Health and Social Care Committee
Supporting people with chronic conditions

Public Health Wales written response

June 2023

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.

NHS and social care services

- The readiness of local NHS and social care services to treat people with chronic conditions within the community.
- Access to essential services and ongoing treatment, and any barriers faced by certain groups, including women, people from ethnic minority backgrounds and disabled people.
- Support available to enable effective self-management where appropriate, including mental health support.

As previously mentioned, a considerable proportion of the burden of disease and ill-health in Wales is preventable through identifying and addressing behavioural and clinical risk factors to prevent disease development and progression. Therefore, these primary and secondary prevention measures are integral to the delivery of local NHS and social care services, which support people with chronic conditions in the community.

There are many examples of prevention in NHS and social care settings, some of which are delivered systematically, such as immunisation and screening programmes. These programmes are successful, not just because the interventions are evidence-based, effective, and deliver value, but because they are underpinned by a whole systems approach. This

includes central policies regarding the target population, clear eligibility criteria, delivery by staff groups who are adequately trained and resourced, and data collection systems to monitor uptake, with equity of uptake routinely analysed and reported.

However, much of the prevention activity which aims to reduce the risk of clinical and behavioural risk factors is opportunistic in nature, implementation may vary in effectiveness and quality, and alignment to clinical guidance and the 'offer' may be inequitable.

In 2019, The Faculty of Public Health report What the NHS thinks about prevention identified barriers, which included "lack of integration of prevention into core services, systems capacity issues, prevention not being seen as the remit of the delivery organisation and staff workload". Whilst there was limited input from leaders in Wales to this work, these barriers were mirrored in engagement work by the Primary Care Division of Public Health Wales (PHW) in 2019, which asked healthcare professionals about perceived barriers to the delivery of prevention in clinical settings. Key barriers identified related to:

1. *Capability (of the workforce)*: for example, lack of confidence to raise the topic of a risk factor such as weight, for fear of harming their relationship with a person, and lack of knowledge about both the services into which they can refer patients for support with behaviour change, as well as the effectiveness of prevention interventions.
2. *Opportunity*: examples included lack of time and lack of remuneration for undertaking prevention interventions.
3. *Motivation*: in particular, that prevention was not considered part of their professional role.

The task 'as a wider system' to create the conditions to enable prevention and early intervention as part of routine care therefore remains, enabling local NHS and social care services to treat people with chronic conditions within their community. This is a strategic priority for Public Health Wales, which is committed to supporting and developing a sustainable health and care system in Wales, focused on prevention and early intervention.

It is well recognised that there are widespread challenges in accessing services, with barriers often being experienced by certain groups. PHW, through our leadership in the development and implementation of the All Wales Diabetes Prevention Programme (AWDPP), has tried to proactively consider and address equity of access and uptake to the Programme. Firstly, during the 'design' phase of the Programme in 2021, we completed

an Equality Impact Assessment, which identified a number of groups that may face barriers to access. This included people from specific minority ethnic groups, who are both at increased risk of developing type 2 diabetes due to their ethnicity, but also less likely to access and therefore benefit from AWDPP services if invited to them, due to a range of factors.

In response to this, we ensured that the development of a minimum dataset, which is being collected by the AWDPP frontline staff, included demographic parameters to allow equitable access to be monitored. These data are now feeding through to the development of an 'Audit Plus' module to enable practices, clusters and health boards to understand their own data. Once the module is live, we plan to publish an 'AWDPP Equity Toolkit' to use alongside this, to support local service providers to gain insight into barriers to access and uptake and to guide appropriate actions in response. It is hoped that this approach will enable barriers to access for certain groups to be identified and effectively addressed to improve the equity of the Programme, with potential learning for other programmes.

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. Reducing health inequalities is a strategic aspiration in Wales and is core principle that underpins the work of Public Health Wales, running through the Integrated Medium Term Plan (IMTP).

Supported self-management is important to both reduce inequalities and to improve the effectiveness of self-management. The NHS and social care services have a key role within supported self-management, whether through signposting and referral to well-being activities/services, or additional capacity in the community through social prescribing and other routes. However, enabling these approaches to deliver supported self-management requires a whole system approach to mainstream prevention, as described above.

