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Russell George MS
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Dear Russell,

Ahead of the Health and Social Care Committee's meeting on 19 June 2024, please find attached the Welsh Government's evidence paper covering the topic 'supporting people with chronic conditions'.

Yours sincerely,

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Welsh Government's Evidence Paper on Supporting People with Chronic Conditions

Health and Social Care Committee – 19 June 2024

Contents

What is required to enable services to better meet the needs of people with multiple conditions (often referred to as "multimorbidity")

One of the successes of our healthcare system over the past 70 years, has been that people in Wales are living longer. However, more of us are living with one or more long term conditions. Multimorbidity is the term used to describe individuals who have two or more coexisting conditions, such as chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD) and diabetes. This is a growing global challenge with substantial effects on individuals, carers and society.

Multimorbidity occurs around a decade earlier in socioeconomically deprived communities and is associated with premature death, poorer function and quality of life, and increased health-care utilization. The mechanisms underlying the development of multimorbidity are complex, interrelated, and multilevel, but are related to ageing, underlying biological mechanisms, and broader determinants of health, such as socioeconomic deprivation. Optimising how we support people with multimorbidity is likely to be beneficial and must remain an area of focus, as well as maintaining a focus on prevention and the psychosocial and behavioural factors that increase the risk of developing multiple long-term conditions, particularly population level interventions.

In 2018, in response to the parliamentary review which set out the case for change in order to respond to the changing needs of the population, the Welsh Government published its vision for care and support in A Healthier Wales (AHW).

AHW highlights the need for better management of long-term conditions within the healthcare system and the need to give patients the confidence and ability to manage their conditions (self-management). There is a need to shift services closer to home and to ensure the workforce is resourced to manage not only an increasing population but also increasing the individual patient demands that result from suffering from more than one long term condition.

Multimorbidity is further highlighted in the National Clinical Framework - A Learning Health and Care System published in March 2021. The National Clinical Framework highlights that the existing clinical model in Wales is speciality focused and there is a need to shift to a patient focused approach. Although the new National Strategic Clinical Networks (Networks) within the NHS Wales Executive (the Executive) each focus on specific conditions, there is also a key role for Networks to consider multimorbidity, both individually and collectively.

Across the UK, improvements in mortality rates have slowed down in the last 10-15 years, manifesting in lack of improvement in life expectancy. This slow-down in mortality improvement can be attributed to a number of factors including reduced improvement in mortality from CVD, increased multimorbidity, and vulnerability to respiratory disease and other winter risks in an ageing population.

For diabetes alone, Public Health Wales (PHW) estimates that on current trends, one in eleven adults in Wales could be living with the condition by 2035 – 90 per cent of which would be Type 2 diabetes, around half of which could be preventable with lifestyle changes. Regarding CVD, stroke is the fourth biggest killer in Wales and a

leading cause of disability. There are currently almost 70,000 stroke survivors living in Wales. With an estimated 7,400 people experiencing a stroke in Wales each year, and more people surviving stroke, the number of stroke survivors is expected to increase by 50 per cent during the next 20 years. An estimated 70 to 90 per cent of strokes are due to modifiable risk factors, including high blood pressure and atrial fibrillation, smoking, drinking too much alcohol, and are preventable through effective primary and secondary care intervention and public health action. Diabetes is of course a risk factor for stroke and addressing the many compounding factors to reduce the risk of developing diabetes will by default reduce the incidence of stroke.

In recent times we are seeing a move from a focus on single-disease issues to recognising that people suffer from more than one chronic condition and the rise of multimorbidity. Some examples of this are provided below. This is a positive sign of the urgent shift needed towards supporting people with multimorbidity.

Workforce

To support this further, the health and care system must also overcome the challenges in the way the workforce is trained and shaped. For a generation, most clinical practice guidelines and health-care training and delivery has focussed on single diseases, leading to care that is fragmented, sometimes inadequate, and potentially harmful. Importantly, for people themselves the single condition focus places a treatment burden on those with multiple conditions that can sometimes be difficult to manage. For example, attending multiple appointments and undergoing investigations, having to repeat their story multiple times, managing multiple interacting medications and their side effects, managing fragmented care and navigating a complex system, trying to manage changes in treatment regimens and care plans, and also trying to learn about their conditions and make necessary behavioural and lifestyle changes.

