NHS National Services Scotland – Response to call for views on the Preventative Agenda by the Health and Sport Committee

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

This is a very wide topic and, rather than list all possible areas for consideration, three key points are outlined below:

- **The creation and use of evidence.** Whilst there seems to be universal agreement of the need to shift the emphasis between treatment and prevention, one of the biggest challenges in the preventative agenda is having the evidence and, thereby, the confidence to make upstream, preventative investment when there are real pressures in dealing with short-term demand challenges – for example, within accident and emergency. There is real appetite in Integration Authorities for an improved ability to model and predict the outcomes from alternative investment. Evidence can also include practical examples (case studies) of successful preventative interventions which can be powerful in terms of, again, increasing confidence;

- **Public engagement.** Linked to the need for evidence of the benefits of a preventative agenda is the need to engage the public in understanding that evidence. This way they will be more likely to be supportive of making practical trade-offs between maintaining investment in acute services (which have an immediate and visible impact) and preventative measures (which tend to have a longer term and less immediately visible impact). Obtaining public support, in turn, encourages cross-party political support;

- **Planning horizons.** Investment in preventative measures tends to have significant impact but over a relatively longer timescale. Set against short term and visible demands to meet in-year targets, this means that movement of funding into the preventative agenda calls for confidence (see above) and a degree of political bravery. Embedding and emphasising the importance of longer term planning horizons will help in this regard.

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?

It may be necessary to, at least temporarily, provide some relaxation of the need to meet short term targets in return for investment in prevention. As per the areas outlined above, in terms of gaining support for this approach, evidence, engagement and workable planning horizons will be required – as will cross-party political support.

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’?

Identifying and tracking spend, and then identifying the evidence of its impact, calls for an investment in analytical skills to create “actionable intelligence” – that’s to say facts, information and insight that encourage changes to be made with the confidence that they offer “best value”. For example, NHS National Services Scotland, through its Local Intelligence Support Team (LIST), has been working closely with, in particular, Health and Social Care Partnerships to provide, locally and on the ground, analytical skills that complement local data and intelligence expertise. LIST works with local partners to identify specific needs and support decision making. Many of the practical steps taken as result of this work have been in line with a preventative agenda.
In short, tracking spend more effectively and creating an evidence base which supports improved decision making will require investment in the availability of data and the analytical resource to interpret it.

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

Please note the points made in answer to the questions above.

In addition, it may be helpful, at times, to adopt more specific language which reflects the different tiers of prevention:

- Primal prevention – preventing harm and illness being passed down generations – for example, providing support and education for new parents;
- Primary prevention – preventing people from becoming ill – for example, work on disease surveillance;
- Secondary prevention – better detection and managing illness that has already occurred – for example, through cancer screening services;
- Tertiary prevention – improved management and control of late stage illness – for example, care plans for elderly patients to help keep them in the community and out of hospital.

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