

Royal College of Physicians of Edinburgh

Scottish Parliament Health and Sport Committee

Call for evidence on Preventative Agenda – February 2017

The Royal College of Physicians of Edinburgh is pleased to respond to the Committee's call for views on issues on preventative spending and the prevention agenda. The College is an independent clinical standard-setting body and professional membership organisation, which aims to improve and maintain the quality of patient care. Founded in 1681, we support and educate doctors in the hospital sector throughout Scotland and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties.

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

Preventative spend is relevant to the current Realistic Medicine agenda and its focus on the overuse of investigation, treatment and potentially unnecessary interventions. The evidence base for various universal screening programmes and preventative measures could be scrutinised to assess whether they are effective, both in terms of cost and preventing disease, with consideration given to discontinuing those which fail this test.

Primary prevention – stopping diseases or events from happening at all – is more efficient and likely much more effective in general terms. Examples might be preventing the emergence of gaps in children's attainment through early nurture of children, prevention of child poverty, and the detection and prevention of problems at very early stages – the result being good children's and adolescent health and wellbeing, leading to resilience in later life. This begins pre-birth, with good preconception and maternal health.

Preventing adverse childhood experiences is less a whole population approach and more targeted to vulnerable and at-risk sub-populations but nevertheless these are cost-effective compared to dealing with the consequences. In identifying these populations, work needs to move beyond identifying geographic areas towards more targeted approaches and interventions for smaller groups and individuals, for example peer support programmes for issues such as healthy eating and breast feeding.

The prevention of alcohol-related harm has wide ranging beneficial effects for both individuals and communities, beginning with minimising harm to children (including fetal alcohol harm, and the wider effects of parental alcohol problems) reducing alcohol related illness in individuals and reducing related social and justice spend. In terms of obesity, preventative measures such as reduced portion or pack size must be considered along with policies such as the sugary drinks tax.

It is important to incorporate physical activity into any preventive strategy for health, and the College fully supports embedding physical activity for health into primary care, secondary care, social care and health education, as well as in the health and social workforce and workplace. Some of the referenced material for this consultation describe successful projects for improving health that are clearly expensive to set up and to sustain, such as sophisticated sports facilities that many families may not be able to access once any initial free places or equipment are no longer offered. Involving and engaging the public is key to identifying the types of physical activity they are more likely to participate in from competitive and team sports and games to individual activities. The

potential for these to have a role in preventing loneliness and isolation in the community should also be considered.

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?

This is a challenging question. Small and incremental improvements above and beyond meeting statutory requirements often create small differences in levels of service provision. The measure may both have an effect that widens inequalities in access to statutory support or, conversely, fairer access to a service under pressure may drive up demand and cost. Only when there is significant reduction in demand is there an opportunity to close capacity down. One driver against savings of this sort is the removal of service capacity that has been avoided through prevention – that is, for example, closing hospital accommodation rather than re-assigning it for other uses. This is necessary to reduce spending in a particular sector.

In the area of youth justice substantial gains have resulted from going beyond statutory requirements and rule-driven management of young people in trouble. However, the gains are complex to appreciate and to replicate – a single centrally-located resource that can be deployed to other uses, flexibility with net effects that result in closure and cost savings. However, this example may well mask cost shifting – to the community – and erosion of quality of service – unless an outcome based approach, backed by sound evaluation, is central to plans and shared across agencies.

The preventative agenda should begin with children and young people and the education system, in the early years and beyond, harnessing the enthusiasm of school, college and university students to explore how Scotland and the wider world can improve its environment. Current concerns over air pollution, pesticide use, carbon capture, emissions, food processing and antibiotic overuse are all potential topics for preventive health initiatives. There is also the opportunity during school years to target and improve both the individual physical and mental health of children and young people and their potential as future parents.

As in the response to the previous question preventative (and other) measures should be scrutinised for benefit and measures be in place for altering/ending those which are failing this test.

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'?

Economists and accountants would be better placed to make recommendations on cost centres and recognition of cost-shifting in detecting the effects of preventative spend. Potential users of any preventive health or integrated service could also be involved in evidence gathering, planning and evaluation from the start.

One example of detectable and clear programme changes that effectively prevented disease is the implementation of the dental action plan for children over the past decade. There was an

appreciable drop in children's caries and dental disease experience, attributable to mass deployment of interventions by the dental service. It is unusual to have such a clear-cut example, as usually important public health advances are complex and reliant on many direct and indirect influences.

Public health practitioners are often dependent on clinicians to collect the information they require for analyses – for some this can feel like data collection is given priority over clinical activity and this can impact on morale. Any new preventative health initiative should either utilise currently available reliable and accurate data or be backed with appropriate administrative and support resources to ensure its effectiveness is reliable for analysis. Many clinicians will have experience of working on effective projects or interventions, funded only in the short term, which suffer when the pump priming or initial enthusiastic improvement champions have moved on, or the project is limited by numbers not need. The result is professionals potentially being demoralised by having to refuse their help to those in obvious need - resulting in inequitable services – currently this description could apply to the Family Nurse Partnership programmes across Scotland.

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

Governance and strategic collaboration have complex features and require a whole system approach to recognising expenditure that gives a more authentic picture. Plans to shift expenditure from reactive/acute to primary/preventative services are complex undertakings; there are few if any 'quick wins'; they take preparation and capacity building to cope with surges in demand in the community, and should include deliberate intentions (and consequence management including political contingencies) to close capacity when, if ever, there is a step change downward in acute service demand.

In the public sector, financial reward often carries perverse incentives – resources then go to patch up places where performance is weakest. Schemes that involve authentic recognition may be reward in themselves, backed by reliable data, a culture of learning, and respect for achievements.