including the introduction of a meningitis B vaccine for babies for the first time and a rapidly implemented programme to immunise teenagers against Meningitis W in response to a UK wide increase in the number of cases. In addition, the implementation of the shingles programme for 70 year olds continued, with the second year of a catch up programme. And this was the second year of the implementation of the extension to the seasonal flu programme to include preschool and primary school aged children, using the new live nasal flu vaccine.

Also of note last year was the ongoing low uptake of MMR, although there is a gradual trend to children receiving their first MMR earlier and the uptake rates are slowly improving. There is still also a relatively low rate of uptake of the pre-school booster by

[62] Source: Information Services Division (ISD) National Services Scotland

age of school entry which is being addressed through the Vacc & Imm Group and individual practices.

There is an active training programme for staff involved in delivering the immunisation programmes. 13 staff are currently registered and actively working on the online training course 'Promoting Effective Immunisation Practice.' Two practice nurses completed the whole course in 2015-16; and two completed the theory elements. 12 staff attended one of the local annual immunisation update training sessions held in June 2015.

Uptake Rates

Uptake of vaccine is measured at certain ages: the uptake is the percentage of children who reach a specified age during a specified time period (a 'cohort') who have had their vaccines. The target we are always trying to reach for any cohort and any individual vaccine is 95%; this is the level at which the virus or bacteria cannot easily spread in the community and we have a 'herd immunity' effect even though not every person is immunised.

Childhood programme

The table below shows that over 95% of babies had their primary immunisations by age one year. Slightly less had rotavirus vaccine, however if this is not given by age 6 months the it is not given at all because of potential complications in older infants. Similarly, over 95% of children reaching age of two had had their primary immunisations, but less had received their 12/13 month jabs: just over 90% for the Hib / Men C and PCV boosters and less than 90% for the first dose of MMR.

Within the group of children who reached the age of five in 2015-16; although over 95% had received their primary immunisations as a baby, only 81.2% had received their pre-school booster which should have been given at the age of three years four months (40 months). Similarly, 95.2% had received their 1st dose of MMR, but only 81.5% had received the second dose which should have been given at 40 months.

There is an increase in these figures between five and six year olds. This is likely to be because in the first year of primary school, children have a P1 health check when immunisation status is checked and they are reminded to get any outstanding

immunisations. However it means that around 20% of children are starting school not fully immunised and therefore there is no herd immunity in this group

Uptake rates for April 2015 – March 2016

Age group	Number of children	Rota-virus	DTaP/ IPV/Hib	DTaP /IPV booster	MenC	Hib / MenC booster	PCV	PCV booster	MMR 1st dose	MMR 2nd dose
Children reaching age 12 months	251	92.4%	95.6%	-	98.0%	-	95.2%	-	-	-
Children reaching age 24 months	251	-	96.0%	-	-	91.6%	-	91.6%	88.8%	-
Children reaching age of 5 years	271	-	95.6%	81.2%	-	92.3%	-	-	95.2%	81.5%
Children reaching age of 6 years	287	-	-	91.6%	-	-	-	-	93.7%	91.6%

Source: Information Services Division (ISD) National Services Scotland

Rotavirus. Given at 2 and 4 months: not given after age 6 months

DTaP/IPV (diptheria, tetanus, pertussis (whooping cough), polio) Given at 2,3,4 months and booster at 40 months

Hib (haemophilus influenza b) Given at 2,3,4 months and booster at 12/13 months

Men C (meningitis C) Given at 3 months and booster at 12/13 months

PCV (pneumococcal). Given at 2 and 4 months and booster at 12/13 month: not given after age 2

MMR (measles, mumps and rubella) Given at 12/13 months and second dose at 40 months

MenB *(meningitis B) Given at 2 and 4 months and a booster at 12/13 months. Started in September 2015 therefore not yet included in uptake figures*

The school based **Human Papilloma Virus (HPV) Immunisation programme** aims to immunisation teenage girls to protect them against HPV which causes cervical cancer. The vaccine is given in school during the spring term: Secondary 1 girls get their first dose

and Secondary 2 girls get their second dose. In 2015, 82.8% of girls in S1 received their first dose of the vaccine and 83.9% of girls in S2 received their second dose.

