

Deep Dive: Secondary Prevention

Knowledge, Research and Information Committee

17 June 2025



GIG
CYMRU
NHS
WALES

Iechyd Cyhoeddus
Cymru
Public Health
Wales

Purpose

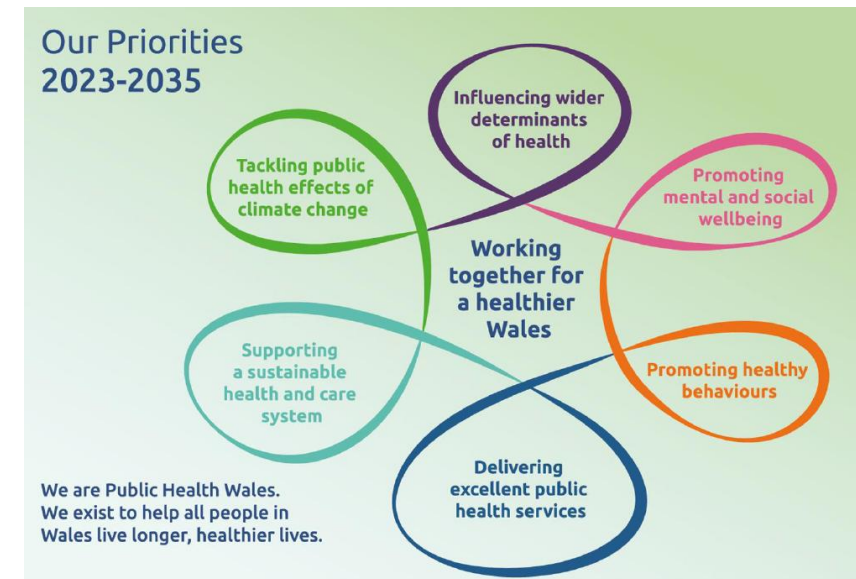
- Provide assurance to the Committee on progress of Health & Wellbeing Directorate work on secondary prevention
- Provide examples of how secondary prevention is embedded in public health programmes and activities across the organisation
- Consider research, data and digital requirements

Background – Our Organisational Approach to Secondary Prevention

PHW Long Term Strategy – Strategic Priority 4:

Supporting the development of a sustainable health and care system focused on prevention and early intervention

Objective: By 2035 we will have maximised opportunities to prevent disease morbidity through a focus on secondary prevention and health and care interactions, including ensuring resources are allocated fairly



Examples of PHW Programmes Addressing Secondary Prevention

- **Public Health Services** - screening programmes
- **Research Data & Digital Directorate** - State of the Nation, Cancer Registries, Suicide prevention, disease registers, prevalence studies and projections, digital, evaluation
- **Nursing, Quality & IG** - user engagement and support/patient empowerment
- **Health Improvement Division** – NERS, Help Me Quit in Hospital settings

Life Course programmes:

- Postnatal health and wellbeing
- Social prescribing approaches for children and young people with mental health and/or wellbeing support needs
- Adverse Childhood Experiences programme
- National Safeguarding programme

Our Organisational Approach to Secondary Prevention

PHW IMTP 2025/2028

SP4: Supporting the development of a sustainable health & care system focused on prevention & early intervention

- SO4.1 By 2028, we will have achieved a coordinated approach to prevention and early intervention in the health and care system.
- SO4.3 By 2028, we will have worked with health boards and the wider public health system to slow the rate of increase of the prevalence of type 2 diabetes increasing and to increase the number of people living well with diabetes in Wales.



Our Organisational Approach to Secondary Prevention

PHW IMTP 2025/2028 – Measuring our progress

We are working towards supporting system wide outcomes:

Reduced avoidable mortality rate (2022, the avoidable mortality rate was 274 per 100,000 population, or 22.7% of all deaths.)