Multiple conditions

- The ability of NHS and social care providers to respond to individuals with multi-morbidity rather than focusing on single conditions in isolation.
- The interaction between mental health conditions and long-term physical health conditions.

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 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.

The interaction between mental health and long-term physical health is complex.

Survey results suggest that 19% of adults in Wales experience two or more long-term conditions. Specific groups in the population are at increased risk of poor mental health and well-being. This can be due to structural factors, such as the conditions in which they live and work; the impacts of factors such as discrimination and stigmatisation; or other health issues, such as living with chronic pain. There can also be inequalities in physical health outcomes for people living with poor mental health i.e. their physical health needs can be overshadowed by their mental health presentations ("diagnostic over-shadowing"), and/or their medication can put them at increased risk of poor physical health.

PHW's work on supporting obesity prevention through primary care has included undertaking a healthcare needs assessment (HCNA) looking at the primary care needs of people living with obesity in Wales. This highlighted the interactions between mental well-being and obesity, a long-term condition, and the impact the two conditions can have on each other. In particular, the HCNA identified a number of factors that are associated with poorer outcomes for those experiencing obesity, including: low self-esteem, societal stigma, self-stigma and perceived judgement. Furthermore, it identified that the opinion of healthcare professionals can have either a negative or a positive impact on motivation and engagement. The HCNA concluded with recommendations including the need for sensitivity in raising weight in consultations, ensuring that people's needs

are met holistically, and considering obesity in the context of a person's physical, mental and social needs, in a non-judgemental way.

In Wales, social prescribing is defined as 'connecting citizens to community support, to better manage their health and well-being'. PHW's Social Prescribing Interfaces report (2022) recognises the interaction between mental health and well-being, social well-being, and long-term physical health and well-being. It also recognises how social prescribing can be used to help individuals manage both mental health and long-term physical health conditions, as either an additional or alternative support to medical treatment.

Social prescribing involves a deliberate, individualised process that connects individuals to non-clinical services and activities, typically provided by the voluntary and community sectors. The Social Prescribing Interfaces report describes the synergies and distinctions between: (1) physical and mental health services; (2) well-being activities and community assets; and (3) social prescribing. Five recommendations have been identified within the report, of which two relate to embedding person-centred approaches and improving the understanding of referrers of the purpose of social prescribing. To support these two recommendations, PHW are developing a suite of resources on 'Meeting health and wellbeing needs through social prescribing' to demonstrate how a broad range of mental, physical and social health and well-being needs can be addressed through social prescribing.

Impact of additional factors

- The impact of the pandemic on quality of care across chronic conditions.
- The impact of the rising cost of living on people with chronic conditions in terms of their health and well-being.
- The extent to which services will have the capacity to meet future demand with an ageing population.

People living with chronic conditions were already more likely to be in poverty before the cost-of-living crisis. The cost-of-living crisis is a public health emergency and 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.

Long-term conditions also impact on an individual's ability to gain or maintain employment, which has a direct impact on household income. There is strong evidence that high quality, fair work has a positive impact on employee health and well-being, whereas unemployment undermines good health. Factors such as impairments and long-term health conditions act as barriers to people getting and being able to stay in work, exacerbating health inequalities. In Wales only 46.9% of the working aged disabled population are in employment (compared to 79.7% of non-disabled working aged people, amounting to a 33% gap) and we have the highest sickness absence rate of any UK region (2.8% in Wales vs a UK average of 2.2%).

The greatest burden of disease in working age adults in Wales is attributed to mental health (including substance misuse) and musculoskeletal disorders, which is widely reflected in studies looking at the most common reasons for sickness absence. The burden of disease changes with age, with rising levels of cancers (neoplasms), cardiovascular disease, neurological disorders (including dementia), other chronic conditions (such as diabetes) and infectious diseases as people age.

Since the COVID-19 pandemic, the number of working age adults across the UK on long-term sickness absence has risen by over a third of a million, contributing to over half of the rising rates of economic inactivity. This is due to a rise in mental illness and nervous disorders (up 22%), musculoskeletal disorders (up 31%) as well as 'other' which includes a range of conditions including long COVID (up 41%).