The **shingles vaccine programme** is to immunise people aged 70 against the herpes zoster virus that causes shingles. The programme started in 2013 and the vaccine is offered each year to anyone that is aged 70 in the September of that year. For the first few years of the programme, there has also been a catch up to immunise others aged 71 to 79. The uptake is measured from September to August each year. In 2014-15, 218 people aged 70 received the vaccine (54.1%) with an additional 161 as part of the catch up programme. For the period September 2015 to July 2016, 235 70 year olds have received the vaccine (66.4%) plus an additional 465 people as part of the catch up.[63]

The **flu immunisation programme** runs each year in the autumn, and individuals at risk of flu are offered a vaccine each year because the flu viruses that are circulating change and so the flu vaccine has to be changed in response. People in Shetland aged 65 and over, pregnant women and other younger people considered to be at high risk if they catch 'flu, are offered the vaccine. For the last two years, all pre-school children aged 2 to 5 years and all primary school aged children are also being offered the vaccination. Most of them will be able to have the nasal spray (Fluenz Tetra) instead of a jab, as will most secondary school aged children in the high risk groups. The nasal spray is more effective than the injection at preventing 'flu in children.

In 2015-16, 72.6% of over 65s in Shetland had flu vaccine (the target is 75%); 49.2% of under 65s in risk groups; 60% of pregnant women; 63% of pre-school children (target is 60%) and 75.9% of primary school children (target is 75%).

Healthcare workers, social care staff and unpaid carers are also urged to have the vaccine. Last year 45.2% of frontline healthcare staff in Shetland had the vaccine; and 59.1% of unpaid carers.

This information has been extracted from GP records; local school health and occupational health data.

[63] Source: Information Services Division (ISD) National Services Scotland

Health Needs Assessments

Conducting health needs assessment is a core part of health improvement business in order to identify and address health need. A **Black and Minority Ethnic Group Health Needs Assessment** is currently being undertaken. This was last done between 2003 and 2005. To take one example, we don't see many people from ethnic minority backgrounds accessing our stop smoking service. Research tells us that there are particular ethnic groups where smoking tends to be more common[64]; so are folk in Shetland different? Do they not smoke, or do they smoke and not want to stop, or do they smoke and want to stop smoking but find accessing support difficult?

The aim of the health needs assessment is to better understand the needs of this community in Shetland and to ensure that our services are accessible and appropriate for them.

Plans for 2016-17

- Audit of people who present with advanced cancers (Detect Cancer Early)
- Local implementation of national DCE awareness raising programmes
- The breast screening unit is in Shetland from April until September 2016: there will be local publicity to encourage women to attend.
- The age range for cervical screening changes in June 2016: there will be local publicity about the change along with continued awareness raising around cervical cancer screening.
- There will be continued implementation of the AA screening programme, including visiting screeners from NHS Grampian to cover maternity leave.
- We will work with the Maternity Department and Child Health to collate data on the antenatal, neonatal and childhood screening programmes to present next year.
- Further local campaign on MMR at age 12/13 months and pre-school – with a focus on nursery and other pre-school settings.

[64] ASH Scotland. *Tobacco Use and Minority Ethnic Groups.* Edinburgh; ASH, 2008.

- Implementation of annual flu vaccination campaign, aiming to increase uptake rates particularly amongst at risk adults and healthcare staff
- Rollout of SIRS (Scottish Immunisation Recall System) for inviting children for their vaccinations into every practice (currently used by two).
- Development of a specific project to identify and work with frequent primary care attenders, promoting self management
- Development of specific self management programmes
- Black and minority ethnic group Health Needs Assessment

8 Delivering health information and education, including the use of social marketing techniques

Within the schools we deliver health education sessions from early years and childcare (nursery) up to secondary. These come in a variety of forms; however each will cover diet, physical activity and mental health. In the nursery sessions this is delivered in the form of play and relaxation, looking at portion size and storytelling; up through the school years the sessions are adapted to suit the age and range of children. One to one sessions have also been arranged in the Secondary age where a concern may be raised as part of GIRFEC (Getting It Right for Every Child) and support can be arranged for the individual and families as part of meeting the child's outcomes.

We have continued to link into the local nurseries and schools to deliver sessions on eating well, active play and offered support to families who are struggling with weight issues. Further training has been delivered to the Midwifery team responsible for weight management at both fertility and during pregnancy. This has resulted in better links made with mothers and families once they are discharged back into the community, and support being offered beyond the period of pregnancy.

Health Information campaigns and promotions

We gained external funding two years ago to develop a web-site which is updated with information on a regular basis. Four main campaigns are chosen through the year and focused on. The team have also worked up a quarterly newsletter and tweet daily.

