Response to Health and Sport Committee Enquiry into the Preventive Agenda

Introduction

The Health and Sport Committee of the Scottish Parliament is holding an enquiry which seeks “to find evidence on and analyse preventative spend through a series of short inquiries on specific health-related topics”. As part of its investigation, it has issued a general call for evidence to help “inform the initial understanding and ensure clarity around about what the committee is seeking to achieve with this inquiry”.

This response is compiled by the Director of Public Health in NHS Fife and the Executive Director of the Fife Health and Social Care Partnership.

Background

Behind this investigation lies a major challenge – how to move health and social care expenditure onto a more secure and sustainable footing for the future. Thinking that a “stitch in time saves nine” suggests there may be better ways of addressing current and future health challenges, which nip problems in the bud or prevent them deteriorating further once diagnosed. This thinking has informed preventive strategies over many decades, leading to population-based screening, immunisation, health promotion and behavioural change programmes. As social determinants of health have been better described, local partnerships have increasingly seen the value of programmes which address poor housing, low educational attainment, employability, green/play space, a living wage and better connectivity for disadvantaged communities. In Fife, these approaches are being followed through in a Fairness Matters Action Plan based on recommendations from the Fairer Fife Commission and a five-year plan for reducing health inequalities launched in 2015 by the Fife Health and Wellbeing Alliance.

All of these initiatives play a role in preventing disease and promoting health. However, there are nagging doubts about their overall effectiveness because healthcare demand continues to rise exponentially and health inequalities are widening. In short, the conceptual underpinnings of prevention are now in question.

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

Given what we have set out in our response so far, the most useful area of this agenda to investigate is the conceptual underpinnings of the approaches currently in use. Are there other ways of thinking and practice that might hold
out more promise than the disjointed incrementalism which characterises so much preventive activity at present? For example, Daniel Wahl’s book, “Designing Regenerative Cultures” points to an ecological rather than economic understanding of health and wellbeing.

In this framing, health is the flourishing of life rather than merely the absence of disease. Prevention in this context is not so much a stitch in time, but a weaving of connections in the web of life. With this understanding, prevention is about strengthening connections and relationships, recognising we are all part of a wider, living system.

A further important conceptual underpinning comes from the evidence of Adverse Childhood Experiences (ACEs) and the neuroscience of trauma. The links between the accumulation of ACEs and poor health outcomes are well documented. Being trauma-informed offers new ways of supporting people into better patterns of relationship. Trauma-informed programmes particularly in the US are showing promise in many areas of public spend such as in prisons, schools and health centres.

Seeing the person, not the behaviour is part of the shift in mindset needed to address the preventive agenda in a more creative way for the future. This is true also at the level of communities, where it is easy for areas of “deprivation” to be labelled as such rather than applauded for their strengths and resilience in the face of huge challenges and disadvantages. Adopting an asset-based approach is essential for addressing the preventive agenda in the future.

- 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?

There are several aspects to this question. The first is the financial challenge facing the NHS and social care in the next three years is unprecedented in its history. The gap between an exponential rise in demand and a much smaller rise in allocation of funds, leads to a bigger funding gap each year. The economic prospects are such that a return to 7% annual rises in funding for the NHS seen in the 2000’s is unlikely in the foreseeable future. In these conditions, realising the potential for prevention becomes imperative rather than optional to safeguard the health of the population.

The second is the focus on statutory duties which are non-negotiable and targets, which could be adjusted in the light of a preventive strategy. The difficulty with targets as currently defined is their lack of connection with clinical outcomes. The four-hour wait target makes no sense for those patients arriving in A&E who require urgent resuscitation. They need to be seen within seconds or minutes of arriving.
At the other end of the spectrum, a person waiting for a knee replacement might have a better clinical outcome by waiting a further month to reduce weight, stop smoking and take iron supplements to address a sub-optimal haemoglobin level. Initiating a preventive strategy as part of planned care becomes an important consideration in the case of the latter.

A third consideration relates to World Health Organisation and EU regulatory standards, particularly around universal childhood immunisations, food, air and water quality, which are essential features of a modern preventive healthcare system. These areas of activity are at risk from the change in the GP contract in which they are no longer required to deliver certain immunisation programmes and cuts in local government funding which is affecting environmental health services. In addition, as the UK negotiates an exit from the EU, Scotland needs to examine whether it can maintain current high levels of environmental regulation under its devolved powers to protect the public's health. Prevention requires thinking about health in all public policy, not just focusing on health and social care systems.

- 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’?

This question relates to the first one and the underlying mindset, which informs the prevention agenda. If health is the flourishing of life and prevention is the weaving of further connections in the web of life, prevention and reactive spend are not opposite poles of a spectrum: both strategies are important. The question is how to get the best out of them simultaneously? Exploring this question in Fife has led us to recognise the importance of “offerings” in a “value-creating system” (described by Ramirez and Pannervik in “Strategy for a Networked World” 2016). These offerings are ways in which the public interfaces with services to create value in their lives. We talk about helping people to “thrive, not just survive”.

If we work in this way, we encourage people to discover their innate capacities and recognise what is important to them in their lives. This becomes an over-arching motivator for them to maintain their health and wellbeing with the result that many are happy to leave behind their dependence on services.

Gathering data and evidence for this approach has been a challenge because this is an extra cost to the local system. However, work with Healthcare Improvement Scotland and Scottish Improvement Science Collaborating Centre has started to try and address these questions.
What is clear is that the new pattern of health and social care will be supported by multiple currencies, not just money and the infrastructure to support the system will be configured around existing resources but re-designed in different ways and in constant dialogue with local communities.

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

The easiest way to make this shift is to focus on personal outcomes. This means asking people, “What is important for you in your life?”, “What would be different if things were better?” rather than “What’s the matter with you?”. It means exploring with them their good days, not just the bad ones and asking them how this is achieved. By building on the good things that are happening, people grow confident about making positive changes.

A further step to help this work is knowing what is available in local communities and signposting people to activities and opportunities that they value.

This approach works well for people with chronic, complex conditions and in the process of rehabilitation from injury. It need not be confined to health and social care but works well in other frontline agencies. Locality planning for health and social care along with the Local Outcome Improvement Plan offer powerful ways to make these connections at the local level, co-creating value with people and communities.

The incentive has to be better outcomes overall – for patients, staff and the financial bottom line. This “triple aim” for prevention offers the greatest hope for the future.

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