

How should we approach health improvement

Academy of Medical Royal Colleges submission to DHSC following a seminar with Professor Chris Whitty, Chief Medical Officer

September / 2020

Background

On 22 September 2020 the Academy of Medical Royal Colleges (the Academy) Council held a seminar with England's Chief Medical Officer Professor Chris Whitty. The focus was on the future of public health service provision in England following the disbanding of Public Health England (PHE). He challenged us to,

“think about what the relative emphasis of public health should be in the future, the ‘non health protection functions of PHE... focus on the functions and not the form at this stage... What should we do more of, what should be added to the portfolio and what should be removed and handed to others? Some things like smoking and obesity reduction are obvious, so what about improving early cancer diagnosis? What about the needs of our younger urban populations vs our older rural populations?”

The points raised below do not, in general, provide direct answers to the questions as to how PHE health improvement functions should be managed in the future but hopefully provide useful wider context for the discussion and any consultation.

The Academy sees the decision to close PHE in its current form as a real opportunity to think about how we approach health improvement more broadly and not simply to provide a structural solution for how a series of PHE functions are managed and provided in the future.

Set out below are the key points from the discussion.

Who should we be targeting?

a) The multi-morbid, older patient

- Highly successful public health strategies have dramatically improved childhood and middle-age mortality, meaning that the predominant burden of disease is in the older person
 - They will often be multi-morbid, and potentially have difficult social situations with increasing rural elderly poverty a challenge
- There needs to be a rethinking around what medicine can provide and should be providing to cater for these patients' needs:
 - This should incorporate the wider integrated care model promoted by NHSE/I involving social prescribing, multi-disciplinary community teams, and a better social-scientific approach
 - A better shared-decision making framework is required in order to ensure that people are more fully involved and informed in decisions around all aspects of their care



- There should be increased focus on what the end stage of these multiple conditions might be, focusing on their quality of life and actively considering their values and wishes from an earlier stage
- All doctors should be mindful of the need for better end-of-life conversations with patients, frequently at an earlier stage than at present
- Rigorous quality improvement methodology should be used to appropriately measure the effects of integrated innovations aimed at addressing these needs
- Can we reach a stage where we have pushed specific diseases “over the touchline” of the average expected age of death?
- Polypharmacy is often an issue in these patients
 - Disintegrated care with multiple specialist teams propagates this problem
 - It is a significant contributor to hospital admissions and poorer quality of life
 - There are too few clinicians taking generalist approaches to clinical care and aiming to rationalise these medicines
 - There are often common underlying risk factors/pathophysiological processes to sometimes distinct disease states
 - A single drug may have a mechanism of action that tackles these distinct disease states through this shared risk factor/pathophysiology, and therefore multiple similar medications are not required
 - Better generalist understanding of pharmacotherapeutics may help to prevent unnecessary polypharmacy
- Generalists versus specialists
 - Our academic (research) and clinical service models are set up to focus on “single-issue” aspects of patients, which is not reflective of the common clinical reality
 - We acknowledge that certain specialties, such as geriatrics and general practice, provide the “holistic” and multi-issue clinical approach appropriate for most of these patients
 - Specialists focusing on single areas issues will obviously remain vitally important for good healthcare delivery, however sometimes struggle to provide this multi-issue approach
 - Specialists should be supported and encouraged to maintain a generalists’ perspective, given the common issues seen in this population
 - We may need to consider incentivisation structures for maintaining better general skills in our workforce including celebration of the importance of generalist expertise within specialties.

b) Patients with psychiatric disease

- It is widely acknowledged that there is an extraordinary burden of mental health issues in society
- “Preventative mental health” is an under-developed concept and should be explored
- Suicide is a significant cause of death in younger age categories and there is scope for significant reduction
- Digital safety is an underexplored area and requires improved understanding. As with digital health literacy, these issues can impact all groups of people but may have a disproportionate impact on disadvantaged groups



- Integrated care systems seem an appropriate place to position mental health services both in terms of scale and range of services required for a given population

c) Children

- The age at which public health measures to improve child health should be targeted is probably increasing (more focused on adolescence)
- We should be cautious that health inequalities in childhood can be very profound
- Mental health concerns are becoming an increasingly prevalent issue in this age-group.

d) Ethnic minority populations

- We need to be far more focused on the profound and widening health inequalities ethnic minority populations are susceptible to
- We need to be better at providing appropriate sources of information and means of communicating to ensure equitable access to healthcare and empowering them to participate in shared-decision making
- We need to consider how the expanding use of digital technologies will impact upon these groups of people
- We should have ethnic minority populations at the fore-front of our thinking regarding the development of these technologies
- We need to acknowledge that past issues have meant many are now wary of speaking out in this area for fear of further personal recrimination – so we need to actively engage with them in order to support them and enable them to speak out.

e) Women's health

- There should be a renewed focus on providing appropriate services promoting women's health
- This should include, but is not limited to, ease of access to sexual health services.

f) Patients undergoing surgery or significant interventions

- There should be a focus on optimising patients prior to surgery or significant intervention regimes (e.g. chemo/radiotherapy)
- This improves outcomes from the treatment
- This is increasingly important as the average age and clinical complexity of patients undergoing procedures is increasing
- “Pre-habilitation” offers an opportunity to mitigate the risk of adverse events related to the treatment, and to review other issues such as polypharmacy
- Exercise programmes are an example of an initiative to promote patient optimisation
- Clear shared-decision making models around treatment options and alternatives should be encouraged.



