

## NHS Borders response to Health and Sport Committee

### 1. Which areas of preventative spending/ the preventative agenda would it be most useful for the Health and Sport Committee to investigate?

NHS Borders welcomes the Health and Sport Committee's inquiry into preventative spend. Prevention is the best way to help manage financial pressures on the health and social care systems (as well as other areas of public expenditure) whilst improving health outcomes and tackling persistent inequalities in health. NHS Borders wishes to draw several themes to the attention of the Committee which we consider warrant investigation in order to develop further the preventative agenda.

*Preventable ill health – health harming behaviors and their determinants:* there are differing definitions of prevention. We would encourage the Committee to adopt a public health focus on primary or secondary prevention that identifies ways of pre-empting the need for treatment and care in the first place by preventing the onset or development of disease. This includes promoting healthy living and tackling the underlying causes of ill health. The Health and Social Care Delivery Plan (1) notes that one of the main public health challenges for Scotland is to tackle key health harming behaviours that affect population health outcomes across age groups in Scotland (diet, physical activity, tobacco and alcohol) and that have significant implications for health and social care needs and for care costs. There is an opportunity to consider the development of a more integrated approach to prevention across these health topics, which have tended to be addressed in isolation. These behaviours are risk factors for a number of preventable diseases including diabetes, heart disease, stroke and some cancers. Many of the health-harming behaviors that characterise the health of the population in Scotland are also associated with poor mental health.

Health literacy is a prerequisite for the effective self management of long term conditions and disability. Realistic Medicine has started to address the importance of health literacy in effective self management. Other opportunities to further develop discussions between the service user and clinician regarding treatment goals should be explored.

The projected increase in the numbers of the population affected by Type 2 diabetes is a an area of great concern to NHS Borders not least because of the age profile of our local population in the coming twenty to thirty years. There is an urgent need to look into effective prevention models that would have applicability in rural and urban Scotland to slow down the numbers of people developing the condition and the complications associated with its onset. Increasing lifestyle education for school children is important in any health improvement strategy e.g. cooking, budgeting, mental health skills. Educating the wider public, particularly those in deprived areas, on the purchase and use of fresh food rather than convenience meals is also an area that can yield cost effective positive outcomes. Closer working between health, local authorities and local physical activity facility providers to provide easy access to physical activity opportunities for all ages is also essential.

*Mental health:* The fact that 1 in 10 children and young people experience mental health problems has a considerable personal, social and economic impact. Poor mental health in adulthood frequently starts during adolescence. Unidentified and untreated problems lead to poorer health, educational and social outcomes with significant costs to the public sector.

There is now considerable evidence on the life situations and circumstances which increase risk of poor mental health – adverse experiences in childhood, experience of loss, change, ill health, social isolation and exclusion, prolonged financial stress and insecurity. There is an important role for community and the voluntary sector in supporting families and communities and in building social connectedness and resilience. There is also a vital preventative role for public policy in reducing child poverty, promoting attainment, good employment opportunities and thriving communities. The prevention of poor mental health is an area that warrants further attention as part of a wider preventative agenda.

*Early Years:* The importance of early years experiences is now well accepted in Scotland and is a recognized priority for policy and delivery with a range of positive outcomes so far. The continuation of this is required in order to have a meaningful long term impact. Public Health Wales has recently reported on a study on the impact of adverse childhood experiences on adult health outcomes which has relevance for Scotland. It is understood that it is proposed to conduct similar research in Scotland which would undoubtedly further understanding of the case for prevention (2). There is growing interest in Scotland in preconception care as it is now acknowledged that the health of the mother before or early in pregnancy impacts on the health of the child long after infancy. Preconception care would aim to improve health for all women of childbearing age and to target support for women at highest risk of poorer medical or social outcomes. We would also support any future Scottish Government legislation to regulate for plain packaging for formula milk, banning relevant advertising and other measures to discourage its use. Breast is Best!

*Youth health:* With the attention to early years, the importance of youth health as a focus for preventative work can be overlooked. Youth health influences health outcomes in later life. Youth health data can: describe the current health and health needs of young people; indicate the medium term outcomes from early childhood; and predict likely future patterns of health and health needs. The inter-generational nature of health outcomes is also significant. Young people may already be parents, or are likely to become parents. Their health and health behaviours can have a profound effect on outcomes for the next generation. Factors that are important in this regard include parental mental health, alcohol consumption, nutrition, physical activity and substance use. There are opportunities to consider the preventative agenda in relation to health of young people that could also support the Scottish Government's goals of closing the attainment gap.

## **2. How can health boards and integrative authorities overcome the (financial and political) pressures that lead to reactive spending/ a focus on fulfilling only statutory duties and targets, to initiate and maintain preventative spend?**

We would suggest this is partly about changing or supplementing current targets and performance management processes more generally. The current review of performance measures is relevant here. Many of the National Indicators in the National Performance Indicators make sense in terms of encouraging investment in prevention but some of the Local Delivery Plan (LDP) standards to which local boards are held to account encourage further investment in hospital or other health service-based

activity to meet existing needs. Whilst this is clearly important to current patients, it also limits room for manoeuvre in trying to invest in more preventative approaches. Statutory duties and targets need to be more in line with what we want to achieve with respect to prevention and a shift in the balance of care and we suggest that this would be a useful area for the Committee to explore. We hope that the forthcoming review of NHS targets will signal a move in this direction.

