ScotPHN report

SCOPING THE PUBLIC HEALTH CONTRIBUTION TO REALISTIC MEDICINE

REPORT FROM SCOTPHN WORKSHOP (SEPTEMBER 2016)

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Preface

In September 2016 a group of Public Health specialists met under the ScotPHN banner to help clarify what should be incorporated into the Public Health response to the Chief Medical Officer's report *Realistic Medicine*.

At that time the workshop was specifically seeking to focus on action "locally and beyond". In practice, the workshop spent the majority of its time exploring what shared learning could be identified from what was already happening within NHS Board areas for local action. Moving beyond this local focus to a more structured "Public Health Offer", was something participants considered at the workshop, but to a lesser extent.

Since then much has happened, not least of which has been the publication of *Realising Realistic Medicine* which detailed early activity across Scotland. More importantly, it identified the conditions which are necessary for achieving system-wide change and set out a number of specific initiatives that can support the change.

I am grateful to all those who participated in the workshop and contributed comments and reflections that have informed the writing of this report. In producing this report now, in June 2017, it must be recognised that its origins are in that initial Public Health learning to support local *Realistic Medicine* activity explored at the workshop.

But we should also acknowledge that this learning has a clear contribution to make in helping us set out what Public Health has to offer in *Realising Realistic Medicine*.

Linda de Caestecker
Director of Public Health, NHS Greater Glasgow & Clyde

Setting the scene – the *Realistic Medicine* "ask"

The workshop started with a scene setting presentation (see Appendix 1).

The Chief Medical Officer's (CMO) annual report *Realistic Medicine*[1] sets out a challenge to those involved in delivery of health and healthcare in Scotland. It asked six questions that were designed to challenge the way in which Scotland thinks about providing health care services. As the infographic (left) shows, these questions focus on creating a service that:

(Source: Realistic Medicine[1])

- delivers person-centred care such that they can share in the decision making about their care;
- becomes more self-sustaining through innovation, reduction in service variation and waste; and
- reduces the risk of harm to those for whom it cares.

In setting out these questions, the CMO also called on health and health care professionals to help create a new "culture" within the NHS and the public it serves. In creating the new culture, the CMO focussed on three specific requests:

1. to share evidence of effective intervention to affect change in the six areas;
2. to be clear on what value can be added from each professional perspective? and
3. to identify how the culture for change amongst professionals and communities can be best created?

These three "asks" formed the basis for the workshop.

In addition to this, workshop participants were also asked to help form the sort of advice that could be shared as the wider, "Public Health offer" by the Scottish Directors of Public Health (SDsPH). In setting this out, the SDsPH asked that the workshop produce a summary of the potential Public Health contribution and a clear approach to:

- the technical skills available from Public Health;
- what leadership, support, and collaboration is available from Public Health;
- how Public Health can support the outcomes orientation of the CMO "ask";
    - specific to a person-centred contribution; or
    - specific to programme support.

In setting this out, the hope was that it would be light of the type of managerial language that can be inaccessible, heavy on what we can do in delivering results, and how we can influence the culture. This request from the SDsPH has been used to help in the drafting of this workshop report.

Learning from local initiatives

The first session of the workshop was taken up with four presentations, each presenting on different aspects of local work that could provide insights into the Public Health contributions to leading and supporting activity to help achieve the type of NHS considered in *Realistic Medicine*.

These presentations are contained in Appendix 1 and considered:

1. *Realistic Medicine and realistic medicines*
   Sharon Pfleger, National Clinical Lead Area Drug and Therapeutics Committee Collaborative & Consultant in Pharmaceutical Public Health, NHS Highland;

2. *NHS Lanarkshire experience of realistic medicine... So far!*
   Ruth Mellor, SpR in Public Health, on behalf of the NHS Lanarkshire Realistic Medicine Virtual Intelligence Group;

3. *The House of Care and Realistic Medicine*
   Rachel Hardie, Consultant in Public Health, NHS Lothian; and

4. *Insulin Pumps*
   Norman Waugh, Professor of Public Health, Warwick Medical School.

In all cases, the presenters are happy to discuss these examples further.

Whilst it is not appropriate to rehearse the detail of each presentation in this report, it did become clear that there were several common messages emerging:

- Public Health skills – especially healthcare public health skills and knowledge - are important in creating environments where change is possible;
- the involvement of Public Health professionals is essential to maintaining both a patient-centred and population focussed approach to actions;
- care is needed to interpret the evidence appropriately – things are not always what they seem at first; and
- Public Health is well-placed to help with delivering realistic agenda – but it takes time and sound relationships with professionals AND the public.

