Health & Social Care Committee: *Supporting people with chronic conditions*

Public Health Wales Briefing Note for Committee 24th January 2024

18th January 2024

Background

In June 2023, Public Health Wales responded to the Consultation by the Committee. In our submission we identified that Chronic or long-term conditions are experienced by 46% of adults in Wales, with 19% experiencing two or more long-term conditions. Musculoskeletal conditions were the most frequently reported at 16%, followed by heart and circulatory problems (11%) and mental health problems (10%).

These conditions are all characterised by their long-term nature and by the potential for prevention either by detecting risk factors and acting before the disease develops or by effective management of risk once the disease has been diagnosed to prevent exacerbation and recurrence of acute episodes.

There are further common features across many long-term conditions:

- The prevalence of many of these conditions is rising globally as well as in Wales and across the UK, as evidenced by the World Health Organisation, Public Health Wales Disease Prevalence programme, and recent Welsh Government Science Evidence Advice.
- With the rise in prevalence, the impact on peoples' lives worsens as well as increasing preventable cost to the NHS, social care and the economy.
- There is a social gradient, with the poorest typically experiencing worst outcomes across the course of a chronic disease.
- The majority of people who develop one long term condition go on to develop more without the right care and support

The global and western experience suggests strongly that unless we focus on prevention, we will continue to see a rise in need for health and social

care from chronic disease which we will be increasingly unable to sustain financially[1].

Recommended focus of policy

We consider that the evidence suggests there should be two foci of policy on chronic conditions, each of which is necessary to reduce the impact of preventable chronic conditions on the population and its health, and on the Welsh economy:

1. Ensuring that people living with chronic conditions receive care and support that gives them the best possible health outcomes for as long as possible.
2. Ensuring that we make a systematic shift to putting prevention at the core of policies and budgets to halt, then reverse, the decline in preventable long-term conditions.

Putting prevention at the core of chronic conditions response

Many long-term conditions are in principle at least partially if not wholly preventable. The right policy choices and service pathways can prevent onset and prevent avoidable disability and early death. A key policy goal to achieve this would be to address the risk factors which contribute to the prevalence and impact of disease.

This requires a comprehensive approach, split across primary, secondary and tertiary prevention, and the determinants of disease. This includes

- **Primary prevention**, which aims to prevent conditions developing in the first place. Some of this can be achieved in relatively short term (eg reducing smoking in the population and as a result heart disease and cancer). Other work needs a more long-term focus and much of this is needed at a societal level:
  - There is increasing recognition of the role of wider determinants, as drivers of non-communicable diseases, and their influence in shaping the physical and social environments in which people live, work, play, learn and love
  - As recognised in A Healthier Wales, a "health in all policies" approach is needed to make a difference to these wider social and economic influences, such as housing, parenting, education and employability, healthy food

[1] Transforming global approaches to chronic disease prevention and management across the lifespan: integrating genomics, behavior change, and digital health solutions - PMC (nih.gov)

supply and making physical activity and conditions for good resilience and happiness core to everyone's life.

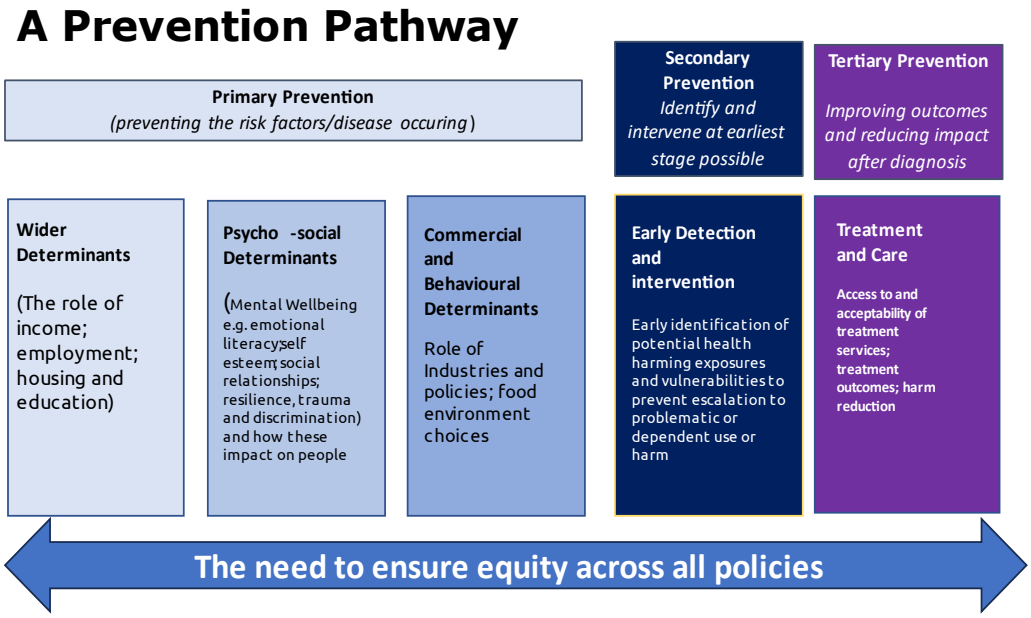
- **Secondary prevention**, aimed at reducing the impact of a condition where there is evidence that this has already begun to occur. The goal here is to identify onset of risk factors and intervene at the earliest opportunity (eg the All Wales Diabetes Prevention Programme)