Whilst all age groups have seen increases in economic inactivity due to ill-health since 2019, over half (55%) of those now out of the labour market are older workers aged 50-64 years. The lowest paid occupations and sectors less adaptable to hybrid and home working, such as retail, wholesale, transport, health, social care and construction, have higher rates of former workers who became economically inactive due to ill-health.

The role of employers in relation to staff health and well-being is wide-ranging but crucially includes being able to proactively support individuals with chronic conditions to come back to work after periods of absence due to ill-health and to stay in work for the longer term. How well employers and line managers deliver effective and supportive sickness absence management is crucial to achieving this, as is a supportive return to work incorporating phasing and adaptations (for example, phased working hours, the ability to work flexibly, and adaptations to the job role and/or the

working environment) as required. Employers also have an important role in taking a proactive approach to recruiting (as well as retaining) disabled people and those with impairments to help address the current 33% gap in employment outlined above and in recognition that being in work is overall better for an individual's health than not being in work.

Employers therefore play a key role in contributing to the health and well-being of their workforce and consequently, the health and well-being of the population as a whole.

The Healthy Working Wales (HWW) programme delivered by PHW supports employers to create healthy working environments, take action to improve the health and well-being of their staff, manage sickness absence well and engage with employees effectively.

The new HWW delivery model is in the process of being transformed to being delivered virtually to groups of employers rather than the previous one-to-one support offered, in order to reach more employers in Wales at some level and make best use of limited resources. This includes the development of online needs assessment tools for employers to identify priority areas for development and enable virtual capacity building via workshops and webinars to help employers develop their skills and increase their confidence in dealing with health and well-being issues. We are also strengthening guidance and developing toolkits for employers on all aspects of health and well-being, including supporting employees with healthy ageing and health impairments, sickness absence management, equality, diversity and inclusion, and all aspects of fair work.

Until recently, PHW was leading a parallel programme, the Employee Health Management Partnership, in collaboration with partner agencies (including primary care, occupational health, allied health professionals, Department of Work and Pensions [DWP], trade unions and employers) to develop joint approaches to preventing people from falling out of work due to ill-health through better sickness absence management and workplace strategies to support employees with ill-health.

The Partnership agreed the following objectives and has undertaken some work towards them; however the programme is currently in abeyance due to capacity challenges:

- Develop a shared narrative and disseminate key messages about the value and ways of supporting people to stay in work and the importance of good sickness absence management;

- Engender greater understanding of the relationship between health and work among health professionals;
- Develop mutual understanding and action between key agencies working on this agenda at a local level e.g. DWP and NHS/primary care;
- Map and consider mechanisms for better integration of relevant services and initiatives to make best use of limited resources;
- Raise awareness of and address the needs of specific groups in the workforce e.g. older workers, disabled individuals;
- Develop joint resources where gaps are identified e.g. effective absence management and supportive conversations in the workplace;
- Embed workplace health in relevant training, policies and practices e.g. training of health professionals;
- Facilitate more proactive use of the 'fit note' by health professionals.

The 'fit note' allows health professionals to advise an employee 'may be fit for work', taking into account the advice given on the note to encourage people back to work if reasonable adjustments can be made by their employer (e.g., phased return, amended duties, altered hours, work environment/equipment adaptations). By law employers must make reasonable adjustments for disabled employees where needed. Data for England (not currently available for Wales) indicate that only 5.7% of the 8 million fit notes issued by general practices during 2022/23 contained 'maybe fit for work' advice. There is enormous scope to use fit notes more proactively as a supportive tool to ensure individuals with chronic conditions return to work in an adapted way that meets their needs and by so doing preventing them from falling out of work altogether.

To inform a programme of work, the Partnership undertook qualitative research with economically inactive individuals on benefits, DWP work coaches, GPs and employers on barriers and enablers to more proactive use of the fit note.

The costs of energy use within the home will be a significant challenge for those with chronic health conditions or who are terminally ill, particularly those reliant on home medical devices requiring electricity.