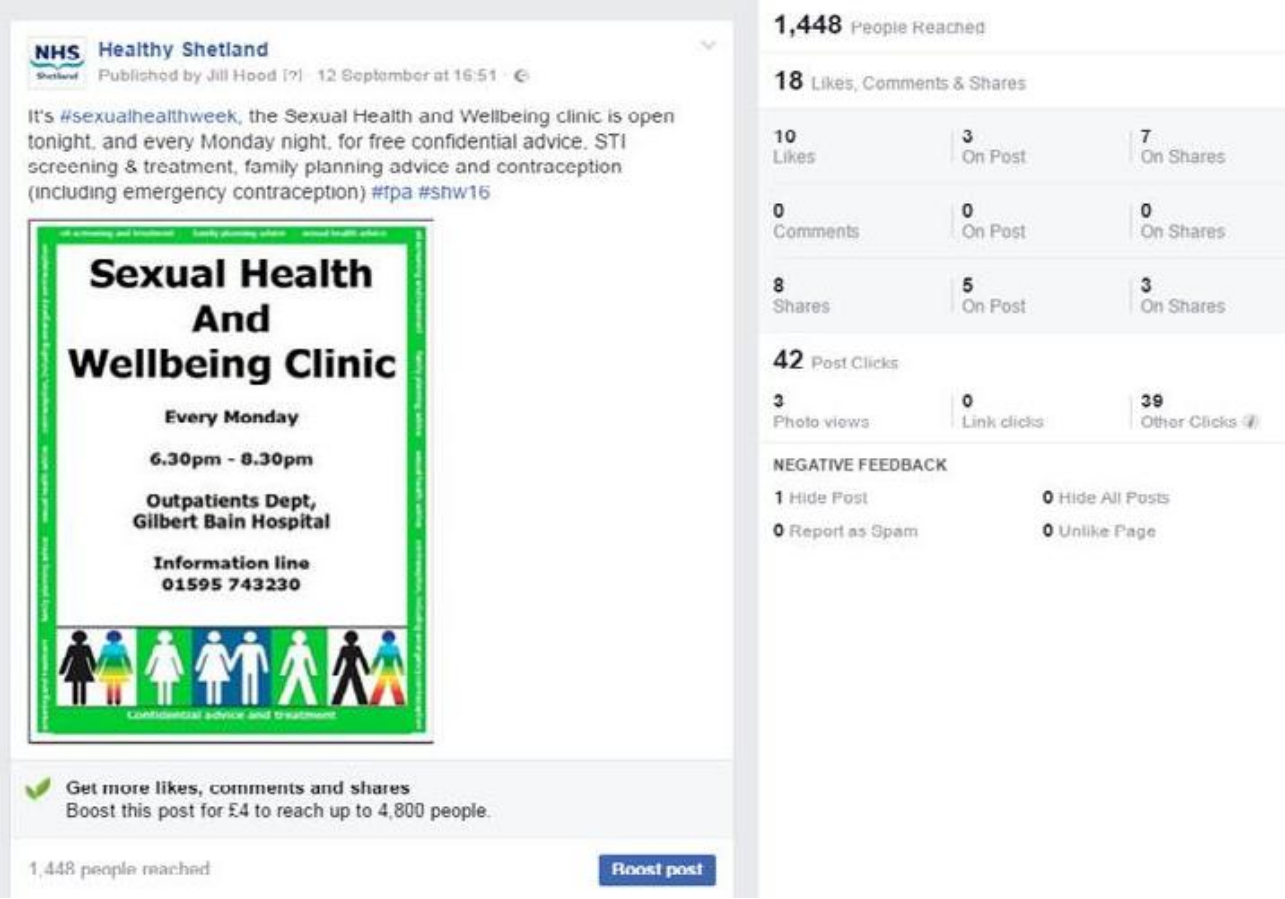
Twitter: We have 171 followers (this is a combination of other organisations and individual people).

Facebook: We have 688 likes on our page.

Our post reach (how many folk actually see it) varies quite a lot but overall posts with images perform much better. Our most successful recently was the revised sexual health clinic poster which was seen by 1,488 people and had been 'liked' 10 times and 'shared' 8 times.

Most of our facebook followers are women aged 25-34. We can use this to target our posts. We also know that more of the people who like our page are online in the evenings

so it's a good idea for us to use the 'schedule' button so that our posts can appear at the times when more of these people are using facebook.



Drink Better

Drink Better is a social marketing approach to tackling the culture of alcohol misuse in Shetland. It is based on a model developed in Quebec, and we have adapted the approach to fit the Shetland context. It is described in more detail in Part I of the Public Health Annual Report.

Schools: a presence in all high schools

The **School Nursing Plan for Scotland** requires a 'drop-in' facility to be available in secondary schools; this doesn't necessarily have to be provided by the school nurse, and at present the health improvement team are providing this role, with plans for school nursing to take it back on in the future. The **Curriculum for Excellence Health and**

Wellbeing outcomes raised the profile of health within education, but schools still feel there is merit in external agencies supporting the delivery of elements of the curriculum.