- **Tertiary prevention**, which aims to reduce the disease, disability, reduction and complications of an established condition. Benefits of undertaking tertiary prevention comprehensively would be

    - Slowing or stopping the progress of disease to complications, disability or death
    - Halting the rise in the proportion of people with one condition developing multiple conditions including poor mental health
    - Slowing then halting the rise in people reporting poor quality of life, inability to work or perform daily activities and as a result needing increasing levels of care

Early intervention can make a substantial difference to peoples' healthy and disability free life expectancy and their quality of life and happiness.

A key point is that addressing chronic conditions needs an approach across all of primary, secondary and tertiary prevention. If primary prevention is neglected, then we will never stop the rise in disease. If tertiary prevention is neglected, then many people with existing disease will progress avoidably to early complications, disability and potentially death. For this reason we recommend a policy approach that adopts a clear pathway to prevention as outlined in the figure below.



Diabetes as an important example

Public Health Wales published prevalence of disease studies on 14th November 2023[2] which showed that there has been a 40 per cent increase in the number of people living with diabetes in Wales in just over the last 10 years - an increase of 60,000 people.

Type 2 diabetes is a leading cause of sight loss and a contributor to kidney failure, heart attack and stroke. In 2021/22 alone, more than 560 people in Wales underwent amputations linked with diabetes. Current estimates suggest 10% of the NHS budget in Wales is spent on the impact of Diabetes. Diabetes related hospital spells cost the Welsh NHS an average of £4,518 per spell in 2021/22, not including spells requiring amputations. £105 million was spent on drugs to manage diabetes in Wales in 2022/23.

More than 200,000 people in Wales are already living with diabetes, around eight per cent of adults. Around 90 per cent of these cases have type 2 diabetes (T2DM), over half of which could be prevented or delayed with behaviour changes.

Projections indicate that by 2035 1 in 11 people could be living with Diabetes Type 2, an increase of 22% or 48,000 new diagnoses. The projections and historical analyses show that the prevalence of diabetes is increasing, and the prevalence of complications in people living with diabetes is increasing. This represents significant preventable cost to the NHS, Social Care and the economy Such an increase in cost and

[2] Diabetes prevalence – trends, risk factors, and 10-year projection - Public Health Wales (nhs.wales)

prevalence would mean more people experience life-limiting illness and potential complications from diabetes, put significant additional pressure on health services and on the economy.

While there are evidence-based programmes in existence to prevent diabetes (including the All-Wales Diabetes Prevention Programme) and enable clinicians and people living with it to have the best possible outcomes, these are not making the scale of impact needed to avoid the projected cost and impact. Diabetes-remission programmes have shown impact for T2DM especially,but a remission programme will not reverse the projected situation in and of itself. The programme is intensive (for some arduous), resource intensive and remission rates decline from one year onwards. This cannot be the main or lasting solution to the rise in prevalence, even though for a defined cohort it will play a part.

Currently Public Health Wales is working with the National Clinical Reference Group for Diabetes, Clinicians, the NHS Value and Sustainability Board, Welsh Value in Health Centre and Welsh Government to develop and agree a programme on Diabetes with the aims of:

- Having more people living well with diabetes (Types 1 and 2) as measured through a reduction in amputations and other diabetes pathways
- Stopping the prevalence of diabetes increasing, focusing principally on T2DM

The importance of Primary Care in supporting people with chronic conditions

The Primary Care Model for Wales recognises the need for a model of care which addresses individuals' social as well as medical needs, and which allows for a more sustainable, holistic approach.

