ARGYLL AND BUTE COUNCIL **COUNCIL**

PUBLIC HEALTH (NHS HIGHLAND) **30 NOVEMBER 2017**

NHS Highland Director of Public Health Annual Report 2017: Realistic Medicine

1.0 EXECUTIVE SUMMARY

NHS Highland's Director of Public Health report for 2017 considers the ethos and role of Realistic Medicine in delivering higher quality health and social care.

Realistic Medicine as a concept was launched by the Chief Medical Officer in her annual report in 2015 and was further developed in her subsequent annual report entitled Realising Realistic Medicine.

The 6 core elements of Realistic Medicine are:
- Shared decision making
- Personalised approach to care
- Reducing unwarranted variation
- Reducing harm and waste
- Managing risk better
- Making innovative improvements

Many of the tenets of Realistic Medicine have long been recognised as indicators of quality and have been at the heart of much improvement work. But through uniting these concepts in one shared philosophy in a challenging financial climate Realistic Medicine has gained a momentum and following across Scotland.

This report includes examples of Realistic Medicine in action from across NHS Highland and reflects on frailty and end of life care in particular as areas from which further benefits could be reaped using a Realistic Medicine approach. Many of the case studies have been kindly provided by the Area Clinical Forum.

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2.0 INTRODUCTION

This year's report begins by illustrating the current challenges facing the health and care of our population from both a Scottish and a NHS Highland perspective. Spending on health and social care delivery has been increasing as a percentage of gross domestic product (GDP) since 1900 and has resulted in an impressive rise in life expectancy. There are multiple drivers for the costs of health and social care delivery including: increased and earlier onset of chronic disease and multi-morbidity conditions, developments in medical and pharmaceutical technology, an ageing population and increases in the national minimum wage.

As a result of all of these factors both health and social care provision has also become more complex and potentially unsustainable so there is a need to adopt new approaches. One example is considering new models of housing provision such as extra care, modular housing as an alternative to current care home and home care arrangements.

In Scotland these challenges have resulted in a shift in thinking about how to maximise value in health and social care and have precipitated Realistic Medicine. Internationally other countries have developed their own approaches, many examples of which are shared in this report. For example the Buurtzorg district nurse model originated in the Netherlands and is being piloted in NHS Highland. A comparison of these international approaches demonstrates they have many similarities however it also highlights the importance of the local culture and context in determining each model's success. In light of this it is recommended that robust evaluation work accompanies any adoption of international models.

3.0 RECOMMENDATIONS

The Council is being asked to consider the presentation and the terms of the report.

4.0 DETAIL

This report considers in depth two areas which could benefit from a Realistic Medicine approach: end of life care and frailty.

1) End of Life Care

Across NHS Highland there is substantial variation in where people die. This variation is affected by geography, gender, condition type and age. Over the last 35 years there has been a reduction in the proportion of people dying at home and an increase in those dying in acute hospital and care homes. Men are more like to die in their own home than women, those dying from dementia and related conditions are most likely to die in community settings and those dying from renal, liver or respiratory related conditions are more likely to die in an acute setting.

Providing good end of life care requires clinical, community and family support. One firmly established way in which clinicians can support end of life care by being proactive in discussing individual's wants and needs and recording this in the form of Anticipatory Care Plans (ACPs) and key information summaries. Prognostic uncertainty has been identified as a barrier to such discussions and the absence of an ACP may result in people receiving futile and invasive treatment. It is estimated that between 30-38% of patients may have received non-beneficial treatment near the end of their lives.

The public health team have been working with Highland Hospice to develop the concept of a Compassionate Community and this is now embedded within the hospice's three year strategy. Helmsdale is also developing as a compassionate community in the form of a Dementia Friendly Community. The public health team have also piloted the use of Eco-mapping in a ward setting to support more personalised care. Eco-mapping is a practical tool which can be used prior to discharge to help both the patient and the healthcare team to map out the range of support a person may have on returning home including both formal and informal supports.

2) Frailty

Frailty is a common condition particularly, although not exclusively, among our older population. Within NHS Highland there are an estimated 13,000 frail older people living in the community and around 1,100 in residential care homes or nursing homes. Frail individuals have up to ten times the rate of adverse outcomes such as falls, and hospitalisation. They are less able to adapt to stressors such as illness and trauma and have higher mortality rates. There is significant variation in emergency hospital admission rates across Highland and Argyll and Bute, suggesting that there is variation in the way in which such frailly is dealt with.

To reduce frailty we need to promote interventions that improve physical functioning, particularly during hospital admissions, by increasing muscle mass and strength, particularly progressive resistance strength training, exercise involving gait, balance, co-ordination, and encourage walking on a daily basis. For hospitalised patients, better outcomes for patients are associated with care delivered by geriatric-specific and multi-disciplinary teams, particularly when these were delivered in designated units or wards. This approach has been successfully used for hip fracture management in Raigmore and resulted in national recognition. Other Interventions identified by the literature that reduce hospitalisation include certain types of nurse-led unit, tele-healthcare for long-term conditions, discharge planning from hospital to home, case management in heart failure and integration with generic case management. Whilst some of this work is already being undertaken there is scope to do more.

5.0 CONCLUSION

Applying Realistic Medicine could assist in delivering the vision laid out in Argyll and Bute Health and Social Care Partnership Quality and Finance plan: that people in Argyll and Bute will live longer, healthier, happier independent lives. In particular it could assist in:

- Efficiently and effectively managing all resources to deliver Best Value
- Support people to live fulfilling lives in their own homes for as long as possible
- Reduce avoidable emergency admission to hospital and minimise the time people are delayed
- Support staff to continuously improve the information, support and care they deliver

6.0 IMPLICATIONS

6.1 Policy

There are no direct policy impacts.

6.2 Financial

Implementing Realistic Medicine and care will provide better health and social care for patients. It is anticipated that through reducing excessive or non-beneficial investigation and treatment and reducing harm, waste and variation in health and social care delivery that efficiency savings would be made.

6.3 Legal

There are no direct legal impacts.

6.4 HR

There are no direct HR impacts.

6.5 Equalities

It is acknowledged that some elements of Realistic Medicine have the potential to be in conflict with each other. For example it may be challenging to provide more personalised care at an individual level whilst reducing unwarranted variation at a population level.

6.6 Risk

Risk assessment not carried out.

6.7 Customer Service

There are no direct Customer Service impacts.

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