Monitor prevalence of non-communicable disease

- Diabetes
- Cardiovascular disease (myocardial infarction, heart failure, stroke/transient ischaemic attack)
- Respiratory disease (asthma and chronic obstructive pulmonary disease)
- Musculoskeletal conditions (osteoporosis and rheumatoid arthritis)

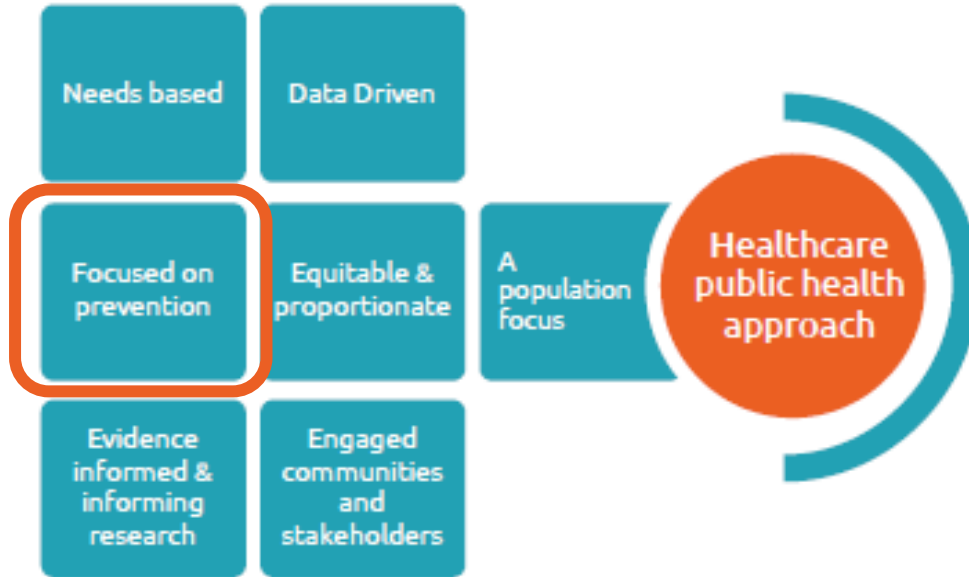
Our Organisational Approach to Secondary Prevention



Healthcare Public Health Framework for Wales – A Whole System Approach



Underpinning principles



Arenas of application



Impacts

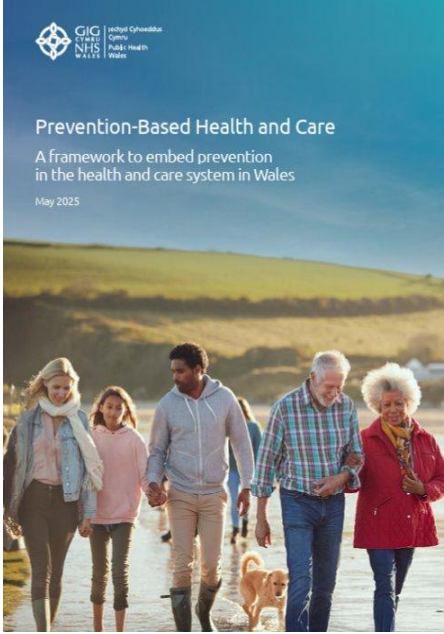


Connected healthcare and integrated health & care system

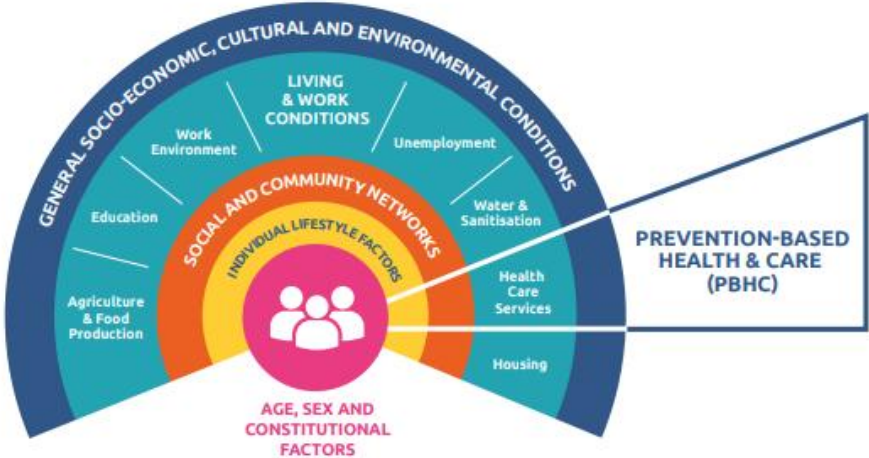


A Healthier Wales

Scope of Prevention-Based Health and Care (PBHC)