Supporting the culture

Following the presentations, the workshop broke up into small groups to consider more fully the sorts Public Health skills and activities that are effective when working with professionals, with patients, and amongst the public in building the type of culture that could sustain Realistic Medicine. The feedback from this group work can be summarised into themes.

1. Restoring Healthcare Public Health

At its heart, *Realistic Medicine* is about creating a sustainable health care service. In doing this, making and supporting the case for preventative services, leading and supporting service redesign processes, undertaking health care need assessments to better match demand and supply to need, and ensuring an evidence-informed approach to development and delivery are essential. These are all within the repertoire of the Public Health professional to use.

However, for these skills to be deployed effectively we need to be conscious of the current low base from which Healthcare Public Health starts. Limited capacity at the local level needs to be freed up to allow health service planning and redesign happen locally, regionally and nationally. Doing things which reduce unnecessary duplication by having a common approach across Scotland is essential to this; even if for no other reason than it is one of the forms of unnecessary variation *Realistic Medicine* is trying to address.

Having such a unified public health approach will resonate with different groups and help make change more likely.

2. Using evidence wisely

Supporting value-based, evidence-informed decision making is vital. Whether to support more realistic policy development and implementation or to create professional and public support for change, evidence is a major driving force. However, such evidence is rarely definitive and almost always requires interpretation and operationalisation. This is something that Public Health professionals can do very well. For example, the recent “rediscovery” of Health Economics evidence to inform financial planning on effectiveness. However, just what metrics such as cost per QALY, or per DALY, or a Programme Budget Residual actually mean in terms of service redesign or service disinvestment is not straight-forward. Equally, it can help establish the sorts of mechanism by which evidence can help to inform difficult clinical decisions on service provision or access to drugs.

Public Health can clearly help in interpreting evidence and, perhaps more importantly, clarifying the limits of such evidence, and helping support the use of professional and public judgement in such situations. In this regard the support Public Health colleague have

provided to formal (and informal) support for “difficult” clinical decision making processes were noted.

3. Leading and Supporting Innovation and Implementation

The role that Public Health continues to make in supporting innovation in healthcare locally and nationally was noted. So too was observation that such support was rarely seen as being from “Public Health”, rather it was subsumed into the overall processes which dealt with such innovation: the Scottish Health Technologies Group; Scottish Medicines Consortium; iHub; and the National Specialist Services arrangements; to name but four. Often this work was seen to focus on the application of technical skills, yet the existing “added value” which Public Health input provides in facilitating technology transfer into clinical practice (and helping understand system effectiveness and affordability) could be strengthened.

In this area, Public Health should provide an alternative voice in challenging the prevailing culture that can bias decision-making and lead to the types of perverse outcomes that see the implementation of hi-tech, but low value interventions, or which increase the financial pressures in prescribing budgets without improving patient outcomes.

4. Empowering Communities

Achieving the necessary change in public expectations requires that local communities – whether communities of interest, or of geography – are engaged and empowered to become active participants in making the decision-making that must underpin *Realistic Medicine.*

Locally Public Health is already engaged with such communities and developing responses to the recent Community Empowerment legislation, albeit in the context of health improvement initiatives. Developing these engagement mechanisms as part of an overall approach to help understand and refocus public expectations is an area that Public Health could clearly add value, widening the scope of existing patient participation approaches to support this part of the initiative. Ensuring there is a clear focus and “offer” on this is something that Public Health need.

5. Creating Realistic Public Health

Public Health – as a “service” – is not independent of the challenges set out by *Realistic Medicine*. As a minimum, strengthening our commitment to shared learning and developing approaches that provide opportunities for meaningful sharing would be important.

However, there is a need for local and national Public Health functions to become more open to change and develop a mechanism for continuous improvement for public health.

Such an approach could build on the existing SDsPH "new ways of working" approach managed by ScotPHN. This would require that Public Health develop – or adopt – a more structured, common approach which may be more helpful. In this regard, the CURVE model for Strategic Improvement (see Appendix 3) was proposed by one workshop participant as one such model that seems well suited to meeting the challenges of *Realistic Medicine*.

