Swindon Joint Strategic Needs Assessment Bulletin

Prevention of Chronic Disease

Key Points

- This JSNA seeks to understand both the burden of chronic disease and risk factors that could inform preventative work across multiple conditions, taking an evidence based approach.
- Estimates suggest about 70,000 people in Swindon Unitary Authority have at least one chronic disease in 2015 including 69% of those over 65. There is evidence that people with chronic diseases are often admitted to hospital due to preventable conditions, such as falls, urinary tract infections and cataracts.
- The review of interventions for primary prevention in Swindon concentrated on two topic areas: 'Smoking Cessation' and 'Diet-Activity-Weight' as the Global Burden of Disease study shows a clear link with many chronic conditions. Compared to other areas Swindon does well on measures of physical activity but less well on smoking and overweight /obesity.
- There is more to be done to be effective in preventing chronic disease. Compared to the evidence base, Swindon had gaps for a number of recommended interventions, e.g. digital interventions for smoking, but fared well in other respects, e.g. full use of pharmaceutical strategies to aid smoking cessation.
- Focus groups in Swindon highlighted the benefit of work, relationships, social support, education, information and maintaining independence for good health, a desire for better health and well-being promotion across the life course and the importance of the link between physical and mental well-being.
- The JSNA makes 9 recommendations which include a focus on life course approaches and the needs of population sub-groups.

What is a Joint Strategic Needs Assessment (JSNA)?

A JSNA helps us to understand:
What we know about the current health and wellbeing needs of local people; how their needs are currently being met; what we think their future needs are likely to be; and how their needs can be best met. We want to understand Swindon's changing population, what is happening in Swindon and what makes a difference to people's health and wellbeing so we can plan for the future.

This Bulletin is a shortened version of the 'Prevention of Chronic Disease' JSNA. The subject area is a complex but urgent one and has many facets. It includes the range of common health conditions which affect the lives and well-being of an ageing population, often beginning in middle age. The interventions which can prevent disease and disability from occurring or which can stop them from becoming worse are reviewed in this JSNA and findings from patient focus groups are reported.

Main Purpose and Methods

The main purpose of the JSNA was to link up a number of perspectives on the health of Swindon:

- to give an overview of the burden of chronic disease in the population of Swindon, with a focus on selected conditions,
- to look at the underlying common causes of chronic diseases, as manifest in risk factors,
- to assess how well the local health community is performing in using interventions from the evidence-base to prevent these conditions from occurring or becoming worse.

The Integrated Care Chronic Disease Management (IC CDM) Group defined the brief for the work, (a subgroup of the Integrated Care Board now the Integrated Care Clinical Board).

Standard sources of data were used for morbidity and mortality, and for risk factors we utilised Public Health England indicators and the Global Burden of Disease model. A subset of chronic diseases agreed by the IC CDM Group were included:

- Cardiovascular Disease,
- Diabetes,
- Chronic Obstructive Pulmonary Disease, Asthma,
- Osteoarthritis of Knee, Osteoarthritis of Hip, Rheumatoid Arthritis,
- Low Back Pain,
- Liver Disease, Chronic Kidney Disease

Other Conditions, (e.g. dementia, Mental Health) were touched upon as appropriate.

In the review of interventions for primary prevention, two topic areas were focused on: 'Smoking Cessation' and 'Diet-Activity-Weight'.

In a set of 'Gap Analyses' the Cochrane Database of Systematic Reviews, the NICE Baseline for Smoking Cessation, and Public Health England's framework, 'What Good Healthy Weight for all Ages Looks Like' were used as standards of good practice. The range of current primary prevention services in Swindon were then compared against these in order to see whether full or partial gaps existed and what could be learnt to inform our prevention work going forward.

To understand the lived experience of people with chronic conditions, five focus groups were carried out in a variety of settings. These included condition-specific groups in a local hospital setting, a group of residents in sheltered housing run by the local council, a group of people supported by community workers in a local community centre, and a group of community workers who supported people living with long-term conditions.

Questions explored included whether there were any key events or activities in their life course which participants believed may have affected their health and wellbeing. Overall, the aspiration of the JSNA was to find a small number of important common strands that might help simplify and optimise our preventive strategies.

The Burden of Chronic Disease

Chronic diseases (also known as Long Term Conditions) are common in the population of Swindon. In all, the Symphony model for Swindon suggests that about 70,000 people in Swindon UA had at least one chronic disease in 2015, (32.2.% of the population), while for people aged 65 years or more the corresponding figure was about 23,000 people (69.3% of the population aged 65 years or over.) These figures include mental health as well as physical health conditions.