Those living in deprived areas are more likely to have pre-existing illnesses that may be exacerbated in winter months. We know that approximately 1 in 3 excess deaths during winter are linked to either living in cold homes or fuel poverty. Significant increases in the costs of energy have increased

the proportion of people in Wales living in fuel poverty, increasing the risk to life posed by cold homes, particularly in winter. At the same time, financial strain from debt, housing instability, unemployment and low income is a primary risk factor for anxiety, depression and even suicide. Furthermore, as is often the case, those who are already struggling will be the hardest hit: this includes people with chronic conditions. Taken together, the outlook for health and well-being across the population in Wales is worrying.

Research partly funded by the NIHR investigated the potential future impact of multi-morbidity among older adults. The study ran a computer model using data on over 300,000 people from three UK population surveys to predict changes in multi-morbidity between 2015 and 2035. It found that by 2035, two-thirds of adults aged over 65 are expected to be living with multiple health conditions. Seventeen percent would be living with four or more diseases, double the number in 2015. One-third of these people would have a mental illness like dementia or depression. Increased life expectancy by around three years for both men and women means people will spend longer living with multi-morbidity.

The estimates have limitations, including self-reporting of conditions and assumptions made around changes in health status. But analyses taking account of such factors gave consistent findings.

The projected increase in multi-morbidity will place greater demand on all areas of health and social care and highlights the need for commissioners to ensure adequate provision of services. It also supports the on-going public health focus on health awareness and disease prevention.

Prevention and lifestyle

- Effectiveness of current measures to tackle lifestyle/behavioural factors (obesity, smoking etc); and to address inequalities and barriers faced by certain groups.
- Action to improve prevention and early intervention (to stop people's health and well-being deteriorating).

PHW's primary focus is on the prevention of ill-health and the reduction of health inequalities. We provide national leadership, co-ordination and support for action to reduce the impact of long-term conditions through

tackling risk factors such as smoking and obesity and by strengthening protective factors such as physical activity and mental well-being.

Investment in health and well-being has wider implications for society and how it operates. A 2016 systematic review of the return on investment of public health interventions demonstrated that on average for every £1 invested in public health, £14 is returned to health services or the wider system. Investing in prevention and early intervention is the right thing to do – it saves lives and money and brings multiple benefits to people's health and well-being.

Public Health Wales' report Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales, provides evidence for the 'best buys' for healthy behaviours. A society that is fully orientated towards enabling health and well-being would be one that also prioritises well-being in its economic decisions – an 'Economy of Well-being'.

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. Within this, there is a consensus that giving every child the best possible start in life, including through support for parents, is fundamental to stopping health and well-being deteriorating.

Effective action at scale to prevent long-term conditions requires action across the whole of society but also action by governments to mitigate the impact of the commercial determinants of health.[1] There is a need to redress the balance between the public/consumer and industry which spends large sums of money persuading and incentivising people to adopt unhealthy behaviours.

The action taken to curb the impact of tobacco on population health provides an insight into action required to address other behaviours.

Smoking remains the leading risk factor for poor health outcomes, partly because for some diseases the risk remains for several years even after someone has stopped smoking, particularly if they smoked for a long time and because of the wide range of conditions that smoking causes including heart and circulatory disease, dementia, cancers and lung disease.

[1] Commercial determinants of health refer to private/for-profit sector activities impacting public health, including the availability of unhealthy commodities such as tobacco, alcohol, or foods high in fat, salt and/or sugar.

However, smoking rates have reduced significantly over recent decades, with the most recent figures suggesting that around 13% of adults in Wales currently smoke. The Welsh Government launched 'A smoke-free Wales' in 2022 with the goal of reducing smoking rates to below 5% by 2030.

However, dietary factors and overweight and obesity far exceed the impact of tobacco, and whereas rates of smoking are falling, rates of overweight and particularly obesity are still increasing. In 2022, most of the adult population of Wales (62%) were either living with overweight or obesity, and 25% were living with obesity, meaning their weight is at a level where it is likely to affect their health. Rates of obesity are higher in those from more disadvantaged backgrounds.