We must do all that we can to support our future workforce to have a broader understanding of prevention and Making Every Contact Count (MECC), and in the complexity of managing multiple interacting conditions. Embedding the principles of shared decision making is pivotal to ensuring effective person-centred clinical and care planning decisions which are grounded in the wellbeing and quality-of-life outcomes and goals that matter to individuals.

Our pre-registration nurse, midwifery and health professional education programmes incorporate learning on positive approaches to supporting people with multiple conditions both within curricula and during practice-based learning (up to 50% of healthcare student programmes. Placement learning opportunities across primary and community care, secondary care and wider service sectors include working within services supporting individuals with multiple conditions. Students have opportunities to be involved in the coordination of care across specialities including screening clinics and acute interventions for chronic conditions (diabetes; coronary heart disease; asthma; thyroid disorders; hypertension; hyperlipidaemia; rheumatoid arthritis; chronic kidney disease; chronic pulmonary disease).

A key element of learning in academic and placement settings involves health promotion and disease prevention, particularly the ability to sensitively and

compassionately support individuals' lifestyle changes that can prevent the onset of chronic diseases; conducting routine screenings and vaccinations to address health issues early; and assisting individuals with necessary information and resources to maintain wellness.

There are also a number of post registration education programmes and standards which include and address comorbidity/multimorbidity. Examples include the General Practice Nursing (GPN) Foundation programme which supports nurses new to general practice to gain skills in hypertension, heart disease, diabetes, asthma and COPD management.

Advanced practice education programmes also contain modules that will involve developing an understanding of altered physiological processes in relation to cardiovascular, respiratory and musculoskeletal disease processes, for example COPD, heart failure, and endocrine, neurological and abdominal disease processes, for example Diabetes and Thyroid disease, Parkinson's disease, liver and gut diseases, and knowledge and skills in relation to examining patients with these conditions.

In addition, the Allied Health Professional Programme is also supporting implementation of Multi-professional Framework for integrated working and maturity matrix, developed by the Strategic Programme for Primary Care. This includes engaging with service users to develop rehabilitation standards, e.g. the Community rehabilitation standards.

Aligned to the Shape of Training review, the Academy of Medical Royal Colleges has revised its curricula to include an emphasis on generalist training to cope with the increasing demand for doctors who can holistically look after patients with comorbidities.

Management of chronic conditions in primary care is an important part of the GP curriculum. GP Specialty trainees observe and run chronic disease clinics and manage patients with chronic disease in daily consultations.

The Strategic Programme for Primary Care (SPPC) is working to ensure that population health needs including supporting people with multiple conditions are met by services in primary and community care. HEIW are collaborating with the SPPC to ensure that education and training of the workforce empowers them to deliver those services through effective multiprofessional teams.

In April 2024, HEIW launched the strategic workforce plan for primary care. The plan contains several actions that will support delivery of high-quality care for people with multiple conditions closer to home. These include building a sustainable GP workforce, education and training for the primary care workforce and appropriate supervision of multi-professional teams.

Specialist assessment is important for some, but supporting people with multimorbidity requires person-centred care, prioritizing ‘what matters’ most to the individual and the individual's carers, ensuring continuity of care from experienced professionals working in a multidisciplinary way with care that is effectively coordinated, with minimal treatment burden, and aligns with the person’s values.

Ageing Well, Older People Frailty and People Living with Frailty

Older people and those living with frailty is one population group that illustrates well the critical importance of the multimorbidity approach. As a well-recognised long-term condition associated with the ageing process, frailty is not an inevitable consequence of ageing but is associated with the presence of multiple interacting conditions. A health and care system attuned to the needs of older people and people living with frailty is essential but challenging to achieve within our current model of health and care, which tends to be weighted towards reactive care and crisis management, and too often results in an avoidable hospitalisation. Achieving optimal quality-of-life outcomes for this population demands a fundamental shift towards a person-centred outcome focussed approach that supports multimorbidity, underpinned by population health management, preventative and anticipatory focussed care, shared decision making and proactive management and care planning. This has been as set out in our complimentary publications; The Integrated Quality Statement (IQS) for Older People and People Living with Frailty and the Strategy for an Ageing Society.