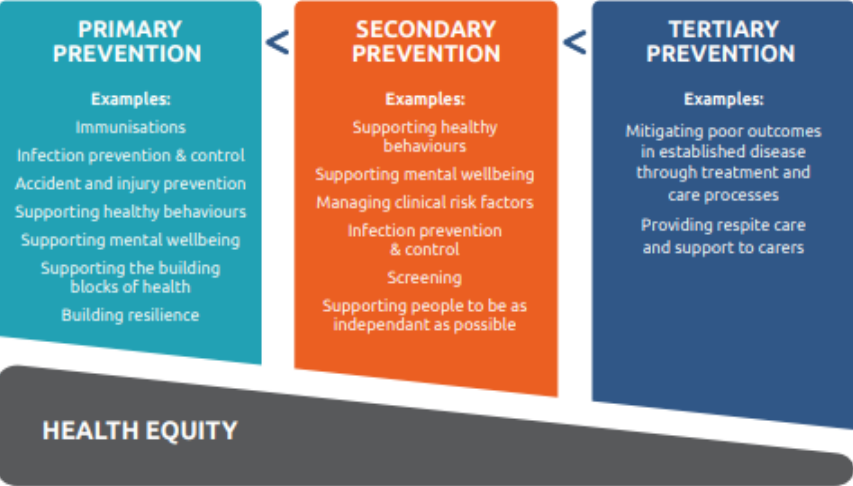
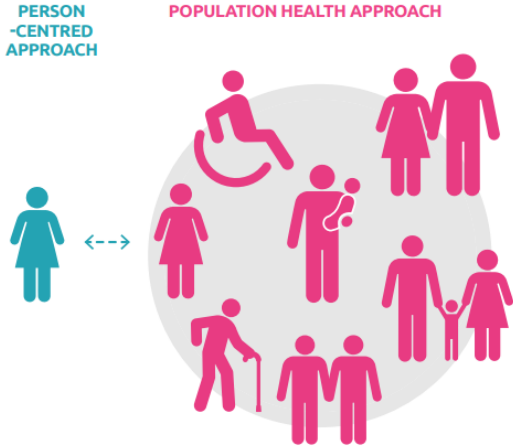