Data from the QOF registers of disease from primary care (for Swindon CCG population as at March 2019) indicate that the level of most physical conditions in Swindon were broadly similar to those in England as a whole. For example, 2.77% of people (6,683) in Swindon were known to have Coronary Heart Disease, 1.54% of people (3,723) were known to have Stroke/Transient Ischaemic Attack and 1.71% of people (4,117) were known to have Chronic Obstructive Pulmonary Disease. However, in all 7.63% of people (14,486) in the Swindon CCG population, were known to have diabetes, a slightly higher prevalence than that recorded for England as a whole. Modelled data for arthritic conditions suggested that the prevalence of osteoarthritis might be higher than in England as a whole: in all 11.1% of people (10,650) in the Swindon population aged 45+ years and 18.8% of people (18,038) in the Swindon population aged 45+ years were estimated to have hip and knee osteoarthritis respectively, and some may have had both. It was common for people with chronic diseases to be admitted to hospital because of falls, urinary tract infections and cataracts, conditions which are preventable.

Risk Factors and Prevention Clusters

In terms of the major risk indicators from Public Health England, Swindon's comparative rankings (relative to similar populations known as statistical neighbours) were less good for:

- Isolation within social care,
- Self-reported satisfaction with life,
- Smoking prevalence,
- Overweight and obesity.

For three indicators Swindon was shown to be significantly worse than England:

- Smoking prevalence,
- Educational attainment,
- Depression.

Swindon's rankings were comparatively good for:

- Deprivation,
- Statutory homelessness,
- Employment,
- Physical activity.

Thus, in terms of lifestyle Swindon presented a mixed picture, comparing well on physical activity, and comparing poorly on smoking and overweight/obesity. Some of the psycho-social indicators (isolation, satisfaction, depression) were also comparatively less favourable for Swindon's population.

In an examination of risk factors from the Global Burden of Disease model, it was difficult to assess which risk factor or cluster of risk factors might have the greatest overall detrimental influence on health in Swindon, but tobacco and high Body Mass Index (BMI) (which is often linked with diet and low physical activity) featured prominently. Accordingly these were chosen as prevention clusters for further scrutiny referred to as 'Smoking Cessation' and 'Diet-Activity-Weight' respectively.

Gap Analysis for Smoking Cessation

Swindon had a higher prevalence of smoking, 17.7% in adults, than England as a whole. Swindon compared well against the NICE Baseline Assessment tool, but when viewed together with the Cochrane Database of Systematic Reviews, a number of gaps emerged. Swindon had omissions, full or partial gaps in the following areas:

- Targets for quit rates not having been met;
- Use of digital technology to support smoking cessation (although texting is currently in use as an adjunct);
- Use of material or cash incentives to support smoking cessation;
- Provision of optimum follow-up services for smoking cessation when people have had a health-check;
- Full use of NHS staff and NHS records to support smoking cessation;
- Group therapy, gradual reduction, and relapse support in smoking are not offered at present;
- Services are not provided in a targeted way to some groups who are at high risk, especially those in deprived groups, although there is some degree of outreach to those with a history of mental illness.

In contrast, Swindon was judged to be particularly strong in:

- Use of pharmaceutical methods (appropriate medicines, nicotine patches and so on) to aid in smoking cessation.

Gap Analysis for Diet-Activity-Weight

In Swindon 63.7% of adults were overweight or obese, similar to the level in England as a whole. At the same time 71.6% of the Swindon adult population was physically active by the Chief Medical Officer's definition, a level better than that in England as a whole. Comparing Swindon interventions for Diet-Activity-Weight with the Cochrane Database of Systematic Reviews there were relatively few omissions. The only full gap for Diet-Activity-Weight was in multi risk-factor interventions for the prevention of Coronary Heart Disease, which in practice corresponds to the primary care healthcheck scheme. Although Swindon has a healthcheck service there is no specific targeting of people in more deprived areas of Swindon, who are the population most likely to gain from this particular approach.

In terms of the PHE framework, 'What good healthy weight for all ages looks like' (a traffic light assessment), Swindon was not assessed to be at Green on any of the Seven Pillars. Swindon was assessed as Red for:

- Systems leadership,
- Community engagement,
- Life course approach.

Swindon was at Amber for:

- a health promoting environment,
- a focus on inequalities,
- monitoring and data collection, and
- A whole systems approach to obesity: local agencies, organisations and stakeholders are at the initial stages of a system-wide approach.

Qualitative Research and Focus Groups

There was a range of responses from the focus groups on the topic of prevention, and several points across the life course where, participants believed, prevention might make a difference.

Common themes were:

- work relationships, social connection and social support, education and information, and independence were important for maintaining good health;
- there was a desire for better health and well-being promotion across the life course;
- the nature of and length of time a person has lived with a chronic condition made a difference to its impact;
- similarly, a person's attitude towards their condition had an effect, and this seemed linked to age;
- Interactions between physical well-being and mental well-being were believed to be important factors to be taken into consideration in primary, secondary and tertiary prevention;

"It doesn't stop me doing anything. It just takes a lot longer to do it."