Maximising opportunities for maintaining and improving the health and wellbeing of people as they age and enter their later year must continue be a priority as our population ages, a demographic projection forecasted to be increasingly challenging each year until the mid-part of the century. It must focus on quality-of-life in later years, not just quantity of life; expanding the years spent with good health and wellbeing - shortening and compressing the amount of time a person spends with ill-health and disability. Developing frailty attuned care will not only improve the quality-of-life outcomes for this population, but also benefit others and the system as a whole.

Aligned to AHW, Building Capacity through Community Care (BCCC), acknowledged the existing demand and capacity imbalance across our health and social care system attributed to an increasingly older population. Our strategic goals can only be achieved by building capacity within our communities and within primary and community care. Primary and community care must be the bed rock and strength of our model through a multiple professional approach with expertise in understanding and managing the complexity of multiple interacting conditions that compound each other and can complicate treatment interactions.

Primary and Community Care

The Primary Care Model for Wales was adopted in 2018 as the agreed approach to organising health and wellbeing services in line with the vision in AHW.

Core to the Primary Care Model for Wales is person-centred care and support with access to the right professional or service at or as close to home as possible. To achieve this, GPs, nurses, pharmacists, dentists, optometrists, allied health professionals (AHPs), social care workers and people working in the third sector collaborate through the clusters to both plan and provide people with a range of ways to access seamless care and support.

Information about individuals is shared appropriately to ensure services are joined-up and provided in a seamless and timely way across the community. Modern technology, local facilities and services are all used to help people lead healthy lives and to support those with an increased risk of urgent care needs, such as people living with several long-term health conditions.

Funding to increase capacity in primary and community care

Welsh Government has provided £8.24m (rising to £11.95m for 2024-25) to increase community health and social care capacity. We have separately invested £5m from 2023-24 to create additional community Allied Health Professionals (AHPs) and £8.3m to widen access to Adferiad Funded Services. Additionally, in the last year nearly £145 million has been invested through the Welsh Government's Regional Integration Fund, on projects delivered by health and social care partners to provide community services.

We expect this funding to be aligned to ensure a well-integrated, multi professional service response in the community. Health boards and their local authority and wider partners are jointly responsible through the pan cluster planning groups for determining how they will utilise this investment, recognising that plans will need to build on local need and existing services.

The NHS Wales Planning Framework is issued to the NHS in Wales on an annual basis to inform their planning. The framework sets out the priorities and NHS organisations are required to develop integrated three-year plans each year, setting out how they intend to deliver healthcare services in line with the requirements of the framework.

Within our integrated health system, NHS organisations' plans must draw on their population needs assessments and demonstrate an integrated planning approach predicated on planned and unplanned care settings (discouraging single condition planning), linking population need to quality, service models, capacity requirements, workforce development and capital and financial planning, all set within the context of the organisations' longer term clinical services strategy. Integrated plans must also align with a range of partnership plans, including primary care plans, Area Plans

developed by Regional Partnership Boards, Wellbeing Plans developed by Public Services Boards as part of the Wellbeing of Future Generations Act requirements and Mental Health Delivery Plans developed by Together for Mental Health partnerships.

The development of NHS Executive signals a new way of working, and the themes set out within their remit from Welsh Government are not specific to disease conditions, settings, or population groups. The NHS Executive includes many national functions and programmes in one entity, and whilst there are differing policy drivers, including Quality Statements, and national programmes, the NHS Executive provides the opportunity to collectively collaborate to align work programmes to ensure a whole system approach.

The NHS Executive has established strategic clinical networks to replace the former condition specific implementation groups and supported the appointment of several new National Clinical Leads. The development of the cardiovascular network is a good example of bringing together a family of networks and partners to improve population outcomes for people with different conditions, that has wider benefits to people and the system as a whole than a single condition approach can provide.

This affords the opportunity for collective collaboration to align work programmes and activity across multiple conditions that require a similar and integrated approach to address some of common lifestyle and other risk factors, and the primary, secondary and tertiary prevention public health activity to address these.