1. Focus on actions within the influence of the health and social care system



2. Recognise different levels of preventative activity exist and all fall within the scope of PBHC

3. Ensure action is person-centered and population health focused

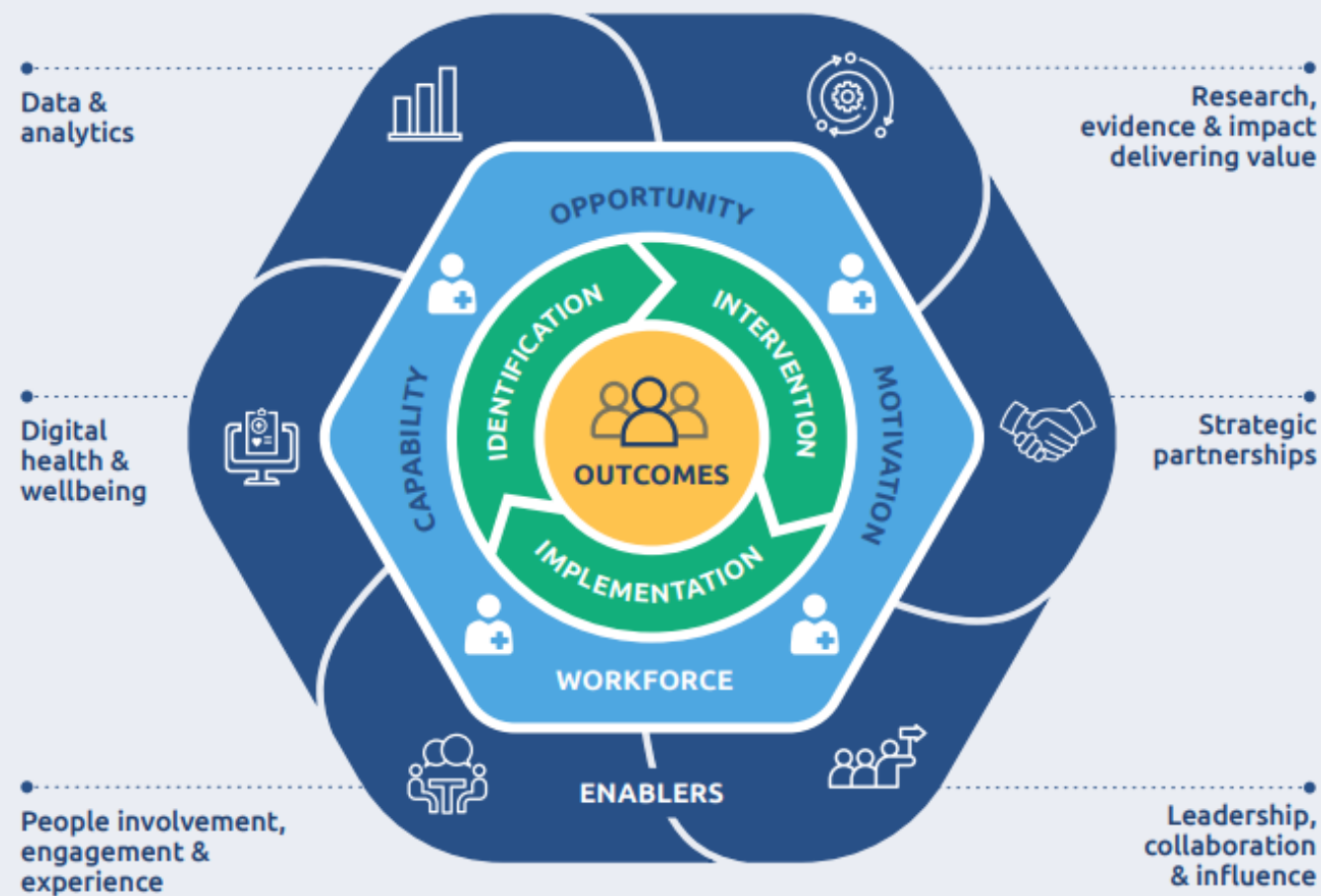


Populations of interest



PREVENTION-BASED HEALTH & CARE

A framework to embed prevention in the health and care system in Wales



Outcomes

- What are the desired outcomes?



Identification

- Who needs to benefit and how can they be reached equitably?

Intervention

- What high quality prevention activity is needed?

Implementation

- How should prevention activity be delivered safely, equitably and in a timely and person centred way?
- Is prevention activity scaled to meet need? Are there gaps in provision? Is there unwarranted variation?



Workforce

- Who will deliver the prevention activity?
- How can optimum conditions be created to support the workforce's capability, opportunity and motivation to deliver prevention activity?