Current situation:

- Unst: initial meeting held to commence fortnightly drop-in from Oct 2016
- Yell: Established fortnightly drop-in, education as requested in response to local identified need.
- Aith: Established fortnightly drop-in, education as requested in line with local identified need.
- Whalsay: Education as requested in response to local identified need
- Brae: Working alongside youth workers that are based there.
- Anderson High School: Working alongside youth workers that are based there.
- Sandwick: Established fortnightly drop-in, education as requested in response to local identified need.

To some extent it feels as if the concept of Health Promoting Schools has been lost since Curriculum for Excellence was developed; this sets out clear requirements for curricular context, as would be expected. However there are issues that we feel are missed, including healthy tuckshops (which Oral Health Promotion are leading a piece of work on) and mental health and wellbeing for children and young people.

Education and training

Health Improvement and Public Health have a wide-ranging role in supporting professionals, volunteers and members of the community in developing their own health improvement roles. The range of training that we deliver - often flexibly and on demand, is available here: www.healthyshetland.com/resources/training

Plans for 16/17

- Agree drop in arrangement in Whalsay School
- Undertake mental health and wellbeing needs assessment for children and young people: work with Integrated Children's Services to formulate plans for filling gaps.

- Work with education service to agree programme for supporting teaching staff in becoming more confident in delivering health related topics.
- Review and relaunch Drink Better Campaign with targeted marketing.

9 Tackling inequalities

We continue to play an active part through partnership work on achieving the healthier and fairer priorities in the Local Outcome Improvement Plan and we were actively involved in providing evidence to Shetland's Commission on Tackling Inequalities.

In Shetland we do not have some of the harder to reach groups such as prisoners and travellers. We do have relatively small numbers of people who are homeless, and these are generally accommodated in temporary accommodation rather than being on the street or in hostels. We have small immigrant populations and few non-English speakers. However, rurality and access is a major issue for us. In terms of socio-economic and remote and rural disadvantage, our **Keep Well** (previously Well North) programme targets and engages with those living in the most disadvantaged areas of Shetland and has been rolled out across all practices including those in the most remote and rural areas. The programme includes a health check (including uptake of screening), healthy lifestyle advice and referral for alcohol problems, smoking cessation and weight management. Our year-end target for Keep Well health checks was exceeded, and our local programme continues despite even larger than anticipated reductions in national funding. Evaluation shows that we are reaching people who often struggle to be engaged with services. Our success in helping people to stop smoking and lose weight is very much tied into this outreach approach.

We continue to implement our **Outcomes Focused Action Plan** to mitigate the unhelpful effects of Welfare Reform. This has included awareness raising for staff on welfare reform to enable staff to identify issues and signpost / refer patients (and themselves / colleagues) to services such as the Citizen's Advice Bureau (CAB) where appropriate. CAB has continued to provide an outreach service to GP practices, including those in remote and rural areas. In health settings, we are also promoting grant schemes to reduce fuel poverty.

The work of the Inequalities Commission and the subsequent *On Da Level* report and delivery plan has firmly focused attention on inequalities in Shetland. All areas for action are relevant to tackling the health inequalities agenda. The team have been involved in progressing actions from the plan in line with current work areas. In terms of health

inequalities the priority for health improvement and public health is to continue to support delivery on the implementation plan.

Vulnerable children and families

Work with vulnerable children and families aims not just to tackle current problems but to prevent patterns repeating in the future. The Life Model is a whole-family approach to supporting the most vulnerable and chaotic families within a community. It was created by services and families in Swindon in 2011.

The drivers for the change in developing a new approach were:

- Previous interventions, over the last 20 years, had not led to positive or long-term change for the families;
- The high cost of delivering services to these families (without substantial results); and
- The desire to move from a service intervention approach for individual family members to an outcome focused approach for the whole family (and extended family) and each person within that family.

The model was developed by living and working alongside families in Swindon. At an early stage it was determined that families need to develop their own solutions, and that, in order to do this, they need to develop high trust relationships with those working with them and repair relationships within their own family. A group of services within Shetland have been looking at developing this approach in Shetland, by using existing resources and re-shaping the way that we work to support the most vulnerable. However this is proving very difficult and other ways of using the key elements, without replicating the whole model are being explored.

Community Justice Partnership

The Government's vision for community justice is that Scotland is a safer, fairer and more inclusive nation where we:-

- prevent and reduce further offending by addressing its underlying causes
- safely and effectively manage and support those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all citizens.

The work to achieve this is to be carried out locally through the Community Justice Partnership which reports to the Community Planning Board. Inequality, exclusion and stigma are key issues for people currently and previously within the criminal justice system. By tackling these and other underlying causes of crime, the aim is to prevent repeat offending in the future. The Public Health team is part of the Partnership and involved in developing and implementing the local strategy.