Tackling inequalities and the barriers faced by certain groups, including people living in poverty and people from ethnic minority backgrounds

Tackling health inequalities remains a key priority for the Welsh Government as we continue to recover from the Covid pandemic and the cost-of-living crisis. It has never been more important to ensure that we develop inclusive, resilient communities and economies where health truly is factored into everything we do.

We know that some individuals with protected characteristics face actual or perceived discrimination when accessing services resulting in unmet health needs and the newly established NHS Health Inequalities Group is working to maximise the impact of the NHS in Wales in tackling health inequalities. The Group's work programme is seeking to add value to existing work programmes, strengthen collaborations, avoid duplication, scale up good practice and seek to fill gaps where necessary.

Other examples of work to tackle health inequalities includes:

- Wider cross-government action such as the Flying Start programme, action to tackle poor quality housing and fuel poverty, our Employability Plan and efforts to tackle air pollution.
- The Socio-economic duty requires specified public bodies to consider how their decisions might help to reduce the inequalities associated with socio-economic disadvantage when making strategic decisions such as 'deciding priorities and setting objectives'.

- Welsh Government guidance for Health Boards on Health and Wellbeing Provision for Asylum Seekers and Refugees (2018) has also been issued which includes a specific focus on chronic conditions. It recognises that the most frequent health problems of newly arrived refugees and asylum seekers include accidental injuries, hypothermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy and delivery-related complications, diabetes and hypertension, all of which can lead to more chronic conditions requiring long-term treatment.
- In addition Welsh Government guidance for Healthcare Practitioners on Working Effectively with Gypsies and Travellers (2015) also recognises the high prevalence of chronic ill health amongst Gypsy, Roma and Traveller communities, such as cardio-vascular disease, cancers, diabetes asthma and other respiratory conditions, as well as higher rates of stroke, and poorer mental health outcomes.

One of the principles underpinning the Welsh Government's draft Mental Health and Wellbeing Strategy (currently out to consultation – see below) is equity of access, experience and outcomes without discrimination and ensuring services and support are accessible and appropriate for all. This means understanding the barriers people face and putting necessary systems in place so that when people get support, there is equity in terms of experiences and outcomes.

To achieve this, support and services will need to be culturally and age appropriate and meet the needs of Welsh speakers, ethnic minority people, LGBTQ+ communities and people with sensory loss. Services will also need to meet the needs of under-served groups such as people with co-occurring substance misuse, people who are care experienced, neurodivergent people and people who are experiencing poverty and people who are experiencing homelessness.

Welsh Government is also committed to embedding the Social Model of Disability throughout everything it does. A Disability Rights Taskforce has been established, which brings together people with lived experience, Welsh Government officials and organisations to identify the issues and barriers affecting the lives of many disabled people.

Additionally, the Welsh Government's Out of Work Peer Mentoring Service (OoWS) helps some of the most vulnerable, and those furthest away from the labour market, to rebuild their lives and to get back into training, education and employment. The service provides free peer mentoring support to people out of work who are recovering from ill-health. Between October 2022 and March 2025, the service will aim to support 10,000 people and potentially improve the health and educational outcomes of children and families living in poverty, where family income improves by gaining employment.

Complementing this is the Welsh Government's In-Work Support Service which provides free and rapid access to occupational support to keep people in work and is essential for reducing ill-health, social exclusion and poverty.

Earlier diagnosis of some long-term conditions, particularly those with risk factors that are modifiable through individual lifestyle changes and public health interventions, will allow better management through those lifestyle changes or more

cost-effective home care. Tackling inequalities in wider determinants like housing, income, education, and employment will also produce health benefits.

Good practice examples of person-centred care for people with multiple conditions which could be mainstreamed into policy and delivery

Integrated Community Care System

An Integrated Care Community System (ICCS) attuned to the care and support needs of people with complex care and support needs is being developed. Older people and people living with frailty is the first population group of focus, underpinned by the IQS. By prioritising community-based care, we aim to support older people to maintain independence and quality of life, while effectively managing healthcare resources.