"There are some things I will never be able to do as well as I used to, like multi-tasking."

"Those things that you did without thinking, you don't do anymore."

"There's always help…people are very kind."

"I can't go anywhere on my own, so I'm stuck."

"My husband is an absolute star."'

"'If I hadn't met [friends], *I don't think I'd have pulled out of this."*

"I had to adjust. I had to find a new version of my best self."

Key Experiences which were felt to affect health

Implications of the Findings and Further Considerations

The main narrative that has emerged in this JSNA is not a straightforward one. Despite all the well-known associations between risk factors, and between risk factors and diseases, it was not easy to identify common strands running through all the data which seemed to account for the greater part of chronic disease in Swindon. Moreover, there was not a 'golden bullet' or small number of interventions which might be likely, by themselves to make a significant impact on the population's health. More surprisingly, we found very little solid evidence in the literature that seemed to address directly the needs of minority groups in our population, with some possible exceptions.

On a more positive note, there were many usable interventions and strategies for prevention in the literature, namely for encouraging Smoking Cessation and improving Diet-Activity-Weight. A large proportion of these interventions are being implemented in Swindon, although there are some gaps which are documented in full in the main JSNA report.

Swindon still has much to attain in reaching the high standards of the PHE's latest framework for healthy weight, but the framework represents a very advanced state of health improvement, in which a whole community is working together in an integrated way.

The strategies and interventions needed to prevent chronic diseases have to match the complexity of the social, biological and environmental life of the population. Furthermore, this complex activity will have to include targeted interventions for minority groups to be really effective in addressing inequalities; a complicating factor is that such targeted interventions are not well-covered in the literature.

The common strands of prevention might lie more in public health workers engaging with points in the life course and with sub-groups in the community rather than searching for a small number of broad spectrum interventions.

Moving Forward Together

An abbreviated version of the recommendations that have arisen from this work are given on the following pages.

The full report will shape the ongoing work of the Integrated Care Chronic Disease Management Group as well as inform thinking across BANES-Swindon-Wilts (BSW) around prevention and delivery of the NHS Long Term Plan.

Recommendations

(1) This JSNA should inform work across the Integrated Care System and in particular workstreams around Ageing Well and Prevention across BSW.

(2) Public Health should consider the gaps in its smoking cessation interventions (digital methods, support for people with a history of mental health problems, the deployment of different types of NHS staff to support smoking cessation) when commissioning or developing services to ensure that local implementation of services is evidence based.

(3) Using the evidence base as outlined in this JSNA should be standard practice when developing new services or in service redesign.

(4) Swindon should consider implementing a whole systems approach to obesity by creating a system of local agencies and organisations working together including full community engagement. This would be led by the Get Swindon Active and Healthy Weight partnership.

(5) Commissioners should ensure that all services have a strong focus on reducing inequalities; this includes improving data collection to monitor contracts to understand the impact on inequalities and vulnerable groups.

(6) Public health should promote a life course approach to health including the importance of different approaches to promoting health at different stages of the life course. This should be informed by knowledge about the trigger points to poor health or increased need such as bereavement, diagnosis or change in work circumstances.

(7) The IC Chronic Disease Management Group should investigate further measures to prevent hospital admissions for people with chronic diseases; many of these admissions are due to other conditions which might have been prevented or alleviated such as falls or Urinary Tract Infections.

(8) Further work is needed to embed an understanding of the importance of the interaction between mental well-being and promotion of physical health in terms of work, relationships, social connection and social support, education and information, and independence, at different stages of the life course. This may be an area that could be considered across BSW.

(9) Further work should include an appraisal of all existing preventive interventions in Swindon to ensure that they are supported by strong evidence, are cost-effective, but also are working optimally in the local context. If a local intervention does not meet these criteria and there is no other good reason to maintain it, then it would be a candidate for disinvestment.

Selected Key References

Cochrane Collaboration. Cochrane Database of Systematic Reviews. https://www.cochranelibrary.com/cdsr/about-cdsr

Institute for Health Metrics and Evaluation: Global Burden of Disease Model. https://vizhub.healthdata.org/gbd-compare/

NICE Baseline Assessment Tools: https://www.nice.org.uk/about/what-we-do/into-practice/audit-and-service-improvement/assessment-tools

Public Health England: Public Health Profiles, https://fingertips.phe.org.uk/.

What good healthy weight for all ages looks like. https://www.adph.org.uk/wp-content/uploads/2019/07/What-Good-Healthy-Weight-Looks-Like.pdf

Where to find more Information

The full JSNA for Prevention of Chronic Disease is available on the JSNA website at http://www.swindonjsna.co.uk/ where a full range of health topics is also covered.

Queries can be made to jsna@swindon.gov.uk.

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