Our diet (including consumption of alcohol), and whether we are active are the leading behavioural causes of overweight and obesity. Just over a half of adults (56%) reach the level of physical activity recommended by the UK Chief Medical Officers of 150 minutes of moderate or vigorous activity a week. We know that the greatest health gains are to be made from helping the 30% of Welsh adults who are currently inactive (active for less than 30 minutes a week) to become more active.

In 2019 the Faculty of Public Health (FPH) undertook a policy development and research project examining the role of the NHS in the prevention of ill-health. They found current NHS priorities for prevention are predominantly risk factor and single-issue based, e.g. screening programmes or interventions to address smoking or harmful alcohol use. However, NHS leaders were most likely to say that the NHS should be prioritising a systems approach to prevention, followed by embedding prevention into routine practice and clinical pathways.

Achieving a 'systematic, holistic and coordinated approach to prevention' in health and care settings is a strategic aspiration, underpinned in Wales by favourable legislation, policy, and extensive NICE guidance. Converting this aspiration into practice, however, remains challenging due to the scale of the task, complexity of the delivery landscape and competing demands. In 2018/19, PHW's Primary Care Hub began developing a conceptual framework for prevention in clinical settings, which deconstructed the elements of a systematic approach to delivering cost effective prevention activities, at a scale that would result in positive health gain at the population level. After being interrupted by the pandemic, this work has resumed and the PHW IMTP 2023/24 objectives include the translation of the conceptual model into a coordinated approach to prevention, to

facilitate delivery of evidence-based, cost-effective prevention interventions, at scale, in health and care settings. The approach aims to:

1) Strengthen prevention interventions with robust, equitable identification of those at risk and aims to recognise the need for high-quality interventions, adopting 'criteria for prevention' to determine what activities should be delivered to whom, to achieve population level health gain.
2) Support the health and care workforce, recognising their key role as a vehicle to deliver prevention interventions, through addressing their capability, opportunities and motivation to fulfil this role.
3) Develop a systems approach to 'enabling factors' by utilising data, generating and applying evidence, embedding evaluation, addressing resources/ infrastructure needs, and influencing policy levers to achieve equitable delivery of prevention activities at scale, in health and care settings.

Risk factors which contribute to the burden of disease require a comprehensive, whole systems approach, spanning from:

- Primary prevention, which aims to prevent conditions developing.
- Secondary prevention, aimed at reducing the impact of a condition where there is evidence that this has already begun to occur.
- Tertiary prevention, which aims to reduce the morbidity and complications of an established condition.

Behavioural risk factors most commonly require primary prevention approaches, whilst clinical risk factors most commonly require secondary prevention interventions.

The four Chief Medical Officers (CMOs) of the UK recently collectively published an editorial in the BMJ on Restoring and Extending Secondary Prevention, in which they argued that the 'evidence that secondary prevention can substantially reduce disease incidence and progression is some of the strongest in medicine'. They suggest there is a need to ensure that people who are already making contact with all parts of the NHS get the secondary prevention that they need. They also advocate for the need for prevention efforts to be extended to population groups with historically low uptake, recognising that disease prevalence is higher than average in many of these groups, so the benefits of secondary prevention are likely to be even greater.

The effectiveness of measures relates to well-established interventions with known efficacy, such as the management of hypertension, atrial fibrillation

and raised cholesterol, as well as more innovative interventions and models of delivery where the evidence base is developing, such as the All Wales Diabetes Prevention Programme.

Healthy Weight Healthy You

The ability to make healthy behavioural and lifestyle choices are influenced by the environment and systems around us. Overweight and obesity is rapidly becoming the leading cause of years lived in poor health, with disability or early death. Currently in Wales nearly two thirds (62%) of the adult population experience overweight or obesity.

The Healthy Weight Healthy You website now provides an evidence-based, bilingual early lifestyle intervention to support the Welsh population with achieving and maintaining a healthy weight with increasing uptake since its launch in January 2023. This has provided additional capacity for the All Wales Weight Management Pathway which is being developed in each of the health boards in Wales to try to meet the significant and increasing population need for those living with overweight and obesity.