Adferiad (Recovery) funded services

Welsh Government is investing £8.3m per annum in the Adferiad (Recovery) funded service model. Initially established to support those with long COVID as a part of our response to the pandemic, this is a community focussed multidisciplinary and blended rehabilitation and recovery approach, which includes self-management and supported self-management strategies, as well as referral pathways to specialist secondary care for those who need it. In 2023, access to these services was widened to people with a range of other long-term conditions but similar recovery and rehabilitation needs to those with long COVID. The increased and ongoing funding is to enable capacity in primary and community care to be expanded to continue to support people with long Covid whilst also creating equitable access to others on a 'needs led' and 'symptom led' basis, for example, people with myalgic encephalomyelitis/ chronic fatigue syndrome (ME/CFS), fibromyalgia, persistent unexplained symptoms and other post-infection associated conditions. Many people accessing these services will have multiple long-term conditions requiring multidisciplinary and co-ordinated care and support to maximise quality-of-life outcomes.

Health and Wellbeing

Cardiff Keeping Me Well website is designed by health professionals who specialise in different therapy services and service users from Cardiff and Vale University Health Board. The information on this website helps people support their health and wellbeing — whether they are preparing for treatment, recovering from treatment, managing a long-term condition or looking to live a healthier and more active lifestyle.

The Cwm Taf Morgannwg University Health Board's older persons mental health team is a multi-professional team providing assessment and treatment by psychologists, medics, mental health nurses and occupational therapists. Each individual has their own care plan. The service respects individuals' rights to exercise control over their own lives, care and ability to make choices in an informed and safe way, whilst aiming to promote the values of independence, choice and empowerment for service users.

Cardiovascular Disease Prevention Group

The Cardiovascular Disease Prevention Group (CVDPG) has been established under the Cardiovascular Strategic Clinical Network and is being led by Public Health Wales. The CVDPG will focus on a range of primary, secondary and tertiary prevention interventions that address the common factors that increase the risk of cardiac illness, vascular disease and stroke.

In collaboration with Strategic Programme for Primary Care, the Six Goals Programme, clinical and policy leads across stroke, cardiac, vascular and diabetes, and relevant third sector partners, such as the Stroke Association, the CVDPG will maintain a focus on **A**trial Fibrillation and **B**lood Pressure management (Hypertension) in the first instance, with plans for focussed activity relating to **C**holesterol and **D**iabetes (the ABCD).

This is a good example of how bringing a family of networks together is facilitating collaborative working across partners towards a common goal to improve population outcomes for people with different conditions.

Children's Continuing Care

Welsh Government published revised guidance on children's continuing care in early 2020 to guide NHS Wales and partners in supporting children and young people with complex health needs.

The continuing care guidance for Wales describes the interagency process, led by health boards, that all organisations should implement in assessing needs and putting in place bespoke packages of continuing care for those children and young people who require it because their needs cannot be met by existing universal or specialist services alone.

The children's continuing care guidance emphasises throughout that the child's needs should be paramount and that any discussions around the financial aspects of providing care should not delay the provision of that care.

National Exercise Referral Scheme (NERS)

The National Exercise Referral Scheme (NERS) is a chronic condition prevention and management programme which aims to improve the health and wellbeing of sedentary and inactive adults who are at risk of developing or who have an existing chronic condition. It provides a 16-week programme of physical activity to individuals referred by NHS health professionals, using behaviour change techniques to embed positive physical activity habits.

Once referred, patients that meet the criteria are invited to their local leisure centre for an initial assessment with a qualified exercise referral professional. They will be offered a tailored, supervised exercise programme for 16 weeks and their progress will be reviewed at key points.

Rehabilitation

The Welsh Government published the All Wales Rehabilitation Framework (2022) to support health boards, trusts, local authorities and third sector partners to better understand the increasing demand for rehabilitation, reablement and recovery throughout health and social care services. The Framework presents a stepped care model that ensures the right level of care in the right place by the right professional. It identifies five principles to develop person-centred rehabilitation services that respond to people's needs, including those living with multiple long-term conditions.

Good rehabilitation is based on a though professional assessment of the persons abilities and needs to form a personnel goal-oriented plan. Rehabilitation should be accessible both as a preventative and recovery focussed intervention. This means people can access it early in their care pathway to prevent deterioration and avoid the need to increase care including admissions. It should be available to everybody to ensure their maximum recovery and return to independence after medical intervention. Rehabilitation is an intervention ideally suited for people with multiple and long-term conditions.