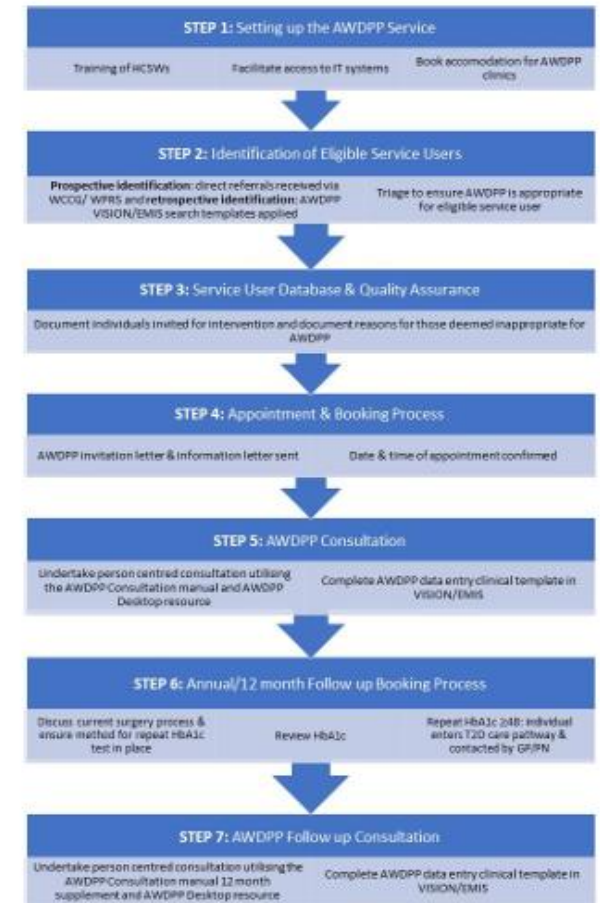
Enablers

- How can enablers support a coordinated and systematic approach to delivering prevention activity?
- How will we know if the desired outcomes are being achieved?

All Wales Diabetes Prevention Programme



- The outcome evaluation showed that the probability of people developing diabetes was 23% lower in the group offered the AWDPP
- This demonstrates that **the AWDPP was effective in reducing the progression to type 2 diabetes**
- This evaluation showcases how a stepped wedge approach can be successfully designed around live, national roll out of an intervention to generate more robust evidence of impact, as there is a comparison group



Tackling Diabetes Together Programme

Impact 2-25-25

ACHIEVED

Bundle of 8 now in IQPD reviews for all University Health Boards. IMTP requirement

diabetes performance metrics and targets in national performance framework to monitor progress

Enabled provision of MyDesmond self management app to every person in Wales with T2D to March 2027

A communication toolkit for Health & Social Care staff on prevention and self management

behavioural systems map produced to help clinicians build a shared understanding of diabetes care with patients

Funding secured for the programme from Public Health Wales to 31st March 2027

Provision of funding to accelerate delivery work of the 5 LADAs and dissemination of lessons

Volunteers living with diabetes recruited to support local systems improve pathways

Patient experience resources for clinicians produced to support clinicians improve self care and uptake of Bundle of 8

Engagement with people with diabetes has co-produced lessons for local systems to improve pathways

National Dietetics Lead clinician employed to provide direct dietetics support to clinicians

Supported the Diabetes Network to refocus its plans and priorities

co-ordination, support, evaluation and advice work on AWDPP

Establishment of a cross system programme board

IN PROGRESS

A digital discovery for delivering a digital-first service for the 8 care processes