Conclusion – *Realising Realistic Medicine*

Since the workshop, an update report – *Realising Realistic Medicine* – has been published.[2] As well as this setting the international context for the approach and presenting case studies of initial activities across Scotland, the report highlighted a number of initiatives that the Scottish Government had put in place to support this work. These were set out in the Scottish Government's Health and Social Care Delivery Plan:[3]

- establishing a *Realistic Medicine* team as part of the National Clinical Strategy work stream to ensure that national policy and implementation guidance is supportive of local actions;
- the Scottish Health Council and the ALLIANCE have been commissioned to explore what *Realistic Medicine* means for the Scottish population and how realising the changes can be co-produced;
- a national health literacy plan *Making it Easy*[4] will be implemented to support *Realistic Medicine* and help the people of Scotland to have the confidence, knowledge, understanding and skills to live well;
- the Scottish Government, General Medical Council and the Academy of Medical Royal Colleges will review the patient consent process and develop new advice for clinicians in the light of the judgement from the UK Supreme Court in the Montgomery case;
- the action plan in response to *Promoting Professionalism and Excellence in Scottish Medicine* report[5] will be refreshed and updated to include a range of high impact actions that will support clinicians with *Realistic Medicine*;
- a Scottish Atlas of Variation will be created and published. This will be supported with a collaborative training programme for clinicians to aid identification of unwarranted variation and promote high value care;
- a single, national pharmacy formulary will be developed to help achieve more equitable access to medicines and maximise the benefits to the population from medicine use; and
- *Realistic Medicine* will be included as a core component of lifelong learning in medical education at undergraduate and specialist training programmes and as part of continuing professional development.

It is clear that many Public Health professionals are already involved in leading and supporting all these initiatives. We need to ensure that what may be called as the Public Health contribution is visible and acknowledged. In this way the added value to our existing – and potential – contributions to delivering *Realistic Medicine* are recognised and sought.

The workshop identified that there was much that Public Health is already contribute – or could contribute - to *Realistic Medicine*. It highlighted that there was an enthusiasm to engage with the approach. The task now is being explicit of what Public Health *will* contribute to *Realising Realistic Medicine* as a matter of course.

References

1 Scottish Government (2016). The Chief Medical Officer Annual Report 2014 -2015: Realistic Medicine. Edinburgh Scottish, Government. (Available at: http://www.gov.scot/Publications/2016/01/3745 Last accessed 13th June 2017)

2 Scottish Government (2017). The Chief Medical Officer Annual Report 2015 -2016: Realising Realistic Medicine. Edinburgh Scottish, Government. (Available at: http://www.gov.scot/Publications/2017/02/3336 Last accessed 13th June 2017).

3 Scottish Government (2016). Health and Social Care Delivery Plan. (Available at: http://www.gov.scot/Publications/2016/12/4275/ Last accessed 13th June 2017).

4 Scottish Government (2014). Making it Easy. (Available at: http://www.gov.scot/Publications/2014/06/9850/0 Last accessed 13th June 2017).

5 Scottish Government (2009). Promoting Professionalism and Excellence in Scottish Medicine: A Report from the Scottish Medical and Scientific Advisory Committee. (Available at: http://www.gov.scot/Publications/2009/06/12150150/0 Last accessed 13th June 2017).

Appendix One: Presentations

- Rachel Hardie: The House of Care and *Realistic Medicine*
- Phil Mackie: Setting the Scene – the *Realistic Medicine* "ask"
- Ruth Mellor: NHS Lanarkshire experience of realistic medicine... So far!
- Sharon Pfleger: *Realistic Medicine* and realistic medicines
- Norman Waugh: Insulin Pumps

Appendix Two: Workshop Participants

Linda de Caestecker	Director Public Health – *NHS Greater Glasgow & Clyde* - CHAIR
Chris Littlejohn	Interim Deputy Director of Public Health – *NHS Grampian*
Phil Mackie	Lead Consultant – *ScotPHN*
William Moore	Consultant Public Health Medicine – *NHS Grampian*
Roberta James	SIGN Programme Lead – *Healthcare Improvement Scotland*
Sharon Pfleger	Consultant Pharmaceutical Public Health – *NHS Highland / Healthcare Improvement Scotland*
Kennedy Muturi Nelson	Information Consultant – *Public Health & Intelligence, National Services Scotland*
Alex Stirling	Consultant Public Health Medicine – *Public Health & Intelligence, National Services Scotland*
Lorna Watson	Consultant Public Health Medicine – *NHS Fife*
Debbie Schofield	Public Health Programme Manager – *NHS Greater Glasgow & Clyde*
S Josephine Pravinkumar	Consultant Public Health Medicine – *NHS Lanarkshire*
Marjorie Marshall	Economic Advisor – *Scottish Government*
Colin Sumpter	Specialty Registrar in Public Health – *NHS Forth Valley*
Fiona Wardell **(V/C)**	Team Lead – *Healthcare Improvement Scotland*
Norman Waugh	Professor in Public Health – *Warwick Medical School*
Ruth Mellor	Specialty Registrar in Public Health – *NHS Lanarkshire*
Rachel Hardie	Consultant Public Health Medicine – *NHS Lothian*
David McAllister	Specialty Registrar in Public Health – *Public Health & Intelligence, National Services Scotland*
Ellie Hothersall	Consultant Public Health Medicine - *NHS Tayside*
Elizabeth Robinson **(V/C)**	PH Principal - *NHS Shetland*
Tim Patterson	Interim Director of Public Health – *Joint NHS Borders / Scottish Borders Council*
Helene Irvine	Consultant Public Health Medicine – *NHS Greater Glasgow & Clyde*
Gordon McLaren	Consultant Public Health Medicine – *NHS Fife*
Oliver Harding	Consultant Public Health Medicine – *NHS Forth Valley*
Jose Ortega **(V/C)**	Consultant Public Health Medicine – *NHS Orkney*
Graham McKenzie	Consultant Public Health Medicine – *NHS Lothian*