The All-Wales Community Rehabilitation Best Practice Standards were published in September 2023 and should be used by all services across Wales.

There are many examples of innovative AHP services providing direct, early access to intervention, community rehabilitation and reablement and other treatments in the community. Rehabilitation, reablement, intermediate care and recovery (mental health) services should be fundamental elements of every care pathway, but particularly for those with long term health conditions.

Allied Health Professionals (AHPs) are experts in delivering treatments and rehabilitation that is particularly important in supporting the complex needs of people who are frail or living with long-term health conditions. The £5m investment to expand AHPs and support worker posts in Primary and Community Care has already resulted in over 88 new (FTE) posts being made available. Increasing community rehabilitation and community-based therapy ensures people recover their ability and confidence to do the things that matter to them in their daily life, enabling more people to live independently without having to rely on unnecessary long-term social care.

Medicines review

People living with chronic conditions are more likely to be prescribed multiple medications and more likely to experience adverse effects as a result of multiple medications. In Wales, we encourage the prescribing of medicines that offer the best health outcomes improving the quality of life for patients living in Wales. The overall aim of value-based prescribing is to optimise the usage of medicines to deliver increased value. Often this requires input from the multi-disciplinary team, with pharmacists and pharmacy technicians supporting GPs and nurses in their prescribing decisions.

Medicines reviews are an opportunity to provide a person-centred approach and involve people with multiple conditions in shared decision making about their care. Reviews can be undertaken by the healthcare team within the GP surgery or via the Discharge Medicines Review scheme, where a person is referred to their community pharmacy team for a review of their medication following a transfer of care between different settings i.e. hospital to home.

Support required to enable effective self-management of chronic conditions where appropriate, including mental health support

New General Medical Services (GMS) Regulations came into effect on 1 October 2023, underpinning the new Unified Contract and representing the most significant reform of GMS contract since 2004. The Unified Contract simplifies and streamlines what services all GP practices in Wales must provide and how they evidence assurance of delivery.

The 2023 Regulations specify that in managing the care of people with chronic conditions, GPs must take into consideration relevant nationally agreed clinical guidance or pathways, in discussion with the individual. This will help to support a consistent and person-centred approach to care.

A new Assurance Framework has been developed alongside the new contract. To ensure a focus on quality of care and improving patient outcomes, the Assurance Framework indicators have been mapped to the Health and Care Quality Standards (2023). Our expectation is that Health Boards will be able to use this Framework to manage their GMS contracts and to monitor local improvement across a range of chronic conditions.

While general practice has a key role to play, people at risk of or living with several long-term health conditions have very individual needs. For effective support, people require access to a range of health and social care professionals working together in a coordinated way through the clusters to help identify these needs and agree with the individual how best to meet those needs, making use of all sources of help. Health boards and local authorities are expected to enable these professionals and services to be organised to work together as a team with the person receiving that care right at the heart of that team and all it plans and delivers.

Through these integrated multi professional teams of GPs, nurses, pharmacists, allied health professionals, social care workers and the third sector, individuals who need support are systematically identified and a care plan is agreed with them with goals and actions to stay well and seek help at the right time in the right way to avoid exacerbations or be responded to at or close to home where urgent care needs do arise.

Mental health

The draft Mental Health and Wellbeing Strategy is currently out to consultation, closing 11 June. Within the strategy we recognise that there is a need to focus on promoting equity when it comes to people's experiences and outcomes (and not just focus on reducing inequity in terms of access to services and support). We know that people with a long-term physical health condition as are more likely to experience mental health conditions than the general population. We are proposing actions that focus on the physical health needs of people with a severe and enduring mental health condition and increasing access to psychological therapies to those with a long-term physical health condition.

The draft strategy also reflects on the need to embed a trauma informed approach. It recognises that trauma-informed organisations understand that adversity, trauma and distress can occur to anyone and at any point across the life course. They aim to create psychosocially healthy conditions for both the workforce and people they support to minimise exposure to adversity, trauma and distress. They will also be confident in understanding what interventions and supportive factors someone may need in place to prevent and mitigate the long-term impact on physical and mental health and wellbeing.