Health and care services, which focus on a single condition alone, are often not person-centred, leading to multiple interactions with healthcare professionals, and an inability to consider a person's needs in a holistic way where the individual is experiencing multi-morbidities/ multiple risk factors. The Prevention Based Health and Care model (PHBC) discussed above, as part of a concerted shift to prevention, could enhance the ability of primary care to enable people with chronic conditions to live as well as possible.

An important issue the committee could ask those it engages with to consider is whether current Primary Care model is optimally designed and resourced to achieve the outcomes that are needed to transform health and wellbeing in Wales.

A Prevention Based Health and Care Framework (PHBC)

In the context of secondary and tertiary prevention, as stated above, many long-term conditions are characterised by their potential for preventive interventions at individual level, either through detecting risk and acting before disease develops, or by effective management of risk to prevent poor outcomes from established disease.

There are many examples of prevention in the NHS and social care, some of which are delivered systematically, e.g. immunisation, screening. However, much of the prevention activity aimed at addressing clinical and behavioural risk factors is opportunistic in nature, implementation may vary in effectiveness, quality and alignment to clinical guidance, and the 'offer' may be inequitable. But the task remains to create the conditions to embed prevention and early intervention into routine care in NHS and social care services.

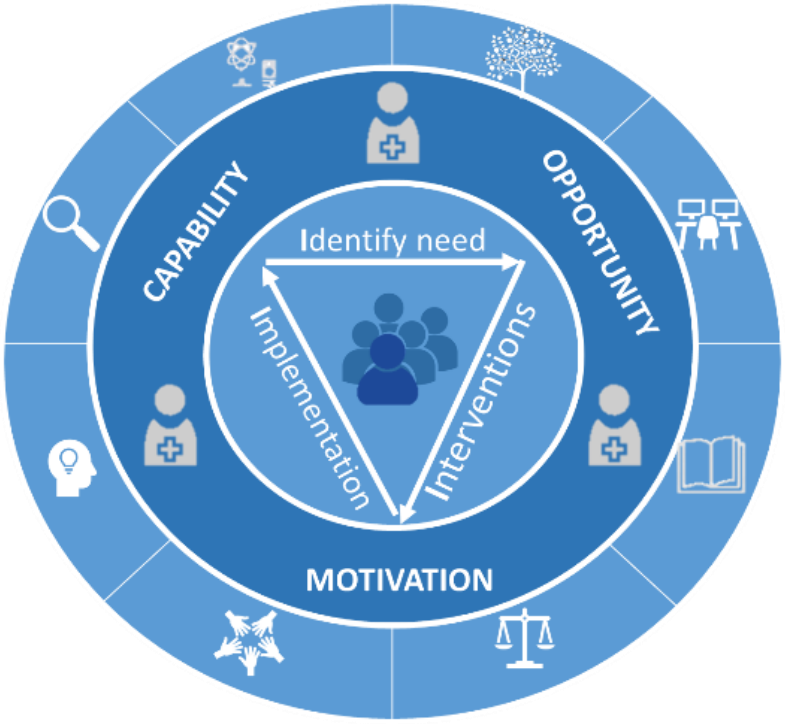
Public Health Wales' Prevention-Based Health and Care (PBHC) Framework looks to maximise the potential population benefits of prevention embedded in health and social care while continuing to meet the needs of individuals and groups. We believe embedding this across health and social care could significantly enhance the impact of secondary and tertiary prevention in supporting people with chronic conditions.

The PBHC Framework encompassing three main components:

1. A ***Prevention Triad***, focussed on:

    1. ***Identification of need***, systematically at both individual and population level
    2. ***Interventions***, which are effective and evidence-based,
    3. ***Implementation***, which is high quality, aligned to the six domains of healthcare quality ie. person-centred, safe, effective, efficient, timely and equitable

2. ***Workforce capability, opportunity and motivation –*** recognising the key role of the workforce, encompassing considerations for the existing workforce as well as recognising emerging evidence for dedicated roles in prevention e.g. social prescribing.



3. ***System factors -*** aligned to the Value in Health programme's 'pillars', these factors recognise that a systems approach can be achieved through: leadership, collaboration and influence, people involvement, engagement and experience, digital health, data and analytics, research, evidence and impact delivering value, and strategic partnerships.