The more recent approach to increase the discretion for local NHS Boards to make decisions about the allocation of the public health budgets in bundles is welcome. In NHS Borders it is proving helpful to develop a coordinated approach to preventative work across funding streams, although this is still at an early stage. We would welcome the opportunity to learn how this is being addressed in other Boards.

The health care system in effect rewards hospitals for dealing with the very complications of disease that we are trying to avoid by increasing budgets for treatment services at the expense of investing in prevention and early intervention. This may alleviate short-term pressures, but failing to invest in preventive measures is a ticking time bomb for the treatment services we are funding now.

These perverse incentives exist in many other areas of public health and can only be tackled by adopting a system-wide approach, rather than budgets for treatment and budgets for prevention operating in silos. It may be misleading to assume that prevention will facilitate disinvestment in the medium term. It is more likely to require upfront investment in prevention alongside the continued support for treatment services to address current need. This would lead in the longer term to the alleviation of pressures on acute services. In short term, it is as important to protect current preventative services as it is to 'make the shift' to preventative spend. There is a risk, particularly in a relatively small organization / partnership that a critical mass of preventative services becomes unviable if these services drop below a critical scale.

The views and expectations of the public are important considerations in relation to preventative activity. The Committee might want to look into how the public can be engaged further in the development of preventative approaches in view of the strong support that came through the recent National Conversation on a Healthier Scotland.

### **3. How could spend that is deemed to be preventative be identified and tracked more effectively? What is required in terms of data, evidence and evaluation to test interventions for producing 'best value for money'?**

More precise measurement of current spend on prevention would be a good thing in principle but challenging in practice. Much of the spending on preventative activities is not categorised as such because, for example, it takes place in routine primary and secondary care or because the primary goal is not prevention, in particular for services outwith the health sector.

We would suggest that the emphasis should be on using data and evidence to identify what we think are the drivers of (inequalities in) preventable mortality and morbidity, many of which we already know well enough, and then use evidence and evaluation to identify the most effective and cost-effective ways of tackling these. However there is a risk from the application of inappropriate methods of assessing evidence, with an overemphasis on outcomes of individual behaviour change rather than across the

breadth of its activities. Systematic review methods need to include a broader range of studies and research methods, including qualitative research. Those who have a direct interest in a health improvement initiative should have the opportunity to participate in all stages of its planning and evaluation. Adequate resources should be devoted to the evaluation and the 'success' of health improvement initiatives should be evaluated in terms of processes as well as outcomes. Expertise in the evaluation of health improvement initiatives needs to be developed and sustained. The use of randomised controlled trials (RCTs) to evaluate health improvement initiatives may, in some cases, be inappropriate, misleading and unnecessarily expensive.

#### **4. How can the shift of spending from reactive/acute services to primary/preventative services be speeded up and/or incentivised?**

The Kings Fund recently produced a report on how to transform community services (3). Key messages included:

- removing the complexity that has resulted from different policy initiatives to develop a simple pattern of multidisciplinary services and teams, based around primary care and natural geographies. These teams need to work in new ways with specialist services – both community and hospital based, to offer patients a much more complete and less fragmented service.
- Reaching out more effectively into communities, to harness the power of the wider community to support people in their own homes, combat social isolation and improve prevention.

The Health and Social Care Delivery Plan (1) sets out the strategic direction for shifting spending from acute to community care. This states that in 2017, Health and Social Care Partnerships – with NHS Boards, local authorities and other care providers – should make full use of their new powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings. Effective clinical involvement and clinical leadership (primary and secondary care) working together with public health professionals are essential components of high-quality commissioning. However it is unclear if the Partnership structures designated in regulations allow this to happen effectively.

The recently agreed Scottish GP contract is still a national agreement that may not suit all Boards particularly rural boards in achieving the aims set out in the King's Fund report mentioned above. More flexibility in the ability to change local primary care services to make them more suitable to meet local needs would have been welcome. Primary care services need to be adequately funded and to be trusted to provide the best possible care for the individual patients in front of them.

Financial pressures may also mean that health related organizations are required to take tough prioritisation decisions but may feel they are not able to keep the public on board as they do this. History tells us that local populations often fiercely resist any changes to local acute service provision. Ongoing monitoring of how successful health care related organizations are in shifting the balance from reactive/acute services to primary/preventative services would be helpful in order to spread learning across the NHS.

## References

- (1) <http://www.gov.scot/Resource/0051/00511950.pdf>
- (3) [https://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/community-services-nigel-edwards-feb14.pdf](https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/community-services-nigel-edwards-feb14.pdf)
- (2) [http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/\\$FILE/ACE%20Report%20FINAL%20\(E\).pdf](http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20(E).pdf)