Within the strategy we also recognise specific needs of supporting those with eating disorders. With funding provided by the Welsh Government, health boards have adapted and expanded services and recruited additional staff. This has enabled easier access for people with eating disorders to specialist services in the community. We have also provided dedicated resources in the new NHS Executive to further support improvements to mental health services, which includes the appointment of a National Clinical Lead for Eating Disorders. Early intervention is vitally important, and the clinical lead is working with Health Boards to implement a new service model of care designed for young people to receive the help they need and to prevent the need for in-hospital care. All health boards continue to make progress to achieving the NICE standards for eating disorders services, earlier intervention and to ensure no one is waiting longer than 4 weeks for an assessment.

The focus on specialist services is only one element of our broader approach. We have continued to dedicate investment in a range of easy to access support including the BEAT Wales helpline and services. This not only helps provide early access and advice but supports many people waiting to be seen by clinicians.
We also need to continue our focus on prevention. This includes work in schools about promoting positive body image. We will be looking for further opportunities to strengthen this through our new Mental Health and Wellbeing Strategy.

Allied health professionals

Allied health professionals (AHPs) are essential members of multiprofessional teams, supporting individuals with a range of long-term conditions. Their skills are critical at all points of every pathway and prevent the development and deterioration from the impact of long-term conditions, and their expertise in rehabilitation and recovery enable people to manage their symptoms, maintain their independence and improve their quality of life. For example, the All-Wales Diabetes Prevention Programme uses the expertise of dietitians to help people make significant life changes with the potential to reverse the development of type 2 diabetes.

The Allied Health Professions Framework: Looking Forward Together sets the vision for the transformation of AHPs services to meet the challenges of including increased access, a greater proportion of the workforce in primary and community services, and the increase of community rehabilitation. This will provide the whole pathway access required to maximise health outcomes.

Priority actions required to improve prevention and early intervention

First 1000 days

Welsh Government remains committed to the first 1000 days centres around providing children with the best possible start in life. During this time, the foundations for future health, mental well-being and social developments are laid. Evidence highlights the significance of this early phase, shaping not only individual lives throughout the life course but also impacting on generations to come.

Making Every Contact Count (MECC)

Through our MECC approach we are aiming to empower staff working particularly in health services, but also partner organisations, to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of chronic disease.

This extends not only to their interaction with clients/patients, but also to their own health and wellbeing and that of their friends, families and colleagues. To be successful MECC must not be seen as a separate public health initiative, but a part of what we all do. Adopting this approach will allow us to move to a position where discussion of lifestyle and wellbeing is routine, non-judgemental and integral to everyone's professional and social responsibility.

Primary prevention

Primary prevention remains a key focus of Welsh Government's approach to chronic conditions and the Tobacco Control Strategy and Delivery Plan is a key example. Tobacco remains a leading cause of chronic conditions such as cardiovascular disease, COPD and coronary heart disease. Preventing people from smoking in the first place is a priority for the Welsh Government, as is helping people to stop smoking for good, which is one of the best things that can be done to improve health

and prevent, or reduce the harm from, long term chronic conditions.

In July 2022, we published *A Smoke-free Wales: Our long term Tobacco Control Strategy for Wales*, which sets out our ambition for Wales to be smoke-free by 2030. It establishes how we will tackle all aspects of smoking. To support the delivery of the strategy, we have put in place a series of two-year delivery plans, the first of which was published in July 2022. Significant progress has been made since the Strategy and Delivery Plan was launched, as outlined in the first annual report.

Other work in this area includes Welsh Government's involvement the Tobacco and Vapes Bill, working jointly with all four UK nations to develop legislation on smoking and to tackle youth vaping.

Tackling obesity is another of Welsh Government's top priorities in the prevention of chronic conditions in Wales. Obesity is one of the leading causes for chronic poor health, being associated with serious illnesses like heart disease, type 2 diabetes, and a number of cancer types, especially hormone dependent ones, as well as the need for joint replacement. Preventing or treating obesity effectively would certainly reduce avoidable harm.

The Healthy Weight, Healthy Wales strategy covers a 10-year period (until 2030) in recognition of the long-term systemic changes that need to take place to effectively address the causes of obesity in Wales. Supporting the strategy are five two-yearly delivery plans which provide detail on the actions needed for a whole systems approach to make positive change.