Appendix Three: The CURVE Model for Strategic Improvement

Oliver Harding,
Consultant in Public Health Medicine,
NHS Forth Valley

CURVE is an acronym that described a series of factors that need to be considered in strategic improvement:

- **C**ulture
- **U**nderstanding
- **R**esponsibility
- **V**alues, value, valuing
- **E**nterprise

Culture

Culture is defined as "what is learned, shared, and transmitted in a group – reflected in that group's beliefs, norms, behaviours, communication and social roles" (Kreuter and Haughton, 2006)

Further it can be defined using the 'model for a person' and extending this to collective attributes of a group or community, including:

- Physical and social environment;
- Behaviour and sensation / perception within this environment;
- Memory, imagination, and emotion;
- Knowledge, skills and creativity;
- Beliefs, values and attitudes;
- Identity; and
- Spirituality / sense of connectedness.

Culture changes over time. The extent to which this can be guided or facilitated is debatable. It has been suggested that certain factors can facilitate culture change at the 'edge of chaos'. These are:

- Diversity;
- Information flow;
- Connectivity;
- Reducing barriers or inhibitors;
- Enhancing or increasing catalysts;
- Watchful waiting; and
- Positive intent.

Understanding

Knowledge is a personal attribute and collective knowledge is a community or cultural attribute. But to be really useful it needs to go deeper to form understanding. There are several senses to the term understanding:

- awareness of a situation in context, its meaning – based on evidence. Being able to see how things relate to each other, often in complex ways; and
- having and demonstrating common understanding between individuals, which relates to empathy and positive intent.

Responsibility

Within the context of family support, for example, improvement ultimately relies on individuals taking responsibility. Such individuals may be children, parents, other family members, peers, public sector or third sector staff. A process of engagement and involvement may be required to facilitate this, as may the meeting of some basic client needs. Within the public sector there is increasing recognition that client rights need to be balanced with responsibilities (as described in the recent Patient Charter for the NHS in Scotland, which is derived from legislation)

Interaction between the themes:

	Culture	**Understanding**	**Responsibility**
Culture	-	Cultural understanding	Cultural responsibility
Understanding	Understanding culture	-	
Responsibility	Responsibility for culture	Responsibility for understanding	-

Values, value, valuing

Fundamental to improvement work is the underlying set of core values to which we are working. NHS Forth Valley has defined its core values as:

- Respect;
- Integrity;
- Person-centeredness;
- Supportiveness;
- Ambition; and
- Teamwork.

Value is also an important concept, as improvement work / redesign is often aimed at increasing the value gained from the use of resources. Value can be subjective however and this needs to be considered.

Valuing can also be important in terms of appreciating resources or actions. For example if the services offered are not valued by clients, uptake will decline as will value.

Enterprise

Organisations and partnerships are engaged in some form of enterprise – establishing a vision and working towards it. Entrepreneurship encompasses core skills that are relevant for improvement work in general:

- Establishing and developing networks, teamwork and collaboration;
- Understanding value and value chains;
- Identifying and developing personal skills;
- Identifying and developing innovative practice; and
- Understanding motivation.

The emergence of the concept of a 'Social Enterprise' is particularly important for the public and third sectors. In the field of social enterprise a "triple bottom line" is described consisting of the 3 'P's:

- Profit (monetary value) – or value for money in public spending;
- People (social value) – quality and effectiveness in making a real difference to people's lives; and
- Planet (ecological value) – long-term sustainability of public services.

Implementation

Each element needs to be considered in some depth. The CURVE model sets out 'what?' but for implementation there needs to be a consideration of 'how?'

ScotPHN report

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