These individual lifestyle and treatment interventions can provide support for those living with overweight and obesity but do not address the wider obesogenic environments that would support healthy choices being the easy choices.

Healthy Weight Healthy Wales

Many of the levers to make significant changes to address obesogenic environments that contribute to overweight and obesity are not within the control of health or individual organisations. Welsh Government launched Healthy Weight Healthy Wales as a long-term strategy to reduce levels of overweight and obesity in the population. It outlines a ten-year strategy and vision for Wales and opportunities to empower people across Wales to make healthier choices which are easy, affordable and sustainable. While is provides a supportive framework for changes to be made over time, it will require a long-term view with ongoing commitment over decades for meaningful change that can address the scale of this challenge.

National Exercise Referral Scheme (NERS)

Being active is dependent on a range of factors but can include where we live; whether we have easy access to places to walk and cycle; whether we have access to frequent and reliable public transport as an alternative to using a car; whether we can afford to go to a gym or leisure centre

regularly; and the kind of work we do. It is recognised that our lives are increasingly sedentary and the need to create opportunities to be active is a relatively recent phenomenon that would not have been recognised by people 100 years ago.

The National Exercise Referral Scheme (NERS) is an evidence-based health intervention incorporating physical activity and behavioural change techniques to support referred individuals to reduce their risk of long-term ill-health by becoming more physically active. NERS provides subsidised access to tailored and supervised exercise for people aged 16 and over who are inactive and at risk of, or currently experiencing, a long-term or chronic health condition.

NERS is funded by Public Health Wales (PHW) which also provides strategic and operational oversight. It is delivered in each of the 22 local authority areas through a grant from PHW which funds 50% of a NERS coordinator as well as exercise referral professionals. The local delivery partners, which include local authorities, leisure trusts and one health board, contribute additional funding and in-kind elements such as use of leisure and community venues and equipment.

In 2010 the scheme was formally evaluated using randomised controlled trial (RCT) methodology which focused on the delivery and impact of the original generic pathway. It found NERS to be a cost-effective intervention for primary and secondary prevention of chronic conditions, especially for coronary heart disease, alongside positive effects on depression and anxiety. Later research to understand 'real world' implementation versus RCT conditions estimated 3.3% of the 'at risk' population were referred during the ten-year period analysed (2008 to 2017). A downward trend over time in referrals from most deprived groups was found alongside a decline in uptake.

Over time, the scheme has developed considerably with variation in delivery between areas. Due to the scheme's success and popularity, capacity is severely stretched in many areas often leading to long waiting times between referral and first appointment. This in turn can lead to high drop-out rates before the first appointment.

NERS has the potential to impact positively on the health of a significant proportion of the adult population through using physical activity to contribute to both primary and secondary prevention of long-term chronic health conditions. PHW is undertaking a review of all aspects of NERS to ensure it can make best use of the available resources to deliver positive

outcomes for those groups in the population with the greatest capacity to benefit as well as to contribute to reducing health inequalities.

Tobacco control

The current prevalence of smoking amongst adults (16+) in Wales is 13%. However, smoking rates are typically higher in groups that are vulnerable or marginalised and/or are experiencing long-term or chronic conditions. For example, English data for 2020-21 suggest that 25.2% of all adults (18+) experiencing any long-term mental health condition and 25.8% of adults with anxiety or depression are smokers. The Welsh Government's Tobacco Control Strategy for Wales and Delivery Plan identifies priority groups to target for cessation support, including those living with deprivation and those from minority ethnic backgrounds. Many of these groups are likely also to include disproportionate numbers of individuals with chronic conditions who are engaging with primary and social care services.

Implementation of tobacco control interventions since the 1980s, and in particular, the consistent focus over the past 25 years, have seen the UK recognised as having amongst the most effective tobacco control policies in Europe. Wales has been a leader in implementing smoke free policies such banning smoking in hospital grounds. The Welsh Government Tobacco Strategy and Delivery Plan has set a goal of reducing the prevalence of smoking in adults (16+) to 5% or less by 2030. The Strategy is focused around three themes: reducing inequalities, future generations and a whole-system approach for a smoke free Wales. The Delivery Plan for 2022-24 identifies five priority action areas: smoke free environments; continuous improvement and supporting innovation; priority groups; tacking illegal tobacco and the tobacco control legal framework; and working across the UK.

