Response from the Royal College of Physicians of Edinburgh to the Senedd Health and Social Care Committee Inquiry into supporting people with chronic conditions.

The Royal College of Physicians of Edinburgh ("the College") welcomes the Senedd Health and Social Care Committee's Inquiry into supporting people with chronic conditions and is pleased to respond to this initial call for views. Our submission is based on the responses we received from Fellows and Members in Wales and in order to make our response as holistic as possible we also sought the views of members of our Lay Advisory Committee, including those with significant experience of the health and social care sector in Wales.

Workforce

The College believes that addressing the significant workforce challenges within the physicianly sector and all across health and social care is vital if our health and social care services are able to support effectively those living with long term conditions and multimorbidity and indeed all others using these services. The most recent annual physicians' census[1] which we conduct with our colleagues in the Royal College of Physicians of London (RCPL) and the Royal College of Physicians and Surgeons of Glasgow (RCPSG) indicated that more than half of advertised consultant physician posts in Wales and England went unfilled last year. 74% of these were unfilled because of a lack of any applicants at all, emphasising the critical situation within the workforce. The census provides detailed forecasts of the numbers of consultants who are expected to retire due to age, also broken down by individual Health Board in Wales, which indicate the potential for workforce pressures to increase in the future. This does not take into account those potentially retiring early from burnout and the impacts of long COVID.

The College considers that it is highly appropriate for the Committee to consider how providers respond to individuals with multimorbidity rather than focusing on single conditions in isolation. We consider that a multidisciplinary team approach can be of real benefit to patients in this context, including the involvement of allied health professionals. Again, it is critically important for there to be sufficient numbers of health and social care staff, including general practitioners, general physicians and psychiatrists, to allow multidisciplinary teams to function effectively.

We welcome the Committee's focus on the extent to which services will have the capacity to meet future demand with an ageing population with multiple comorbidities and increasing community needs as this is of major importance. We believe comprehensive and detailed NHS and social care workforce planning is required to equip our services and allow them to meet the demographic challenges which will impact on all communities in the years ahead.

The impact of the pandemic on quality of care across chronic conditions

In general, the College is aware that the COVID-19 pandemic resulted in severely disrupted health and social care provision and in particular an adverse effect on initial diagnosis (e.g. cancellation of screening services) with subsequent delays in management of long term or chronic conditions. The suspension, understandable in the

[1] The 2021 Consultant Census Report | Royal College of Physicians of Edinburgh (rcpe.ac.uk)

context, of a significant amount of non-urgent clinical services during the pandemic may have resulted in more people developing chronic long-term conditions and there is evidence that the pandemic has resulted in those who already had long term conditions experiencing worsening and progressive symptoms, and reductions in quality of life with some requiring long periods of hospitalisation leading to deconditioning or even dying.

Lay Committee members referred to evidence to support significant numbers of unpresented or missed diagnoses of long-term conditions given the pandemic. Recent research published in the British Journal of General Practice (2023:73) from Swansea University suggests over 400 missing diagnoses across 17 long-term conditions within a typical 10000 patient General Practice in Wales. This research cites that amongst the most affected conditions were chronic obstructive pulmonary disease (COPD) and anxiety disorders corresponding to more than 30 and 80 'missing' diagnoses respectively. This research has cited as an example a 38% reduction in new diagnosis for COPD (343 people per 100,000). It reinforces the urgent need for health services, including primary care, to be supported and adequately resourced to address any growing backlog of diagnoses.

The readiness of local NHS and social care services to treat people with chronic conditions within the community

The College understands that both local NHS and social care services have a willingness to treat people with chronic conditions within the community. However, in terms of capability and capacity, the picture is patchy and hospital admission following an acute episode can often be a demonstration of this with the lack of resource and staffing to facilitate services to maintain patients in the community setting. Medical care services designed as an alternative to admission are important but their efficacy, in terms of health outcomes, must be continuously evaluated. The discussion surrounding those with long-term conditions, who are stabilised and considered as being medically fit for discharge ("no criteria to reside"), is often focused on a discharge direct to an appropriate care setting whether that be residential or Nursing/EMI. What is often overlooked is the intermediate opportunity of reablement to achieve an individual's optimal health; being medically fit and achieving optimisation are different states as there is significant deconditioning even after a short hospital admission. Whether the patient goes straight home or not, there should be access to reablement services.

Reablement consists of a specialist reablement team (nurses, therapists such as physiotherapy, speech and language therapy, social workers and care staff) who work collaboratively with those who are medically fit to be discharged from hospital but remain with multimorbidity in order to undergo rapid, intensive interventions to help regain lost abilities and/or learn new ways of doing things, within the context of their long-term conditions - enabling that individual to realise their optimal level of health.

Rapid discharge is of paramount importance to give the best chance of optimisation and without this the opportunity of optimisation through reablement diminishes and indeed regresses where many remain in hospital not requiring medical input and not receiving reablement intervention. The picture in Wales is mixed with a lack of reablement places in many cases (one exemplar is Bonymaen House, Swansea). This is a significant contributor to those with multimorbidity requiring unnecessary readmission to hospital or a decreased opportunity to return to home avoiding a permanent move to a care home and potentially losing independence.

Prevention, health inequalities and barriers to care

The College would welcome the Committee focusing a large part of its inquiry on prevention. We have consistently argued that sustained, long-term investment in preventative health and support to maintain health can help improve population health and reduce the demand for, and pressure on, paramedic interventions, acute health

and community services and, consequently, some of the costs associated with those services. We consider that we need to move away from the NHS being primarily a reactive service that treats illness; a "National Illness Service", to one where there is also a pro-active focus on good health promotion.

The fact that it has been estimated that 89% of deaths in the UK are caused by non-communicable diseases[2] illustrates the importance of urgent action regarding prevention. Supporting and promoting preventative health measures plays a part in reducing health inequalities which we consider remains another urgent priority. Doctors cannot fix health inequalities and many of the fundamentals of prevention may be considered to have political rather than medical solutions.

We share the concerns about the widespread evidence of the extent of health inequalities in Wales, including data from Public Health Outcomes Framework, most recently in relation to disparities in low birth weight and in older people reporting good health[3].

The College recognises the links between multimorbidity and higher treatment burden, reduced quality of life and a higher risk of mortality in the population as a whole and the links between socio-economic factors and prevalence of multimorbidity. Lay Committee members referred to a significant body of epidemiological evidence which indicates that those from ethnic minority backgrounds may have a higher propensity to develop multimorbidity. Those from ethnic minorities can be disadvantaged in terms of socioeconomic position as a result of racism and racial discrimination, which reduces access and opportunities within employment, education, healthcare, housing, and other sectors (Watson et al Lancet Public Health 2021 6(3)).

Access to essential services is generically focused but given the higher propensity amongst ethnic minority groups to develop multimorbidity, there are strong arguments to identify specific public health interventions to delay the onset of long-term conditions that are context based in communities.

In particular, Lay Committee members felt it may be appropriate for the Welsh Government to consider placing a greater focus on potential issues around structural racism and discrimination leading to unequal access to education, housing, all of which are strongly associated with poor long term health and increased multimorbidity as one significant cause of health inequality within ethnic minority groups.

[2] House of Lords - The Long-term Sustainability of the NHS and Adult Social Care - Select Committee on the Long-term Sustainability of the NHS (parliament.uk)
[3] Public Health Outcomes Framework (2022) - Public Health Wales (nhs.wales)