Gender Based Violence

Nationally **Gender Based Violence** (GBV) is considered an issue of gender inequality with the new Violence Against Women Strategy reflecting that. Locally, although we recognise that GBV affects women disproportionately, we consider anyone who is affected by GBV as vulnerable, potentially isolated and disadvantaged. Domestic Abuse and other gender based violence services in Shetland are delivered by a number of organisations and departments within the Voluntary Sector, Shetland Islands Council, Police Scotland and NHS Shetland, which are overseen through the Shetland Domestic Abuse Partnership. Public health is currently leading on a health needs assessment and development of a '**Domestic Abuse and Sexual Violence Strategy'**.

Plans for 2016/17

- Continue to demonstrate the need for genuine multi-disciplinary and holistic support for vulnerable children and families which focuses on life circumstances and breaking the cycle.
- Re-prioritisation of health improvement activity in the context of continued reduced funding to ensure that health inequalities and prevention, in particular through delivery on the actions as set out in the *On Da Level* Implementation Plan.
- Completion of Domestic Abuse and Sexual Violence Strategy.

10 Targetted more: future work

Looking at the Health Map, there are obvious areas that we have not yet focused on and need to target more. We know that in terms of inequalities our work is firmly focused on delivery of the *On da level* implementation plan. In addition in line with Marmot Report on tackling health inequalities we need to further develop a community asset based approach. The move to working from localities has meant that we have been accessing people who are in greater need which again supports the health inequalities work. As a short-term measure this is proving effective in targeting people who are subject to health inequalities. By targeting our Keep Well checks we are again reaching this group. We achieve good outcomes in all the programmes that we deliver whilst meeting set targets. It is therefore important the direct delivery of programmes in localities and targeted Keep Well checks does not stop until an alternative mode of delivery, proven to be more or equally as effective is in place. However, in the longer-term services must be refocused and owned by communities and at public policy level as we know that this is where the greatest impact can be had in terms of public health.

All health staff have a role to play in tackling the wider determinants of health. In primary care, we still need to develop the capacity to do prevention, early intervention, supported self-management and anticipatory care effectively and as a core part of the service we deliver. As stated previously we know that this will pay dividends in terms of better health and quality of life, and reduce the demands on services in the longer term.

In secondary care we need to continue our work through MCNs and the wider workforce by helping staff see their role in health improvement, reinforcing the messages of the Health Promoting Health Service and 'Making Every Health Care Contact Count'. Everyone has a role to play, at times needing to step back to think about the causes of the causes, not merely treating the symptoms. Training staff in all areas of health and social care to deliver health improvement programmes, and brief advice is also required in order to increase capacity across all sectors as part of the longer-term plan, as well as recognition of and action on the wider determinants of health.

The integration agenda presents an opportunity for real joint working across sectors. The Unst **Otago Pilot Programme** which was supported by health improvement is an example

of a project which has relied on integrated working and we will use this as learning for future projects.

Over the next two years we need to work to ensure that we are influencing policy and strategy where we are not currently. We want to work with the following organisations to influence their agendas, to make them as positive and health promoting as possible. Health is everyone's business, and we need to work out what the specific arguments for specific settings would be in order to engage them fully. Critical partners include:

- Integrated Joint Board
- All Shetland Islands Council Executive Managers and Elected Members
- Third Sector
- Zetrans
- Economic Development
- Shetland Recreational Trust
- Shetland Charitable Trust
- Agriculture sector
- Shetland Arts
- Shetland Area Licensing Board

We know that delivering health improvement and public health goes far beyond the role of our teams. We know that health improvement is more than government targets. We have come a great way in targeting our services more but with the current economic position and the need to focus on prevention and early intervention becoming higher on the agenda it is even more imperative that the focus is maintained.

APPENDIX A

CCBT FIRST YEAR EVALUATION

The Computerised Cognitive Behavioural Therapy (CCBT) programme 'Beating the Blues' as part of a European Funded Project pilot. It consists of eight weekly one hour sessions done at weekly intervals and is designed for mild to moderate depression or anxiety. Health Improvement's role was to support people to start the programme and continue with it. NHS Shetland was the only board that delivered support alongside the programme in this way. A pathway and information sheet was developed to outline how the support should be delivered. The end of year evaluation has shown than Shetland performed well within Scotland in terms of completion rates: which has led to funding being extended by a further 12 months and includes an upgrade and update of the CCBT programme.

Shetland Data

The information below has been extracted from the Beating the Blues program.

Usage Data

Stage of Treatment	Patient Numbers
Started Treatment	208
Still Active in Treatment (active in last 4 weeks)*	87
Completed all 8 Sessions	43
Completed 5 Sessions (clinical dose)	60

Completion Rates

Completion rates are calculated only on those patients who are not currently active in the treatment. This equates to 121 patients.