Programme Director role recruited

Working with Directors of Planning to embed Diabetes in IMTPs

Strategic Dietetic Role in recruitment

Working with Directors of Nursing to increase bundle of 8 uptake

Programme Director role recruited

Evaluation of AWDPP

Patient led peer support in development

National Quality Improvement project for primary care underway

25/26

26/27

27/28

2028

High Impact Intervention

Prevention

High Impact Interventions

Formulary

Hybrid Closed Loops

AWDPP Scale and Spread

Prevention Plan

Gestational Diabetes

Remission Options

Education for self-care

Adherence to the bundle of 8

Accountability

Interoperable systems

Workforce development

Review of the pathway

A step-change in diabetes management and prevention across Wales

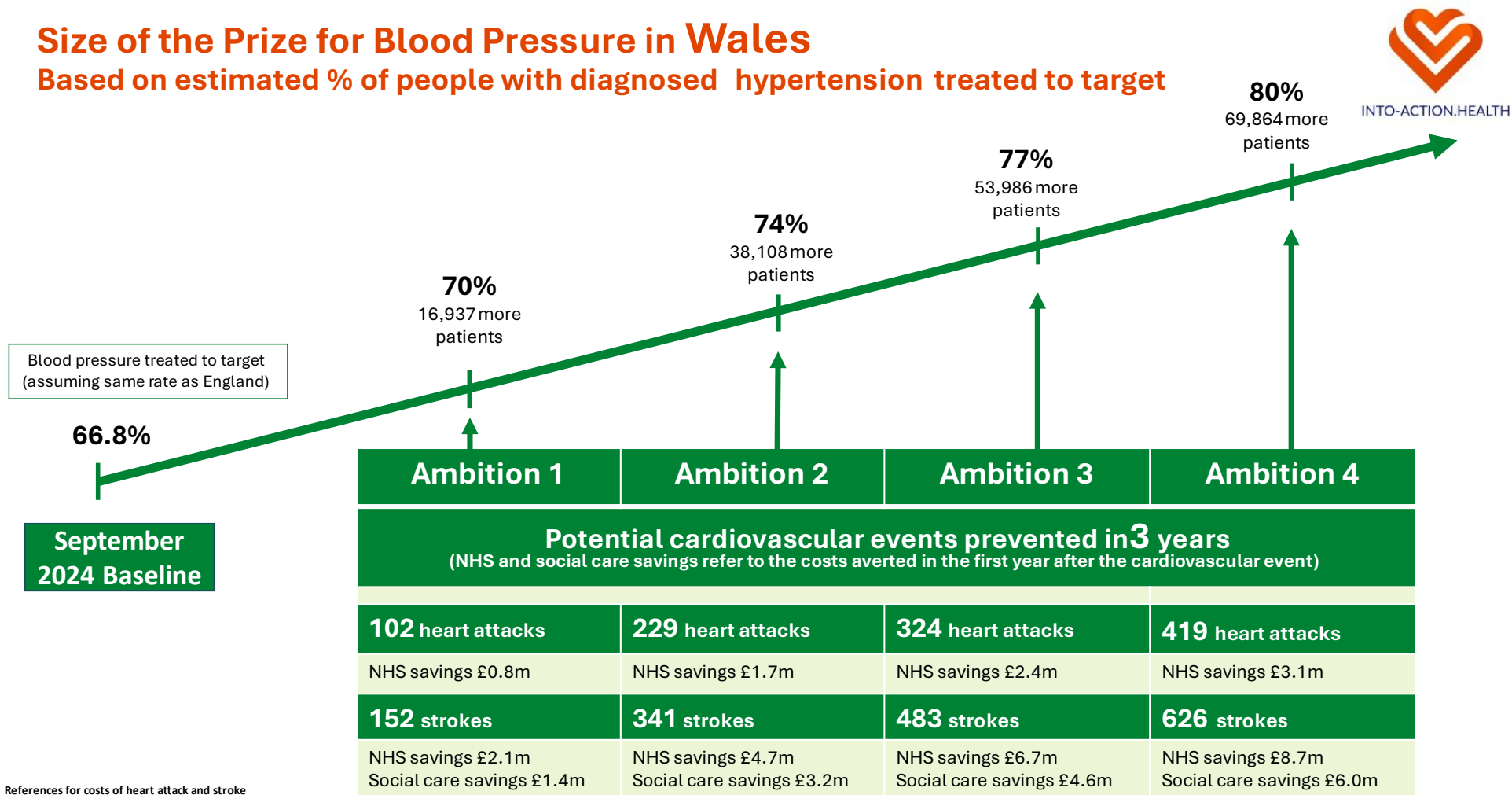
Bundle of 8 moving to 9 + Education for self-care

Digital Enablement & System Connectivity

Cardiovascular Disease Prevention

Size of the Prize for Blood Pressure in Wales

Based on estimated % of people with diagnosed hypertension treated to target



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References for costs of heart attack and stroke

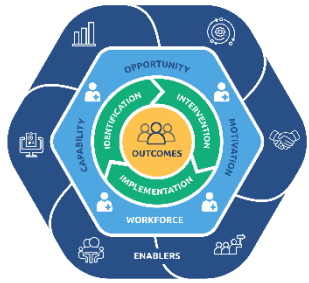
Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and cost-effectiveness analysis.

Kerr M (2012) Chronic kidney disease in England. The human and financial cost.