Where should we be targeting changes?

a) Geography

- Internal migration means that there is often a mismatch between a geographical area's capability of providing a given health service and where the demand for those services is concentrated
 - It is unclear how the COVID-19 pandemic may impact this phenomenon so this needs to be actively monitored for emerging trends (i.e. will people migrate out from cities to more rural areas as they need to commute less)
 - We may need to be open with patients regarding what services are available to them locally and that they may need to travel for certain services
 - This is relevant for a wide range of issues including the multi-morbid, older patient but also for issues relating to sexual, alcohol and addiction health
- This relates to issues of specific service provision and distribution of the health and care workforce. We need to start thinking about how we can attract doctors (and other relevant workers) to these more rural areas
 - This is particularly the case for younger doctors
 - Incentivisation structures may be required – though beware of 'bonded schemes' – mixed international evidence

b) Locally-led innovations

- There is general agreement that many public health innovations should be locally led, whilst recognising that many public health activities function well at a regional level, as this facilitates better integrated care approaches and better understanding of local population needs
- We should be cautious that this does not lead to inequalities across the country because of some local authorities performing better than others
 - This has been apparent during the COVID-19 pandemic
 - This requires strong local leadership
- A strong national body to provide input and additional support where necessary is important
 - This will also allow for "surge capacity"
 - We need to strike a careful balance between this local and national approach
 - National programmes with local nuance may be an appropriate model to pursue
 - A national strategy for reducing inequalities
- Finding the right balance of local, regional and national is crucial
- It is essential to avoid and indeed undo the fragmentation of health, social care and mental health services which has caused huge difficulties in recent years
 - There should be a focus on joint-commissioning.

c) Workplace

- We should appreciate the role that being in employment generally and the workplace specifically can play in improving an individuals' health from both a psychological and physical perspective – work is good for health



- We appreciate that there are still workplace risks which need to be managed and mitigated
- We should work to improve possibilities for individuals with a variety of health issues to find work that is suited to them

d) Virtual technologies

- The pandemic has emphasised the role for virtual technologies in healthcare delivery.
- Public health delivery should also look to embrace the possibilities of these technologies at scale
- This may help to level up, but also exacerbate certain health inequalities so major efforts are required to ensure accessibility to the most in need
- We need to consider the wide range of people we will seek to engage through these means, who will come from a range of age groups, ethnic backgrounds and socio-economic backgrounds

e) Urgent and Emergency Care

- We acknowledge that Urgent and Emergency Care services should focus upon delivering emergency care to those patients who require this
- Currently Urgent and Emergency Care services often provide a “safety-netting” service to the wider system for issues that should be more under the remit of alternative services
 - These issues are often more appropriately managed in primary care, mental health service or social care settings
 - No patient should be admitted to hospital on an acute care pathway because of failures of the system to deliver care or diagnostics in a timely way
- There should be expansion and investment in alternative services for these patients
 - Examples of these include: Pharmacy, minor injury units, out of hours GP services, 111 services
 - There should be a clear means of access for patients to these alternative services that primary care and 111 are able to direct them towards

4. Other issues discussed

a) Engagement with patients

- A recurring theme is that we need to rethink how we engage with patients on issues regarding their health and what their relationship with the healthcare service should be
- Genuine shared decision making must be at the core
- Patients need to be empowered with information and opportunities to improve their health
- We need to consider how this empowerment process and the toolkit needed may be different for patients from different social and ethnic backgrounds
- We need to have a focus upon what health outcomes are important for our patients and how we can work with them to achieve those



b) Cancer

- This is a cause of death that is of increasing proportions now that we have significantly improved in other areas, such as cardiovascular disease
- Focusing resources on prevention and early detection is demonstrably better than focusing on expensive treatments for more advanced cancer
 - This should be reflected in incentivising drug development targeting the earlier, rather than later, stages of the disease
 - Co-morbid and frailer patients will tolerate a less aggressive intervention far better than the necessarily more aggressive interventions that are required if the cancer is detected later
- Consider the role and development of screening programmes
 - There should be a more sophisticated means of stratifying who gets screening
 - Moving from our current 1970s approach of blanket 'age and sex-based screening', this should take a more holistic approach and consider genetic profile amongst a range of person-specific factors
 - We need to think about how we integrate new technologies into screening programmes as well as improving existing ones.

c) Improved access to diagnostics

- Increased direct access to testing for the population and a range of primary healthcare professionals
- Caveat that these should have clear clinical justification to avoid iatrogenic harm
- Compared to some other countries, early diagnostics (e.g. colonoscopy) are not as easily accessible currently – we can and should do better

d) Transfer of data collection functions of PHE

- PHE currently collects lots of “real-world” data that provides vital information to identify health needs at a national and local level
- This data can inform the commissioning of services
- This data collection function must be transferred to an appropriate body

e) Other key areas for future strategy

- Anti-microbial resistance
- Exercise programmes and use of a range of HCPs in delivery
- Aligning screening programmes to current need
- Social-prescribing
- The value of small interventions making a big impact
- Develop a yardstick by which to measure any proposal for change. For example
 - Is it able to produce and use timely data to inform effective and evidence based commissioning?
 - Does it cover all disadvantaged groups?



- Is it able to tackle health inequalities in an evidence based way?
- Can it ensure that clinical expertise and Local Authority expertise are combined to in the design of services to ensure optimal population-based healthcare?
- Does it enshrine shared-decision making?

There will be others

Acknowledgements

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