Evidence shows that the best chances of success come from policies which are aimed at the whole population, improving quality of life and environments. Strategies that focus on prevention are more effective because weight maintenance is much easier than weight loss.

Tackling substance misuse (drugs and alcohol) is another method for preventing chronic conditions that is rooted in a harm reduction approach that recognises addiction as a health and care issue as opposed to one that is solely related to criminal justice. We want to ensure that people in Wales are aware of the dangers and the impact of substance misuse, including their contribution to chronic health conditions.

Preventing future substance misuse is as important as treating the established problem and we aspire to a position where no-one in Wales is ignorant to the consequences of misusing drugs or alcohol, or about where they can seek help and support.

We have protected and increased funding for our frontline substance misuse services, which has risen this year to over £67m, with a further £2m allocated directly to our substance misuse Area Planning Boards who commission services in their areas. Current areas of focus are: the distribution of Naloxone; the national implementation of injectable buprenorphine (Buvidal); continued work with our Area Planning Boards to ensure a range of services and support is in place to support people who are experiencing alcohol problems; the introduction of a minimum unit price (MUP) for alcohol which will help reduce alcohol related harm and support

people to drink responsibly.

Another means of prevention of chronic conditions that Welsh Government employs are the national population screening programmes recommended by the National Screening Committee. These cover all ages, from pregnancy, maternity and newborn, through school age vision and hearing, and adult cancer screening programmes. Population screening programmes in place for breast, bowel and cervix contribute to improving cancer outcomes through early diagnosis and treatment, reflecting one of the Welsh Government's top priorities. Public Health Wales is scoping how a targeted lung cancer screening programme could be delivered, in line with the recent NSC recommendation for a targeted programme.

Cardiovascular screening is also offered through the National Screening Committee recommended Wales Abdominal Aortic Aneurysm Screening Programme (WAAASP). Men aged 65 are invited for a one-off screen to look for swelling in the aorta. The aim of the programme is to identify and treat AAAs early, reducing the number of ruptured AAA and deaths in Wales.

The Diabetic Eye Screening Wales programme looks for diabetic eye disease in people aged 12 and over who have been diagnosed with diabetes. Diabetic eye screening can find changes in the eyes before it affects eyesight. Finding changes early and having treatment can prevent sight loss.

The HIV Action Plan for Wales 2023-26 contains 30 actions aimed at achieving the World Health Organization's goal of zero new HIV infections by 2030. The actions are focussed on five key areas: prevention; testing; clinical care; living well with HIV and tackling HIV-related stigma.

These programmes are a good example of effective equitable preventative health interventions as they are offered to all the eligible population across Wales.

Welsh Government is working to expand primary and community multiprofessional teams, e.g. community resource teams, mental health teams and dementia services, and make them more equitably available across Wales as part of the community infrastructure programme.

Secondary prevention

The Welsh Government secondary prevention approach to chronic conditions includes focusing on the avoidance of complications of chronic disease through patient empowerment and good chronic condition management.

In August last year, the Welsh Government announced the '3Ps' Policy, Promote, prevent and prepare for planned care, in line with the commitments made in the Planned Care Recovery and Transformation Plan to better support and inform people with long-term conditions and those waiting for planned care in Wales.

We have invested just under £6million this year to support health boards to deliver on this commitment by establishing a single point of contact within each health board where people, based on their individual care needs, can access advice, support and be connected to their local community assets.

This model, combined with supported self-management, enables and empowers individuals to become more confident partners in their care and to better self-manage their condition through specialist information, advice and education programmes.

Social prescribing is another area which Welsh Government is focusing on, as it can help manage a person's chronic condition to avoid complications. Social prescribing is an umbrella term that describes a person-centred approach to connecting people to local community assets. Community assets include community groups, interventions and services which could be delivered online or in person, as well as buildings, land or even a person within a community.

It recognises that the health of people is determined by a range of social, economic and environmental factors; supporting people to take greater control of their own health and supporting the broader preventative agenda. It is also seen by many as a mechanism to help address issues in relation to loneliness and isolation, promote well-being and to prevent the development of non-communicable diseases.

As outlined within our Programme for Government, we are committed to developing a National Framework for Social Prescribing which delivers a vision of social prescribing in Wales that is of a consistent high-quality standard across the country.