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“ABCD Plus” CVD Prevention Plan for Wales

Aims and Objectives aligned to the [Prevention-Based Health and Care framework](#)



***ABCD Plus** is a holistic, person-centred approach, which integrates the management of multiple high impact, modifiable clinical and behavioural risk factors for those with or who are at high risk of developing CVD. These risk factors include [Atrial fibrillation](#), [Blood pressure \(hypertension\)](#), [Cholesterol \(hyperlipidaemia\)](#), [Diabetes \(and pre-diabetes\)](#), **Plus** (key risk factors such as smoking, diet, physical activity, and alcohol consumption, alongside wider determinants of health such as financial wellbeing)

Aim



OUTCOMES: To reduce the incidence and prevalence of CVD mortality and morbidity in Wales, and inequalities in CVD outcomes

Objectives



IDENTIFICATION: To enable identification and management of people with ABCD risk factors using evidenced-based, equitable approaches and to improve people’s understanding and awareness of their ABCD Plus risk

INTERVENTION: To deliver ABCD Plus, for those with ABCD risk factors

IMPLEMENTATION: To agree activity needed to deliver ABCD Plus at scale, avoiding unwarranted variation



WORKFORCE: To develop long-term capacity, knowledge and skills across the wider primary and community care workforce, to deliver ABCD Plus*, for those with, or at high risk of having, ABCD risk factors

SYSTEM ENABLERS:

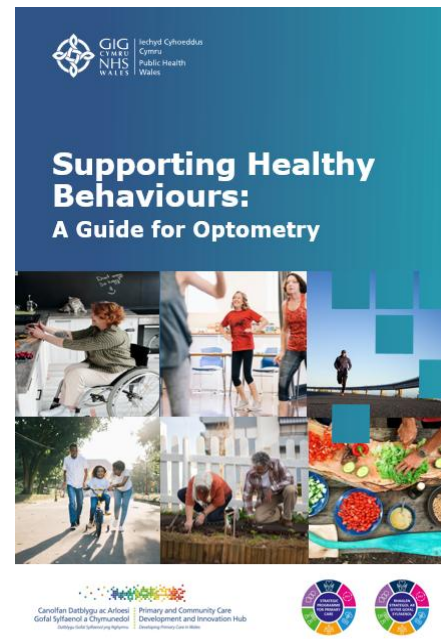
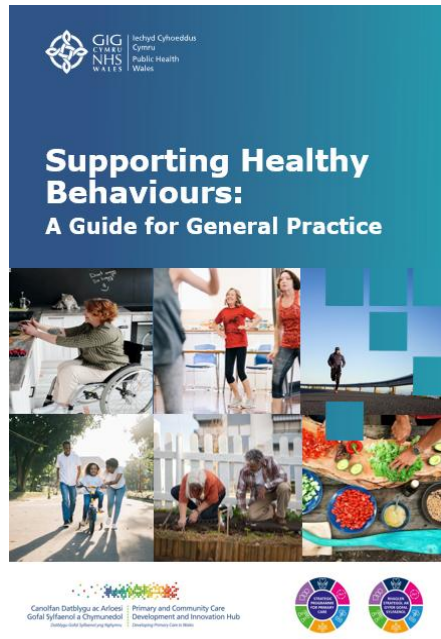


To develop connected data and digital systems to streamline identification of people with ABCD risk factors

To provide the primary and community care workforce with the tools to undertake risk stratification and prioritisation to manage people with the highest risk first

To support, with public and patient involvement, the ongoing monitoring of population health indicators for those ABCD risk factors, and collaborate with key stakeholders to develop the evidence base as novel approaches evolve

Supporting Healthy Behaviours in Primary Care



Areas for quality improvement in primary care:

- Improve the **identification** of people who require support with adopting healthy behaviours
- Improve the **recording** of assessments and the action taken to support people to adopt healthy behaviours
- Optimise **referrals** for people who require support with healthy behaviours, where available and appropriate
- **Review** skills/service gaps to support people to adopt healthy behaviours and take action to address gaps.

Research, Data and Evidence Needs and Issues....

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- Access to data / GMS Disease registers
 - Prevalence studies and projections
 - NHS P&I Power BI Dashboards (*Diabetes, Respiratory...*)
 - Supporting NHS Wales work on PHM – NDR and cloud critical
 - Evidence reviews and evaluation support
 - Opportunities with SAIL
 - Links with Universities for evaluation
 - User engagement and insight