Quitting smoking at any age brings health benefits, including for those who already have a chronic disease. Ensuring that smokers with chronic conditions in Wales have access to high quality cessation provision through health and social care services in Wales is an essential element in supporting them to manage their own health effectively and reducing the inequalities.

Help Me Quit (HMQ) is the national brand for smoking cessation services in Wales. HMQ provides evidence-based interventions tailored to the needs of individual smokers via a national hub to co-ordinate referrals and a national telephone support service, both within Public Health Wales and local services managed within local health boards.

A number of current activities led by Public Health Wales working across the system and in alignment with Welsh Government strategies will develop the capacity for those working in NHS and social care services in the community to support those with chronic conditions. These include improving the IT infrastructure for referral and patient management and improving understanding of the profiles and needs of priority groups with relatively high rates of smoking.

Diabetic Eye Screening Wales (DESW)

Diabetes is the leading cause of preventable sight loss in the UK. Making changes to diabetes management, or having specialist treatment, can slow or reverse changes caused by diabetic retinopathy. The aim of the Diabetic Eye Screening Wales (DESW) Programme is to reduce the incidence of sight loss due to diabetic retinopathy – damage to the back of the eye. People with diabetes aged 12 or over are invited to attend a screening appointment. This is a national screening programme with consistent, high standards of service delivery across the whole of Wales and robust assurance processes in place.

At the start of the pandemic in March 2020, Diabetic Eye Screening temporarily paused sending screening invitations. People who had not had their screening pathway completed had their screening results and were referred to hospital eye services if this was required. When screening restarted in September 2020, a risk-based approach was taken with those known to be at higher risk of sight-threatening retinopathy prioritised based on their previous screening result. Additional screening venues were sought to improve screening capacity, which included arts centres, stadiums, scout huts and theatres. In the summer of 2022, PHW opened a screening dedicated venue in Mountain Ash, Rhonda Cynon Taf, which enabled significant increase in availability in this area. A further venue in Llanishen, Cardiff will be opening from May 2023.

The recovery after the pause is still ongoing and is a key focus for PHW. As well as optimising current pathways, transformational work is underway to introduce more innovative approaches, including the upgrade of the DESW IT system. Also, in December 2022, the Welsh Government announced the forthcoming implementation of the Low Risk Recall Pathway based on a recommendation from the Wales Screening Committee. This pathway is planned to be introduced in Wales from summer 2023 and DESW is currently working with key stakeholders to plan the communication of this change.

Screening programmes – tackling inequity across the screening pathway

Screening aims to detect the early stages of disease or prevent disease occurring. Through identification of people at higher risk of having a health condition, more effective treatment options or information can be offered to inform decision-making about their future care. Screening can also reduce the chance of developing a serious condition, preventing ill-health and the harm that would have otherwise occurred.

In 2021, PHW Screening produced an inequity report using data from across screening specifically focused on inequity of uptake across the division for the first time. Previously, each screening programme had produced individual reports.

It described a social gradient, with increasing deprivation resulting in decreasing participation in screening. As people from more deprived communities have higher rates of cancer mortality from bowel, breast and cervical cancer, the people who are at greatest risk have the lowest uptake of preventative screening that can save lives and reduce complications.

This demonstrates the continued need to understand the complex barriers to screening uptake for people from more deprived communities in Wales, who are at higher risk of experiencing chronic conditions.

The Screening Inequity Strategy has highlighted commitments to explore and address potential barriers and enablers across five key areas:

1) **Communication**: including providing clear, consistent and accessible information to enable informed decision making;
2) **Community and engagement:** building sustainable networks with people from local communities, the third sector and statutory organisations, and involving service users and people from underserved groups;
3) **Collaboration:** working across the health system in Wales;
4) **Service delivery**: including mapping service user journeys across the whole pathway and adopting a consistent approach to equity and Health Impact Assessment; and
5) **Data and monitoring:** ensuring that action to address screening inequities is data-driven