Completion Point	Rate %
All 8 Sessions	36%
At least 5 Sessions (clinical dose)	50%

These numbers are comparable with face-to-face treatment and do not reflect those patients that have dropped out prior to the fifth session as they feel the treatment has been successful. This rate does not include those that do not start treatment.

Clinical Outcomes

Clinical outcome data comes from the CORE OM, which is comprised of 34 questions presented to the patient at the start of the first and fifth sessions and the end of the eighth session. Due to the smaller number of patients analysed the improvement is slightly below the national average where the reduction is to 1.1 for all 8 sessions, the starting point is roughly the same.

APPENDIX B

EVALUATION OF THE FIRST EIGHT SESSIONS OF UNST OTAGO PILOT

The Otago exercise programme is a strength and balance programme which is designed to help people reduce their risk of falling by improving strength, balance and confidence.

It is particularly suited to people who:

- Have experienced a fear of falling
- Sometimes feel unstable on their feet
- Can lack confidence when walking
- Have experienced a fall(s)

The NHS Shetland physiotherapy team led the roll out of this programme in Unst with co-ordination support provided by members of the health improvement team. The programme ties in well with health improvement as it is a multifaceted programme which touches on all areas of health from nutrition to foot care. It provides a way of ensuring that holistic health improvement in vulnerable older people takes place, whilst also increasing mobility.

This project involved input from occupational therapists, podiatry, physiotherapy, opticians, health improvement practitioners, the practice nurse, community nurses, pharmacy and social care staff from Bruce Hall Terrace and Nordalea Care Centre.

Physiotherapy results:

Attendance and progress records were kept at each session. Number of participants attending was as follows:

All 8 sessions	7 out of 8 sessions	6 out of 8 sessions	5 out of 8 sessions	Total number of regular attendees
9	5	1	4	**20**

The physiotherapy measures that were taken at the start of the programme were repeated at the end of the programme and the results were as follows:

- 100% of participants had improved muscle strength
- 100% of participants had improved balance

- 100% of participants had improved confidence
- 100% of participants had increased exercise tolerance

Maintenance of the initial post programme benefits is reliant on regular practice of the exercises by the participants. This is further enhanced by having ongoing follow up classes with participants with full benefits of the programme only being evident 12 months post programme. Unfortunately due to staff shortages it has not been possible to do the follow-up classes as planned. Furthermore plans for the follow up sessions to be run by the Shetland Recreational Trust (SRT) did not go ahead. Therefore, it is predicted that outcome measures in the longer term will be lower than anticipated.

Medication Reviews

All participants underwent medication reviews (which includes consideration of the impact of medication on falls).

Occupational Therapy

As part of the multi-factorial falls risk assessment the occupational therapists (OTs) were able to identify if any individual required a home assessment which was then followed up by the OT team. In addition all participants were given a home safety checklist to complete and bring back, these were all returned and any subsequent actions were undertaken by the OT team.

Participant Surveys:

Participants were issued an anonymised post-programme survey to complete. There was a 95% response rate to the survey from those that regularly attended the programme.

The results of the survey were:

- 95% of respondents said they would recommend the programme to a friend or family member.
- 95% of respondents rated the different aspects of the programme as good or very good (this included: assessment pre-programme, exercise sessions, talks, cup of tea and chat, venue).

- 100% of respondents said that:
    - They felt included in the group,
    - Doing exercises as part of group made them feel confident,
    - They felt the exercise sessions were at the right pace,
    - They felt that the leaders of the exercises sessions and talks were professional, confident, reliable and approachable.
    - They found the talks helpful

- 53 % of respondents managed to practice the exercises twice a week at home between sessions, with 42% managing this sometimes.
- 95% of respondents said they had experienced benefits from being on the programme. This was based on a multiple choice question where they could select more than one answer:

Answer Options	Response Percent	Response Count
Improved mobility	52.6%	10
Improved confidence	84.2%	16
I felt more independent	36.8%	7
Reduced pain	10.5%	2
Social benefits	63.2%	12
Improved knowledge	68.4%	13
Other	5.3%	1
Please expand on your answers		8
answered question		**19**
skipped question		**1**

When asked to expand on their answer comments were as follows:

- Apart from all round improvement it was contact with the physios and a trust that they knew what they were talking about. The time passed quickly as everyone enjoyed it.
- So good to engage in physical activity with such good leadership and in company. Very difficult to regulate alone. Made me realised there was help with pain in shoulder (after fall) and knees (painful climbing up and down stairs) with physio input plus the benefits of the programme.
- The course has made me more mobile i.e. joints seem more mobile, The talks and the social interaction after the Otego session were also very good.
- I am able to move around more easily. I know better how to do things to help keep myself mobile and really enjoyed the company.
- My legs got stronger. I felt more independent because I could use my walker. I have more understanding of the correct exercises to do.
- Had I been able to continue to the end and not hurt myself I am sure I would have benefited from it.
- More improved confidence, slightly improved independence.
- Although my mobility did not improve, it kept me moving and more supple. This is due to my condition. Overall the programme was excellent and had many benefits

- 63% of participants said that the programme had enabled them to do things they could/did not do before. Comments on this were as follows:

  - Mum more confident, can stand on her own without grabbing for Zimmer etc. can get into the shower with less help, recovered quicker after sliding off the bed onto the floor
  - Only because I am fairly fit and mobile so far
  - Carry trays on the buffet on Northlink ferry. Carry a cup in each hand. Hang out clothes on a windy day. It gave me a lot more confidence
  - My problem is not so much physical as fogginess in my head
  - Still of an age that I am still quite sure on my feet. Went on programme thinking of the future and looking at ways to try and ensure that I do everything I can to prevent me from falling
  - I am more confident getting in and out of chairs and going up and downstairs. I also find it easier dressing and undressing
  - some of the exercises I had not done before
  - balancing on one leg much improved

- I feel more confident using my walker
- Because I hurt myself and I have been less able. I still do the neck exercises
- To walk more confidently
- Not suitable for me
- Got up the stairs

APPENDIX C
PRIMARY CARE SURVEY

Health Improvement staff have now been based in health centres across Shetland for 18 months. Earlier this year we asked primary care staff to tell us how they found the service and how they thought it should be developed. The results presented below are a summary of the anonymised responses from the 35 primary care staff who replied.

100% of respondents answered 'yes' to the question 'Have you found it useful to have a health improvement practitioner working in your practice?'

There was general agreement that Health Improvement Practitioners (HIPs) bring a level of flexibility, skill and experience that isn't otherwise available. Holistic support as well as specific behavioural support (weight management, smoking cessation) has been provided to patients, but staff have also used the HIP 'as a useful resource to augment our own knowledge', and to discuss patients with.

'Many patients come with problems...that require a more holistic approach, and HIP proves an excellent resource for those needs that cannot be met by a prescription.'

'I feel that the patient is getting a much better service from having a dedicated health improvement officer, as personally, I can't give the same expert advice that a HIO (Health Improvement Officer) can give'

'We have managed to get patients to engage who have never engaged before'

'I think the HIOs make a valuable contribution to the patient experience as we are able to offer a more holistic approach right on the patients' doorstep. From a multi-disciplinary team perspective, it's a great all round service – someone to discuss patients, seek advice from, etc. In my opinion, an extremely valued and integral member of the team.'

'I use the HIP a lot following up families with obese children. The whole families need help, and often part of the problem is motivation for exercise and lack of access to services...'

'Healthier patients are less likely to need GP appointment slots, which can be allocated more readily to more urgent problems'

'I am amazed at how much you do offer'.

‘What they offer is invaluable and professionally delivered; they are very forward thinking’.

‘Changed my life’

‘I am really impressed with the services we have been given access to. This has freed up clinical time and provided a more seamless service.’

‘Me (and a lot of my patients) would be heading towards insulin’.

‘Invaluable, please don’t change it.’

Clearly the extra capacity created is welcomed; this creates an ability to ‘strike while the iron’s hot’, and the HIPs have been able to offer regular follow-up and ongoing support to patients and clients. Staff report that patients are very satisfied with the service and that the clinical time of GPs and practice nurses has been freed up, which has been welcomed.

However there is more work to be developed. Some Primary Care staff were unaware of the range of services that can be offered and didn’t feel they knew enough about the skill set of a HIP to know what they could or couldn’t ask them to do. So one action this coming year will be to publicise these and to make it clear that Health Improvement Practitioners are an incredibly holistic, flexible and adaptable resource which should be used in areas of greatest need – in group work as well as work with individuals; that they have skills in organisational change and development as well as individual behaviour change; that they can work in whatever setting is more appropriate – whether this be a patient’s home, the surgery, a youth club or the local garage; and that they are trained to seek solutions to problems and to overcome barriers. They have skills in needs assessment, data gathering and analysis, so can help organisations to understand and analyse patterns of health and ill health within their organisations, and help to prioritise actions to address these.

The full survey report is available from the Health Improvement Team.