Through a partnership and co-production approach, PBHC is designed to enable stakeholders to identify how PBHC can be embedded at all population levels from neighbourhoods/ clusters, to local authority, health board and national levels

The PBHC Framework, to be published by Public Health Wales in April 2024, will illustrate PBHC in practice by using case studies to recognise existing good practice and exemplars, to demonstrate the application of the framework through condition-based, place-based and lifecourse lenses.

Whilst people can and should be empowered to directly access community assets to support their health and wellbeing, it is recognised that a spectrum of support is required to enable effective behaviour change so that people can engage in activities and access the interventions or services they need. This is illustrated in the diagram below (figure 1). The level of support a person needs will vary over a person's lifetime and be dependent on the circumstances people find themselves in and how we behave towards people seeking support is crucial.

Mental Health

There is growing evidence that people with chronic disease face mental health challenges, and that many people with long term mental ill-health also experience preventable chronic physical diseases, and may have poorer physical health than people without long term mental ill-health[3]. The committee could usefully consider the nuanced inter-relationships between mental and physical ill-health in chronic disease as part of seeking a strategic shift to preventing and managing chronic disease.

Self-Management and peer-support

There is a substantial role for self-management and self-care in chronic disease[4], but this needs to be carefully planned and designed. There is a good body of evidence[5],[6] on the role of self-management for people living with chronic disease, including forty years' experience from HIV and other fields. Self-management and peer support efforts need to be designed in a way which is relevant to peoples' life experience and situation.

Empowering people to take action to support their own health and wellbeing

Public Health Wales contributed a section on empowering people to take action in the National Framework for Social Prescribing publiced by Welsh Government in January 2024. We reproduce part of this section here to assist members:

> *As shown in the diagram, people are often prompted to act following contact with a health or other professional who provides advice, signposting or referral to a specific community asset they feel may be beneficial.*

[3] Supporting the physical health of people with severe mental illness (nihr.ac.uk)
[4] Type 2 diabetes self-management schemas across diverse health literacy levels: a qualitative investigation: Psychology & Health: Vol 37, No 7 (tandfonline.com)
[5] Helping patients help themselves: A systematic review of self-management support strategies in primary health care practice - PMC (nih.gov)
[6] Improving patient education: a new guide for policy-makers and health professionals to support self-management of chronic conditions (who.int)

*'**Making every contact count**' is an approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing.*

*In other circumstances, dedicated wellbeing support is needed to enable behaviour change such as the **help me quit** stop smoking programmes, allowing for a much more detailed discussion between the individual and the professional. As the model for social prescribing in **section 4** demonstrates, social prescribing also involves dedicated time for a detailed discussion to understand 'what matters' to an individual and to develop a person-centred action plan.*

Finally, it is recognised that where people have more complex clinical or social care needs, these may need to be met through statutory healthcare or social care services for example a substance misuse service.

Genomics

While there are some chronic conditions which have a genetic component, the promise of genomics is not yet realisable for every chronic condition and while in some areas these technologies show promise, they will not replace a concerted preventive approach described above in the scale and pace needed to avert increasing growth in avoidable disease, disability and death. For the next generation we will still need a concerted portfolio of prevention activities.

Inequalities

Whilst a number of behavioural and clinical risk factors for the development and progression of chronic conditions can be addressed

through effective self-management, it is also recognised that there are inequalities and wider determinants affecting the ability of people to self-manage these risk factors.

Access to health and care services, the quality of those services and the way they are experienced by people, are determinants of health and may contribute to health inequalities. Health inequalities are differences in health across the population, and between different groups in society, that are systematic, unfair and avoidable.

Supported self-management is therefore important to both reduce inequalities and to improve the effectiveness of self-management.

The impact of additional factors such as the cost-of-living crisis, is likely to exacerbate existing health inequalities. People living with chronic conditions were already more likely to be in poverty before the cost-of-living crisis and this will therefore hit people with chronic conditions harder. The National Survey for Wales results (2021-22) indicate that 19% of those living with a long-term condition experience material deprivation compared to 7% of those without a long-term condition

A life-course approach can provide a framework for understanding and addressing the root causes of inequalities with prevention and early intervention. Action is needed across the life-course, encompassing early years, children and young people, adults and older adults.

Contributors

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