Appendix D

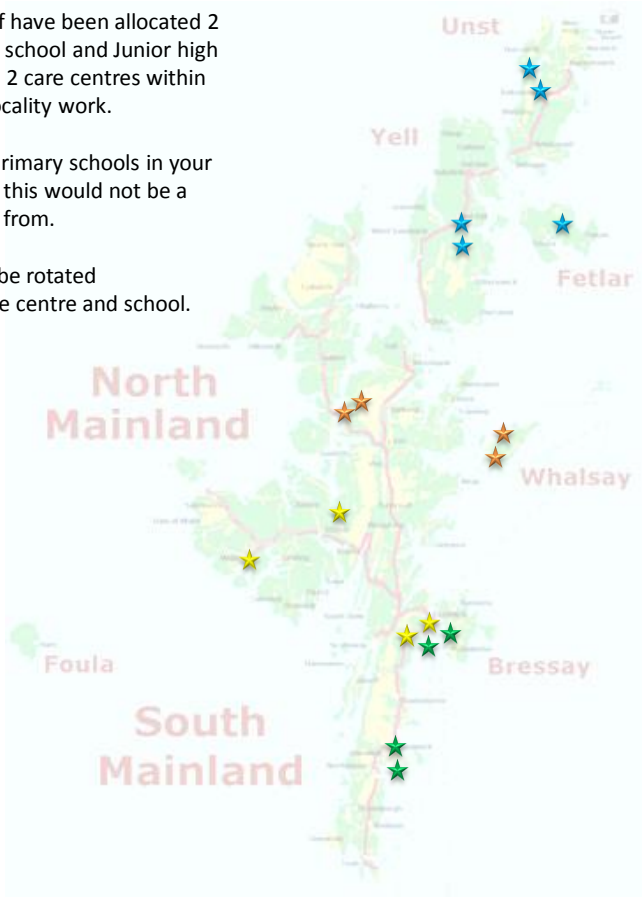
Health Improvement Staff and localities

Schools and Care Centres

Full time staff have been allocated 2 schools (high school and Junior high Schools) and 2 care centres within the area of locality work.

Link in with primary schools in your area also but this would not be a base to work from.

Time should be rotated between care centre and school.



Lauren
• Unst – Unst H.C (Tuesday fortnightly) and Nordalea Care Centre, Baltasound school JHS and Fetlar school.

• Yell H.C (Monday) – Isleshaven Care Center, Mid Yell JHS.

Nicola
•Hillswick H.C (Tuesday) Brae H.C (Monday) and Northhaven Care Centre and Brae High School.
•– Whalsay H.C (Thursday fortnightly) and Fernlea Care Centre and Whalsay JHS.

Jill
•Lerwick H.C (Thursday) and Anderson High School and one of ET or Taing
•Walls H.C (Tuesday fortnightly) and Wastview Care centre, Aith JHS.

Lucy
• Lerwick H.C (Thursday fortnightly)– Anderson High School and one of ET or Taing
•Sandwick JHS and Overtonlea Care Centre

Mel
• Levenwick H.C (Thursday)

Appendix E

Glossary

ABI	Alcohol brief Intervention
Active Travel	Incorporating physical activity into travel, rather than relying on cars
BBV	Blood Borne Virus
BMI	Body Mass Index (BMI) is calculated by dividing an individual's weight in kilograms by their height in metres squared.
CAB	Citizens Advice Bureau
CMO	Chief Medical Officer: Chief advisor to the Scottish Government on protecting and improving the population's health
CMP	Condition Management Programme
CCBT	Computerised Cognitive Behavioural Therapy
DCE	Detect Cancer Early
EMIS	Egton Medical Information Systems – Electronic Patient Record System
GBV	Gender Based Violence
GIRFEC	Getting It Right for Every Child
HBSC	Health Behaviour in School Children (Survey)
HCV	Hepatitis C Virus
HIP / O	Health Improvement Practitioner / Officer
HIV	Human Immunodeficiency Virus
HPHS	Health Promoting Health Service
HWL	Healthy Working Lives
Incidence	The number of new cases of a particular condition disease during a specific period of time, e.g. 20 cases of flu in Shetland during a year
Keep Well	A programme which includes Health checks to identify risk factors for heart disease and stroke
MCN	Managed clinical network
NPS	Novel Psychoactive Substance
Otago	A programme which aims to prevent falls, by developing balance and gentle physical activity
Prevalence	The number of cases of a particular condition or disease at a specific point in time
SCHWL	Scottish Centre for Healthy Working Lives
SDCMH	Scottish Development Centre for Mental Health
SCOTT	A child healthy weight programme
SALSUS	Scottish Adolescence Substance Use Survey
SIMD	Scottish Index of Multiple Deprivation
Unit of alcohol	One **unit of alcohol** (UK) is defined as 10 millilitres 8 grams of pure alcohol – this is designed as a way of being able to compare the alcohol content of one drink with another.